

Health Systems in Transition

Vol. 12 No. 6 2010



France

Health system review

Karine Chevreul
Isabelle Durand-Zaleski
Stéphane Bahrami
Cristina Hernández-Quevedo
Philipa Mladovsky

Cristina Hernández-Quevedo and Philipa Mladovsky (Editors) and Elias Mossialos (Editor in chief) were responsible for this HiT profile

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Health Systems in Transition

Karine Chevreul, *URC Eco (Paris Health Services and Health Economics Research Unit, AP-HP)*

Isabelle Durand-Zaleski, *URC Eco (Paris Health Services and Health Economics Research Unit, AP-HP)*

Stéphane Bahrami, *URC Eco (Paris Health Services and Health Economics Research Unit, AP-HP)*

Cristina Hernández-Quevedo, *European Observatory on Health Systems and Policies, LSE Health*

Philipa Mladovsky, *European Observatory on Health Systems and Policies and LSE Health*

France:

Health System Review 2010



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Keywords:

DELIVERY OF HEALTH CARE

EVALUATION STUDIES

FINANCING, HEALTH

HEALTH CARE REFORM

HEALTH SYSTEM PLANS – organization and administration

FRANCE

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Printed and bound in the United Kingdom.

Suggested citation:

Chevreur K, Durand-Zaleski I, Bahrami S, Hernández-Quevedo C and Mladovsky P. France: Health system review. *Health Systems in Transition*, 2010; 12(6): 1–291.

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Preface

The Health Systems in Transition (HiT) profiles are country-based reports that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each profile is produced by country experts in collaboration with the Observatory's staff. In order to facilitate comparisons between countries, the profiles are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a profile.

HiT profiles seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe. They are building blocks that can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems;
- to describe the institutional framework, the process, content and implementation of health care reform programmes;
- to highlight challenges and areas that require more in-depth analysis;
- to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries;
- to assist other researchers in more in-depth comparative health policy analysis.

Compiling the profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including the

World Health Organization (WHO) Regional Office for Europe Health for All database, national statistical offices, Eurostat, the Organisation for Economic Co-operation and Development (OECD) Health Data, the International Monetary Fund (IMF), the World Bank and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate series.

A standardized profile has certain disadvantages because the financing and delivery of health care differs across countries. However, it also offers advantages, because it raises similar issues and questions. The HiT profiles can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative and material is updated at regular intervals.

Comments and suggestions for the further development and improvement of the HiT series are most welcome and can be sent to info@obs.euro.who.int.

HiT profiles and HiT summaries are available on the Observatory's web site at www.euro.who.int/observatory.

Acknowledgements

The Health Systems in Transition (HiT) profile on France was co-produced by the European Observatory on Health Systems and Policies and URC Eco, the health economics and health policy research unit (*Unité de recherche en économie de la santé d'Ile-de-France*) at the Assistance Publique-Hôpitaux de Paris (AP-HP).

URC Eco is the National Lead Institution (NLI) for France. The Observatory runs an NLI network and works with each NLI to co-produce jointly-owned HiT profiles for their country. The HiT is published using the standard methodology of the Observatory series. It benefits from the national knowledge and expertise, research inputs and networks of the NLI. The NLIs are selected on the strength of their health services and public health background.

URC Eco is a publicly-funded research and knowledge unit that is part of the AP-HP consortium, the largest teaching hospital system in Europe. URC Eco's primary mission is to inform the decision-making process of stakeholders in the health care system, including policy makers, institutions and professionals in the areas of health economics, health services research and health policy analysis. To that end, URC Eco carries out research at the local, national and international levels with a focus on the assessment of diagnostic, therapeutic and organizational innovation, the supply of health care (costs, pricing, organization, quality, efficiency and resource allocation methods), the health care process (doctor-patient interaction, determinants of health services utilization) and health care policy (legislation, regulation, financing and insurance).

Located in Paris, URC Eco is a group of about 20 researchers from a variety of backgrounds and experiences (mainly researchers in social policy, public health specialists, economists and statisticians).

This edition of the Health Systems in Transition (HiT) profile on France was written by Karine Chevreul, Isabelle Durand-Zaleski and Stéphane Bahrami (URC Eco). It was edited by Cristina Hernández-Quevedo and Philipa Mladovsky (European Observatory on Health Systems and Policies). The Research Director for the French Health System Review was Elias Mossialos. The European Observatory on Health Systems and Policies is especially grateful to Laure Com-Ruelle, Research Director in IRDES (Institute for Research and Information in Health Economics) and Yves Charpak, public health expert, Director of Research and Prospect in the French Blood Agency (*Établissement français du sang*), who formerly worked in WHO Regional Office for Europe, for reviewing the report and for their important contributions.

This edition draws upon sections of the first HiT on France, which was published in 2004 and written by Simone Sandier, Valerie Paris and Dominique Polton.

The authors greatly benefited from the help of members of URC Eco, with a special mention for Karen Berg Brigham, Nathalie Bongoua and Marie Gunullu. They would like to thank Marc Perronin from IRDES particularly for his contributions to the text on voluntary health insurance.

The HiT reflects data available as of late 2009, unless otherwise indicated, and the organization of the health system as it was in mid 2010. This HiT uses EU15 to refer to the 15 countries that joined the EU before May 2004; and EU27 when referring to all 27 Member States of the EU as of 2009.

The European Observatory on Health Systems and Policies is a partnership between the WHO Regional Office for Europe, the Governments of Belgium, Ireland, Finland, the Netherlands, Norway, Slovenia, Spain and Sweden, the Veneto Region of Italy, the European Commission, the European Investment Bank, the World Bank, UNCAM (French National Union of Health Insurance Funds), the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. The Observatory team working on the HiT profiles is led by Josep Figueras (Director), Elias Mossialos (Co-director), and Martin McKee, Reinhard Busse and Richard Saltman (heads of the research hubs).

The production and copy-editing process was coordinated by Jonathan North with the support of Steve Still (design and layout), Jane Ward (copy-editing) and Elizabeth Hoile (proofreading). Administrative and production support for preparing the HiT was provided by Caroline White.

List of abbreviations

Abbreviations	French name	English name
AAH	allocation aux adultes handicapés	Allowance for disabled adults
ACAM	Autorité de contrôle des assurances et des mutuelles	Mutual Insurance Funds Control Authority
AcBUS	accords de bon usage des soins	Targeted agreements on good practices
ACOSS	Agence centrale des organismes de sécurité sociale	Central Social Security Agency
ACS	aide pour une complémentaire santé	Health insurance voucher plan
AEEH	allocation d'éducation de l'enfant handicapé	Special education allowance for children
AFSSA	Agence française de sécurité sanitaire des aliments	French Food Safety Agency
AFSSAPS	Agence française de sécurité sanitaire des produits de santé	French Health Products Safety Agency
AFSSET	Agence française de sécurité sanitaire de l'environnement et du travail	French Agency for Environmental and Occupational Health Safety
AIDS	–	Acquired immunodeficiency syndrome
ALD	affection de longue durée	Chronic illness
AME	aide médicale de l'état	State medical help
AMM	autorisation de mise sur le marché	Market authorization
ANAES	Agence nationale d'accréditation et d'évaluation en santé	Agency for Accreditation and Evaluation of Health Care
ANAP	Agence nationale d'appui à la performance des établissements de santé et médico-sociaux	National Agency to Support the Performance of Health and Social Care Organization
ANESM	Agence nationale de l'évaluation de la qualité des établissements et services sociaux et médico-sociaux	National Agency for the Quality Assessment of Health and Social Care Organizations and Services
ANR	Agence nationale de la recherche	National Research Agency
ANRS	Agence nationale de recherche sur le sida et les hépatites	National AIDS and Hepatitis Research Agency
APA	allocation personnalisée d'autonomie	Personal autonomy allowance
ARH	agence régionale de l'hospitalisation	Regional Hospital Agency
ARS	agence régionale de santé	Regional Health Agency
ASA	amélioration du service attendu	Improvement in the relative expected benefit

Abbreviations	French name	English name
ASIP Santé	Agence des systèmes d'information partagés de santé	Agency for Health Information Systems
ASMR	amélioration du service médical rendu	Improvement in the relative medical benefit
ATIH	Agence technique de l'information hospitalière	Agency for Information on Hospital Care
BEH	bail emphytéotique hospitalier	Long-term leases
CADES	Caisse d'amortissement de la dette sociale	Agency for Funding Social Security Debt
CAF	Caisse d'allocations familiales	Family Allowance Fund
CAP1	contrat d'amélioration des pratiques individuelles	Individual contract for professional practice quality improvement
CBP	contrat de bonne pratique	Good practice contract
CCAM	classification commune des actes médicaux	Common classification of medical procedures
CEAP	Commission d'évaluation des actes professionnels	National Commission for Medical Procedure Evaluation
CEESP	Commission d'évaluation économique et de santé publique	Commission for Economic Evaluation and Public Health
CépiDc	Centre d'épidémiologie sur les causes médicales de décès	Epidemiology Centre on Medical Causes of Death
CEPS	Comité économique des produits de santé	Economic Committee for Health Products
CFES	Comité français d'éducation pour la santé	French Committee for Health Education
CHG	Confédération des hôpitaux généraux	Confederation of General Hospitals
CHSCT	comité d'hygiène et de sécurité des conditions de travail	Committee for Hygiene, Safety and Working Conditions
CHS	centre hospitalier spécialisé	Psychiatric hospital
CHU	centre hospitalier universitaire	University hospital
CISS	collectif interassociatif sur la santé	Inter-association Collective of NGOs Acting for Patient Rights
CIRE	cellule interrégionales d'épidémiologie	Regional epidemiology unit
CMH	coordination médicale hospitalière	Coordination of Hospital Medicine
CMP	centre medico-psychologique	Ambulatory care centre
CMU	couverture maladie universelle	Universal Health Coverage
CMU-C	couverture maladie universelle complémentaire	Complementary universal health coverage
CNAMTS	Caisse nationale d'assurance maladie des travailleurs salariés	General scheme
CNEDIMTS	Commission nationale d'évaluation des dispositifs médicaux et des technologies de santé	National Commission for the Evaluation of Medical Devices
CNOM	Conseil national de l'ordre des médecins	National Council of the Physicians Association
CNSA	Caisse nationale de solidarité pour l'autonomie	National Solidarity Fund for Autonomy
CODAMUPS	comité départemental de l'aide médicale urgente, de la permanence des soins et des transports sanitaires	Committee for Emergency Care, Continuity of Care and Transportations
COG	convention d'objectifs et de gestion	-
COMPAQH	coordination pour la mesure de la performance et l'amélioration de la qualité hospitalière	Coordination for hospital performance and quality of care measurement
CPAM	caisse primaire d'assurance maladie	Primary Health Insurance Fund

Abbreviations	French name	English name
CPS	carte de professionnel de santé	Electronic identification card for health care workers
CRAM	caisse régionale d'assurance maladie	Regional health insurance fund
CRDS	contribution pour le remboursement de la dette sociale	Contribution for solving social security debt
CRS	conférence régionale de santé	Regional Health Conference
CRSA	conférence régionale de la santé et de l'autonomie	Regional Conference on Health and Autonomy
CSG	contribution sociale généralisée	General social contribution
CSMF	Confédération des syndicats médicaux français	Confederation of French Medical Unions
CSP	contrat de santé publique	Public health contract
CT	Commission de la transparence	Transparency Commission
CTIP	Centre technique des institutions de prévoyance	Centre for Provident Institutions
DAM	délégué de l'assurance maladie	SHI medical representative
DCIR	données de consommation inter-régime	Interscheme consumption datamart
DDASS	direction départementale des affaires sanitaires et sociales	Departmental Directorate of Health and Social Affairs
DGCS	Direction générale de la cohésion sociale	General Directorate for Social Policy
DGOS	Direction générale de l'offre de soins	General Directorate of Health Care Supply
DGS	Direction générale de la santé	General Directorate of Health
DMFT	dents cariées, absentes ou obturées	Decayed, missing, filled teeth
DMP	dossier médical personnel	Electronic patient record
DNDR	dotation nationale de développement des réseaux	National Network Funding Scheme
DPC	développement professionnel continu	Professional continuous development
DRASS	direction régionale des affaires sanitaires et sociales	Regional Directorate of Health and Social Affairs
DREES	Direction de la recherche, des études, de l'évaluation et des statistiques	Directorate of Research, Studies, Evaluation and Statistics
DRG	groupe homogène de diagnostic	Diagnosis-related group
DSS	Direction de la sécurité sociale	Directorate of Social Security
ECN	épreuves classantes nationales	–
EEA	accord économique européen	European Economic Agreement
EFS	Etablissement français du sang	French Blood Agency
EGB	échantillon généraliste de bénéficiaires	General sample of beneficiaries
EHESP	Ecole des hautes études en santé publique	School of Higher Education in Public Health
EHPA	établissements d'hébergement pour personnes âgées	Retirement homes
EHPAD	établissement d'hébergement pour personnes âgées dépendantes	Residential care homes for disabled frail elderly
EMA	Agence européenne des médicaments	European Medicines Agency
EMA	Agence européenne pour l'évaluation des médicaments	Agency for Evaluation of Medicinal Products

Abbreviations	French name	English name
ENCC-HAD	échelle nationale des coûts communes en hospitalisation à domicile	National cost scale for hospital at home
ENCC-MCO	échelle nationale des coûts communes en médecine, chirurgie, obstétrique	National cost scale for medicine, surgery, obstetrics sector (acute care sector)
ENCC-SSR	échelle nationale des coûts communes en soins de suite et réadaptation	National cost scale for rehabilitation services
ENSP	Ecole nationale de santé publique	National School of Public Health
EPAS	échantillon permanent d'assurés sociaux	Permanent sample of beneficiaries
EPP	évaluation des pratiques professionnelles	Evaluation of professional practice
ERASME	Extraction, recherches et analyses pour un suivi medico-économique	Extraction, research and analysis for health economic monitoring
ESAT	établissement et service d'aide par le travail	Helping through work service
EU	Union européenne	European Union
EU15	–	The 15 countries that joined the EU before May 2004
EU27	–	All 27 Member States of the EU as of 2009
EUNetPAS	Réseau de l'Union Européenne pour la sécurité des patients	European Union Network for Patient Safety
FAM	foyer d'accueil médicalisé	Medicalized reception centre
FAQSV	fonds d'aide à la qualité des soins de ville	Health Insurance Fund for Improvement of Ambulatory Care
FEHAP	Fédération des établissements hospitaliers et d'aide à la personne	Federation of Personal Assistance Institutions
FFSA	Fédération française des sociétés d'assurance	French Federation of Insurance Companies
FHF	Fédération hospitalière de France	French Hospital Federation
FHP	Fédération hospitalière privée	Federation of private hospitals
FIQCS	fonds d'intervention pour la qualité et la coordination des soins	Quality and coordination of care fund
FIQSV	fonds d'intervention pour la qualité des soins de ville	–
FMC	formation médicale continue	Continuous medical education
FMF	Fédération des médecins de France	Federation of Doctors in France
FNIM	Fédération nationale indépendante des mutuelles	National Federation of Independent Mutual Benefit Societies
FNMF	Fédération nationale de la mutualité française	National Federation of Mutual Benefit Societies
GATT	accord général sur les tarifs douaniers et le commerce	General Agreement on Tariffs and Trade
GDP	produit intérieur brut	Gross domestic product
GEMA	groupement des entreprises mutuelles d'assurance	Grouping of Mutual Benefit Societies (local fund from Alsace-Moselle)
GHM	groupes homogènes de malades	Homogeneous patient groups
GHS	groupes homogènes de séjours	Homogeneous hospital stay groups
GMSIH	groupement pour la modernisation du système d'information hospitalier	Group for the Modernization of Hospital Information Systems
GP	médecins généralistes	General practitioner

Abbreviations	French name	English name
GRSP	groupement régional de santé publique	Regional Public Health Group
HAD	hospitalisation à domicile	Hospitalization at home
HAS	Haute Autorité de santé	National Health Authority
HCAAM	Haut conseil pour l'avenir de l'assurance maladie	High Council for the Future of Health Insurance
HCSP	Haut conseil de la santé publique	High Council of Public Health
HIV	–	Human immunodeficiency virus
HPST Act	loi hôpital, patients, santé et territoires	Hospital, Patients, Health and Territories Act
HTA	évaluation des technologies de la santé	Health technology assessment
IGAS	Inspection générale des affaires sociales	Inspector of Health and Social Affairs
INCa	Institut national du cancer	National Institute for Cancer
INPES	Institut national de prévention et d'éducation pour la santé	National Institute for Prevention and Health Education
INPH	Intersyndicat national des praticiens hospitaliers	National Inter-Union of Hospital Physicians
INSEE	Institut national de la statistique et des études économiques	National Institute for Statistics
INSERM	Institut national de la santé et de la recherche médicale	French National Institute of Medical Research
InVS	Institut national de veille sanitaire	National Institute for Public Health Surveillance
IRDES	Institut de recherche et documentation en économie de la santé	Institute for Research and Information in Health Economics
IRSN	Institut de radioprotection et de sécurité nucléaire	Radioprotection and Nuclear Safety Institute
LPP	liste de produits et prestations remboursables	List of reimbursable medical devices and health materials
LSAC	liste des spécialités agréées aux collectivités	Specific list of drugs
LSPR	liste des spécialités pharmaceutiques remboursables	List of reimbursable drugs
MAINH	Mission nationale d'appui à l'investissement hospitalier	National Mission for Hospital Investment
MDPH	maison départementale pour les personnes handicapées	Departmental Information Service on Services for the Disabled
MEAH	Mission nationale d'expertise et d'audit hospitalier	National Mission in Charge of Hospital Expertise and Audit
MG France	Syndicat des médecins généralistes	French Federation of General Practitioners
MHC	soins de santé mentale	Mental health care
MIGAC	mission d'intérêt général et d'aide à la contractualisation	Mission for General Interest and Assistance for Contracting
MISP	médecin inspecteur de santé publique	Medical inspectors in public health (civil servants)
MMG	maison médicale de garde	Ambulatory care centre
MPH	master de santé publique	Master of Public Health
MRS	mission régionale de santé	Regional Health Mission
MSA	Mutualité sociale agricole	Agricultural scheme
MT	médecin traitant	Preferred doctor

Abbreviations	French name	English name
NABM	nomenclature des actes de biologie médicale	Biological laboratory tests and procedures
NATO	Organisation du traité de l'Atlantique Nord	North Atlantic Treaty Organization
NGAP	nomenclature générale des actes professionnels	General nomenclature of medical procedures
OECD	Organisation de coopération et de développement économique	Organisation for Economic Co-operation and Development
ONDAM	objectif national des dépenses assurance maladie	National ceiling for health insurance expenditures
ONDPS	Observatoire national de la démographie des professions de santé	National Observatory of Health Professionals
ONIAM	Office national d'indemnisation des accidents médicaux	National Office for the Compensation of Medical Accidents
OQN	objectif quantifié national	National Quantified Target
PCEM	premier cycle des études médicales	First phase of medical studies
PCH	prestation de compensation du handicap	Disability compensation allowance
PDS	permanence des soins	Continuity of care system
PHRC	programme hospitalier de recherche clinique	Hospital clinical research programme
PLATINES	plateforme d'informations sur les établissements de santé	Information Platform on Health Care Organizations
PMI	protection maternelle et infantile	Mother and child health service
PMSI	programme de médicalisation des systèmes d'information	Programme of Medicalization of Information Systems
PMSI-HAD	programme de médicalisation des systèmes d'information : l'hospitalisation à domicile	Programme of Medicalization of Information Systems: hospital at home
PMSI-MCO	programme de médicalisation des systèmes d'information: médecine, chirurgie, obstétrique	Programme of Medicalization of Information Systems: medicine, surgery and obstetrics (acute care)
PMSI-SSR	programme de médicalisation des systèmes d'information: soins de suite et réadaptation	Programme of Medicalization of Information Systems: rehabilitation sector
PNIR	programme national inter-régimes	Risk policy management programme
PNNS	programme national nutrition santé	National Health Nutrition Programme
POSU	pôle spécialisé d'accueil et de traitement des urgences	Specialized emergency units
PQE	programme de qualité et d'efficacité	Programme for quality and efficiency
PRES	pôle de recherche et d'enseignement supérieur	Research and higher training networks
PRIAC	programme interdépartemental d'accompagnement des handicaps et de la perte d'autonomie	Interdepartmental programme for the disabled and for the loss of functional autonomy
PRS	plan stratégique régional de santé	Regional Strategic Health Plan
PSD	prestation spécifique dépendance	Individual dependency allowance
PSPH	participant au service public hospitalier	Participants in public hospital service
RIM-Psy	recueil d'informations médicalisées en psychiatrie	Summary of medical information for psychiatry
RMO	référence médicale opposable	Mandatory clinical guidelines
RSI	régime social des indépendants	Scheme for self-employed people
RSS	résumé standardisé de sortie	Standard discharge summary

Abbreviations	French name	English name
SA	service attendu	Expected benefit
SAE	statistique annuelle des établissements de santé	Annual Statistical Survey of Health Establishments
SAMU	service d'aide médicale urgente	Medical emergency call centre
SAU	service d'accueil des urgences	General emergency care unit
SERC	service rendu à la collectivité	Social benefit measure
SHI	–	Statutory health insurance
SIMPATIE	Amélioration pour la sécurité des patients en Europe	Safety Improvement for Patients in Europe
SML	Syndicat des médecins libéraux	Union of Self-employed Doctors
SMR	service médical rendu	Medical benefit
SMUR	service mobile d'urgence et de réanimation	Mobile intensive care unit
SNAM-HP	Syndicat national des agents médicaux des hôpitaux publics	National Union of Hospital Medical Personnel
SNIIR-AM	Système national d'information inter-régimes de l'assurance maladie	The SHI inter-scheme system
SNPH	Syndicat national des praticiens hospitaliers	National Union of Hospital Physicians
SREPS	schéma régional d'éducation pour la santé	Regional Health Education Plan
SROS	schéma régional d'organisation sanitaire	Regional Health Organization Plan
SROSMS	schéma régional de l'organisation sociale et médico-sociale	Regional scheme of health and social care sector organization
SSIAD	service de soins infirmiers à domicile	Community nursing service
SSR	soins de suite et de réadaptation	Follow-up and rehabilitation unit
STIC	soutien aux technologies innovantes et coûteuses	Supporting funds for expensive innovative technology
T2A	tarification à l'activité	Case payment system
UCCSF	Union collégiale des chirurgiens et spécialistes français	Union of French Surgeons and Specialists
UMP	Union pour un mouvement populaire	Union for a Popular Movement
UNCAM	Union nationale des caisses d'assurance maladie	National Union of Health Insurance Funds
UNOCAM	Union nationale des organismes d'assurance maladie complémentaire	National Union of Complementary Health Insurance Organizations
UNPS	Union nationale des professions de santé	National Union of Health Professions
UPATOU	unité de proximité, d'accueil, de traitement et d'orientation des urgences	Local emergency care unit
URCAM	union régionale des caisses d'assurance maladie	Regional Union of Health Insurance Funds
URC Eco	Unité de recherche en économie de la santé d'Ile-de-France	Paris Health Services and Health Economics Research Unit
URML	union régionale des médecins libéraux	Regional Union of Self-employed Doctors
URPS	union régionale des professionnels de santé	Regional Union of Health Professionals
URSSAF	union pour le recouvrement des cotisations de sécurité sociale et d'allocations familiales	Union for the Recovery of Social Security Contributions and Family Allowances
USLD	unités de soins de longue durée	Long-term care units
VHI	–	Voluntary health insurance

Abbreviations	French name	English name
WHO	-	World Health Organization
WTO	-	World Trade Organization

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Abstract

The Health Systems in Transition (HiT) profiles are country-based reports that provide a detailed description of a health system and of policy initiatives in progress or under development. HiTs examine different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems; describe the institutional framework, process, content and implementation of health and health care policies; and highlight challenges and areas that require more in-depth analysis.

The French health care system is a mix of public and private providers and insurers. Public insurance, financed by both employees and employer contributions and earmarked taxes, is compulsory and covers almost the whole population, while private insurance is of a complementary type and voluntary. Providers of outpatient care are largely private. Hospital beds are predominantly public or private non-profit-making.

The French population enjoys good health and a high level of choice of providers. It is relatively satisfied with the health care system. However, as in many other countries, the rising cost of health care is of concern with regards to the objectives of the health care system. Many measures were or are being implemented in order to contain costs and increase efficiency. These include, for example, developing pay-for-performance for both hospitals and self-employed providers and increasing quality of professional practice; refining patient pathways; raising additional revenue for statutory health insurance (SHI); and increasing the role of voluntary health insurance (VHI).

Meanwhile, socioeconomic disparities and geographic inequality in the density of health care professionals remain considerable challenges to providing a good level of equity in access to health care.

Organizational changes at the regional level are important in attempting to tackle both equity and efficiency-related challenges. While the organizational structure of the system remained very stable until the mid 1990s, in the following decade many changes occurred and several new institutions were created. Concurrently, the respective power and involvement of the parliament, government, local authorities and SHI in the policy-making process have evolved. However, the Ministry of Health has retained substantial control over the health system, although ongoing reforms at both the regional and the national levels may challenge its traditional role.

This edition of the French HiT was written concurrently with the vote and implementation of the 2009 Hospital, Patients, Health and Territories Act, which dramatically changed again the organizational structure and management of the health care system at the regional and local level. In order to ensure a comprehensive description and understanding of the system, the HiT, therefore, describes both the previous organization and the reorganization following the Act. However, the implementation process of the Act and its formal application was still a work in progress at the time of completing the French HiT.

Executive summary

Introduction

France is situated in western Europe. It is composed of 26 regions that cover 100 *départements*, which include 36 679 municipalities. In 2008, France had a population of 65.5 million inhabitants. Approximately 15% of the population has an ethnic origin other than metropolitan French (this includes the population of its overseas departments and territories). The French political system is a parliamentary democracy with a president and with a bicameral parliament consisting of a National Assembly and a Senate.

The overall picture of the state of health in France contains apparent contradictions. On the one hand, indicators such as life expectancy, life expectancy without disability, and healthy life expectancy show that the health of the population is good. In terms of international comparisons, women live longer and old people remain in better health than in many European countries. France also compares well with regard to cardiovascular diseases, while its relative position with respect to mortality caused by alcoholism, cirrhosis and cancer of the cervix is improving. On the other hand, France suffers from a high rate of premature male deaths from accidents and unhealthy habits (smoking and alcoholism), and social and geographic inequalities in health remain substantial. Finally, reproductive health shows relatively good indicators, and among the EU27 countries, France has the highest birth rate and fecundity indicator (total period fertility = 2 in 2007).

Organization and governance

The French health care system is of a mixed type, structurally based on a Bismarckian approach with Beveridge goals reflected in the single public payer model, the current increasing importance of tax-based revenue for financing health care and strong state intervention.

There is SHI, which, under various schemes, currently covers almost 100% of the resident population. The delivery of care is shared among private, fee-for-service physicians, private profit-making hospitals, private non-profit-making hospitals and public hospitals. In addition to the health care sector and the social sector, there is a health and social care sector, known as the third sector, which provides care and services to elderly and disabled people.

Jurisdiction in terms of health policy and regulation of the health care system is divided among the state (parliament, government and the Administration of Health and Social Affairs), SHI and, to a lesser extent, local communities, particularly at the regional level. However, trends in the last two decades of reforms have attempted to devolve a greater remit in governance and health policy decision-making, in particular in the area of planning, to the regional level. Several regional institutions were created to represent the main stakeholders, such as SHI schemes, the state, health professionals and public health actors at the regional level. However, with the aim of achieving better governance of the system at the regional level, better responsiveness to needs and higher efficiency, the 2009 Hospital, Patients, Health and Territories Act (*loi hôpital patients, santé et territoires*; HPST) merged most of these institutions into a single “one-stop shop”, the regional health agency (*agence régionale de santé*; ARS). Cutting across the traditional boundaries of health care, public health and health and social care sectors, the ARS has responsibility for ensuring that health care provision meets the needs of the population by improving articulation between ambulatory and hospital sectors, and health and social care sector services, while respecting national health expenditure objectives.

Financing

Financial responsibility for health care in France is mainly borne by SHI. However, SHI only funds around three quarters of health spending, leaving considerable scope for complementary sources of funding such as private VHI.

In 2007, total expenditure on health in France was estimated at €208 billion or 11% of gross domestic product (GDP), of which 79% is publicly funded. Expenditure on personal health care accounted for 88% of total expenditure on health and represents an average of €2895 per person. As in many other countries, health care expenditure in France grew more rapidly than national wealth for many years, with the exception of the 1997–2000 period. This growth mainly reflected an increase in the volume of care consumed. Since 1996, SHI annual expenditure has been capped by a national ceiling for SHI expenditure

(*objectif national des dépenses assurance maladie*; ONDAM) approved by the parliament. However, with few exceptions, this soft prospective budget has been exceeded every year.

SHI coverage is established according to resident status. SHI covers a broad range of services and goods that are provided in hospital or defined in positive lists for outpatient care. The rate of coverage varies across goods and services (from 15% for drugs with the lowest improvement in medical benefit to 80% for inpatient care). However, there are several conditions for which patients are exempted from co-insurance, such as chronic conditions or pregnancy after the fifth month. Since 2004, additional co-payments have been introduced with the aim of controlling demand and SHI expenditure. These cannot be covered by VHI.

SHI resources mainly come from income-based contributions from employers and employees. Since 1998, as a result of attempts to widen the social security system's financial base, employees' payroll contributions have been almost fully substituted by an earmarked tax called the "general social contribution" (*contribution sociale généralisée*) based on total income and not only on earned income as it previously was. Additional revenue accounts for around 13%. It comes from specific taxes such as "sin" taxes or taxes on the pharmaceutical companies' turnover.

VHI provides reimbursement for co-payments and better coverage for medical goods and services that are poorly covered. Over the last decades, VHI has gained an important role in ensuring equity of access and financing health care. It finances 13.4% of total expenditure on health and covers 88% of the population on a private basis. Since 2000, in order to ensure that measures increasing patients' co-insurance would not increase social inequities in access, public complementary insurance (complementary universal health coverage (*couverture maladie universelle complémentaire*, CMU-C)) is offered on a voluntary basis to lower socioeconomic groups. It covers 7% of the population.

Funding for long-term care for the elderly and disabled is partly ensured by a dedicated fund created in 2004, the National Solidarity Fund for Autonomy (*Caisse nationale de solidarité pour l'autonomie*; CNSA). Its resources come from SHI and the "solidarity and autonomy contribution" that is generated from the revenue of an unpaid working/solidarity day (*journée de solidarité*) called for the French working population. Local authorities, the general councils and households also participate in financing these categories of care.

Since 2004, hospital acute care is paid by using a type of DRG payment method (*tarification à l'activité*; T2A). Self-employed professionals are paid on a fee-for-service basis. Tariffs are negotiated in pluriannual agreements between SHI and representatives of health professionals. Financial incentives to improve quality and efficiency of doctors' practice were recently implemented through individual contracts to general practitioners for practice improvement.

Regulation and planning

Planning and regulation involve negotiations among provider representatives (hospitals and health professionals); the state, represented by both the Ministry of Health and the Ministry of the Budget Public Accounts, the Civil Service and State Reforms; and SHI. The outcome of these negotiations is translated into administrative decrees and laws passed by the parliament. These include public health acts, social security funding acts and reform acts. In the context of increasing health care expenditure and the increasing deficit of SHI, the role of the state in planning and regulation has increased over the past two decades.

Providers are paid by SHI (or directly by patients who are later reimbursed). The statutory tariffs are set through negotiations between providers and SHI and are approved by the Ministry of Health. Quality of care is regulated at the national level. Hospitals must undergo a certification process every four years but there is no formal re-certification or re-licensing process for health professionals. However, doctors, pharmacists, dentists and midwives are required to follow lifelong learning activities through professional continuous development. Responsibility for capacity planning is shared by the central and the regional level. At the regional level, the ARSs were implemented in April 2010 to coordinate ambulatory and hospital care and health and social care for the elderly and disabled through a regional strategic health plan (*plan stratégique régional de santé*; PRS) that is based on population needs. Each sector's planning process will have to comply with the PRS. This is a first attempt at regional planning of the ambulatory care sector.

Physical and human resources

In France, there is a high level of facilities, equipment and other physical resources. However, there are strong disparities in geographic distribution.

Hospitals are in four main categories: regional hospitals, general hospitals, local hospitals and psychiatric hospitals. Capital investment is either covered by reimbursements for services delivery or funded through specific programmes. Two nationwide investment plans were launched in the last decade in order to attain quality and safety standards. The ARSs are responsible for the control of capital investment and purchasing major medical equipment.

Following the general trend in European countries, the number of full time acute beds per 1000 inhabitants has been steadily declining over the last 20 years. In 2008, it was 6.9, which is above the EU15 and EU27 averages. Reduction in acute care capacity was accompanied by the transformation of acute beds into rehabilitation and long-term care units and the development of day surgery and hospitalization at home.

About 7.6% of the French population works in the health care sector. Nurses and nursing aides form the largest group of professionals, accounting for approximately half of the health care workforce. Registered health professionals also include medical professionals (physicians, dentists and midwives), pharmacists, professionals involved in rehabilitation (physiotherapists, speech therapists, vision therapists, psychomotor therapists, occupational therapists and chiroprodists) and technical paramedical professions (hearing aid specialists, opticians and radiographers). The other professions usually identified as contributing to health care include clerical and technical staff working in hospitals, laboratory technicians, paediatric auxiliaries, dieticians, psychologists and ambulance drivers.

Workforce forecasting and careful planning of educational capacity is mostly made at the national level through the use of *numerus clausus* for medical professionals. It seeks to prevent shortages or oversupply of health professionals. However, it does not control for the geographical distribution of medical professionals, as self-employed professionals are free to choose where they practise. In order to solve the resulting great disparities in the distribution of medical professionals, there has been increasing transfer of tasks from medical to other professionals such as nurses and development of incentives for attracting health professionals to under-served areas.

Provision of services

Both public and private providers deliver health care to the French population. Primary care is mostly delivered in the ambulatory care sector by self-employed professionals while secondary care can be delivered both in the ambulatory and the hospital setting. From the late 1990s, GPs have gained a major role in the coordination of care with the implementation of a semi-gatekeeping system that provides incentives to people to visit their GP prior to consulting a specialist. Drugs are dispensed by self-employed pharmacists, while the price of drugs, as in most countries in the Organisation for Co-operation and Development (OECD), is set administratively for all drugs covered by SHI. France is the third largest market for pharmaceutical drugs in the world. Hospital care is delivered by public, private non-profit-making and private profit-making hospitals. Long-term care for elderly and disabled is provided through both residential care and home care. Mental health care is delivered by both the health sector and the social and health care sector. As in many other European countries, mental health care policy in France during the second half of the 20th century was influenced by a general movement towards community-based organization of mental health care services – the so-called “deinstitutionalization” process.

Principal health care reforms

The main objectives of the reforms to the health care system of the last decade were to contain SHI expenditures without damaging equity in financial access, to increase geographic equity in access to care and to meet the increasing demand for long-term care. Decentralization and a change in the balance of power between the state and SHI were the main instruments used to achieve these objectives.

For containing SHI expenditure, two categories of measures were used. The first, called the “strict accounting cost-containment policy”, primarily focused on decreasing the size of the benefit basket and levels of coverage, resulting in a shift towards VHI coverage. After 2004, several new mechanisms were introduced. A coordinated care pathway was implemented with higher co-insurance for patients consuming care out of this pathway, and new categories of co-payment for patients were created with the introduction of deductibles on some categories of care such as drug packages, doctors and nurses consultations or patient transportation. Finally, there was stricter control

of statutory tariffs, and in 2008 economic considerations were introduced in health technology assessment (HTA). However, it is unlikely that in the short run this last measure will directly influence HTA decisions.

The second category of measures was called the “medically based cost-containment policy”; it was developed in the 1990s after a long period of strict accounting policies that led to ongoing conflicts between doctors and SHI. Medically based cost-containment focuses on the reduction of financial and equity loss due to medical practice variations and aims to improve medical practice. The main tools used are the implementation of lifelong learning, the development of practice guidelines by national agencies and the introduction of good practice commitments within professionals’ collective agreements with SHI. At first, coercive measures such as fines for not following continuous education were used to enforce this new policy, but this was slowly abandoned for a move towards the development of incentives, most recently the introduction of payment for performance for individual doctors based on achieving good practice targets. Overall, it appears that the coercive medically based cost-containment policy did not lead to major improvements in collective practice and much is expected from the pay-for-performance approach.

In order to facilitate geographical equity in access to care, the HPST reinforced local planning and simplified regional governance of the health care system by creating the ARSs. In addition to creating the PRS, which should lead to a common approach in planning for the hospital, ambulatory and health and social care sectors, it made formal legal provisions for the transfer of tasks between professionals. It also linked the regional medical *numerus clausus* to needs. In order to optimize the distribution of doctors without impairing freedom of settlement, incentives to increase the attractiveness of underrepresented specialties and medically under-served areas are being developed. For instance, wages for hospital doctors will possibly increase in contexts where there is a high need for their specialties, and contracts with medical students and self-employed health professionals with financial incentives to practise in under-served areas will be implemented on a voluntary basis.

The increasing demand for long-term care has been of major concern in the government’s plan. However, despite strong government support for increasing service delivery, two main challenges remain: making the sector more attractive for workers and offering public coverage of long-term care for the elderly in order to achieve greater equity in access.

Assessment of the health system

The French health care system has long enjoyed the reputation of being one of the best in the world. It has become synonymous with universal health coverage and a generous supply of health services. This reputation comes in large part from success in meeting its goals of full coverage, access without waiting lists, patient choice and satisfaction. The combination of a basic universal public health insurance system and voluntary complementary private insurance, which provides reimbursement for co-payments required by the public system as well as coverage for medical goods and services that are poorly covered by the public system, results in low out-of-pocket costs and high medical care utilization. France's average life expectancy of over 80 years is in part testament to the strong combination of good health care and good public health policies in France. Despite these positives, there also are some shortcomings, especially when considering efficiency and socioeconomic inequality in health. Major problems include lack of coordination between hospital and ambulatory services, between private and public provision of care, and between health care and public health. Health expenditures per capita are higher than the OECD average, ranking usually third or fourth after the United States, Germany and Switzerland, depending on the data used and year. The high level of health expenditure has become increasingly important at a time when the public system is facing chronic deficits, which are likely to increase with the current economic downturn.

1. Introduction

1.1 Geography and sociodemography

The French Republic is a country whose metropolitan territory is located in western Europe. France is further made up of a collection of overseas islands and territories located on other continents. Metropolitan (mainland) France extends from the Rhine river to the Atlantic Ocean and from the Mediterranean Sea to the English Channel and North Sea. Metropolitan France is usually referred to as a “hexagon” because of its geographical form. It is bordered by Germany, Switzerland, Italy, Monaco, Belgium, Luxembourg, Andorra and Spain (Fig. 1.1).¹ France is also made up of a number of territories in North America, South America, the southern Indian Ocean, the Pacific Ocean, the Caribbean and Antarctica (sovereignty claims in Antarctica are governed by the Antarctic Treaty System). These territories have varying forms of government ranging from “overseas department” to “overseas country”.

The geography of metropolitan France is varied, from coastal plains in the north and west to mountain ranges in the south-east (the Alps) and the south-west (the Pyrenees) (Fig. 1.1). The French mountains contain the highest point in western Europe, Mont Blanc, at 4810 m (15 781 ft). There are many other elevated regions such as the Jura, the Vosges, the Massif Central and the Ardennes, which are quite rocky and forested. France also possesses extensive river systems such as the Rhône, the Garonne, the Loire and the Seine.

Because of its overseas departments and territories, France has the second-largest exclusive economic zone in the world, covering 11 035 000 km² (4 260 000 square miles), second only to that of the United States, 11 351 000 km² (4 383 000 square miles).

¹ The maps presented in this document do not imply an expression of any opinion whatsoever on the part of the Secretariat of the European Observatory on Health Systems and Policies or its partners concerning the legal status of any country, territory, city or area or of its authorities or concerning the delimitations of its frontiers or boundaries.

Fig. 1.1

Map of France



Source: CIA 2009.

There are significant variations of climate within France. Northern and north-western France is most affected by the changeable weather brought in by the Atlantic. Southern France has a Mediterranean-type climate and is warmer than the north. In summer, the difference is particularly noticeable. Central and eastern France, roughly east of a line through Dunkirk, Paris, and Lyon, has a more continental climate.

On 1 January 2008, the French population totalled 63.8 million inhabitants in metropolitan France and 1.7 million inhabitants in the French overseas departments of Guadeloupe, French Guyana, Martinique and Réunion.

Metropolitan France covers an area of about 545 000 km², giving an average population density of 98/km², which places it in 17th position in the European Union (EU), far behind the Netherlands, the United Kingdom and Germany. However, average density conceals considerable variations; half of the population live in just over 10% of this territory, while large areas remain sparsely populated.

France became urbanized more slowly than other European countries, but since the 1950s, the rate of urbanization started to increase rapidly. By 2007, 77% of the population was living in urban areas. Since the end of the 1990s, this urban growth has mainly taken place in outer suburbs and rural areas surrounding towns, rather than in the city centres.

As a result of decreasing rates of fertility and increasing life expectancy, the French population is ageing. Today, one in six is over 64 years of age, compared with one in eight 30 years ago. Population ageing is set to continue as the “baby boomers” born after the Second World War reach old age. According to demographic projections, from 2020 onwards, those aged over 60 will outnumber those aged under 20 (accounting for 27% and 23% of the population, respectively). Table 1.1 shows the most recent demographic indicators.

Table 1.1

Population/demographic indicators for metropolitan France, 1970–2008, selected years

	1970	1980	1990	2000	2005	2008
Total population	49 780 543	54 334 871	57 996 000	60 508 000	62 730 000	62 753 140
Female (% of total)	51.2	51.2	51.3	51.4	51.4	51.4
<20 years (% of total)	33.2	30.6	27.8	25.6	24.9	24.6
≥59 years (% of total)	48.8	52.4	53.2	53.8	54.3	53.4
≥75 years (% of total)	18.0	17.0	19.0	20.6	20.8	21.9
Population growth (annual % change in the population)	na	na	0.5	0.4	0.6	0.6
Average population density (people/km ²)	na	na	102.8	106.7	110.1	110.2
Fertility rate, total (births/woman)	2.48	1.95	1.78	1.87	1.92	1.99
Birth rate per 1000 people	16.7	14.8	13.4	13.1	12.7	13.0
Death rate per 1000 people	10.7	10.2	9.3	9.0	8.7	9.0
Age dependency ratio ^a	0.61	0.57	0.52	0.53	0.53	0.53
Percentage urban population	34.8 ^b	39.9 ^c	41.9	44.2 ^d	na	na
Percentage rural population	14.9 ^b	14.5 ^c	14.7	14.3 ^d	na	na
Percentage as single-person households	20.3 ^b	24.6 ^c	27.1	31	32.8	na

Source: INSEE 2008, 2010.

Notes: ^a Age dependency ratio is (population aged 0–14 + population 65+)/ (population 14–64); ^b Data from 1968; ^c Data from 1982;

^d Data from 1999; na: Not available.

Seventy per cent of the French population have undergone upper secondary education. The French religious composition is as follows: Roman Catholic 83–88%, Muslim 5–10%, unaffiliated 4%, Protestant 2%, and Jewish 1%.

France is ethnically heterogeneous, with more than a hundred different ethnic groups in its territory. People of Arab and sub-Saharan origin coming from the former colonies predominate. In 2007, approximately 15% of the French population (10 million) had an ethnic origin other than metropolitan French. This share is particularly important in the population in the overseas departments and territories. In metropolitan France, immigrants are generally concentrated in the suburbs of large cities. Recent immigrants have lower health status than people who are born in France (Dourgnon et al. 2008). This is partly explained by lower socioeconomic status, lower complementary voluntary health insurance (VHI) coverage and by the economic level of the country of origin. Immigrants also have a lower access to health care. These barriers to access health care services are greater for specialists visits than for visits to a general practitioner (*médecins généralistes*; GP) (Dourgnon et al. 2009).

1.2 Economic context

In 2008, the gross domestic product (GDP) of France rose to €1950 billion (Table 1.2), which is an annual increase of 4.7% in relation to 1998. This figure places France slightly below the EU average for per capita GDP. The budget deficit was 2.9% of GDP in 2008 compared with 2.7% in 2007 and 2.4% in 2006.

Table 1.2
Macroeconomic indicators, 2008

Indicators	2008 (or latest year available)
GDP	€1 949 331 million
GDP, PPP	US\$ 2 139 920 million
GDP per capita	€29 763 million
GDP per capita, PPP	US\$ 32 684
GDP average annual growth rate (last 10 years)	2.35%
Value added in industry (% of total value added)	14.1%
Value added in agriculture (% of total value added)	2.2%
Value added in services (% of total value added)	58.6%
Annual budget deficit	€56.3 billion
Overall public debt (% GDP)	€1 314.1 million (67%)
Labour force total	27 697 million
Unemployment total (% of labour force)	8.1%
Official exchange rate (2008 average)	US\$ 1 = €0.7306
Interest rate	4.3% (average in 2007 for a government bond with residual maturity of 10 years)
Poverty rate	13% (income <60% median income 2006)

Sources: OECD 2009a, 2009b.

Notes: PPP, purchasing power parity.

In 2006, 27 607 million people were active in the labour market (that is, 43.3% of the population). Women represented 47% of the country's workforce, and their participation in the labour market has increased dramatically in recent decades. The unemployment rate was 8.3% in May 2008, a decrease in relation to 1998. In the past 25 years, the structure of employment has moved away from agriculture (which today accounts for only 3.7% of the workforce), manufacturing and construction (currently 22.6% of the workforce) and towards commercial activities and the services sector, which now involve 20.3 million people (73.7% of the workforce).

Thirteen per cent of the population is below the poverty rate, defined as 60% of median income. Income differs across the population; the income ratio of the richest 10% and the poorest 10% was 5.6 in 2005 and the Gini index was 0.327. In comparison with other European countries, income is more equally distributed than in Spain, the United Kingdom or Italy, but less than in Sweden and Germany (Table 1.3).

Table 1.3

Income inequality in selected European countries, 2005

Country	Richest 10% to poorest 10%	Richest 20% to poorest 20%	Gini index
Sweden	6.2	4.0	25.0
Germany	6.9	4.3	28.3
France	9.1	5.6	32.7
Spain	10.3	6.0	34.7
Italy	10.6	6.5	36.0
United Kingdom	13.8	7.2	36.0

Source: UNDP 2008.

1.3 Political context

France is a republic with institutions governed by the 1958 constitution, which reinforced the role of the executive authorities (the President of the Republic and the government) in relation to the legislative authorities.

The President of the Republic is elected by direct universal suffrage. The president's term of office until 2000 was seven years, but it was then reduced to five years. The government, led by the prime minister, who is nominated by

the President of the Republic, develops and guides policy implementation. The prime minister is accountable to parliament, which exercises legislative power and is made up of the National Assembly and the Senate.

The National Assembly has 577 deputies who are elected by direct universal suffrage. Voting takes place on the basis of a single majority vote (that is, voting for one deputy only) in two rounds, within the framework of constituencies of variable size (one deputy for approximately 100 000 inhabitants). The National Assembly's session is five years, but it can be shortened if the President of the Republic decides to dissolve the National Assembly, as happened on 21 April 1997 for the fifth time since the inauguration of the Fifth Republic in 1958.

The Senate consists of 331 senators who are elected for nine years by indirect universal suffrage, through an electoral college consisting of elected people in each department. One-third of its membership is renewed every three years. The method of polling, the senators' term of office and the fact that the Senate cannot be dissolved give this assembly a high level of political stability.

In the past 25 years, the civil service, against the background of its long tradition of centralizing policies, has undergone substantial changes and become more decentralized. There are three levels of administration: the municipality, the local authority (department) and the region. These three levels are both administrative constituencies of the state and decentralized local communities run by assemblies elected by the local population. They have their own separate areas of responsibility and are autonomous in these areas. However, the state defines the competencies of each level of administration.

The 36 679 municipalities² form the basic structure of France's administrative organization. They are run by municipal councils elected for six years by direct universal suffrage. The mayor is both the elected authority of the municipality and the representative of the state in the territory of the municipality. The areas of responsibility of the municipalities relate to local activities and are extensive in the economic and social sectors.

Departments, 96 of which are in metropolitan France and four overseas (Martinique, Guadeloupe, Réunion and French Guyana), are territorial communities with an elected local assembly (the General Council; *conseil général*) that has authority in the areas of health and social care and the financing and provision of lower secondary education (*collèges*). The *préfet* represents the state's authority in the department.

² There are fewer than 1000 inhabitants in 80% of municipalities.

The 100 departments are grouped in 26 regions, 22 of which are in metropolitan France and four overseas (coinciding with the four overseas departments). Created in 1955 to provide a structure for regional planning and development, the region became an administrative territorial community in 1982, with an elected assembly (the Regional Council, *conseil régional*). Its specific jurisdiction mainly covers planning, development, economic development, vocational training and upper secondary educational institutions (*lycées*).

Configuration of the current government

The current President of the Republic, Nicolas Sarkozy, was elected in May 2007 for a five-year period. Following this, in June 2007, the election of deputies resulted in a national assembly with a right wing majority: 55.5% (320) of the deputies are affiliated to the president's party (*Union pour un mouvement populaire*, UMP), 35.4% (204) are *socialiste, radical et citoyen* (citizen), 4.1% (24) are democrat and republican left (*gauche démocrate et républicaine*), 4% (23) are centrists and six deputies are not affiliated with any party. From this date, François Fillon has been the Prime Minister, and there have been very few changes in the government composition, which is currently composed of 39 ministers and secretaries of state.

Interestingly, while the French national assembly has a right wing majority, this is not the case at lower levels. Indeed, after the 2008 election of general councils of local authorities at the department level (*conseil généraux*), only 37 out of the 100 departments are right wing, and after the March 2010 election of regional authorities (*conseil régionaux*), only 3 out of 26 regions are right wing.

Laws and regulations

Regulations (such as acts, ministerial decrees, administrative orders) related to a specific field such as public health, social security, military justice and taxation are compiled together in a book called the “code” (coming from the Latin *codex*). There are around 60 codes in total. The codes that are directly related to health care are the social security code (*code de la sécurité sociale*), the mutual societies code (*code des mutuelles*), the public health code (*code de la santé publique*) and the social action and families code (*code de l'action sociale et des familles*). However, health care is also under the rules included in other codes such as the labour code (*code du travail*) and the commercial insurance code (*code des assurances*).

For major reforms and yearly decisions that affect the social security budget, regulations related to health care are enacted by legislation (acts) after discussion in parliament. Following the vote of an act, decrees (*décrets*) for applications are issued by the prime minister. When specified in acts, some decrees issued by the prime minister have to be assessed by the Council of State (*Conseil d'Etat*). Lower level regulations such as administrative orders (*arrêtés*) are signed by ministers only.

France and international organizations

France joined the EU from its creation date.

France also belongs to several international organizations, for example the United Nations, the European Economic Agreement (*accord économique européen*; EEA), the Organisation for Economic Co-operation and Development (OECD), the World Trade Organization (WTO), the North Atlantic Treaty Organization (NATO) and the Council of Europe.

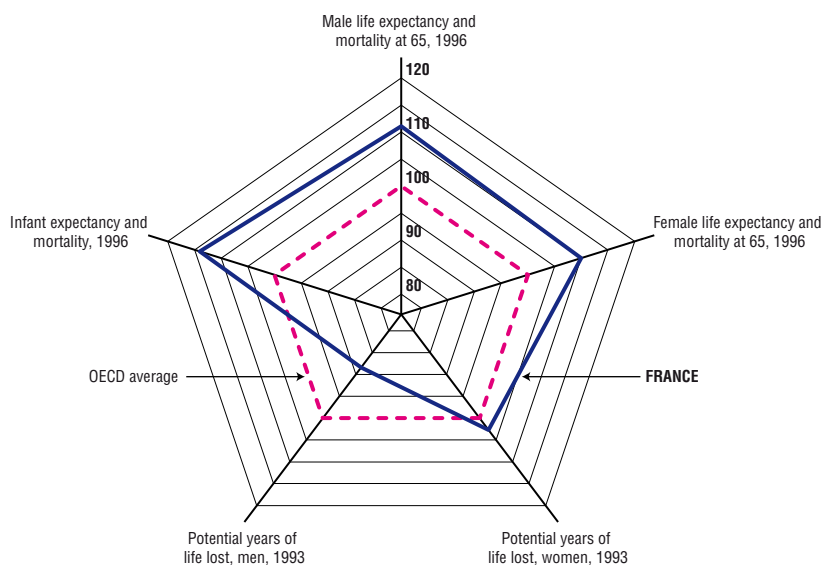
France has signed several treaties that have a direct or indirect impact on health, such as the General Agreement on Tariffs and Trade (GATT) and the European Rights Convention.

1.4 Health status

The overall picture of the state of health in France contains apparent contradictions. On the one hand, indicators such as life expectancy (Fig. 1.2), life expectancy without disability (73.1 years in 1999) and healthy life expectancy (72 years in 2003) show that the health of the population is good. In terms of international comparisons, women live longer and old people remain in better health than in many European countries. France also compares well with regard to cardiovascular diseases, while its relative position with respect to mortality caused by alcoholism, cirrhosis and cancer of the cervix is improving. On the other hand, France suffers from a high rate of premature male deaths from accidents, smoking and alcoholism.

Life expectancy at birth in France is increasing steadily, by three months per year for men and by two months per year for women. The gap between male and female life expectancy remains high, although it is narrowing (Table 1.4).

Fig. 1.2
Health status indicators, France versus the OECD average



Source: OECD 2000.

Table 1.4
Mortality and health indicators, 1970–2006, selected years

Mortality and health indicators	1970	1980	1990	2000	2006
Life expectancy at birth, female (years)	76.7	79.1	81.8	82.8	84.1
Life expectancy at birth, male (years)	69.1	70.8	73.4	75.3	77.2
Life expectancy at birth, total (years)	72.9	74.9	77.6	79.3	80.9
Mortality rate, adult female (per 1000 female adults)	10 ^a	9.5	8.7	8.5	8.2 ^b
Mortality rate, adult female (60 per 1000 female adults (65))	–	–	67	61	57
Mortality rate, adult male (per 1000 male adults)	11.3 ^a	10.8	9.9	9.5	9.1 ^b
Mortality rate, adult male (60 per 1000 male adults (65))	–	–	115	100	91
Mortality rate, infant (per 1000 live births)	15.1	10	7.3	4.4	3.6
Mortality rate (6 per 1000 live births)	21.7	12.9	9.1	5.5	4.5

Sources: INSEE 2008; INED 2008; Eco-Santé 2009; OECD 2009a.
Notes: ^aData from 1975; ^bData from 2005.

The main causes of death in France are cancer (29% of deaths), cardiovascular diseases (28.8%), accidents (7.4%) and diseases of the respiratory system (6.4%) (Table 1.5). However, these death rates differ between men and women, with women's death rates being systematically lower.

Table 1.5
Mortality by cause of death in 2008

Main causes of death	No. deaths	% deaths	Rate per 100 000 population
All causes	529 703	100.0	808.1
Malignant neoplasms	153 880	29.0	232.9
Diseases of the circulatory system	152 322	28.8	232.6
External causes, poisoning	38 969	7.4	61.3
Undefined morbid conditions	35 363	6.7	53.3
Diseases of the respiratory system	33 772	6.4	51.4
Disorders of the nervous system	25 109	4.7	38.7
Diseases of the digestive system	23 543	4.4	35.7
Endocrinal diseases	20 310	3.8	30.9
Mental disorders	17 376	3.3	26.5
Infectious diseases/parasites	10 169	1.9	15.6
Diseases of the genitourinary organs	8 200	1.5	12.6
Diseases of the osteo-articular system	3 631	0.7	5.6
Diseases of the blood or haematopoietic organs	2 181	0.4	3.3
Diseases of the skin, cutaneous tissue	1 951	0.4	3.0
Congenital abnormalities	1 516	0.3	2.5
Perinatal conditions	1 411	0.3	2.2

Sources: CèpiDc 2008; INSEE 2008.

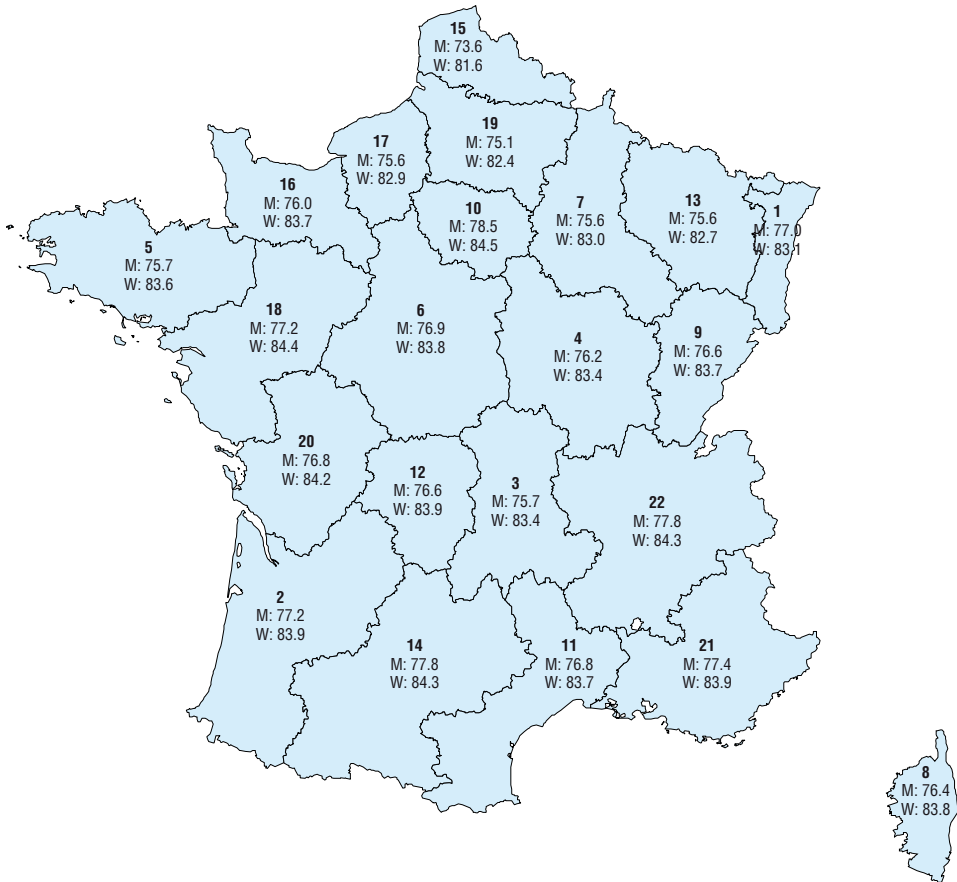
Social and geographical inequalities in health remain substantial (Fig. 1.3). All indicators show higher mortality rates in the northern part of France (from Brittany in the west to Alsace in the east), and in regions located on an axis from the north-east to Auvergne in the centre of the country. Along this axis, the higher rates of mortality concern all causes of death, whereas in the northern crescent (Brittany, Normandy, Nord-Pas-de-Calais and Alsace), risk factors such as alcohol consumption explain some of the higher mortality. Alcohol and tobacco use are not independent of socioeconomic status and are often higher in poorer regions affected by worse rates of unemployment and other socioeconomic indicators.

Lifestyle factors affecting health status

Tobacco and alcohol, respectively, are the first and second most common causes of avoidable mortality. In 2000, tobacco was estimated to cause over 60 000 deaths, that is 1 death in 9, and alcohol to cause 37 000 deaths. In 2004, 33% of men were regular daily smokers and 26% of women. In 1999, the average annual alcohol consumption per inhabitant aged over 14 years was 14.4 litres. Tobacco and alcohol control policies progressively rose through the implementation of several regulations based on strong pricing and taxation policies aimed at decreasing accessibility. A tobacco ban first in public places and workplaces was progressively implemented in France (Act of 31 December 1970,

Fig. 1.3

Life expectancy at birth by region, 2008



Source: INSEE 2008.

Notes: France: 30 064 001 men and 32 041 886 women. M: Men; W: Women; 1: Alsace; 2: Aquitaine; 3: Auvergne; 4: Burgundy; 5: Brittany; 6: Centre; 7: Champagne-Ardenne; 8: Corsica; 9: France-Comté; 10: Ile-de-France; 11: Languedoc-Roussillon; 12: Limousin; 13: Lorraine; 14: Midi-Pyrénées; 15: Nord-Pas-de-Calais; 16: Normandy (Basse); 17: Normandy (Haute); 18: Loire Valley; 19: Picardy; 20: Poitou-Charentes; 21: Provence-Alpes-Côte d'Azur; 22: Rhône-Alpes.

Act of 9 July 1976, Act of 10 January 1991, Act of 21 July 2009). Since 1 January 2008 tobacco consumption has been prohibited in bars, pubs, restaurants, hotels, casinos and night clubs. People not respecting this ban can be fined €68.

In 2008, annual alcohol consumption decreased to 12.3 litres per inhabitant aged over 14 years. Despite a steady decrease over the last 50 years, this number remains higher than the target of 11.5 litres set by the 2004 Public Health Act (*loi relative à la politique de santé publique*; no. 2004-806 of 9 August 2004), (DREES 2010; see Section 6.1). Average male consumption is double the female

rate. Percentage of regular daily smokers decreased to 27% in males and 22% in females but this was also below the target (the 2004 objectives had a target for 2008 of 25% for men and 20% for women) (HCSP 2010),³ but it is nevertheless below the 2006 average percentage of daily smokers (27%) in the 27 Member States of the EU as of 2009 (EU27) (WHO Regional Office for Europe 2009).

Socioeconomic health inequalities

France has long reported health inequalities across socioeconomic groups that are wider than in most other European countries (HCSP 2002).

The French trends in improving health status, reflected for instance by the increase in life expectancy and the decrease in infant mortality, have not been equally beneficial across socioeconomic groups, with the greatest improvement being observed among the most well-off. For example, life expectancy at 35 is seven years lower for working class men and three years lower for working class women than for executives (DREES 2008). These inequalities also exist when looking at morbidities such as dental problems, cardiovascular diseases or obesity (Table 1.6).

Table 1.6

Social inequalities in health and access to care between workers and executives

	Average number of diseases declared	Obesity (% of population)	Dental problems (% of population)	Access to dentist care in the last 2 years (% of population)
Workers	3.1	14.7	47.2	62.9
Executives	2.5	5.9	31.9	82.5

Source: Allonier et al. 2010.

These social health inequalities result not only from risk factors such as alcohol and tobacco consumption but also from a difference in access to health care that seems to increase over time. In 2008, 16.5% of the population aged 18–64 years reported having forgone health care in the last 12 months for financial reasons, while this share was 14% in 2006 (Allonier et al. 2008, 2010). This inequity in access is concentrated in a limited number of goods and services for which patients' out-of-pocket expenditure is the highest (DREES 2008). Dental health care is of greatest concern (10.7% of the population aged 18–64 years have forgone dental health care in the last 12 months), followed by spectacles (4%) (Allonier et al. 2010). Forgoing health care increases inversely

³ *Haut conseil de la santé publique* (the High Council of Public Health; HCSP) is described in Section 2.3.1.

with the level of income: people in the poorest quintile (under €820 a month) forgo three times more care than people in the richest quintile (more than €2000 a month) (Allonier et al. 2010).

Several public policies have been implemented since the late 1990s to tackle this issue; they mainly focused on improving access to health care but have not shown significant results (see Section 6.1.5).

Sexually transmitted diseases and human immunodeficiency virus

In recent years, there has been a growth in sexually transmitted diseases such as gonorrhoea, chlamydia and syphilis. Gonorrhoea has risen steadily from 1996: 65% of cases are in homosexuals (males and females), 28% in heterosexual males and 7% heterosexual females. The number of cases of syphilis increased after 2000 but has remained stable since 2002: 82% are in homosexual males, 13% in heterosexual males and 5% in heterosexual females, with a majority of cases in the Parisian area (HCSP 2010).

In 2007, the incidence of human immunodeficiency virus (HIV) infection was 6500 new infections per year (that is, 103 per million inhabitants) but it has steadily decreased over the years. Heterosexual transmission accounted for 59% at that time, and half of these infections were in people coming from sub-Saharan African countries. Transmission was 13% among injecting drug users and 38% among homosexuals in 2007. In contrast to overall incidence, the incidence in the latter population increased from 2003 to 2006. There are geographical disparities, with higher rates in the Parisian area and overseas departments (DREES 2010).

By the end of 2007, a total of 63 500 cases of AIDS had been recorded in France. Out of these, 35 000 had died. After reaching a peak of 5800 cases a year in 1996, the AIDS incidence decreased dramatically to 2300 cases per year in 1998, following the increased use of antiretroviral drugs. Since then, the incidence has decreased at a slower rate, to reach about 1200 cases per year in 2007 (that is, 2 per 100 000 incidence rate). In 2007, 61% of transmission was heterosexual, 27% male homosexual transmission and 10% through injecting drug user. The male:female ratio decreased up to 2004 and has remained constant since then at around 2.2:1. France remains one of the western Europe countries with a high rate of AIDS; however, it is below European countries such as Portugal and Spain (DREES 2010).

Dental health and immunization

Oral health estimated by decayed, missing or filled teeth (DFMT) is 1.2 in France (2006), which is the same level as in Belgium, Italy and Spain and below that in the United Kingdom and Germany (0.7 in 2007).

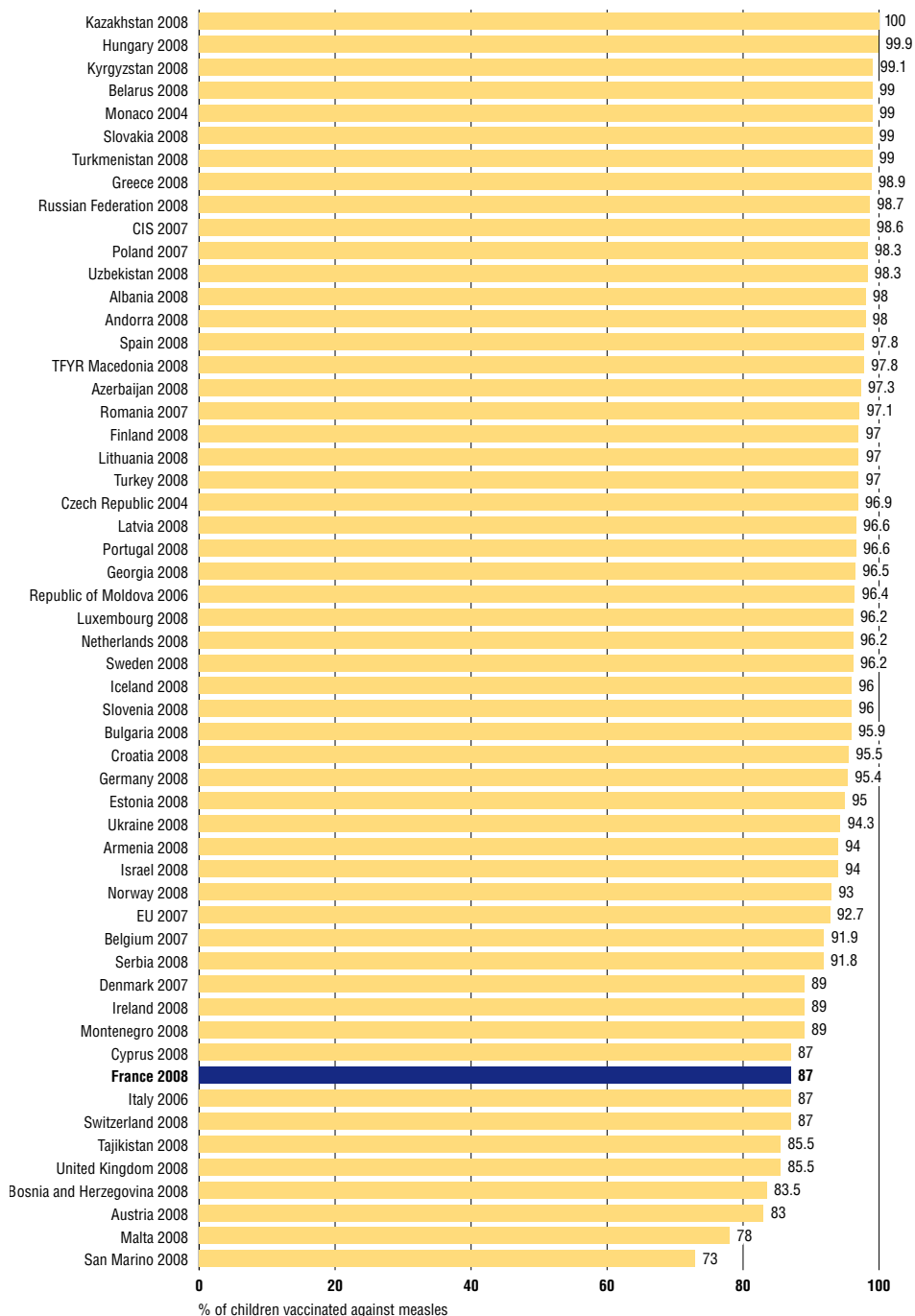
One of the measures for improvement of health status in France is the national immunization programme (see Section 6.1.2). Only three immunizations are obligatory for the general population: tetanus, diphtheria and poliomyelitis; however, many others are recommended depending on age (InVS 2010). Vaccination coverage varies with the type of vaccination and age. One of the public health objectives of the 2004 Public Health Act was to reach at least 95% coverage rate at appropriate ages in 2008; this target has been partially met. Weaknesses remain with insufficient coverage in teenagers and in a low rate of uptake of measles and hepatitis B vaccination in children (HCSP 2010). Immunization for measles is below the EU27 average (Fig. 1.4).

Maternal and child health

With regard to reproductive health, the overall French situation is good (HCSP 2010). In 2007, the French number of neonatal deaths per 1000 births was 2.4 (Table 1.7), which is lower than the EU27 average of 3.0. The maternal death rate shows a favourable trend (despite data problems; see Table 1.7). Among the EU27 countries, France has the highest birth rate (13% in 2008) and fecundity indicator (total period fertility equals 2 in 2007); the EU27 average is 10.9 and 1.5, respectively. The average age of women at the time of giving birth grew from 28.8 years in 1999 to 29.8 years in 2008. However, the adolescent rate of pregnancy did not decrease as much as did the pregnancy rate for women in their twenties, which may be related to a problem in access to contraception for young women, which would be supported by the increasing trend in voluntary abortion in this group of women.

Fig. 1.4

Levels of immunization for measles in the WHO European Region, latest available year



Source: WHO Regional Office for Europe 2009.

Notes: CARK: Central Asian Republics and Kazakhstan; CIS: Commonwealth of Independent States; Eur-B.C: Regions as in the WHO list of Member States, last available year; TFYR Macedonia: The former Yugoslav Republic of Macedonia.

Table 1.7

Maternal and child health indicators, 1990–2007, selected years

Indicators	1990	1995	2000	2007 or latest year available
Adolescent pregnancy rates, 15–19 years (%)	4.2	–	3.7 (1999)	3.4 (2009)
Infant mortality (per 1000 live births)	7.3	4.9	4.4	3.6
Neonatal mortality (per 1000 live births)	3.6	2.9	2.8	2.4
Perinatal mortality (per 1000 births)	8.3	7.4	6.6 ^a	10.8
Maternal death (per 100 000 live births)	10.4	9.6	6.5 ^a	7.6

Sources: Eco-Santé 2010; OECD 2010; INSEE 2010.

Note: ^a Because of changes in the data collection process after 2003, trends are not interpretable.

2. Organization and governance

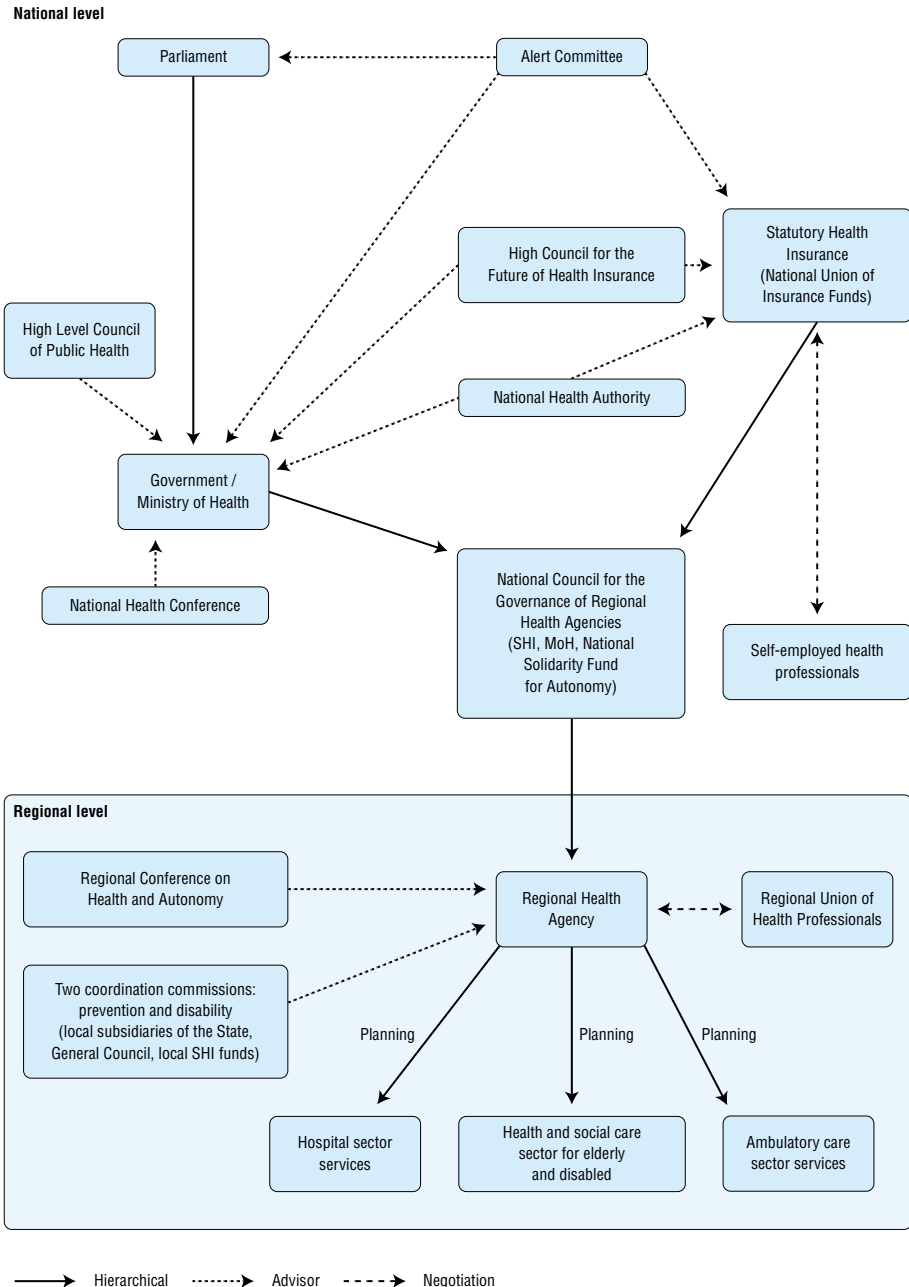
2.1 Overview of the health system

The French health care system could be described as a mixed model that is structurally based on a Bismarckian approach with Beveridge goals such as universality and unity, which has led towards an increasingly Beveridgian type system. There is statutory health insurance (SHI), which, under various schemes and as a result of reforms extending over a 55-year period (from its creation in 1945 to the extension of SHI coverage to all residents in 2000), currently covers almost 100% of the resident population (both legal and illegal). Jurisdiction in terms of health policy and regulation of the health care system is divided among:

- the state: parliament, the government and various ministries;
- SHI;
- to a lesser extent, local communities, particularly at the regional level.

The delivery of care is shared among private, fee-for-service physicians, private profit-making hospitals, private non-profit-making hospitals and public hospitals (Fig. 2.1). Acute care hospitals, excluding psychiatric hospitals, are financed by a diagnosis-related group (DRG)-based prospective payment system. There is an implicit basic benefit package that is represented by the procedures and technologies listed on the SHI schedule. SHI covers, on average, 75% of this basic benefit package expenditure, but private complementary coverage can be purchased to top up the SHI coverage up to 100%. To the side of the health care sector, there is a health and social care sector, known as the “third sector” (in addition to the health sector and to the social sector), that provides care and services to elderly and disabled people.

Fig. 2.1
 Organization of the health system in France, 2010



Notes: SHI: Statutory health insurance; MoH: Ministry of Health.

The institutional organization of the system in France was profoundly affected by a series of reforms, most significantly the 1996 reform also known as the “Juppé reform” (after the name of the acting prime minister at that date, Ordinances no. 96-344, no. 96-345, no. 96-346 of 24 April 1996), and by the 2004 Health Insurance Reform Act (Act 2004-810 of 13 August 2004). In addition to introducing parliamentary control over the health care system and its resources and attempting to clarify the respective roles of the state and SHI, the 1996 reform significantly reinforced the role of the regions, creating new institutions at the regional level (see Section 2.4). The Social Security Finance Act of 2000 gave the state responsibility for the whole hospital sector, including private profit-making hospitals that previously were regulated by SHI (Franc, Polton 2006). In 2004, the Health Insurance Reform Act and the Public Health Act were passed. The reforms changed the governance of the system (Cases 2006) by increasing the role of the parliament in setting health priorities and in establishing national management of SHI. The parliament also acquired a new role with its “Alert Committee” (*Comité d’alerte sur le respect de l’objectif national de dépenses d’assurance maladie*; see Section 3.4), which is activated when the social security deficit reaches a predefined threshold. The government, however, retains the leading role in proposing both Public Health and Social Security Finance Acts to the parliament and in writing the by-laws and decrees that result from the Acts passed. In 2004, Act 2004-626 of 30 June created a new fund, the National Solidarity Fund for Autonomy (*Caisse nationale de solidarité pour l’autonomie*; CNSA) to provide support to people living with disabilities (see Section 3.4). The 2009 Hospital, Patients, Health and Territories Act (*loi hôpital, patients, santé et territoires*; Act no. 2009-879 of 21 July 2009; HPST) merged several regional institutions into a “one-stop shop” by creating the regional health agencies (*agences régionale de santé*; ARSs) (see Section 2.4). The rest of this chapter describes these reforms and their effects in more detail.

2.2 Historical background

From mutual benefit associations to the creation of social security and universal health coverage

The present system of social security, including SHI, was established in 1945, at the end of the Second World War.

Prior to this, the 19th century had been marked by the rapid rise of the mutual benefit movement, which is still an important force in French political life. By 1900, the number of mutual benefit associations had reached 13 000, with 2.5 million members. They continued to develop in the early decades of the 20th century, and in 1940 these associations had nearly 10 million members.

In the meantime, an Act on Social Insurance was passed in 1930, signalling the emergence of a statutory insurance system. This legislation created a system of compulsory protection paid for by employers for employees in industry and business whose earnings fell below a certain level. It provided coverage in five areas: illness, maternity, disability, old age and death. By the outbreak of the Second World War in 1939, two-thirds of the French population was covered for illness by mutual benefit associations, with free choice of the organization providing coverage. The creation in 1945 of SHI within the social security system changed the role of these associations, which either disappeared or became providers of complementary insurance (see Section 3.3.2).

The social security system officially came into being with the Ordinance of 4 October 1945. Social security consists of compulsory protection, with four branches covering health (disease, maternity, incapacity, death), work-related illness and injuries, family allowances, and retirement (pension and widowhood). SHI is the branch of social security covering health. The Ordinance of 1945 was written by the government and approved by the parliament. Funding for the coverage was to come from contributions from both employers and employees. SHI provided benefits in cash and in kind. The principle of expanding coverage to the whole population had been raised as early as 1945 but was only put into practice in stages. In the early post-war years, priority was given to reconstruction, so the provision of social security was aimed primarily at workers and their families. SHI was only extended to farmers in 1961 and to self-employed non-agricultural workers in 1966.

This process of expanding coverage was recognized in the statutes of 1974, which established a system of personal insurance provided by SHI for those who did not fall into any of the categories already covered. In order to obtain this insurance, individuals had to pay a contribution or, if they had insufficient means, request the department (the local authority; see Section 2.4) to make a contribution on their behalf. In practice, however, access to public health insurance remained problematic for certain population groups.

In addition to expanding coverage, the founders of the social security system, largely inspired by the Beveridge report in the United Kingdom, aimed to create a single block system guaranteeing uniform rights for all. However,

this goal could not be achieved because of opposition from certain social-professional groups who already benefited from insurance coverage that had more favourable terms than those offered to the general population of salaried employees, and who succeeded in maintaining their particular systems, which are still in existence today (civil servants, seamen, miners, railway workers, employees of the national bank, etc.).

Today, three main SHI schemes cover 95% of the population: the general health insurance scheme, which covers employees in commerce and industry and their families and civil servants; the agricultural scheme; and the national insurance fund for self-employed people (see Section 2.3.5). Health insurance in France has, therefore, always been more concentrated and uniform than in other Bismarckian systems (such as the German system). Another key difference is that the French SHI has never really had the management responsibilities accorded to sickness funds such as those in the German health care system. The state rapidly took responsibility for the financial and operational management of SHI (for example, setting premium levels and the prices of goods and services).

Difficulties arose in the 1980s with a growing number of unemployed being deprived of their right to SHI, which was linked to professional activity. While the safety net of medical assistance in the form of state medical help for those with low incomes remained (see Section 3.2), the conditions under which it applied and the degree of generosity in its coverage depended on the resources and policies of general councils (local authorities at department level, see Section 1.3). Successive rounds of legislation, therefore, softened the conditions governing access to compulsory insurance coverage and obliged the general councils to finance the individual insurance contributions of certain groups of the population (for example, since 1992, recipients of minimum welfare benefits).

The 1999 Universal Health Coverage Act (*couverture maladie universelle*; CMU Act; Act no. 99-641 of 27 July 1999), which came into force on 1 January 2000, established universal health coverage, opening up the right to SHI coverage financed mostly by the state through a special fund, the CMU Fund (*Fonds CMU*), on the basis of residence in France (see Section 3.2). This changed the old system of individual insurance, with contributions that could be financed by the general councils according to income scales that varied from one department to another, to a system based on the logic of the right to social protection through insurance. Since this reform, those whose income is below a certain level (2.3% of the population in 2006) are entitled to free public coverage.

The CMU Act, therefore, further shifted the balance of the health insurance system away from a work-based system towards a system of universal health coverage. This evolution had already begun with the so-called Juppé reform of 1996, which introduced two important changes:

- in the method of funding health insurance, the part of the contribution based on earned income (wages) was mostly substituted by a contribution based on total income, which was more like an earmarked tax (*contribution sociale généralisée*, CSG; see Section 3.3.1);
- from 1997 onwards, parliament was given a role in determining policy directions and expenditure targets of the institutions responsible for operating health insurance.

The CMU Act also contains other provisions that represented a major development in the French social security system: in addition to universal health coverage, those with incomes below a certain level were given the right to free complementary voluntary health insurance (VHI) coverage (see Section 3.3.2).

2.3 Organization

2.3.1 The parliament

Since 1996, the parliament passes an annual Act on Social Security Finance. This Act is proposed by the government, based on the reports of (1) the Accounts Commission (*cours des comptes*), which is an independent public body responsible for monitoring state and social security bodies to ensure adequate control over and proper use of public funds; (2) the High Council for the Future of Health Insurance (*Haut comité pour l'avenir de l'assurance maladie* (later changed to the *Haut conseil pour l'avenir de l'assurance maladie*; HCAAM)); (3) the High Council of Public Health (*Haut conseil de la santé publique*; HCSP); and (4) the National Health Conference (*Conférence nationale de santé*) (the last three advisory bodies are described in Section 2.3.7). This Act:

- sets a projected target (ceiling) for health insurance spending for the following year, known as the national ceiling for health insurance expenditures (*objectif national des dépenses assurance maladie*; ONDAM);
- approves a report on trends in policy for health and social security;
- contains new provisions concerning benefits and regulation.

The parliament also approves the revenue side of the budget based on the contribution rates for employers and employees, and specific earmarked taxation proposed by the government.

The 2004 Health Insurance Reform Act created the Alert Committee, whose role is to inform the parliament, SHI and the government if health expenditure goes beyond the expected level approved by the parliament. The Directorate of Social Security (*Direction de la sécurité sociale*; DSS) of the Ministry of Health (see below) is then required to take measures to reduce expenditure, such as increasing co-payments on drugs or visits by self-employed doctors or postponing planned increases in professionals' fees (see ONDAM in Section 3.4).

2.3.2 Ministry of Health

The Administration of Health and Social Affairs (*Administration sanitaire et sociale*) comprises four directorates, which have the following responsibilities:

- General Directorate of Health (*Direction générale de la santé*; DGS): health policy;
- General Directorate of Health Care Supply (*Direction générale de l'offre de soins*; DGOS): management of resources; previously limited to hospitals, the scope of this directorate now covers the entire health care system;
- Directorate of Social Security (*Direction de la sécurité sociale*; DSS): financial matters, supervision of SHI;
- General Directorate for Social Policy (*Direction générale de la cohésion sociale*, DGCS): health and social care for elderly, disabled or vulnerable people.

Depending on the government in place, the Administration of Health and Social Affairs will be under the responsibility of one or more ministers and the Ministry in charge of health will include the four directorates or less. For example, prior to the 2007 election, the four directorates were under the supervision of the Ministry of Health, which was then called the Ministry of Health and Solidarity (*Ministère de la santé et des solidarités*). However, as of June 2010, under the government which took power in 2007, the Ministry of Health only comprises three of the directorates listed above (the General Directorate of Health, the General Directorate of Health Care Supply and the Directorate of Social Security) and the supervision of the Directorate of Social Security is also under the supervision of the Ministry of the Budget, Public Accounts, the Civil Service and State Reforms (*Ministère du budget,*

des comptes publics, de la fonction publique et de la réforme de l'état), which is also responsible for the SHI budget and of the Ministry of Labour, Solidarity and Public Service (*Ministère du travail, de la solidarité et de la fonction publique*). The responsibilities of the Ministry of Health have been extended to youth, sports and associations, and it has been renamed the Ministry of Health, Youth, Sports and Associations (*Ministère de la santé, de la jeunesse, des sports et de la vie associative*). Because of these frequent changes, the Ministry in charge of health will be referred to generically as the Ministry of Health (MoH).

The Administration of Health and Social Affairs is represented at the regional level by the ARSs, which were created by the 2009 HPST Act. Established in April 2010, the ARSs have increased the integration of health care financing and public health planning at the regional level. Within their remit, they have the full organization of health care planning, delivery and finance, together with the public health programmes at the regional level (see Section 2.4).

The Ministry of Health controls a large part of the regulation of health care expenditures on the basis of the overall framework established by the parliament. It is responsible for:

- dividing the budgeted expenditure between the different sectors (hospitals, ambulatory care, mental health care, social and health sector for disabled) and, where hospitals are concerned, between the different regions;
- deciding on the number of medical students to be admitted to medical school each year (*numerus clausus*), the number of hospital beds and the amount of equipment, including expensive medical technologies;
- approving the agreements signed between SHI and unions representing self-employed health care professionals;
- setting the prices of specific medical procedures and drugs on the basis of proposals from the National Health Authority (*Haute autorité de santé*; HAS) ad hoc committees;
- establishing safety standards in hospitals;
- defining priority areas for national programmes; these currently include cancer, rare diseases, health and environment, unhealthy behaviour and addiction, and quality of life of people suffering from chronic illnesses.

In conjunction with the Ministry of the Budget, Public Accounts, the Civil Service and State Reforms, the Ministry of Health prepares the annual Social Security Finance Acts passed by the parliament, which follow the template of the organic law for the Social Security Financing Act (Act no. 2005-881 of 2 August 2005).¹

2.3.3 Subordinate agencies/arm's length bodies

Agence française de securite sanitaire des produit de sante (AFSSAPS). The French Health Products Safety Agency is the competent authority for all safety decisions taken concerning health products from their manufacturing to their marketing. The AFSSAPS carries out three core missions: (1) scientific evaluation, (2) laboratory control and advertising control, and (3) inspection of industrial sites. The Agency also coordinates vigilance activities relating to all relevant products.

Agence française de securite sanitaire des aliments (AFSSA). The French Food Safety Agency regulates food products. It is a public independent organization contributing to the protection and improvement of public health, animal health and welfare, vegetation and environmental health, through monitoring, alert, research and research instigation.

Agence française de securite sanitaire de l'environnement et du travail (AFSSET). The mission of the French Agency for Environmental and Occupational Health Safety is to contribute to ensuring health safety in all types of surrounding, including occupational environments, and to assess environmental health risks, specifically within the occupational environment.

Agence de la biomédecine. The 2004 Bioethics Act (no. 2004-800 of 6 August 2004) created the French Biomedicine Agency, the only such public body in Europe. The French Biomedicine Agency is a public organization under the supervision of the Ministry of Health, operating in four key areas of human biology and medicine: assisted reproductive technologies, prenatal and genetic diagnosis, embryo and stem cell research, and the procurement and transplant of organs, tissues and cells, previously entrusted to *l'Etablissement français des greffes* (French Transplant Agency) between 1994 and 2005.

Etablissement français du sang (EFS). The French Blood Agency was created in 2000 under the supervision of the Ministry of Health. It is the single operator for blood transfusions in France. Its mission is to ensure the availability and the safety of red blood cells, platelets and plasma throughout France.

¹ Organic laws (such as budgetary laws) supplement constitutional provisions for purposes of implementation.

Institut national de prévention et d'éducation pour la santé. The National Institute for Prevention and Health Education is a public establishment created by the 2002 Act relating to patient rights and to the quality of care (see Section 2.5). The Institute plays a major role in public health. It is specifically in charge of implementing policies in matters of prevention and health education within the more general framework of public health policy set by the government. The 2004 Public Health Act broadened the scope of its initial mission to include participating in the management of emergency or exceptional situations that have serious consequences on the general population's health and in health education training.

Institut national de veille sanitaire (InVS). The National Institute for Public Health Surveillance is a governmental institution reporting to the Ministry of Health. It is responsible for surveillance and alert in all domains of public health. Created on 1 July 1998 to reinforce health surveillance and the safety of products intended for human use, its mandate was enlarged by the Public Health Act of 9 August 2004, in order to face new challenges highlighted by recent health crises and emerging risks. Current mandates include monitoring and permanent observation of population health conditions, health surveillance and health alerts.

Institut de radioprotection et de securite nucleaire (IRSN). The Radioprotection and Nuclear Safety Institute was created in 2002. It is placed under the joint authority of the ministries of the environment, health, industry, research and defence. The IRSN's field of expertise covers all of the risks related to ionizing radiations used within industry and medicine, as well as natural radiation rays.

Agence technique de l'information hospitaliere (ATIH). The Agency for Information on Hospital Care was set up in 2000 (Decree no. 2000-1282 of 26 December 2000) to manage the information systematically collected from all hospital admissions and used for hospital planning and financing.

Institut national du cancer (INCa). The National Institute for Cancer is the national health and scientific agency in oncology. It was set up by the first cancer plan implemented for the period 2003–2006 and created by the 2004 Public Health Act (see Section 6.1). Its objectives are to:

- survey and assess the measures taken against cancer
- develop guidelines for the management of patients with cancer
- inform professionals and the public
- provide expert opinion on any cancer-related topic

- contribute to continuing medical education (*formation médicale continue*; FMC) in the field of cancer
- monitor and finance research and development in cancer
- develop public-private partnerships
- contribute to European and international programmes.

Agence nationale d'appui à la performance des établissements de santé et médico-sociaux (ANAP). Set up by the 2009 HPST Act, the National Agency to Support the Performance of Health and Health and Social Care Organization is a public entity created by the merger of three former entities: the Group for the Modernization of Hospital Information Systems (*Groupement pour la modernisation du système d'information hospitalier*, GMSIH), the National Mission for Hospital Investment (*Mission nationale d'appui à l'investissement hospitalier*, MAINH) and the National Mission in Charge of Hospital Expertise and Audit (*Mission nationale d'expertise et d'audit hospitalier*, MEAH). The mission of ANAP is to provide advice and support to health and social care organizations for internal reorganization plans; when facing financial difficulties for asset management; for merger and acquisition programmes; for assessment, audit and expertise of strategic plans, with a particular focus on buildings, equipment and the information systems; and for audits of performance. ANAP is also required to provide support to the ARSs (see Section 2.4) and to the Ministry of Health in monitoring the performance of health and social care organizations and in the strategic planning of health care provision and delivery. The development of tools to monitor and improve the performance of hospitals and social care organizations is also in the remit of ANAP.

Agence nationale de l'évaluation de la qualité des établissements et services sociaux et médico-sociaux (ANESM). The remit of the National Agency for the Quality Assessment of Health and Social Care Organizations and Services is to promote an environment of “empathic treatment” (“*bientraitance*”) in health and social care, which encompasses the promotion of patient rights and the development of preventive measures to avoid mistreatment, in particular in vulnerable populations such as elderly, disabled people, children, adolescents and socially excluded people. It produces practice guidelines for the health and social care sector and evaluates organizations and services.

2.3.4 Independent authorities

The National Health Authority (HAS) was set up by the French Government in August 2004 in order to bring together under a single roof a number of activities designed to improve the quality of patient care and to guarantee equity within the health care system. HAS activities are diverse. They range from the assessment of drugs, medical devices and procedures to publication of guidelines and accreditation of health care organizations and certification of doctors. All are based on rigorously acquired scientific expertise. HAS is not a government body; it is an independent public body with financial autonomy. It is mandated by law to carry out specific missions on which it reports to government and parliament. It liaises closely with government health agencies, SHI, research organizations, unions of health care professionals and patients' representatives. HAS is staffed by about 350 people (including doctors, other health care professionals and economists). Its agenda is defined by a board of eight directors designated by the President of the French Republic, the President of the National Assembly, the President of the Senate and the President of the Economic and Social Council. The HAS Board provides governance. Each board member heads a specialist committee and is responsible for a specific mission or specific aspects of a mission.

2.3.5 Statutory health insurance

SHI is composed of several schemes. The three main schemes and beneficiaries (figures for 2008) are as follows:

1. The general scheme (*Caisse nationale d'assurance maladie des travailleurs salariés*; CNAMTS) covers 56 million employees in commerce and industry and their families (87% of the population) and CMU beneficiaries (1.4 million people, 2.3% of the population in 2006).
2. The agricultural scheme (*Mutualité sociale agricole*, MSA) covers farmers and agricultural employees and their families (3.6 million people or around 6% of the population).
3. The scheme for self-employed people (*régime social des indépendants*, RSI) covers craftsmen and self-employed people (with the exception of agricultural self-employed people), including self-employed professionals such as lawyers (3.4 million people, about 5% of the population).

Smaller schemes cover certain categories of the population, also on a work-related basis. Several of these schemes are linked to the general scheme, as is the case for local and national civil servants, doctors working under state health agreements, students and military personnel. Other schemes (such

as those for miners, employees of the national railway company, the clergy, seamen and the national bank) have their own particular form of organization and function autonomously. For historical reasons, people from the Alsace and Moselle regions benefit from a specific scheme offering better cover of medical goods and services in return for higher contribution rates.

Because of social changes, the population covered by the agricultural scheme and some of the smaller schemes such as miners, is shrinking and getting older.

Each of the three major health insurance schemes is made up of a national health insurance fund and local structures corresponding to the degree of geographical distribution involved. In the case of the general scheme, local structures are:

- 105 local funds (*101 caisses primaires d'assurance maladie*, CPAM, in metropolitan France) which have departments as their geographic base and affiliate the inhabitants of their geographic area, reimbursing the costs of treatment for this population;
- 16 regional funds (*caisses régionales d'assurance maladie*; CRAM) (covering areas that are wider than the administrative region) whose responsibilities are limited to accidents at work and work-related illnesses, and (in the area of work-related illnesses) to the control of hospitals and to the implementation of preventive measures. The regional funds, therefore, have a remit that differs from the remit of the local funds.

Almost the entire population is covered by the different schemes, to which individuals and families belong based on their employment status. For working people, it is not possible to opt out except in some specific cases (expatriates and employees of international corporations or institutions). There is no competition between schemes because an individual has no choice over which fund they are enrolled in.

The three main insurance schemes were federated by the Reform Act of 2004 in a National Union of Health Insurance Funds (*Union nationale des caisses d'assurance maladie*, UNCAM) that also has structures at the regional level (*Union régionale des caisses d'assurance maladie*; URCAM) (see Section 4.1.1). This new federation has become the sole representative of the insured in negotiations with health care providers.

2.3.6 Professional organizations

There are two types of professional organizations: professional associations or chambers (*conseil de l'ordre*) and trade unions.

Professional associations or chambers for doctors, pharmacists, dentists, midwives, physiotherapists and nurses are concerned with medical ethics and the supervision of professional practice. Trade unions look after the interests of different professional groups. For most medical specialties, both a union and an association exist. The association is in charge of all matters pertaining to the scientific activities of a speciality, such as developing guidelines or review criteria for continuing medical education (FMC), while the union is in charge of the negotiations between the professionals and SHI (see Section 4.1.3).

Trade union representation is very fragmented, not only because of the existence of different professions, but also through differences in status, for example between salaried and self-employed professionals. Furthermore, next to “vertical” unions, which represent interests at the national level, “horizontal” unions have developed at the departmental level. There are five unions for self-employed doctors that are considered to be representative and competent to sign fee agreements with SHI: the Confederation of French Medical Unions (*Confédération des syndicats médicaux français*; CSMF), the Union of Self-Employed Doctors (*Syndicat des médecins libéraux*; SML), the Federation of Doctors in France (*Fédération nationale indépendante des mutuelles*; FMF), the Union of French Surgeons and Specialists (*Union collégiale des chirurgiens et spécialistes français*; UCCSF) and the French Federation of General Practitioners (*Syndicat des médecins généralistes*; MG France). As a result of this diversity, the unions’ positions on government measures can differ. Only 15–20% of physicians in private practice are union members (Borgetto 2008).

The role of the unions is mostly to negotiate with SHI on the level of fees, the authorization of extra-billing and referral patterns. The success in 2009 of direct contractual agreements, known as CAPIs (individual contracts for professional practice quality improvement (*contrats d’amélioration des pratiques individuelles*)), between SHI and individual office-based physicians can be viewed as a setback for the unions, which strongly opposed these contracts (see Section 7.1.3). The novelty of these contracts, and one of the reasons for the opposition of unions, is that the contracts are negotiated directly between SHI and individual physicians, thereby bypassing the unions. As of mid-2009, only months after their introduction, these contracts were adopted by 10–15% of office-based physicians.

Physicians working in public hospitals pay a membership fee to the National Union of Hospital Physicians (*Syndicat national des praticiens hospitaliers*; SNPH). This organization provides financial assistance in case of illness, which

has resulted in membership of almost 100%. In 2009, the SNPH played an important role in opposing the HPST Act, which aimed to give hierarchical power to hospital directors over physicians (see Section 7.1.4).

Fragmentation of professional representation is not exclusive to doctors. For example, the 4000 private laboratories that carry out analyses for outpatients have no fewer than four representative organizations, resulting mainly from divisions between representatives of large laboratories and the champions of small local units.

Act 93-8 of 4 January 1993 created the regional unions of self-employed doctors (*union régionale des médecins libéraux*; URML) to ease the relationships between health professionals and SHI by creating a single body competent to negotiate professional matters with SHI bodies at the regional level (see Section 2.4). The URMLs are professional representatives of about 120 000 physicians in private practice. Since 1994, these regional unions of self-employed doctors, the representative boards being elected on the basis of union lists, have had the tasks of analyzing the functioning of the health care system, private medical practice, epidemiology and the evaluation of health care needs, coordinating with other health care professionals and providing information and training for doctors and patients. These unions are funded by specific contributions from doctors. All office-based self-employed physicians must be affiliated to a regional union, which is to say that they must pay the membership fee. The elected representatives of the regional trade unions are often also members of the above-mentioned national trade unions, which further confuses their respective roles.

The 2004 Health Insurance Reform Act established an umbrella organization to represent all health care professionals in private practice, the National Union of Health Professions (*Union nationale des professions de santé*; UNPS). This umbrella organization sets the agenda for negotiations between health professionals and SHI and VHI at the national level (see Section 4.1.2). Following the 2009 HPST Act, regional unions of health professionals (*union régionale des professionnels de santé*; URPS) were created to negotiate with the ARS, and they replaced and extended the role of the URMLs to all types of health professional in a region (see Section 2.4).

Hospitals are represented by different organizations, depending on their status (public, private non-profit-making or private profit-making) such as the Confederation of General Hospitals (*Confédération des hôpitaux généraux*; CHG), the Coordination of Hospital Medicine (*coordination médicale hospitalière*; CMH), the National Inter-Union of Hospital Physicians

(*Intersyndicat national des praticiens hospitaliers*; INPH) and the National Union of Hospital Medical Personnel (*Syndicat national des agents médicaux des hôpitaux publics*; SNAM-HP), the French Hospital Federation (*Fédération hospitalière de France*; FHF) for public hospitals, the Federation of Personal Assistance Institutions (*Fédération des établissements hospitaliers et d'aide à la personne*; FEHAP) for non-profit-making private hospitals and residential care services for elderly, and the Federation of Private Hospitals (*Fédération hospitalière privée*; FHP), which represents profit-making private hospitals.

Finally, pharmaceutical manufacturers and producers of medical devices (equipment, artificial limbs, prostheses, etc.) each have their own union.

In addition to their professional organizations and unions, health professionals may also join any of the trade unions that exist to represent workers in all fields of industry and services.

2.3.7 The policy formulation process

The Ministry of Health has substantial control over the health system, although recent and ongoing reforms both at the regional and the national levels may challenge its traditional role. For example, at the regional level, the regional health authorities (see Section 2.4) have public health and health care planning and financing responsibilities within their remit; at the national level, since 2004 the HAS independently monitors technologies, hospitals, professionals and the basic benefit package (see Section 2.3.4).

The policy agenda is set by the Ministry of Health as acts approved by the parliament that define health targets pursuant to the 2004 Public Health Act. However, this is done jointly with the Ministry of the Budget, Public Accounts, the Civil Service and State Reforms when it comes to the organization of the financial collection and delivery of health services in the annual Social Security Finance Act.

Policy formulation is done with the help of several advisory committees or councils such as HCAAM, the National Health Conference and the HCSP.

HCAAM is an independent committee that publishes an annual report on the situation of the health care system, with an emphasis on financial and equity issues. It gathers all stakeholders and provides detailed figures and policy forecasts, together with policy proposals to ensure the sustainability and fairness of the system. It is a very influential council whose proposals are backed by figures and whose members are chosen by the Ministry of Health from high-profile professionals.

The National Health Conference was created as a permanent body by the 2004 Public Health Act; it brings together representatives of the health professions, health care facilities, regional health conferences (*conférence régionale de santé*; CRS) and a number of additional experts to discuss and define health care priorities at the national level. The strategy is mainly implemented through regional strategic health plans (*plan régional stratégique*; PRS), previously developed by the ARSs in consultation with the stakeholders who participate in the CRSs on health and autonomy (see below).

The HCSP was created by the 2004 Public Health Act and formally established in 2007 to replace the former High Committee on Public Health. It is composed of independent experts in the field of public health and provides guidance and assists in decision-making regarding public health problems and issues related to the organization of health care. It undertakes regular overviews of the population's health status, prepares general analyses and forecasts of public health problems, contributes to the definition of public health objectives and makes proposals for strengthening preventive measures. It can also be consulted on specific questions concerning the organization of treatment, and in that context it can set up working groups to produce reports on issues and formulate proposals. It is in charge of assessing the implementation of the 2004 Public Health Act, to monitor its 100 health target objectives (see Section 6.1) and to suggest new objectives. To achieve such goals, it uses information from surveys conducted by independent research organizations (Danet, Salines 2008). Indicators used in the assessment include mortality and life expectancy, regional differences in mortality, access to care, tobacco and alcohol use, diet and exercise, environmental risks, workplace environment and prevalence of chronic diseases. The recently published April 2010 report assesses current public health objectives and suggests new ones (HCSP 2010) (see Section 6.1.6).

2.4 Decentralization and centralization

Regional level

The general philosophy of decentralization in France has been a marked reluctance to reduce central control over policy and finance, and, as a result, it has mainly taken place as a form of deconcentration. A process of regionalizing the organization and management of the French health care system began in the early 1990s. In the first instance, this process was based on the regional directorates of health and social affairs (*directions régionales des affaires sanitaires et sociales*; DRASS), which were subsidiaries of the Ministry of

Health at the regional level and were given increasing responsibilities for hospital planning and budget allocations to hospitals. Later, several additional organizations were set up, resulting in a regional landscape with multiple actors. Prior to 2010, in each of the 26 regions, these actors were:

- the Regional Hospital Agency (*Agence régionale de l'hospitalisation; ARH*)
- the Regional Union of Health Insurance Funds (URCAM)
- the Regional Union for Self-employed Doctors (URML)
- the Regional Health Conference (CRS)
- the Regional Public Health Group (*groupement régional de santé publique; GRSP*)
- the Regional Health Mission (*mission régionale de santé; MRS*).

The ARH was created by the 1996 reform and took over the remit of hospital capacity planning from the state (DRASS) and from the regional health insurance funds (CRAM), which previously shared management of this sector. It was also given the responsibility of financing hospitals (public and private) within the framework of the regional hospital subtarget of the ceiling for SHI expenditure (ONDAM) (see Section 3.4). An ARH director was appointed by the Council of Ministers and was directly responsible to the Minister of Health.

The URCAMs, also created by the 1996 reform, brought together the three main health insurance schemes at the regional level (see Section 2.3.5). They coordinated the work of the local funds and gave impetus to a regional policy of risk management. In relation to the ARH, their function was to influence and stimulate, but they did not have authority over the regional and local funds.

The URMLs were created in 1993 (Act 93-8 of 4 January 1993; see Section 2.3.6) to engage in dialogue with institutions in charge of planning and regulations at the regional level (ARH and URCAM).

The CRSs (created by the 1996 reform and given a permanent status by the 2004 Public Health Act) feed into the regional planning process, bringing together all the regional actors involved in organizing, financing and delivering health care (the federations of private and public hospitals, health professionals, health insurance funds and patient representatives) to assess regional health needs, discuss additional regional priorities for service delivery and advise regional decision-makers on an implementation strategy. For instance, one result of this was that in 10 regions, equity of access to care was identified as an additional priority, leading to the creation of about 300 centres providing

24-hour access for patients in low-income groups. The regional conferences also provide the National Health Conference (see Section 2.3.7) and the Ministry of Health with information on regional issues and health needs.

The GRSP was introduced by the 2004 Public Health Act. It was in charge of designing, implementing and monitoring the regional public health plan the results of which form the national public health targets established by the 2004 Public Health Act (see Section 6.1). It is chaired by the Regional Prefect (representative of the state). Members of the group include local representatives of national public health agencies (see Section 2.3.3), payers and regional planners.

The MRS was created by the 2004 Health Insurance Reform Act to reinforce the partnership between the state and SHI. Chaired alternatively by the head of the ARH or the head of URCAM, its mission was to improve the efficiency of the system by improving, among others, ambulatory care planning through health professionals' geographic distribution and coordination.

The 2004 reform also introduced the concept of the ARS, which would replace regional and departmental institutions in charge of the provision and funding of public health and health care. However, ARSs were not created until the 2009 HPST Act. With the aim of achieving better governance of the system at the regional level and better response to needs and higher efficiency, the ARS was formed to merge seven regional institutions from 1 April 2010: the ARH, the URCAM, the CRAM (see Section 2.3.5), the DRASS, the departmental Directorate of Health and Social Affairs (*direction départementale des affaires sanitaires et sociales*; DDASS) (which were the subsidiaries of the Ministry of Health at the department level), the GRSP and the MRS.

Cutting across the traditional boundaries of health care, public health and health and social care sectors for elderly and disabled, the ARS has responsibility for ensuring that health care provision meets the needs of the population in improving articulation between ambulatory and hospital sectors and health and social care sector services, while respecting national health expenditure objectives (ONDAM).

The ARS implements regional health policy in relation to occupational health services, mother and child health services (*protection maternelle et infantile*; PMI), and university and school health services. It monitors the regional health status of the population, establishes that hygiene rules are respected and participates in prevention and patient health education. It assesses health professionals' education. It also carries out SHI regional programmes,

notably in risk management. It gives authorizations for the creation of new health services and social and health services for the elderly and disabled. In the environment and health sector, it also covers water and air quality and safety. It is provided with information on regional issues, health and health and social care needs by the Regional Conference on Health and Autonomy (*conférence régionale de la santé et de l'autonomie*; CRSA), which replaces the CRS and extends its competencies to the health and social care sector for elderly and disabled.

The ARS is also advised by two commissions for coordination of public policies that group representatives of the state, of general councils and other local authorities, and of local social security schemes. One is dedicated to prevention, school health, occupational health and mother and child health. The other is dedicated to health and social care for elderly and disabled.

The ARS is a subsidiary of the state under the watchdog of the ministers in charge of health, social security, the elderly and disabled. However, it is an autonomous body, and its director, appointed by the Ministry of Health, has extended autonomy with regards to SHI and CNSA budget management and capacity planning in the region. The Surveillance Council (*Conseil de surveillance*) headed by the regional prefect is in charge of approving the budget and the expenses of the ARS and of giving its opinion on the PRSs, which are the main regional capacity planning tool (see Section 4.2).

In order to implement national policies at the regional level, services of the state do not communicate directly with the ARS but should be approved first by the National Council for the Governance of Regional Health Agencies (*Conseil national de pilotage des ARSs*), which pass orders on to the ARS. The National Council groups together representatives of SHI, CNSA and the ministries in charge of health, social security, and the elderly and disabled.

Moreover, following the 2009 HPST Act, in order to enlarge the discussion between the ARS and health professionals, the URML was replaced by the Regional Union of Health Care Professionals (URPS), which is not limited to self-employed doctors but also includes representatives of all categories of self-employed health professionals.

Institutions at the department level

Each ARS covers several departments. The ARS is represented in each department by a local delegation (*délégation territoriale de l'agence régionale de santé*) that is in charge of the implementation of the ARS's regional policies and of supporting local actors in the implementation of their projects. It brings the decision-making process closer to the field.

Several health and social services that are not under the remit of the ARS come under the jurisdiction of the General Council (see Section 1.3). These include:

- health and social care institutions and services for elderly and disabled people (nonmedical facilities come under the authority of the general councils, who supervise them and finance them through social assistance budgets, while facilities combining social and medical services come under the joint supervision of the state and the general councils);
- social welfare and work programmes responsible for the financial support of those with low incomes, the elderly and disabled people in institutions and for financing assistance in the home;
- protection of children, particularly through the management of mother and child health centres, which offer consultations and free health care;
- prevention of certain diseases, such as tuberculosis, sexually transmitted diseases and cancer;
- public health and hygiene (environmental health, sanitation, etc.), in conjunction with municipalities.

Table 4.1 has a more detailed analysis of decentralization in regulatory functions.

2.5 Patient empowerment

In recent years, the search for ways to take more account of the expectations of health care users has been an important issue of public debate. A pivotal act was passed in 2002, the Patients' Rights and Quality of Care Act, also known as the Kouchner Act (after the name of the acting Minister of Health at that date) (Act no. 2002-303 of 4 March 2002; *loi relative aux droits des malades et à la qualité du système de santé*). This Act defined:

- requirements of solidarity towards disabled people;

- principles of health democracy (in particular, the rights and duties of patients and health professionals);
- quality requirements of the health care system;
- principles for compensating victims of health hazards;
- professionals' liability.

The following section has more details.

2.5.1 Patient information

Information on the quality of health services is increasingly available to the public. Information on hospitals is available on the web site of HAS, although it concerns only the outcome of the accreditation process. Physicians who underwent the practice appraisal procedure can advertise this in their office or on their letterhead, but no standardized process is currently in place to disseminate the information. Other sources of information include a yearly star ranking of hospital departments in newspapers and magazines. For example, *Le Point* magazine usually provides a star ranking of public and private hospital wards for a variety of medical and surgical specialties in its September issue.

Freedom of information is governed by legislation that dates back to 1789; in addition, France applies EU jurisprudence (*Cour européenne des droits de l'homme*, 21 January 1999, no. 29183/95).

2.5.2 Patient rights

Patient information on the process of care is mandated by law and has to be provided faithfully and understandably. Courts have repeatedly ruled that a signed document was neither necessary nor sufficient since physicians can simply ask the patient to sign without giving sufficient information, although many professional organizations continue to use information leaflets that patients must sign before undergoing an invasive procedure. The recommended form of information and consent is by writing in the patient's chart the exact information process that took place before the procedure. Patients have access to their medical charts.

The activities of certain patient associations have been a factor in the development of patient rights. The AIDS epidemic was the trigger for a transformation in the types of action used by associations concerned with health care. Having achieved visibility through public interventions, these associations are no longer restricted to their traditional role (patient support, fund-raising to finance research) but seek to affect the direction of research and enforce the concept of the patient as an active agent in his or her own

health care. Alongside the strengthening of these patient associations, there also has been a reinforcement of general-purpose organizations, such as consumers associations. The Inter-Association Collective of NGOs acting for patient rights (*collectif interassociatif sur la santé*; CISS) was created in 1996 but gained additional power and legitimacy after the 2002 Act on Patients' Rights and Quality of Care. It is the umbrella organization for 25 associations active in the field of health care (focusing on various groups such as patients, disabled people, consumers, families) and a member of the European Patient Forum. The 2002 Act also further developed the role of patient associations, allowing them to act as patients' representatives, to sit on the board of hospitals and to participate in both regional and national health conferences (Société française de santé publique 2004).

The access of those who might otherwise be excluded is mainly ensured through the tools that have been introduced in the 2002 Act to ensure this solidarity and protection:

- provision of assistance from a “qualified person” to help to enforce patient rights (Article L.311-5, 2003-1094 Decree);
- information booklet provided to every person admitted to hospital (Article L.311-4); chart of rights and freedom (*La charte des droits et des libertés*; Article L.311-4), which states the principles that apply to all hospitalized people, such as non-discrimination, respect of dignity and privacy, right to information, protection, informed consent and autonomy;
- provision of a specific “admission contract” that must be given to individuals who are admitted for an extended period of time (over 2 months) in an institution (Article L.311-4, 26 November 2004 Decree), which is signed by the patient or his representative.

2.5.3 Patient choice

France is usually perceived as a country where there is extended patient choice, particularly when compared with systems with traditional gatekeeping such as the United Kingdom. However, although universal coverage is theoretically guaranteed by SHI and by the safety net of universal medical coverage, there has been concern over the actual ability of patients either in remote rural areas or with limited financial capacity to choose their providers. The 2006 report of HCAAM (HCAAM 2006) commented on the difficulty in regions with a low density of professionals to get an appointment with a physician who does not bill in addition to the official fee that serves as the coverage base for SHI (“extra-billing”). It also reported the results of a survey of physicians in private

practice with regards to their readiness to give appointments to patients with universal medical coverage for whom extra-billing is not possible. The survey found that specialists and dentists who usually bill extra tended to refuse 40% of patients. Another survey noted that 9% of the French population did not seek specialist care and 40% did not seek dental care because of financial limitations (DREES 2008). Moreover, the introduction of the coordinated health care pathway with the “preferred doctor scheme” (see Section 6.3.4) was considered to diminish patient choice according to financial criteria, since, in order to not face a decrease in the SHI coverage rate, a patient is obliged to consult their preferred doctor in the first instance.

2.5.4 Patients and cross-border health care

In 2007, French patients receiving care elsewhere in the EU cost France €226.53 million, while EU citizens receiving care in France brought in €482.62 million, a net positive balance of €256.09 million. This positive balance was fairly stable over the previous 10 years. The most important providers of patients are neighbouring countries: Germany, Belgium, the United Kingdom, Spain and Italy.

France receives its money from the other Member States exclusively through invoiced credits; that is, it does not use lump-sum payments. Trans-border agreements for the use of hospital facilities have been made between France and Spain in the area of Cerdania (France)/Cerdanya (Spain), a sparsely populated area in the Pyrenees. The most well-known experience of cross-border health care to be sought in France is from British patients who were discouraged by the waiting lists in their country. However, the most important patient movements currently take place between France and Belgium, with common protocols for emergency care and quality assurance. The Franco-Belgian cooperation has been established by four hospitals in neighbouring cities of Mouscron, Roubaix, Tourcoing and Wattrelos, supported by SHI in both countries. It allows patients from either country to receive care without preliminary authorization.

2.5.5 Complaints procedures

The 2002 Act on Patients’ Rights and Quality of Care and the by-laws resulting from it determined the general rules for patient complaint and compensation procedures. Procedures are similar for primary and specialized care. However, differences exist across places where care is delivered.

In public hospitals, the first step of a patient’s complaint (before a formal case is brought against the hospital) is dealt with by a conciliatory procedure, involving the hospital mediator (usually a senior physician) and the patient or the patient’s family.

Patients with complaints against self-employed doctors (office-based or working in private profit-making hospitals) may bring a case against doctors in the courts of justice and may also bring a case to the physician's professional association (Section 2.3.6). The physicians' associations are qualified to take disciplinary sanctions against physicians.

All drug-related events must be reported by physicians to the regional centre for pharmaceutical vigilance. The centre is responsible for making the required inquiries and notifying the manufacturer.

The 2004 Public Health Act provides specific protection for vulnerable populations: minors, pregnant women, disabled people, prisoners and mentally ill people.

2.5.6 Patient safety and compensation

The 2002 Act on Patients' Rights and Quality of Care established the possibility for patients to obtain compensation without demonstrating that there was a fault from either a health professional or an institution. It also simplified the procedure for patients who bring a case to court. In order to receive compensation, patients previously had to bring evidence of a physician's (or hospital's) fault in every case. The 2002 Act reversed this situation in certain cases, where the burden of proof must then be borne by the professional or the institution. The current law distinguishes three types of responsibility:

- where there is a proven medical error and compensation is paid by the physician's personal insurance in the case of office-based physicians or the hospital's insurance otherwise;
- where there is responsibility without fault for hospital-acquired infections ("without fault" meaning without required evidence of a fault): patients are compensated by the hospital's insurance;
- where there is responsibility without fault for other events, also called therapeutic hazards, patients are compensated by SHI through a specific institution, the National Office for the Compensation of Medical Accidents (*Office national d'indemnisation des accidents médicaux*; ONIAM).

The 2004 Health Insurance Reform Act established a national reporting procedure for adverse events and "near misses" occurring during surgical and invasive medical procedures. Although control and enforcement may seem difficult, physicians have an incentive to comply with this requirement. First, compliance with the reporting system allows them to fulfil their obligation

of professional practice appraisal. Second, for physicians in private practice, compliance with the reporting allows them to claim rebates in their professional liability insurance.

2.5.7 Patient participation

A 2006 survey of the French population found that 80% of patients were satisfied with the current organization and funding basis of the health care system (Boisselot 2006). The *Eurobarometer* for 2002 (European Commission 2002) reported that 70% of the French population was satisfied with the health care system, ranging from 59% for those aged 30–44 years to 78% for the population under 30 years (Table 2.1) (see also Section 8.5).

Table 2.1

Percentage of population satisfied with the health care system, by age group (years)

Age group (year)	% population satisfied
0–29	78
30–44	59
45–64	70
65+	68

Source: European Commission 2002.

2.5.8 Physical access

By law, all public buildings must ensure access for people in wheelchairs and ensure that toilets can be accessed by people in wheelchairs. The accreditation procedure that all health care institutions undergo every four years serves as enforcement of the law.

3. Financing

Financial responsibility for health care in France is mainly borne by Statutory Health Insurance (SHI) as a branch of the wider system of social security. It has almost reached universal coverage (99.9% of the population), although it only funds three quarters of health spending, leaving considerable scope for complementary sources of funding (Fig. 3.1).

3.1 Health expenditure

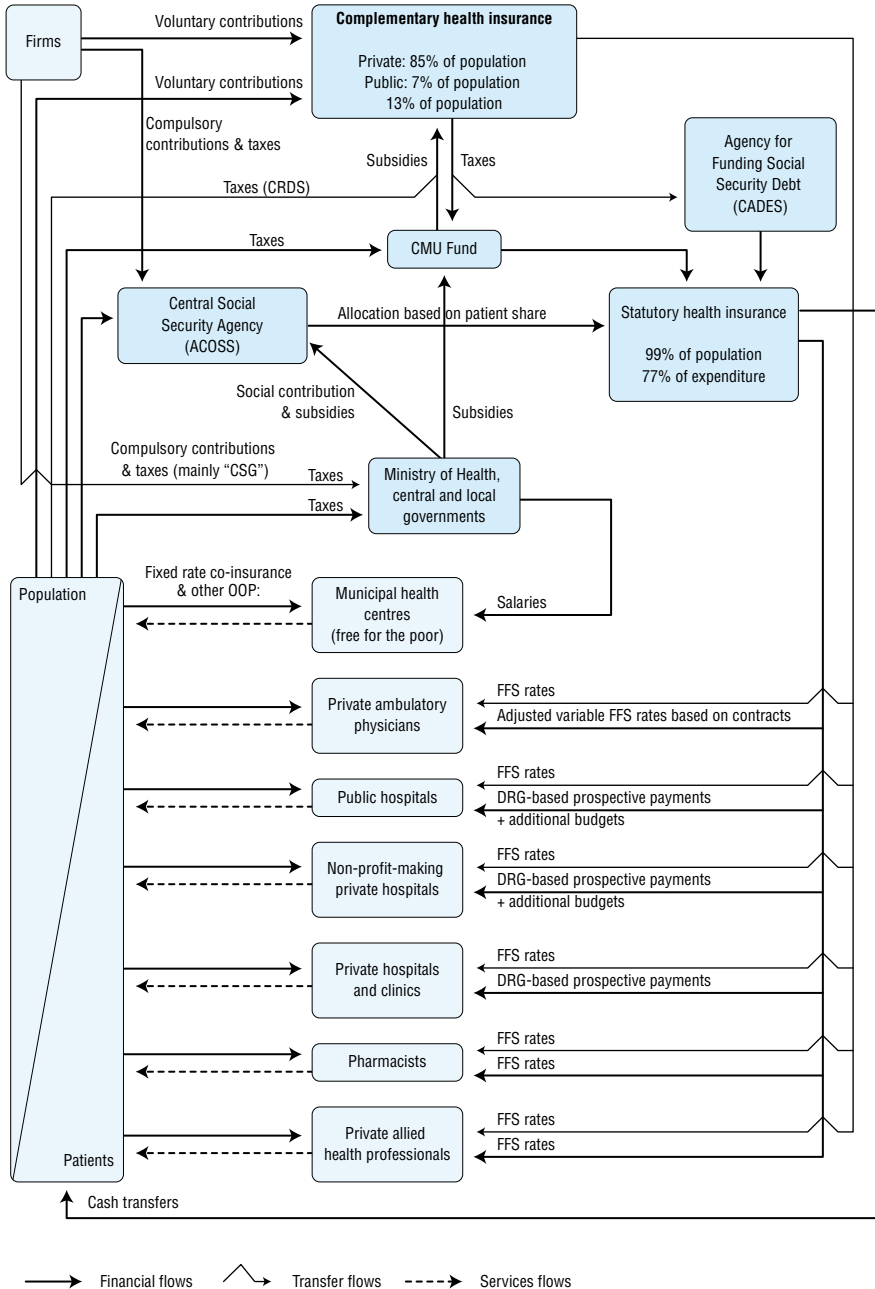
In 2007, total expenditure on health in France was estimated at €208 billion, or 11% of GDP¹ (Table 3.1). Expenditure on personal health care accounted for €184 billion or 88% of total health care expenditure, representing an average of €2895 per person. The figure for total health care expenditure includes personal expenditure plus expenditure activities related to research (3.4%), teaching (0.6%), health administration and insurance (6.9%) and public health and prevention (1.9%). However, expenditure on preventive care is much higher when taking into account personal preventive care provided out of public health programmes. A recent report estimated that preventive care expenditure reached €10.5 billion in 2002, accounting for 6.8% of total expenditure on health (Renaud, Sermet 2008).

Several arguments have been put forward by the government to justify cost-containment as a central objective in plans for health care reform. As in other countries, health care expenditure in France grew more rapidly than national wealth for many years, with the exception of the 1997–2000 period (Fig. 3.2). Total expenditure on health as share of GDP has risen slightly faster than in neighbouring countries (with the exception of the United Kingdom), from 8.4% in 1995 to 11% in 2007 (Table 3.2).

¹ Data on health care expenditure reported in this section are issued from the National Health Accounts, which uses a comparable approach to that of the OECD.

Fig. 3.1

Financial flows in the health care system, 2008 (excluding long-term care and prevention)



Source: OECD 2002 (data updated by IRDES in 2006 (Allonier et al. 2006) DREE in 2007 (Fenina et al. 2007) and URC Eco in 2008).
Notes: FFS: Fee-for-service.

Table 3.1

Health care expenditure 1990–2007: (a) trends in health care expenditure;
(b) mean annual growth rates in health care expenditure

(a) Trends in health care expenditure

Expenditure	1990	1995	2000	2005	2007
TEH					
Value at current price level (billion euros)	86.4	123.9	145.2	191.6	208.4
As % of GDP France	8.4	10.4	10.1	11.1	11
per capita PPP (US\$ in 2000 price)	1813	2330	2542	2941	3010
Personal health care expenditure					
Value at current price level (billion euros)	80.8	108.5	127.2	168.7	184
Public expenditure as % of TEH	76.6	79.6	79.4	79.3	79
Private expenditure as % of TEH	23.4	20.3	20.6	20.7	21

(b) Mean annual growth rates in health care expenditure

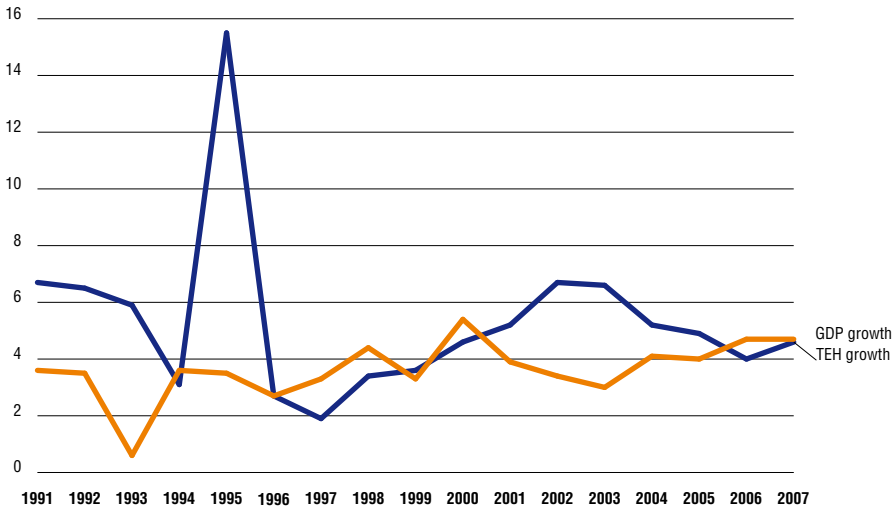
Expenditure	1990–1995	1995–2000	2000–2005	2005–2007
TEH (million euro)	6.6	3.2	5.7	4.3
TEH PPP per capita PPP (US\$ in 2000 price)	5.7	1.8	3.1	1.2
Personal health care expenditure (million euros)	6.9	3.4	6.5	4.5
TEH as % of GDP (average)	8.9	10.2	10.5	11.0
Public expenditure on health as % of GDP (average)	6.8	8.2	8.4	8.7
Out-of-pocket payments as % TEH (average/GDP year 2000 = 100%)	11.4	7.3	7.0	6.8

Sources: Eco-Santé 2009; OECD 2009a.

Notes: PPP, purchasing power parity. TEH: Total expenditure on health.

Fig. 3.2

Percentage growth rate in total health expenditure (TEH) and gross domestic product (GDP), 1991–2006



Sources: Eco-Santé 2009; OECD, 2009a.

Table 3.2

Comparison of trends in health expenditure as a percentage of gross domestic product

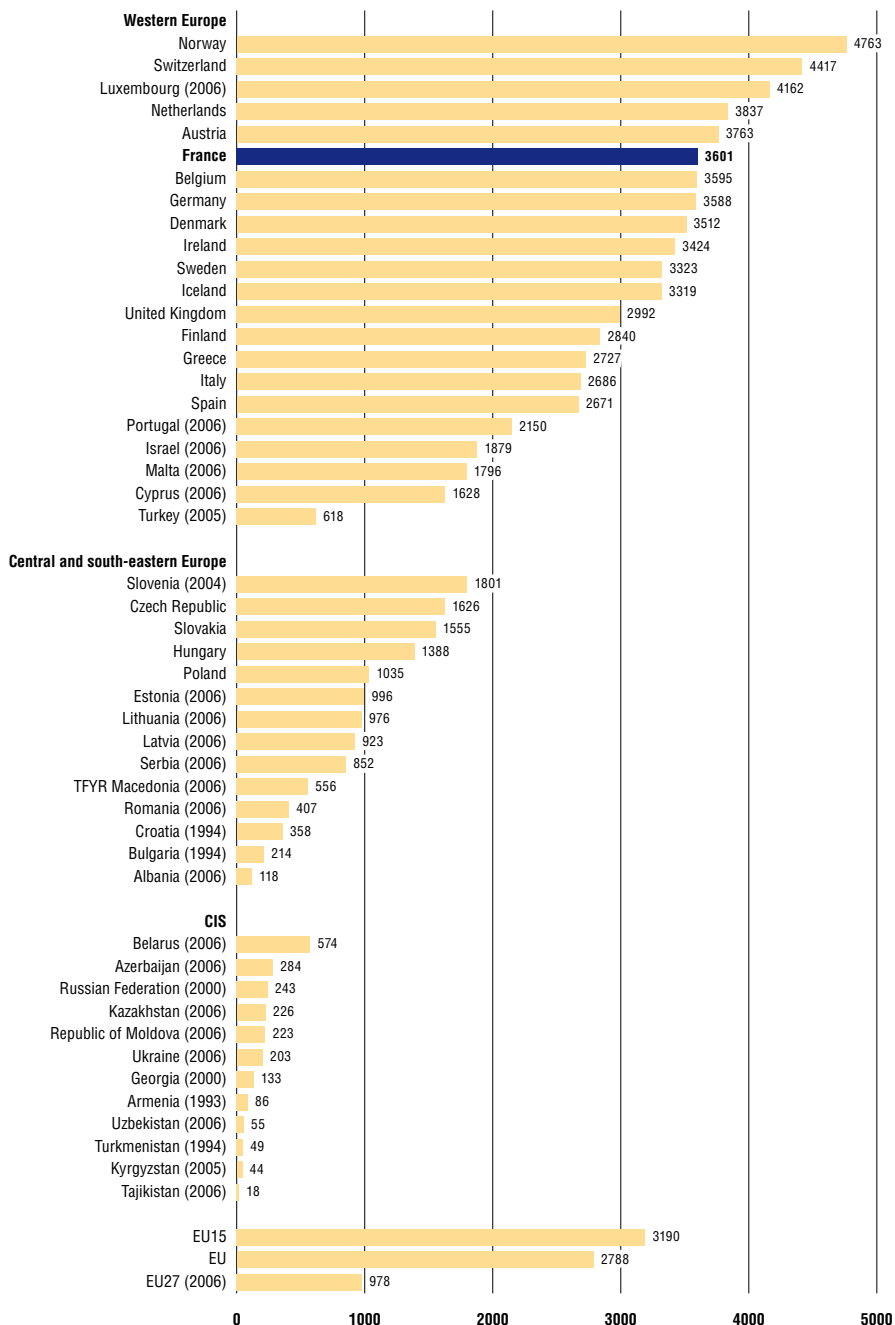
	1990	1995	2000	2005	2006	2007
France	8.4	10.4	10.1	11.1	11.0	11.0
Germany	8.3	10.1	10.3	10.7	10.6	10.4
Spain	6.5	7.4	7.2	8.3	8.4	8.5
United Kingdom	6.0	6.9	7.2	8.2	8.4	8.4
Italy	7.7	7.3	8.1	8.9	9.0	8.7

Sources: Eco-Santé 2009; OECD 2009a.

In 2006, France ranked ninth among OECD countries and sixth among WHO European Region countries (2005 figures) (Fig. 3.3) for the level of per capita health care expenditure but in first place for health care expenditure as a proportion of GDP (Fig. 3.4). France is above the regression curve that marks the average relationship between the wealth of a country and the amount of per capita health care expenditure among OECD countries. Taking its wealth into account, France, therefore, spends more on health care than other OECD countries. However, with an 80% share of public health care expenditure it ranks only tenth among WHO European regions countries (Fig. 3.5).

Fig. 3.3

Health expenditure in WHO European Region (purchasing power parity per capita), latest available year

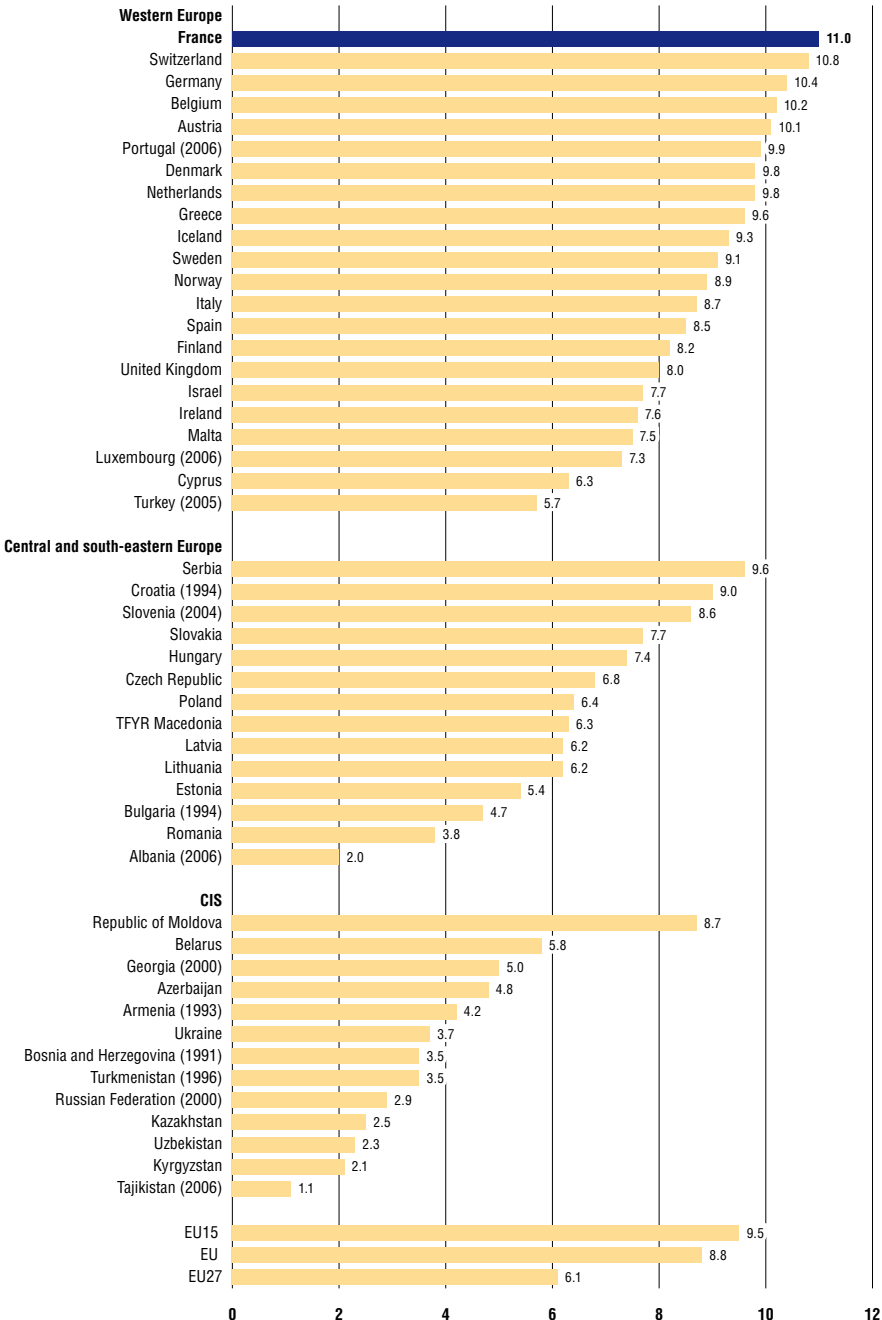


Source: WHO Regional Office for Europe 2010.

Notes: Eur-A,B,C: Regions as in the WHO list of Member States, last available year.

Fig. 3.4

Health expenditure as a percentage of GDP in the WHO European Region,
latest available year

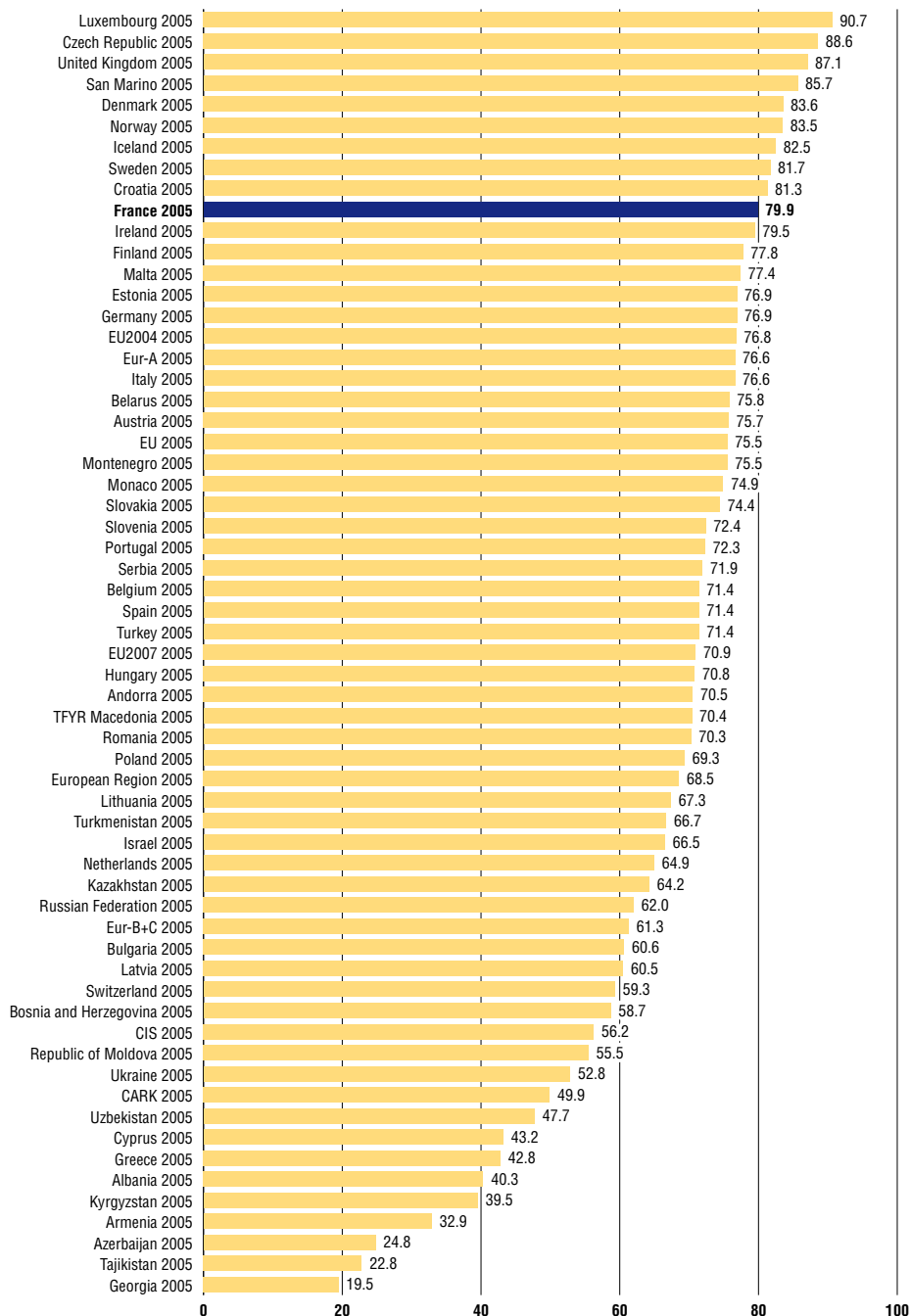


Source: WHO Regional Office for Europe 2010.

Notes: Eur-A,B,C: Regions as in the WHO list of Member States, last available year.

Fig. 3.5

Public sector health expenditure as a percentage of total health expenditure, latest available year



Source: WHO Regional Office for Europe 2010.

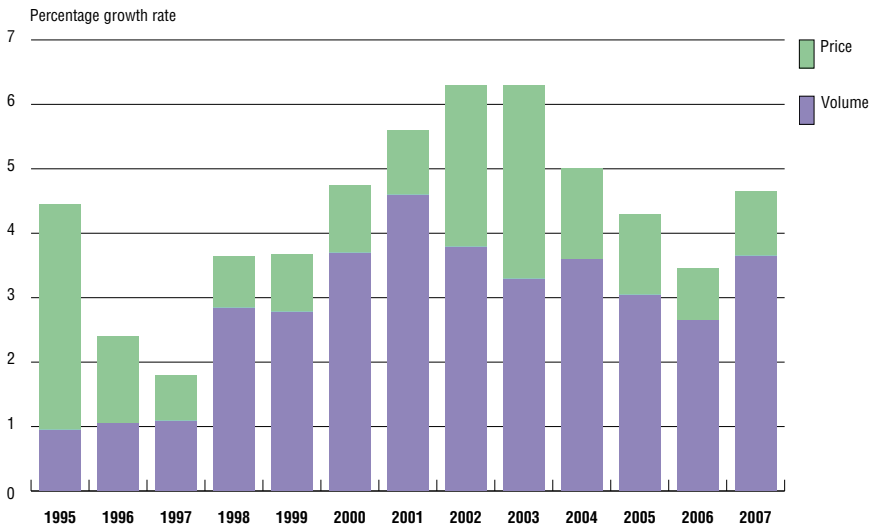
Notes: Eur-A,B,C: Regions as in the WHO list of Member States, last available year.

The evolution of health care expenditure is a result of growth in the volume of care provided and growth in the price of that care, which is, in turn, linked to general inflation and specific conditions governing the means of production. Overall, the health care price index has developed at a similar pace to the general price index. This is the result of contrasting trends in the relative price of different types of care in different sectors (significant and rapid growth in hospital prices and slower growth in the price of drugs).

In 2002 and 2003, health care prices increased much faster than previously owing to an increase in outpatient prices linked to a significant rise in doctors' fees (statutory tariffs) (Fig. 3.6). The decrease that followed is mainly related to a decrease in drug prices and, to a lesser extent, in other goods (Fenina et al. 2007).

Fig. 3.6

Percentage growth rate of personal health expenditure on services and goods in total expenditure and volume, 1995–2007



Source: Fenina et al. 2007, 2008.

In 2007, total expenditure on health care consumption, by type of service, was divided as follows (Tables 3.3 and 3.4):

- 42.5% on hospital inpatient care in health care institutions in the public and private sectors, of which 5.4% related to day care;
- 2.7% for domiciliary services;
- 29.7% on outpatient care, of which 17.5% related to care provided by doctors, 4.5% to dental care and 5% to services provided by ancillary services (for example, laboratory tests, imaging and patient transport);
- 16.3% on drugs and 4.2% on other medical devices and appliances (for example, bandages and minor supplies, lenses and orthopaedic appliances).

Table 3.3

Total expenditure by service input

	Percentage of total expenditure (million euros at 2000 GDP price)					
	1990	1995	2000	2005	2006	2007
Health administration and insurance	1.6 (1614)	8.2 (10 103)	8.2 (11 372)	7.1 (12 329)	7.0 (12 380)	6.9 (12 368)
Education and training	na	0.6 (722)	0.6 (817)	0.5 (922)	0.5 (940)	0.6 (1001)
Health research and development	na	1.8 (2232)	2.0 (2781)	3.5 (6042)	3.4 (6023)	3.4 (6046)
Investment in medical facilities at primary, secondary, tertiary, intermediate, social care levels	2.5 (2475)	2.4 (2999)	2.3 (3162)	2.8 (4858)	2.8 (4932)	2.9 (5233)
Public health and prevention	2.3 (2313)	2.9 (3631)	3.0 (4095)	2.1 (3605)	2.2 (3851)	1.9 (3478)
Medical devices and therapeutic appliances	3.2 (3215)	2.8 (3484)	3.0 (4126)	4.1 (7183)	4.2 (7352)	4.2 (7621)
Medicines	16.9 (16 703)	16.0 (19 814)	18.2 (25 218)	16.7 (9146)	16.4 (28 969)	16.3 (29 398)
Medical services						
<i>Hospital care</i>	45.7	42.4	40.2	42.4	42.3	42.5
Inpatient care	44.3 (43 897)	39.2 (48 422)	35.7 (49 437)	37.0 (64 419)	36.9 (65 278)	37.0 (66 595)
Day care	1.4 (1410)	3.2 (3999)	4.5 (6163)	5.4 (9376)	5.4 (9632)	5.5 (9919)
<i>Outpatient care</i>	33.5	30.4	30.0	29.4	29.7	29.7
Ambulatory physician services	23.7 (23 504)	21.6 (26 710)	21.4 (29 537)	17.4 (30 311)	17.5 (30 957)	17.5 (31 416)
Ambulatory dental services	5.7 (5609)	5.1 (6251)	4.8 (6668)	4.6 (7932)	4.6 (8075)	4.5 (8076)
Ancillary services	3.8 (3726)	3.3 (4058)	3.4 (4680)	5.0 (8776)	5.1 (9075)	5.0 (9032)
Long term nursing care at home	0.3 (268)	0.4 (433)	0.4 (504)	2.4 (4236)	2.5 (4504)	2.7 (4877)
Total expenditure on health	99 160	130 190	145 182	173 732	176 230	179 938

Sources: Eco-Santé 2009; OECD, 2009a.

Note: na: Not available.

Table 3.4

Public expenditure by service input

	Percentage of public expenditure on health (million euros at 2000 GDP price)					
	1990	1995	2000	2005	2006	2007
Health administration and insurance	0.3 (245)	7.2 (7009)	6.9 (7458)	5.7 (7906)	5.5 (7821)	5.5 (7743)
Education and training	na	na	na	0.6 (826)	0.6 (842)	0.6 (896)
Health research and development	na	2.3 (2232)	2.6 (2781)	2.1 (2934)	1.9 (2619)	1.8 (2532)
Investment in medical facilities at primary, secondary, tertiary, intermediate, social care levels	3.3 (2475)	3.1 (2999)	2.9 (3162)	3.5 (4858)	3.5 (4932)	3.1 (4374)
Public health and prevention	1.9 (1423)	2.8 (2682)	2.8 (3048)	1.8 (2482)	1.9 (2719)	1.7 (2347)
Medical devices and therapeutic appliances	1.3 (956)	0.8 (799)	0.6 (697)	2.0 (2826)	2.1 (2972)	2.2 (3109)
Medicines	13.6 (10 332)	12.7 (12 333)	15.8 (17 127)	14.5 (20 208)	14.2 (20 106)	14.3 (20 394)
Medical services						
<i>Hospital care</i>						
Inpatient care	53.3 (40 447)	46.7 (45 351)	42.8 (46 344)	43.8 (60 956)	43.6 (61 606)	44.0 (62 493)
Day care	1.7 (1293)	3.8 (3733)	5.3 (5753)	6.3 (8832)	6.4 (9034)	6.5 (9232)
<i>Ambulatory care and services</i>						
Ambulatory physician services	20.4 (15 473)	19.1 (18 573)	18.7 (20 311)	14.1 (19 607)	14.1 (19 971)	14.2 (20 195)
Ambulatory dental services	3.1 (2359)	2.7 (2634)	2.3 (2501)	2.1 (2942)	2.1 (2989)	2.2 (3059)
Ancillary services	4.0 (3001)	3.4 (3279)	3.6 (3926)	5.3 (7412)	5.4 (7667)	5.3 (7573)
Long term nursing care at home	0.4 (268)	0.4 (433)	0.5(504)	2.9 (4056)	3.1 (4312)	3.3 (4675)
Total public expenditure on health	75 939	103 742	115 252	137 695	139 451	142 134

Sources: Eco-Santé 2009; OECD, 2009a.

Expenditure corresponding to different types of health care has undergone differing patterns of development, leading to a change over time in the structure of health care expenditure. The hospital sector expanded until the beginning of the 1980s, but since then it retracted before stabilizing at around 42% of total health care expenditure and 48% of personal expenditure (Tables 3.3 and 3.5). This trend can be found in many countries and reflects both France's policy of controlling hospital budgets and technical developments that have been conducive to the growth in outpatient care.

Table 3.5

Share of personal health care expenditure by type of care (%)

Type of care	1985	1990	1995	2000	2005	2006	2007
Hospital services	52.2	48.8	49.0	46.5	48.1	48.1	48.1
Inpatient care	51.0	47.3	45.3	41.3	42.0	41.9	41.9
Day care	1.2	1.5	3.7	5.2	6.1	6.2	6.2
Ambulatory care and services	47.8	51.2	51.0	53.5	51.9	51.9	51.9
Outpatient care	23.8	25.3	25.0	24.7	19.8	19.9	19.8
Ancillary services	3.7	4.0	3.8	3.9	5.7	5.8	5.7
Home care	0.2	0.3	0.4	0.4	2.8	2.9	3.1
Medical goods	20.2	21.5	21.8	24.5	23.7	23.3	23.3
Drugs	17.3	18.0	18.5	21.1	19.0	18.6	18.5
Medical devices and prostheses	2.9	3.5	3.3	3.4	4.7	4.7	4.8
Total	100	100	100	100	100	100	100

Sources: Eco-Santé 2009; OECD, 2009a.

Trends in expenditure in other areas have differed from trends in hospital expenditure. In 1980, expenditure on drugs accounted for 17.3% of personal health care expenditure, while in 2000 it accounted for 21.1%, and then decreased again to 18.5% in 2007 (Table 3.5). The initial rise reflected the growing role of drugs as a substitute for hospital treatment and also technological innovation leading to the introduction of many new, effective but expensive drugs. The subsequent decrease resulted from the introduction of tight constraints on the price and the use of innovation.

Expenditure on ambulatory care and services has been relatively stable as a proportion of total expenditure on health care. However, this constancy is a result of contrasting trends: a decrease in outpatient care expenditure and an increase in ancillary services and in medical goods. As described later in this chapter, among medical goods, the constant rise in medical devices expenditure is of growing concern because it is poorly financed by public expenditure (see Section 3.3.3).

3.2 Population coverage and basis for entitlement

In France, the coverage of health care costs accounts for 85% of SHI expenditure. The remaining 15% goes to cash benefits in the form of daily allowances for maternity, sickness or occupational accident leave and disability pensions.

As a general rule, in the ambulatory sector patients are expected to pay health care providers themselves and then claim reimbursement of a share of their expenses from their health insurance fund. However, there are situations in which the patient is exempt from making the initial direct payment. This system of direct payment by the health insurance fund to the provider is known as “third-party payment” (*tiers payant*). The third-party payment system is becoming increasingly common in ambulatory care. It applies to beneficiaries defined by the Universal Health Coverage Act (CMU Act) (described below), those involved in occupational accidents and patients admitted to hospital. It may also be used in laboratories, pharmacies, hospital consultations and outpatient clinics, and by some doctors for expensive examinations and treatments. In total, third-party payment accounts for about 75% of health care expenditure.

The following sections give details of the general principles of coverage, describing which people are covered, for which type of care or health goods and at what level.

Population coverage

French SHI has almost reached universal coverage, covering 99.9% of the population in 2008 (62.7 million people of whom 56 million are covered by the general scheme; see Section 2.3.5).

Historically, SHI developed as part of the broader social security system (see Section 2.2). People are covered on an employment basis and any dependants of the insured person are also covered. Employees cannot opt-out. Coverage has gradually been extended from covering employees in industry and commerce to covering the population in general, incorporating students (in 1948), career soldiers (in 1949), farmers (in 1961) and self-employed professionals (in 1966–1970).

For those who were not covered by SHI on an employment basis (for example, people with different sources of revenue, those with low income and the unemployed) voluntary opting-in was introduced in 1978. These people pay a fixed premium to SHI. Prior to the CMU, this could be financed for people with low income by the general councils (see Section 1.3 for a description of general councils).

Since 1 January 2000, the CMU Act has completed this extension of insurance by offering basic health insurance coverage to the poorest who are legitimately resident in France, whatever their employment status. The CMU coverage depends on residence in France. Contributions depend on the level of income: people with a taxable income of less than €9020 per year are

exempted from paying contributions, while people above this ceiling pay 8% of their taxable income. Additionally, free voluntary health coverage is offered to people below a defined ceiling² (see Section 3.3.2). Thus, the criteria for coverage have progressively moved from employment status to resident status.

For foreigners “*de passage*” and illegal residents (that is, foreigners without residence cards), the state medical help (*aide médicale d'état*; AME) usually covers access to consultations, hospital stays and prescriptions for tests, medical devices and so on.³ Patients do not have to pay for care, while providers will be paid directly at the SHI official tariffs.

Prisoners and their families are systematically covered by the general scheme (CNAMTS) for the duration of their stay in jail.

Definition of benefits

Medical goods and services covered

Medical goods and services qualifying for coverage by SHI include:

- hospital care and treatment in public or private institutions providing health care, rehabilitation or physiotherapy;
- outpatient care provided by GPs, specialists, dentists and midwives;
- diagnostic services and care prescribed by doctors and carried out by laboratories and paramedical professionals (nurses, physiotherapists, speech therapists, etc.);
- pharmaceutical products, medical appliances and prostheses prescribed and included in the positive lists of products eligible for reimbursement;
- prescribed health care-related transport.

In order to be eligible for coverage, diagnostic services, treatment, drugs and prostheses should have been provided or prescribed by a doctor, a dentist or a midwife and distributed by health care professionals or institutions registered by SHI.

The benefit package covered by SHI is defined differently for outpatient and inpatient care. The types of outpatient care that are covered are stated in explicit positive lists (see Table 3.6 below): the three official lists are procedures for health care professionals, the list of reimbursable drugs (*liste des specialites pharmaceutiques remboursables*; LSPR) and the list of reimbursable medical

² As of January 2010, this ceiling ranges from €7521 for a single person household to €3760 per person for a household of six and €3008 for each additional person.

³ This applies to individuals who are resident in France for over three months and have taxable income below the CMU ceiling.

devices and health materials (*liste de produits et prestations remboursables*; LPP). These are the same whatever the SHI scheme. They are displayed on the SHI web site.

For hospital inpatient care, there is a specific list for drugs (*liste des spécialités agréées aux collectivités*; LSAC) and the above explicit positive lists only apply for procedures paid for outside of the DRG system. In hospital, expensive and innovative drugs and devices that are paid in addition to the DRG tariffs are listed on special lists. For other categories of care, because hospitals are paid on a DRG basis, there is an implicit understanding of the range of services that can be delivered to patients.

Unless it is specified elsewhere (in a piece of regulation or a specific guideline for instance), hospital clinicians can decide what care to provide and what drugs to prescribe to patients (as long as drugs have market authorization (*autorisation de mise sur le marché*; AMM)). Therefore, innovative procedures or products are often introduced first in hospitals (and not paid separately on top of the DRG system) and second, inscribed on one of the lists mentioned above (lists included in Table 3.6 or special lists for innovative care are paid for on top of DRG tariffs).

Table 3.6

Positive lists entailed in the SHI benefit package

List	Area of coverage
<i>Nomenclature générale des actes professionnels</i> (general nomenclature of medical procedures; NGAP)	Health professionals' procedures
<i>Nomenclature des actes de biologie médicale</i> (biological laboratory tests and procedures; NABM)	Biological laboratories tests and procedures
<i>Classification commune des actes médicaux</i> (common classification of medical procedures; CCAM)	Doctors' technical procedures
<i>Liste des spécialités pharmaceutiques remboursables</i> (list of reimbursable drugs; LSPR)	Pharmaceuticals
<i>Liste des spécialités agréées aux collectivités</i> (specific list of drugs; LSAC)	Pharmaceuticals
<i>Liste de produits et prestations remboursables</i> (list of reimbursable medical devices and health materials; LPP)	Medical devices and related services

Initially, SHI was supposed to focus on the coverage of curative care, in case of illness or accident. In practice, however, more and more preventive care is covered, particularly for preventive treatment provided in a doctor's practice, such as mammography or cervical smear tests. Compulsory or recommended immunizations are also reimbursed, and care of pregnant women and newborn babies is free. Since 2007, a fixed budget of €50 per year is allocated to smokers for covering smoking cessation goods.

The range of services covered by SHI does not include cosmetic surgery or most types of thermal spa treatment; nor does it include some services of uncertain effectiveness. The choices required in the allocation of scarce resources may result in non-reimbursement for certain procedures (for example, bone densitometry performed in the private sector as a preventive measure) or limits on the frequency with which they can be reimbursed (for example, mammography for screening purposes).

For common health care or products, volumes of care are not specified. However, for expensive procedures or devices, volumes can be stated. This is the case, for example, with in vitro fertilization (*fécondation in vitro*), the full coverage of which is limited to four attempts, or drug eluting stents, for which one stent is covered by injury and no more than two per artery.

For certain kinds of care, such as physiotherapy and thermal spa treatments, prescription by a doctor is not a sufficient condition for reimbursement. Coverage for these kinds of treatment by SHI is subject to prior authorization through the doctors advising the the SHI Medical Service Office (*médecins conseil du service médical*), and after examination of the patient's case history and possibly an interview of the patient.

Actors involved in defining the benefit package

The positive lists are defined at the national level and apply throughout France in all regional authorities. Drugs and medical devices are added to the list by the Ministry of Health, while procedures are added by SHI (UNCAM) (see Section 2.3.5), on the advice of designated committees of the National Health Authority (HAS) (see Section 2.3.3 for more details on HAS).

One of the main roles of HAS is to produce scientific expertise on health goods and procedures. When a company or medical professional applies for a new service to enter one of the positive lists, a specific HAS committee issues advice on the service under consideration to whoever is in charge of defining if the service should enter the positive list or not (the Ministry of Health or SHI (UNCAM)).

To support its scientific opinion, HAS has developed the concepts of “medical benefit” and “the improvement of the medical benefit” (see Sections 4.2.1 and 6.6.1). A recent development, made in the 2008 Social Security Financing Act, has introduced the use of economic evaluation. This is considered a step forward, although its exact role and future implementation remain unclear (see Section 7.1.3).

The overall process is defined through regulation, as follows (see Table 3.7):

Drugs. The Transparency Commission (*Commission de la transparence*; CT), a HAS committee, advises the Ministry of Health, which decides whether or not to include the drug in the positive lists. It also advises SHI, which decides rate of coverage and the Economic Committee for Health Products (*Comité économique des produits de sante*; CEPS) which decides on statutory fees for drugs if they are listed.

Medical devices. The National Commission for the Evaluation of Medical Devices (*Commission nationale d'évaluation des dispositifs médicaux et des technologies de santé*; CNEDIMTS), a second HAS committee, advises the Ministry of Health, which decides whether to include it or not in the positive list. It also advises CEPS, which decides on the SHI price of the medical device if listed.

Medical procedures. The National Commission for the Evaluation of Medical Procedures (*Commission d'évaluation des actes professionnels*; CEAP), a third HAS committee, advises UNCAM (SHI), which decides whether or not to include it in the common classification of medical procedures (*classification commune des actes médicaux*; CCAM), jointly with representatives of the medical profession. Official tariffs depend on the level of technicality and resources required by the procedure (see Section 3.6.1).

Table 3.7

Key actors regarding coverage, rate of coverage and pricing of services and goods covered by SHI

Stage	Drugs	Medical devices	Diagnostic and therapeutic procedures
Clinical studies	Industry	Industry	Teaching hospitals and health professionals
Introduction to the market	Notified bodies for CE marking; AFSSAPS	Notified bodies for CE marking; AFSSAPS	–
Assessment of clinical benefit	Transparency commission	CNEDIMTS	CEAP
Coverage decision: registration on a positive list	Ministry of Health	Ministry of Health	SHI
Coverage rate	SHI	SHI	SHI
Pricing	CEPS	CEPS	SHI

Notes: CE marking: Certifies that a product has met EU consumer safety, health or environmental requirements; AFSSAPS: French Health Products Safety Agency; CNEDIMTS: National Committee for Evaluation of Medical Devices; CEAP: National Commission for the Evaluation of Medical Procedures; CEPS: Pricing Committee.

The committees for drugs and for devices are defined by administrative order (articles R163-15 and R165-18 of the social security code). They are composed of scientific experts and representatives of the minister in charge of health and of SHI. CEAP, however, is only composed of scientific experts and is not defined through regulation.

CEPS is an interministerial committee defined by decree (article D162-2-1 of the social security code). It is composed of representatives of the minister in charge of health, minister in charge of economy, the minister in charge of research, of SHI and of the National Union of Complementary Health Insurance Organizations (*Union nationale des organismes d'assurance maladie complémentaire*; UNOCAM) (see Section 4.1.1). In conjunction with pharmaceutical and medical firms, it decides on the price of goods and also, indirectly, on whether or not a service will be registered in a positive list, since a service cannot enter a positive list without a price.

Trends in the benefit package

Historically, the French health care system has been considered generous in terms of services covered, partly since the trend has been to increase the size of the positive lists without taking any health care medical goods or services off. Also, entry to the positive lists per se has been less of a focus of debate than the level of coverage and the price of the service. However, recently, the French health care system has become more selective in terms of reimbursement. The idea of taking or keeping some services off the list is now accepted, especially in terms of drugs and new products. For example, in the mid-1990s, removing some drugs with no proven efficacy from the positive list was proposed, although this was not politically easy and implementation took more than 10 years. In 2003, the Ministry of Health finally decided to de-list hundreds of these drugs, which occurred in three waves between 2003 and 2005. This gave the impetus to the delisting policy and similar decisions have followed since then (see Section 6.6.1).

Level of coverage

While, it is generally accepted that the French health care basket is very generous in terms of good and services covered, coverage is generally not 100%. A share of the tariff is left to the patient. This varies with the category of goods and care (Table 3.8) (see Section 3.3.3). Initially, it also varied across schemes, but there is now a single rate of coverage for a defined category of goods or services, whatever the scheme.

Table 3.8

Examples of reimbursement rates

Categories of goods and services	Reimbursement rate (%)
Inpatient care	80
Visitor to a doctor	70
Dental care	70
Medical auxiliaries	60
Laboratories	60
Pharmaceuticals ^a	15, 35, 65 or 100

Note: ^aVaries by level of medical benefit and severity of illness, see text.

The level of the SHI rate of coverage by type of care is as follows:

Inpatient care. The coverage rate for hospital care is 80%, but it rises to 100% (that is, no co-insurance) in a number of cases:

- after the 31st day of a hospital stay;
- for treatment involving a level of surgery weighting above appendectomy (but see below on the €18 co-payment);
- maternity care.

Whatever the level of coverage of care, patients have to pay a flat-rate catering fee of €18 per day for accommodation in hospital (€13.5 in mental health departments). This can be covered by voluntary health insurance (VHI).

Outpatient care provided by self-employed health professionals. Reimbursement rates range from 70% of the statutory tariff for health care provided by doctors and dentists to 60% for medical auxiliaries and laboratory tests (Table 3.8). However, for treatment procedures or tests with a tariff above €91, patients are fully covered.⁴ The reimbursement of services provided by medical auxiliaries and laboratory tests is conditional on a doctor's prescription.

Pharmaceuticals. Most drugs are covered at a rate of 65%, but this varies from 100% for non-substitutable or expensive drugs to 15% for drugs judged to have a low medical benefit. Taking into account the respective weight of the different types of eligible drug consumed and the proportion of expenditure fully reimbursed (that is, without any contribution from the patient), the average rate of reimbursement for drugs is estimated to be 73%. In the case of drugs, extra-billing, which occurs when health professionals charge the patients above the SHI statutory tariff (see Section 3.6.1), is not allowed and, therefore, the market price is the same as the SHI statutory tariff.

⁴ This is called K50 exemption (*exonération K50*).

Medical devices. Medical devices and prostheses are subject to various rates of coverage depending on the medical device. In this sector, there is a very high level of extra-billing (60% of overall medical devices expenditure) and most often the market price is not fixed; what is negotiated with the industry is the SHI statutory tariff, which is used as a basis for reimbursement. In many cases (for example, spectacles, dentures, hearing aids), the levels of reimbursement are particularly low (see Section 3.3.3).

Incentives for gate-keeping and coordinated health care

The 2004 health care reform attempted to make patients more responsible in their way of consuming care by introducing additional co-insurance and what is called the “preferred doctor” scheme. This is a coordinated care pathway that represents a soft form of gate-keeping. Patients are asked to register with a preferred doctor of their choice, whom they should visit before accessing another doctor. However, they can opt out of this pathway and have direct access to specialists or other GPs for an additional out-of-pocket payment that is 40% of the SHI tariff. The preferred doctor is most often a GP, but people can also choose a specialist of any kind working in the private or public sector (see Section 6.3.4).

Full coverage for defined categories of people

In certain circumstances, patients are exempted from co-insurance and are covered for 100% of the statutory tariffs. There are three types of exemption:

- exemption linked to health status, in particular when the insured person is suffering from one of 30 specified long-term illnesses (*affection de longue durée*; ALD);
- exemption linked to the nature of the treatment provided, such as certain hospital treatments and infertility treatments;
- exemption linked to the person concerned, such as those involved in accidents at work, pregnant women after the fifth month of pregnancy, disabled children and pensioners.

Exemptions on economic grounds do not exist. However, the CMU Act provides complementary VHI coverage for people with low incomes (*couverture maladie universelle complémentaire*; CMU-C), which has the same effect as an exemption on economic grounds but cannot be considered an exemption because payers differ (CMU-C is paid by the CMU Fund; see Section 3.3.2).

The ALD scheme comprises a list of 30 (mostly chronic) diseases or disease groups. All expenses related to the treatment of one of the ALD-listed diseases will be fully covered by SHI up to the statutory fees. Eligibility for exemption

from co-insurance for a patient with any of these conditions is determined by the GP presenting the patient to SHI, which will decide whether or not the patient qualifies for full coverage. Patients with multiple conditions or with a (costly) single condition not listed (for example, a rare disease) may also be eligible for full coverage under the ALD system if accepted by the relevant health insurance fund.

In recent years, the addition of new conditions to the ALD list has been generally determined by the level of costs associated with the treatment of the condition, that is, the condition was added as soon as a new costly treatment became available (for example, treatments for HIV, hepatitis and multiple sclerosis). As a result, the ALD list comprises all the main chronic conditions, although all disease stages are not always considered (for example, depression and chronic obstructive pulmonary disease will be considered only if at an advanced stage) (Table 3.9). In 2009, 8 million people benefited from exemptions through this scheme.

Table 3.9

List of long-term conditions (*affection de longue durée*; ALD)

No.	Disease/disease group	No.	Disease/disease group
1	Disabling stroke	16	Parkinson's disease
2	Aplastic anaemia and other chronic cytopenias	17	Hereditary metabolic conditions requiring long-term specialized treatment
3	Chronic arteriopathies with ischaemic manifestations	18	Cystic fibrosis
4	Complex schistosomiasis	19	Chronic nephropathy and primary nephrotic syndrome
5	Severe heart failure, arrhythmias, valvular cardiomyopathy, congenital cardiomyopathy	20	Paraplegia
6	Active chronic diseases of the liver and cirrhoses	21	Polyarteritis nodosa, acute disseminated erythematus lupus, generalized progressive scleroderma
7	Primary severe immunodeficiency requiring long-term treatment, infection by HIV virus	22	Severe progressive rheumatoid polyarthritis
8	Diabetes type 1, diabetes type 2	23	Long-term psychiatric conditions
9	Severe forms of neurological and muscular conditions (including myopathy), serious epilepsy	24	Ulcerative colitis and severe progressive Crohn's disease
10	Chronic severe constitutional and acquired haemoglobinopathies, haemolysis	25	Multiple sclerosis
11	Haemophilia and constitutional conditions of severe haemostasis	26	Severe progressive structural scoliosis (the angle of which is equal or superior to 25 degree) until rachidian maturation
12	Severe arterial hypertension	27	Severe ankylosing spondylarthritis
13	Coronary heart disease	28	Organ transplant sequelae
14	Chronic obstructive pulmonary disorder	29	Active tuberculosis, leprosy
15	Alzheimer's disease and other dementias	30	Malignant tumours, malignant lymphatic or hematopoietic tissue

Additional flat co-payments

Deductibles for regular care and goods

In order to raise additional revenue for SHI, additional flat-rate deductibles⁵ were introduced in 2005; €1 is charged on every physician visit, biological test and radiograph up to a ceiling of €4 per day and €50 per year for each of these types of care. This means that €1 is taken out of the SHI contribution to the fees incurred by the patient.

In early 2008, these deductibles were extended to drugs, ancillary care and ambulance transportation: €0.5 is charged for every drug package⁶ and ancillary care service and €2 per transportation. These payments can be made up to a second ceiling of €50 for each of these types of care, above which patients no longer have to pay these deductibles.

The money raised through this last group of deductibles is estimated to reach €850 million per year. It is used to finance the increasing expenditure related to Alzheimer disease, the cancer plan and palliative care.

With regard to the hospital flat rate fee for accommodation (hospital catering co-payment) (see Section 3.2), not all patients covered for 100% of the SHI tariff are exempted from these types of deductible. Only CMU-C beneficiaries, people under 18 years of age and pregnant women from the sixth month are exempted, representing 36.6 million people.

VHI does not cover the deductibles introduced in 2005 and 2008 (except if they offer “non-responsible contracts”, discussed in Section 3.3.2).

The €18 co-payment for expensive care

Since 1 September 2006, patients have had to pay a flat rate of €18 for care with a statutory tariff over €91 (such as most magnetic resonance imaging and surgical procedures weighting above appendectomy). This measure introduced out-of-pocket payment for care activities that were until then fully covered (see above). People covered for 100% of the SHI tariff do not have to pay this €18 co-payment and VHI can cover it.

⁵ Technically, the term “deductible” usually refers to a fixed amount that is required to be paid by a patient before a third-party payer will begin to reimburse for services. However, in France, the term is used to describe the amount that is deducted from the tariff covered by SHI. For example, if €20 is paid by the patient to the health care professional and the patient sends his/her claim for reimbursement to SHI, first the amount covered is calculated: for example 70% of the total cost (70% of €20 is €14). Then the “deductible” is taken from this amount (€1, for example). Finally, €13 in total is reimbursed to the patient.

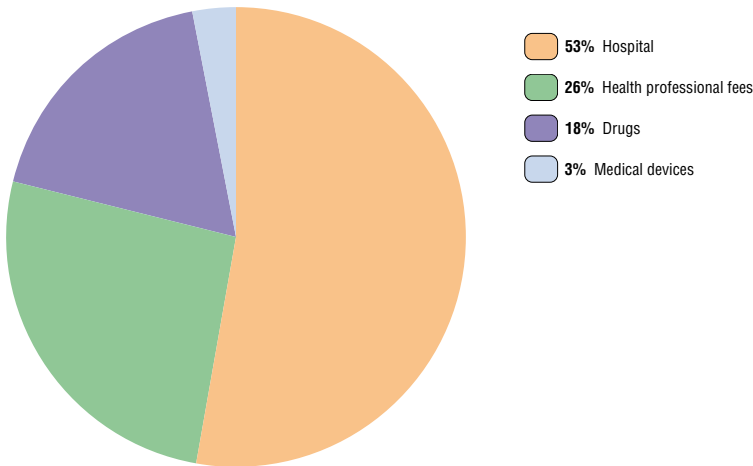
⁶ Excluding goods and services provided in a prevention programme such as immunization.

SHI expenditure by type of care

Over a half of SHI health care expenditure is dedicated to hospital care, a quarter to health professionals' fees in the ambulatory care sectors and 21% to medical goods (Fig. 3.7).

Fig. 3.7

SHI health care expenditure by type of care, 2008



Source: Eco-Santé 2010.

However, this mix has changed over time (Table 3.10), with medical goods and drugs increasing since 1980 while hospital care shows the opposite trend.

Table 3.10

SHI expenditure as a percentage by type of care, 1980–2008

Type of care	1980	1985	1990	1995	2000	2005	2006	2008
Hospital inpatient and day care	59.2	58.1	57.8	58.1	54.7	53.4	53.2	52.9
Ambulatory care by health professionals and services	25.5	26.0	26.4	25.6	25.6	25.4	25.7	26.0
Medical goods	15.2	16.0	15.7	16.3	19.6	21.2	21.1	21.1
Drugs	14.6	15.3	14.8	15.1	17.3	18.2	17.9	17.6
Medical devices and other goods	0.6	0.7	0.9	1.3	2.3	3.0	3.2	3.5
Total	100	100	100	100	100	100	100	100

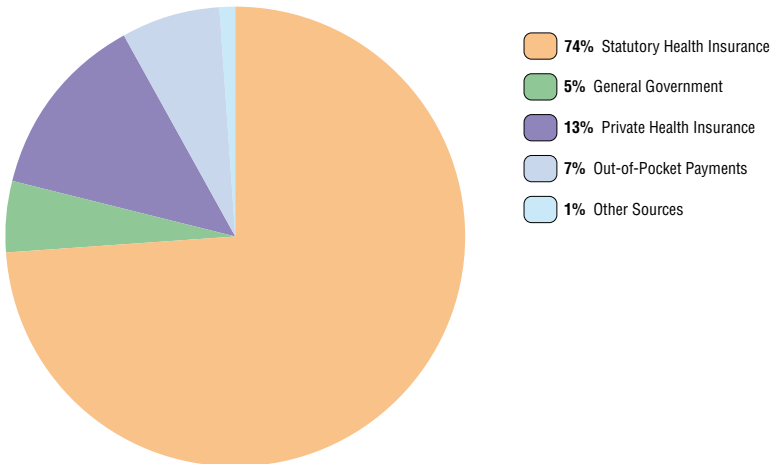
Sources: Eco-Santé 2010; OECD 2010.

3.3 Revenue collection/sources of funds

In 2007, SHI financed 80.4% of personal health care expenditure and 73.8% of total expenditure on health. Consequently, while France has a universal public health insurance system, the coverage it provides is not complete; 5.2% of total expenditure on health is financed by the state and around 20.2% by private sources. As a result, 88% of the French population has private complementary VHI that covers 13.4% of total expenditure on health (7.7% by mutual insurance associations, 3.3% by private insurance companies and 2.5% by provident institutions), leaving 6.8% to be paid by private households (Table 3.11 and Fig. 3.8). It should be noted, however, that while the amount of health care financed by the state, local authorities, social security and complementary VHI is relatively well known, the amount spent by private households is less certain and probably underestimated.

Fig. 3.8

Percentage of total expenditure on health according to source of revenue, 2007



Sources: Eco-Santé 2009; OECD 2009a.

Table 3.11

Sources of revenue as a percentage of total expenditure on health, 1990–2007

	Percentage of total expenditure on health (%)					
	1990	1995	2000	2005	2006	2007
SHI	74.3	75.1	74.9	74.3	74.0	73.8
General government	2.3	4.6	4.5	4.9	5.1	5.2
Out-of-pocket payments	11.4	7.6	7.1	6.8	6.8	6.8
Private health insurance	11.0	11.9	12.7	13.2	13.3	13.4
Other sources	1.0	0.8	0.8	0.8	0.8	0.8

Source: Eco-Santé 2009; OECD 2009a.

The mix of sources of funding varies across sectors and over time. Since the early 1990s, around 92% of hospital expenditure has been financed by SHI, but the share of outpatient care financed by SHI is smaller and has decreased over time, from 77% in 1980 to 65% in 2008. This can be explained, on the one hand, by the fact that in outpatient care some professionals are allowed to charge patients above the official SHI tariffs (extra-billing) and, on the other hand, by the fact that, since the late 1970s, most reforms have sought to limit the chronic shortage of SHI funds and have significantly increased patient co-payment on medical goods and overall outpatient care.

3.3.1 Compulsory sources of financing

SHI sources of funding

Between 1946 and 1991, SHI was almost exclusively funded by contributions from employees and employers as a proportion of wages and salaries, initially with a ceiling on contributions and later without any ceiling. The contribution rates for SHI have steadily increased to cover health care expenditure, which has grown faster than the level of overall contributions for social security. Between 1992 and 1997, contribution rates remained stable at 6.8% of gross earnings for employees and 12.8% for employers. The current (2010) employer contribution rate is 13.1%.

Since 1998, as a result of attempts to widen the social security system's financial base, employees' payroll contributions have fallen from 6.8% to 0.85% of gross earnings in 2010. They are mainly substituted by an earmarked tax introduced in 1991 called the general social contribution (CSG) based on total income. The CSG rate varies depending on the source of income. It was initially a two-tier rate but slowly evolved to a range, with an increased rate for revenue from capital or from games (for example, lotteries and casinos) and a decreased rate for revenue from those with low incomes. It is 7.5% (of which

5.1% goes to SHI) on earned income, 8.2% (5.95% for SHI) on capital, 9.5% on winnings from gambling, 6.6% on pensions and 6.2% on benefits (for example, allowances for sick leave and maternity leave). This rate is decreased to 3.8% of earned income for low-income people exempted from income taxation, which represent almost half of French households. As such, CSG can be considered to be a progressive tax. A share of CSG contributions are general tax deductible from income. This share is equal to 5.1% on earned income, 4.2% on benefits and 3.8% on other sources of revenue.

The revenue base of SHI has, therefore, been widened and partially disconnected from earnings, making it less vulnerable to wage and employment fluctuations. This change is in line with the role that was given to parliament in defining health sector financing policies and controlling certain aspects of the health care system after the 1996 reform (see Section 7.1.2).

The pharmaceutical industry is also required to contribute through a 1% tax on their turnover, a tax on advertising, a tax on drug retailing and an additional tax if their turnover goes above a ceiling set in the Social Security Financing Act. In 2007, this levied €662 billion for SHI.

Additional revenue for SHI is levied on the profit of companies with a turnover of more than €760 000. This 0.03% tax is estimated to have levied €15.4 billion in 2008. Other taxes are levied on polluting activities of companies.

Furthermore, in 2004, after the heat-wave crisis, a new source of revenue was introduced to improve long-term care and support services for the elderly and people with disabilities, such as community care services or nursing homes. A new fund was created, the National Solidarity Fund for Autonomy (CNSA). This pools together SHI funds allocated to social and health services for the elderly (about €5.7 billion) and for the disabled (€6.6 billion) and the “solidarity and autonomy contribution” that is generated from the revenue of an unpaid working day (the solidarity day) for the French working population (about €2 billion) (see also Sections 6.8.2 and 7.1.4).

Finally, part of SHI finance comes from the state budget. Indeed, in order to encourage employment of low-waged workers in domiciliary support services or in defined geographical areas, employers' contribution is in these cases set at a decreased level (about two-thirds of the regular rate). Most of this loss of revenue is compensated by the state and the overall final loss of revenue for SHI related to this mechanism is estimated to be about €2.4 billion per year.

Table 3.12 shows the structure of the SHI general scheme funding up to 2007. In 2007, employers' contributions, employee's contributions and CSG revenue accounted for 87.1% of total health insurance revenue. The remainder was provided mainly through state subsidies and earmarked taxes (for example, on tobacco and alcohol consumption). In comparison with health insurance funding in 1990, the most striking change is the substitution of most employee payroll contributions with income tax (CSG).

Table 3.12

Revenue received by SHI (the general scheme) in 1990, 2000 and 2007

Revenue	Percentage (billion euros)		
	1990	2000	2007
Employees contributions	32.2 (20.1)	3.4 (3.4)	2.9 (3.8)
Employers contributions ^a	63.1 (39.3)	51.1 (49.8)	46.6 (61.8)
Total contributions	95.2 (59.4)	54.5 (53.2)	49.5 (65.6)
General social contribution (CSG)	0.0	34.6 (33.8)	37.6 (49.8)
Specific taxes (for example, cars, tobacco)	1.6 (1.0)	3.3 (3.3)	3.4 (4.5)
Taxes on pharmaceutical companies	0.0	0.8 (0.7)	1.2 (1.6)
Total taxes	1.6 (1.0)	38.7 (37.8)	40.9 (54.2)
State compensation for the loss of contributions ^b	0.5 (0.3)	4.9 (4.8)	7.8 (10.3)
Adjustment between health insurance schemes	1.1 (0.7)	0.3 (0.3)	0.7 (0.9)
Other	1.5 (1.0)	1.6 (1.5)	1.1 (1.5)
Total revenue	100.0 (62.3)	100.0 (97.6)	100.0 (132.5)

Source: Commission des comptes de la sécurité sociale 2001, 2009.

Notes: ^aThis includes contributions paid by SHI on behalf of doctors; ^bthe state compensates SHI for the loss of contributions directly related to economic policy decisions; a recent example is the reduction of employers' contributions for employees working in support services at home.

Main body responsible for collecting compulsory funds

The Union for the Recovery of Social Security Contributions and Family Allowances (*Union pour le recouvrement des cotisations de sécurité sociale et d'allocations familiales*; URSSAF) has 99 local bodies for the general scheme (see Section 2.3.5) plus four specific centres for the other schemes (including one for the sailors' scheme); these bodies are in charge of collecting contributions and CSG at the local level. The money levied flows into a single national pool managed by the Central Social Security Agency (*Agence centrale des organismes de sécurité sociale*; ACOSS) and is distributed among the different national branches (SHI, retirement fund, family allowance, etc.) on the basis of the contribution rates defined by law.

In 2007, 76% of the CSG was allocated to the general scheme, of which 62% was for SHI. Altogether, 70% of the money raised via the CSG was given to SHI (all schemes included).

Because SHI schemes vary in their level of resources and in the characteristics of the population covered, health insurance schemes are subject to a financial adjustment mechanism that takes into account their demographic profile.

Main body responsible for solving the social security funding shortage

The 1996 reform created a new social contribution, the contribution for solving social security debt (*contribution pour le remboursement de la dette sociale*; CRDS) (Ordinance no. 96-50 of 24 January 1996), in order to face the increasing deficit of the social security system (estimated at that time as being between €30 and €38 billion). An important share of this debt was related to SHI expenditure exceeding income. CRDS is equal to 0.5% of revenue whatever the source of revenue (earned income, benefits, capital, sale of assets, etc.). At the same time, a special fund was created to manage the social security debt, the Agency for Funding Social Security Debt (*Caisse d'amortissement de la dette sociale*; CADES).

Initially it was planned that CADES and CRDS would be in place over a period of only 13 years; however, the increasing deficit of social security has led the government to extend the debt that CADES has to reimburse (an additional €13 billion in 1997 and €50 billion in 2004) and extend the term of CRDS and CADES up until the solvency of the debt.

In order to ensure that the social debt will not be continuously transferred to the next generation, during the vote of the 2005 Social Security Finance Act (no. 2005-881 of 2 August 2005), the parliament inserted a clause specifying that any new debt transferred to the CADES should be accompanied by an increase in the agency's income, ensuring that the length of time required to solve the debt would not be extended.

3.3.2 Voluntary health insurance

Overall, SHI finances 77% of total health care expenditure. Therefore, while France has a universal public health insurance system, the coverage it provides is not complete and the 20% share of private expenditure explains why 88% of the French population has private VHI.

The role of private voluntary health insurance

Historically, the primary role of VHI is complementary coverage for user charges: VHI covers the discrepancy between SHI coverage and health care expenses. Indeed, in France, unlike in some other countries, private insurance is not used to jump public sector queues or to obtain access to elite providers. All VHI provides is reimbursement for co-payments and better coverage for

medical goods and services that are poorly covered, most notably dental and optical care for which charging over the statutory fees is the rule. With the wide development of a market that is almost saturated, a few VHI providers recently extended complementary coverage. These providers may compete on offering contracts that cover goods and services not covered by SHI, such as omega-3 fatty acids and surgery for short-sight.

The role of VHI has also been of a supplementary type with regards to private amenities that are not included in the benefit basket. For instance, a good number of VHI providers offer contracts that cover the price of a private room up to a defined tariff per day.

Contracts differ on the level of coverage of the cost left to the patient after SHI reimbursement. VHI usually fully covers the patient's cost-sharing for drugs other than those considered to be "of low medical benefit" and for health professionals' procedures and tests up to the official SHI tariff. However, VHI contracts differ on the level of coverage of the cost that is charged above the official tariffs (extra-billing), of the cost of low-benefit drugs, medical devices, private amenities and the cost of services not included in the SHI benefit package where these are covered. An analysis of modal contracts⁷ shows that, for a specialist visit priced €60 including extra-billing, one-third of contracts offer coverage above the official tariff and the overall rate of coverage is 120% of the official tariff (Arnould, Rattier 2008). An increasing number of VHI firms offer tailor-made contracts where people can choose the rate of coverage for each type of care.

Supply-side incentives to support public sector objectives

There is no restriction on what insurers are permitted to cover; however, there are strong incentives for them to support public sector objectives and the solidarity principle.

First, in 2002, the solidarity-based contract category (*contrats solidaires*) was introduced. In order to belong to this category, contracts have to offer premiums that are independent of pre-existing conditions and that do not require a health questionnaire. VHI providers' income generated by the premiums from contracts that do not follow these criteria is taxed at a 7% level (this is an additional tax which was introduced on top of the regular taxes paid by VHI).

Later, in 2004, the latest round of French health care reforms attempted to make patients more responsible in their way of consuming care by introducing deductibles and what is known as a "coordinated care pathway" (see Sections 3.2

⁷ "Modal" refers to the mode, which in statistics is the value that occurs most frequently in a data set.

and 6.3.4). In order to insure the efficacy of these measures and to give patients incentives to follow the pathway, the concept of “responsible contracts” (*contrats responsables*), for which VHI firms are eligible for financial rebates, was created. On the one hand, with the aim to decrease moral hazard, they should not cover some of the deductibles recently introduced (€1 for GP visit, €0.5 for every drug package and ancillary care service and €2 for transportation such as ambulance or medical taxi) and the additional co-insurance and co-payment on doctor fees when patients opt out. On the other hand, to ensure equity of access, they should cover 100% of the registered GP’s fees and of the specialists’ fees when patients follow the recommended pathway, at least 95% of the cost of important drugs that are covered at a 65% level by SHI, and at least 95% of the cost of laboratory tests covered by SHI. Lastly, they should cover at least two types of important preventive service from a list defined by HAS. As with the solidarity-based contracts, premiums from contracts that follow these criteria are exempted from a 7% tax. These reforms were very successful and by 2006, almost all VHI contracts were “responsible contracts” (Arnould, Rattier 2008).

Individual and group contracts

VHI coverage can be purchased by individuals or by firms for their employees. In 2006, a general population survey (Kambia-Chopin et al. 2008a) showed that 40% of people privately insured are covered by a company group contract.

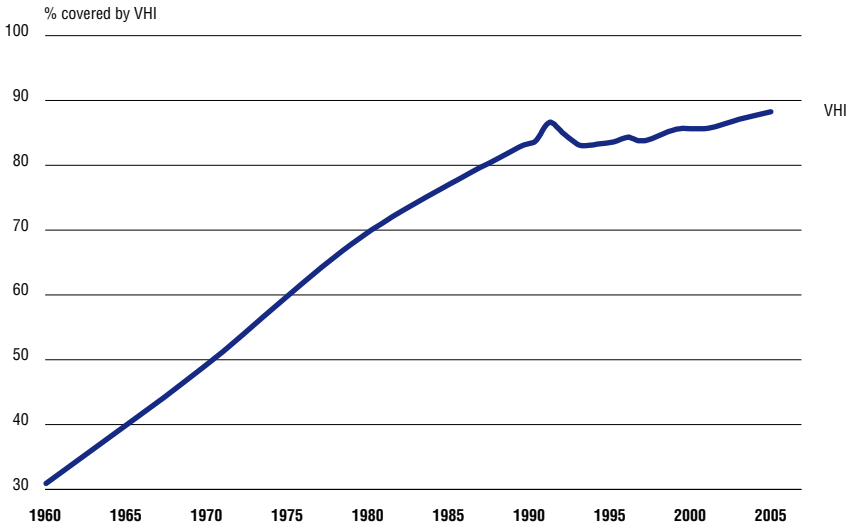
Group contracts usually offer broader coverage than individual contracts. Some 85% of them are sponsored by an employer who pays, on average, 60% of the premium (Buchmueller, Couffinal 2004). The premium is usually not risk rated according to age, but about 30% of contracts are priced proportionately to wages.

Population coverage and demand-side measures to increase coverage

The population covered by a VHI contract increased from 50% in 1970, to 69% in 1980, 83% in 1990 and 88% in 2006 (Fig. 3.9). Therefore, the diminishing share of SHI coverage of outpatient care slowly transferred the cost to VHI (see Section 7.1.3).

Fig. 3.9

Trend in the share of persons covered by VHI, 1960–2006



Sources: INSEE (1991–1992) (ESSM survey); IRDES various years from 1992 (*L'Enquête sante protection sociale*).

Many factors have contributed to the growth of the population covered. On the one hand, since the 1970s, the diminishing share of SHI coverage of outpatient care has slowly increased households' out-of-pocket payment and VHI has gained a growing role ensuring continued access. On the other hand, the overall growth of population wealth has favoured insurance coverage and insurance companies have broadened their range of contracts in order to attract younger and healthier uninsured people. Over this period, the government has developed several demand-side measures to increase the rate of the population covered by VHI.

First, fiscal rebates are offered to employers that buy and offer group contracts to their employees, while employees can deduce the cost of premiums from their taxable income. In 2003, 40% of firms were offering and sponsoring a health insurance contract to at least a portion of their employees (Buchmueller, Couffinhall 2004).

Second, because poorer people were not able to access private VHI for economic reasons, two measures were implemented to meet equity concerns. In 2000, the CMU Act (see Section 3.2) introduced CMU-C, which is free public complementary health insurance provided on a voluntary basis by a public SHI scheme. Individuals whose annual income is below €7521 (as of January

2010)⁸ are eligible. CMU-C is paid by the CMU Fund, which is mainly financed through a tax on VHI contract premiums (€1.8 billion in 2009) (Fig. 3.1). In 2008, CMU-C covered 7% of the population. As a result, complementary health insurance covers 95% of the French population.

Third, in order to help people at the margin of the CMU income ceiling to access VHI, a voucher scheme called *aide pour une complémentaire santé* (ACS), also financed by the CMU Fund, was created in 2004 by the Health Insurance Reform Act. Financial assistance in the form of a “health cheque” (*cheque santé*) is offered to people whose income is below a ceiling equal to 120% of the CMU ceiling. The amount offered depends on the patient’s age. In 2010, it ranged from €100 per year for people aged under 25 years to €400 for people aged above 60. In 2008, it was €220 on average. However, only a small share of the targeted population currently uses the scheme: around 380 000 people out of a targeted 2.2 million (3.5% of the whole population) (Fonds CMU 2008).

Disparities in coverage

Access to VHI remains largely linked to social status. Among the population with no complementary coverage, 53% reported that they did not access VHI because of financial barriers and among the 4% of people that had recently lost their complementary coverage, 30% reported that it was due to financial problems (Kambia-Chopin et al. 2008b).

Access to VHI also varies by age group. The highest rates of people without VHI are observed among those aged between 20 and 29 years and those over 80 years. For the former, this may result from lower health care needs, while reasons for the latter may be related to lower income and lower access to group contracts through loss of group coverage at retirement and higher premiums because of age-rating.

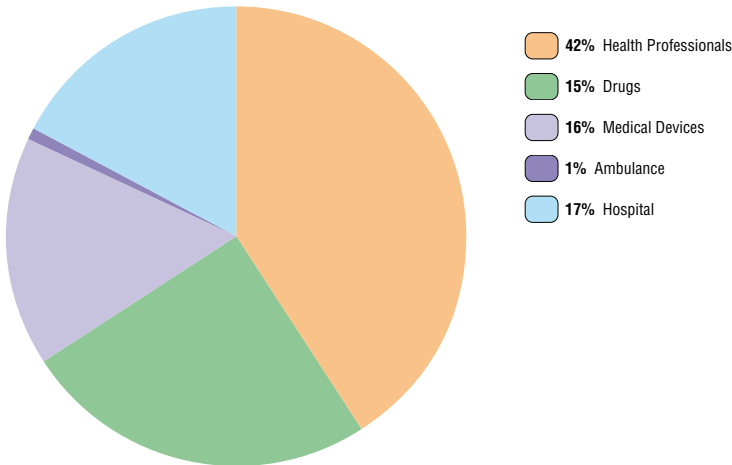
The growing role of VHI in financing health expenditure

VHI expenditure is divided as follows: 41% on fees to health professionals, 25% on drugs, 16% on medical devices and 17% on hospital care (Fig. 3.10).

⁸ This ceiling varies with the size of the household: since January 2010, it ranges from €7521 for a single person household to €3760 per person for a household of six and €3008 for each additional person.

Fig. 3.10

VHI expenditure by type of care, 2008



Source: Fenina et al. 2008.

In 2007, the share of total health expenditure financed by VHI was 13.4%, and 13.7% of personal health care expenditure on services and goods. However, just as SHI coverage varies across sectors, the VHI share also varies. Indeed, VHI financed 35.6% of medical device expenditure (eye wear, dental prosthesis, etc.), 20.9% of health professional fees but only 5.3% of hospital expenditure.

In the mid 1980s, VHI financed less than 6% of total health expenditure. This share reached 11% in 1990. Since that time, despite SHI's decreasing coverage rate of outpatient care services, the share of health expenditure financed by VHI did not rise greatly, reaching 13% in 2006. This is because, with the ageing of the population, the number of people exempted from co-payment for chronic conditions has increased, leading to the share of SHI coverage of outpatient costs being higher than expected (HCAAM 2008a).

Nevertheless, premiums have dramatically increased in the last 10 years. In 1998, the average premium of an individual contract was €340 per capita, while in 2006 it was €530 (Allonier et al. 2008).

Market overview

There are three categories of operator in the VHI market: mutual insurance companies (*mutuelles de santé*), commercial insurance companies and provident institutions. They differ according to their logic and principles. These principles are translated into specific regulatory texts grouped in several *Codes* (defined in Section 1.3).

The mutual insurance companies

The main operator group is the mutual insurance companies (see Table 3.13). Existing since the 19th century, the mutual companies pre-date the creation of the social security system. By the start of the Second World War, mutual insurance companies, the only insurers in the market, covered two-thirds of the population. The law that set up the social security system (19 October 1945) redefined the role of the mutual companies as being complementary to that of SHI. By 1960, only around 31% of the population benefited from this type of coverage.

Mutual insurance companies are non-profit-making firms. They are regulated by the mutual insurance code (*code de la mutualité*), which is articulated around a social doctrine: they aim to achieve solidarity and mutual aid. This implies that they avoid, as much as permitted by competition, differentiation in premiums for a given level of coverage. For this reason, they make limited use of risk rating. Moreover, some mutual companies also adjust their premium according to income.

Commercial insurance companies

The second category, in terms of significance in the health insurance market, is commercial insurance (see Table 3.13, below). In contrast to the mutual companies, commercial insurance companies do not explicitly have social goals. They are regulated by the commercial insurance code under which private insurance is a commercial activity. Therefore, they can use a large set of characteristics (including health status) to rate premiums. In the health insurance market, the activity of commercial insurance companies is mainly concentrated in individual contracts (60% of their turnover) but group contracts are not negligible (40% of their turnover).

Provident institutions

Provident institutions are the third, and smallest, category (Table 3.13). They have a non-profit-making aim and specialize in providing group contracts for companies that have a policy of mandatory enrolment in VHI for their employees (nearly 80% of their turnover). They are regulated by the *code de la sécurité sociale* but also by the commercial insurance code for their offer of individual contracts. They were created at the end of the Second World War to manage the supplementary retiree pensions for senior executives and intellectual professionals (occupational groups based on the International Standard Classification of Occupations, in its 1988 version; International Labour Organization 1988). They progressively enlarged their activity to the coverage of “heavy risk” and finally offered VHI.

Table 3.13

Significance of the different categories of insurers offering VHI

	Mutual societies	Provident institutions	Commercial insurance companies
Number	848	45	98
% of total number	85.6	4.5	9.9
% of VHI turnover	58.8	16.8	24.4
% of VHI health care funding	56.7	18.6	24.7
% of health insurance contract	59.7	13.8	26.6
% of privately insured ^a	59.2	15.1	27.4

Sources: Fonds-CMU 2008 (turnover); Fenina et al. 2007; Allonier et al. 2008 (percentage of contracts for private insurance).
 Note: ^aThis exceeds 100% as one person may be covered by several contracts provided by different categories of insurer; VHI.

Specificities of coverage by category of insurer

There are specificities in the populations covered by each type of insurer. In spite of their evolution towards more commercial practices, the mutual companies still have a higher proportion of elderly people: people aged over 64 years represent 14.8% of their insured versus 10.9% for commercial insurance companies and 12.8% for provident institutions. Nevertheless, this difference may be explained by a cohort effect as mutual companies were the only category of insurer that operated in the health insurance market before the 1980s. So, despite the fact that people may switch between insurers, individuals who subscribed before this time have a higher propensity to be covered by a mutual company.

Sharp contrasts can also be observed according to the profession of the head of the family. Members of farmer households are highly overrepresented among commercial insurance companies. Provident institutions are characterized by a higher proportion of executive households (Table 3.14).

Table 3.14

Complementary VHI coverage by social category, by age and reported health status (% of persons covered), 2006

Category	Percentage of persons covered		
	Mutual insurance companies	Provident institutions	Commercial insurance companies
Social			
Farmers	3.7	0.6	10.2
Commercial craftsmen	7.2	8.4	11.5
Managerial, academic, professional	18.8	22.5	18.9
Intermediate categories (teachers, administrative)	25.2	20.3	19.7
Office employees etc.	9.6	3.5	5.4
Commerce employees	2.6	2.2	2.8
Skilled workers	26.0	34.0	24.5
Unskilled workers	7.0	8.6	7.1
Total	100	100	100
Age (years)			
<16	18.2	21.2	22.7
16–39	29.9	28.8	31.9
40–64	37.1	37.2	34.6
≥65	14.8	12.8	10.9
Total	100	100	100
Health status			
Very good	29.8	32.3	32.6
Good	50.8	50.2	51.4
Fair	16.1	15.1	14.4
Bad	2.7	1.8	1.4
Very bad	0.5	0.6	0.3
Total	100	100	100
Chronic health problems or chronic disease	22.4	20.1	19.2

Source: Allonier et al. 2008.

Market performance

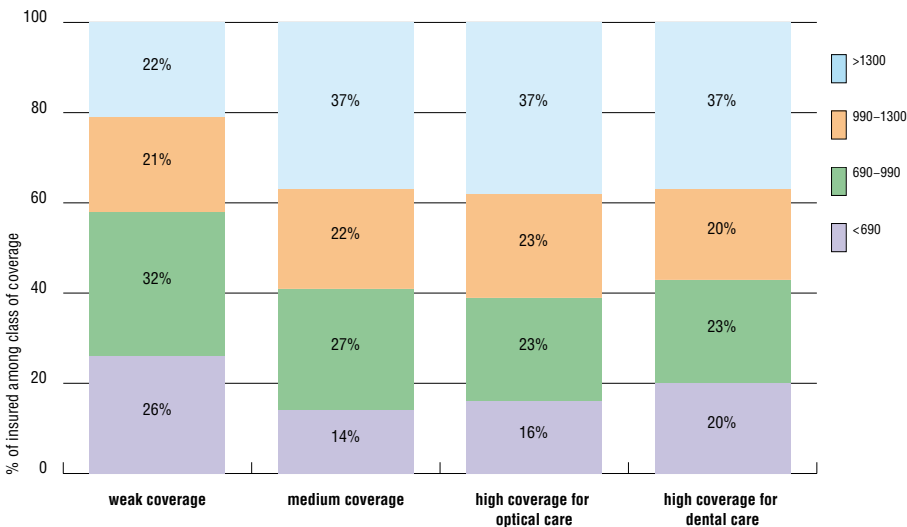
Complementary VHI increases financial protection of the French population. In doing so, it also greatly increases equity of access in particular for categories of care that are covered through the rules of “responsible contracts”. Indeed, for GP and specialist visits, excluding extra-billing and important drugs (covered at 65% rate by SHI), cost-sharing after VHI coverage is low for the 93% of the population that has complementary coverage. This is explained by the government’s efforts in developing access to VHI contracts for lower income groups by introducing CMU-C and the voucher scheme (ACS). An evaluation

of the impact of the public complementary insurance confirms an increase in access to care in people with CMU-C (Grignon, Perronnin 2003). However, this enhancement of equity of access is largely limited to the categories of care listed above.

First, the coverage of other services, in particular medical devices, varies considerably across contracts and VHI firms (see Table 3.16, below). Second, wealthier people are more likely to be covered by VHI and buy contracts with higher premiums (Kambia-Chopin et al. 2008a), which can be indirectly associated with broader coverage. This was found, for example, in a survey showing that people with higher incomes are better covered for spectacles and dental care (Couffinhal, Perronnin 2004) (Fig. 3.11).

Fig. 3.11

Quality of complementary VHI coverage according to income level (euros)



Sources: Couffinhal, Perronnin 2004 (data from IRDES *Enquête sur la santé et la protection sociale* 2000–2002).

Notes: Weak and medium coverage includes both optical and dental care combined. Columns may not total 100% due to rounding.

The trend of increased user charges and thus increased VHI participation in financing the health system decreases equity of finance. While the SHI premium and the 30% of group and individual contracts that are offered by mutual insurance companies for civil servants are priced proportionately to revenue, VHI premiums are not. As a result, richer people pay less as a

proportion of their income to the financing of health care than poorer groups. Moreover, the SHI premium is not related to age and risks, while VHI premiums are set at a variable level.

Following this, there is a growing debate among stakeholders about the role of VHI in the sustainability of the current system based on social redistribution across age and wealth. Indeed, the recent increase in user charges has led to a more than 7% rise in the price of premiums (HCAAM 2008a) causing concern that premium prices seem to increase at a greater rate than benefits. Indeed, between 2001 and 2006, VHI turnover increased by 48% (Fonds CMU 2008) whereas the benefits increased by only 32% (Fenina et al. 2007) for a stable share of population covered (Allonier et al. 2008).

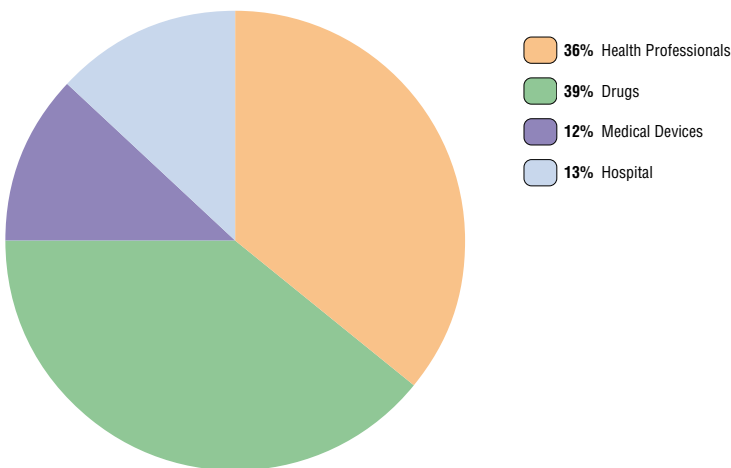
3.3.3 Out-of-pocket payments

In 2008, 27% of total health care expenditure was not paid/reimbursed by SHI. Out of this share, VHI financed a 11% share and patients a 7.5% share.

As we have seen, SHI coverage varies across sectors and, as with VHI, household out-of-pocket expenditure on health varies inversely with the level of SHI coverage (Fig. 3.12): 51% of out-of-pocket expenditure is accounted for by medical goods, 13% by hospital care and 36% by payments to self-employed health professionals.

Fig. 3.12

Household out-of-pocket expenditure by type of care, 2008



Source: Fenina et al. 2008.

Patients are directly responsible for (see Section 3.2):

- the cost of health care not included on one of the positive lists covered by SHI (such as non-prescription drugs);
- co-payment (such as the hospital catering daily flat rate);
- discrepancies between the statutory tariffs and the amount that is reimbursed by SHI (co-insurance);
- additional co-insurance of 20% in case of access to care out of the coordinated care pathway;
- professionals' extra-billing charges.

Table 3.15 shows the structure of total health care expenditure on services and health goods with respect to reimbursement by SHI. It shows that since 2000, despite an increase from €115.1 to €156.6 billion, the share of this total expenditure reimbursed by SHI has remained stable, at around 77%.

Table 3.15

Payments from SHI as a proportion of total health care expenditure on services and health goods in 2000, 2004, 2005, 2006

	Percentage of total health care expenditure (billion euros)			
	2000	2004	2005	2006
Total expenditure on health services and medical goods	100 (115.1)	100 (144.9)	100 (151.2)	100 (156.6)
Direct payment for non-reimbursable services and medical goods	4.7 (5.4)	5.0 (7.2)	4.9 (7.4)	4.9 (7.7)
Expenditure subject to SHI reimbursement	95.3 (109.7)	95.0 (137.7)	95.1 (143.8)	95.1 (148.9)
Drugs and services with no reimbursement claims	2.1 (2.4)	1.8 (2.6)	1.8 (2.7)	2.0 (3.2)
Expenditure subject to reimbursement claims	93.2 (107.3)	93.3 (135.1)	93.3 (141.1)	93.1 (145.7)
Extra billing	4.0 (4.6)	4.5 (6.5)	4.4 (6.6)	4.3 (6.8)
Expenditure elected to reimbursement	89.2 (102.7)	88.8 (128.6)	88.9 (134.5)	88.7 (138.9)
Co-insurance, hospital catering co-payment	12.2 (14.0)	11.5 (16.7)	11.7 (17.7)	11.7 (18.3)
SHI expenditure	77.1 (88.7)	77.3 (111.9)	77.2 (116.8)	77.0 (120.6)

Source: Fenina et al. 2007.

Notes: TEHSG: Total health care expenditure on services and health goods.

In 2006, direct payments for goods and services that are not reimbursed by SHI accounted for 4.9% (€7.7 billion) of the €156.6 billion that is spent on health services and goods. Since VHI has a small supplementary coverage role on services not covered by SHI, only a small share of this expenditure is not paid by patients.

Out of the remaining €148.9 billion of expenditure which was subject to SHI reimbursement, health care expenditure for which there was no claim of reimbursement (because patients failed to send their claim) accounted for €3.2 billion (2%), extra-billing charges for €6.8 billion (4.3%) and co-insurance and hospital catering co-payment for €18.3 billion (11.7%).

Overall, the level of charges left to the patient is 23%, which is often covered by VHI. Deductibles introduced in 2008 are expected to shift an additional €1.5 billion to patient charges. The €1 deductible amounts to an average of €16.4 per year per person, while the deductible on drugs, nursing procedures and health care transportation is €27 per year per person.

The latest figures available suggest that extra-billing has also increased since 2006. It is estimated to have reached around €10.6 billion in 2008. Extra-billing is frequent; half of the population pays at least one extra-billing charge per year. However, the charges vary widely in number and amount across sectors (Table 3.16).

- In the outpatient sector, extra-billing for doctors' fees accounts for €1.5 billion; it is frequent, but the charges are not high, ranging from a few euros to a few tens of euros.
- In the inpatient sector, extra-billing often reaches a few hundred to a few thousand euros (HCAAM 2008a). If patients are not covered by VHI, their out-of-pocket payments are significant.
- In the medical devices sector, there is the largest share of extra-billing charges; in 2008, this was estimated at €8.8 billion, in an overall market of €19 billion. VHI covers about 50% of this, but coverage varies a lot across medical devices and contracts. For example, overall household expenditure accounts for 44% and 40%, respectively, of the costs of spectacles and dental prostheses (HCAAM 2008b), with out-of-pocket payments ranging from €32 to €336 and €212 to €527, respectively, depending on type of VHI and contract (Arnould, Rattier 2008).

Table 3.16

Median out-of-pocket expenditure by type of insurers and category of contracts, 2006

	Mutual insurance companies (euros)		Provident institutions (euros)		Commercial insurance companies (euros)	
	Individual contracts	Group contracts	Individual contracts	Group contracts	Individual contracts	Group contracts
Basic spectacles (reference price: €200)	84.22	32.16	72.58	21.94	52.58	–
Complex spectacles (reference price: €500)	266.42	274.67	349.67	216.67	336.42	255.67
Digital hearing aids (reference price: €3000 for 2)	1990.59	2001.45	2001.45	1592.09	2480.76	1542.12
Dental prosthesis (reference price: €750)	444.75	444.75	481.25	427.50	527.50	212.50

Source: Arnould, Rattier 2008.

3.3.4 Other sources of financing

Financing care for the elderly

After the 2003 heat-wave, the elderly became a major concern for policy-makers in France. As a result, many policies were set up to develop services, and the CNSA was created in 2004.

An annual growth of 1% over the next 30 years is expected in the number of frail elderly people with neurodegenerative diseases (such as Alzheimer's and Parkinson's diseases) or with loss of functional autonomy. Expenditure to cover long-term health and social services for this population was estimated to reach around €16 billion in 2005 (0.94% of GDP). This expenditure is expected to go up between 3 and 4% per year, reaching 1.5% of GDP in 2025.

There are currently three sources of funding for long-term health and social care for the frail elderly in France.

At the national level. The CNSA, which receives resources from SHI (the national target for SHI expenditure, ONDAM, for elderly; see Section 3.4) and the solidarity day, currently (in 2010) raising €2 billion, of which €1.3 billion is for long-term care. It finances long-term care in nursing homes and community services for the elderly (€5.2 billion) as well as a share of long-term care allowances for the frail elderly (*allocation personnalisée d'autonomie*; APA) that are used to finance domiciliary staff or home care devices (€1.5 billion).

At the local level. Local authorities (*départements*) finance a large share of long-term care allowances for the frail elderly (APA, €3.2 billion). Many other local actors undertake social actions to support the frail elderly.

Households. The out-of-pocket payments for care in residential care services made by households is currently €1500 per month on average. The constant increase of this figure is a major concern for the government as it challenges equity in access to long-term care.

A report issued in 2007 (Gisserot, Grass 2007) estimated that, on top of the funding through SHI, an additional €250 to €430 million will be required every year for the next 20 years for financing the expected needs of the elderly and dependent population.

Moreover, because of the growing concerns about the rise of household out-of-pocket payments, the government has proposed developing a “fifth branch of social security” to cover elderly needs. A reform was initially planned for the end of 2007. However, finding new sources of resources has been challenging, and the reform launch has been postponed several times to an unspecified date (see Section 7.2).

Financing care for the disabled

There are currently five sources of funding for health and social care for the disabled (all causes of disability) (see also Section 6.8.2):

At the national level. There are three funding pathways.

- The CNSA receives resources from SHI (ONDAM for the disabled; see Section 3.4); from the solidarity day, which in 2008 provided €2.2 billion of which €0.9 billion was for long-term care for the disabled; and from the supplementary social security contribution to support the underprivileged (0.1% of CSG: €1.1 billion). CNSA finances domiciliary staff or devices in organizations caring for disabled people (€7.3 billion) as well as a share of the two allowances for the disabled: the disability compensation allowance (*prestation de compensation du handicap*; PCH), €550 million, and a small share of the special education allowance for children (AEEH), €19 million.
- The Family Allowance Fund (*Caisse d’allocations familiales*; CAF), which is a branch of the social security system, finances most of the AEEH: €608 million.
- The state directly finances certain services, for example the helping through work service (*établissements et services d’aide par le travail*; ESAT) and adapted enterprises: €1.6 billion.

At the local level. The general councils (departments) also finance social and health services for the disabled (€3.8 billion in 2007) and contribute to the disability compensation allowance which finances PCH.

Households. The out-of-pocket co-payment for care financed by SHI in residential homes for disabled adults is €18 per day in 2010 (there is no out-of-pocket payment for children). Out-of-pocket payment for this type of care financed by general councils varies across departments (however, it is estimated to also be, on average, around €18 per day).

Table 6.5 and 6.6 lists the funders of each category of services.

Financing mental health care

Mental health care is provided by private practice health professionals, private psychiatric hospitals or the public mental health care areas (*secteur*) (see Section 6.11.1). Care provided for mental illness by GPs and psychiatrists in private practice is covered by SHI at the usual rate. However, people presenting an ALD-23 (long-term psychiatric condition) are fully covered (see Section 3.2). Care provided by psychotherapists or psychoanalysts is fully financed by patients.

Care provided in public mental health care areas and in private psychiatric hospitals for adults and children is financed by SHI. As in the general hospital sector, patient co-payment (*ticket modérateur*) is 20% of a daily tariff that varies across hospitals. The hospital flat-rate fee for accommodation is lower than in the general hospital sector, at €13.5 per day in 2010 (see Section 3.2). Both the *ticket modérateur* and the hospital flat-rate fee for accommodation can be fully covered by VHI.

People with mental disabilities also receive care and services from the health and social care sector for the disabled (see Tables 6.5 and 6.6 for institutions that provide services for mentally ill patients), of which the financing sources are described above in the financing care for disabled subsection.

The expenditure on mental health services has been estimated as €16.6 billion in 2007, divided into €13.4 billion for health care services (8.3% of total health care expenditure on services and goods) and €3.2 billion for the health and social health care sector for the disabled (unpublished data from URC Eco).

3.4 Pooling of funds

All money levied for social security is allocated among its branches on the basis of the contribution rates defined by law (see Section 3.3.1). Because SHI retrospectively reimburses care that has been provided, there is no formal resource allocation mechanism in France, although the creation of the national ceiling for SHI expenditure in 1996 has provided SHI with a soft tool to control and allocate health care expenditure.

The national ceiling for SHI expenditure

Every year since 1996, within the context of the Act on Social Security Funding (*loi de financement de la sécurité sociale*), the parliament approves a maximum national ceiling for SHI expenditure (ONDAM) for the following year, including spending limits for specific health care sectors (ONDAM subtargets). Its decision is based on reports of the General Accounting Office (*Cour des comptes*) and the National Health Conference, which represents all stakeholders including the regional hospital associations. The Act sets a projected target (ceiling) for SHI expenditure for the following year.

If the system is found to exceed its projected budget (currently by more than 1%), a special parliamentary Alert Committee can ask the head of the Directorate of Social Security (the watchdog for all social security branches) to present a financial rescue plan. The Alert Committee was created in 2004 and is composed of the secretary general of the Social Security Accounting Commission (*Commission des comptes de la sécurité sociale*), the head of the National Institute for Statistics (*Institut national de la statistique et des études économiques*; INSEE) and an additional expert appointed by the president of the Economic and Social Council.

In order to set the ONDAM for the coming year ($n+1$), the government proposes an annual maximum growth rate for SHI expenditure. This rate is applied to the current year's (n) actual expenditure. However, often the current year's expenditure is a provisional estimate that is calculated in September, since voting on the ONDAM takes place before the end of the year. When genuine expenditure is known for year n , the change in expenditure in year n amounts to a ratification of overspending and to the integration of this overspending into the baseline used for defining the ceiling for the following year ($n+1$).

Table 3.17
Trends in national ceiling for health insurance expenditures (ONDAM) and actual expenditure, 1997–2008

Variables	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
ONDAM (billion euros)	91.5	93.6	96.0	100.3	105.7	112.8	123.5	129.7	134.9	140.7	144.8	152.0
Actual expenditure (billion euros)	91.4	95.1	97.6	103.0	108.9	116.7	124.1	129.9	135.1	141.9	147.7 ^a	152.9 ^a
Actual expenditure ONDAM (billion euros)	0.1	-1.5	-1.6	-2.7	-3.2	-3.9	-0.6	-0.2	-0.2	-1.2	-2.9 ^a	-0.9 ^a
Growth rate for ONDAM (%)	1.7	2.4	1.0	2.9	2.6	3.6	5.3	4.5	3.9	2.3	2.1	2.8
Growth rate for actual expenditure (%)	1.5	4.0	2.6	5.6	5.7	7.2	5.8	4.7	4.8	3.1	4 ^a	3.4 ^a

Source: Eco-santé 2010.

Note: ^aProvisional result.

Table 3.18
Expenditure in 2007 and the national ceiling for health insurance expenditures (ONDAM) for 2008 and its distributions across sub-targets

	Expenditure in 2007 (billion euros)	Revised expenditure adapted to changes across sub-targets (billion euros) ^a	ONDAM targeted expenditure for 2008 (billion euros)	ONDAM growth rate for 2008
Care in private practice	69.4	69.3	70.6	1.9
Health care provided by hospitals paid on a DRG basis	47.4	47.4	48.9	3.2
Health care in other hospitals	18.2	18.2	18.8	3.3
Health and social care for elderly financed by SHI	4.8	5.0	5.4	8.0
Health and social care for disabled financed by SHI	7.0	7.0	7.4	5.7
Other type of care	0.8	0.9	0.9	0.0
Total	147.7	147.9	152	2.8

Source: 2008 Social Security Finance Act (loi no. 2007-1786 décembre 2007 de financement de la sécurité sociale pour 2008).

Note: ^aThe subtarget composition is decided by the government, which may decide to move expenditure from one subtarget field to another. Therefore, in order to calculate the ONDAM target for the following year, the revised expenditure is calculated in order to incorporate these changes for forecasting.

Table 3.17 shows the ceilings and the expenditure actually incurred during the period 1997–2008. With the exception of the first year, actual expenditure has exceeded the ONDAM target, although between 2003 and 2005 it was very close. The discrepancy between the expected and the actual expenditure rose again after 2005, although it should be noted that this was in the context of a lower growth rate (tighter budget).

Prior to the establishment of the Alert Committee in 2004, the credibility of this system was questionable since there were no effective mechanisms to ensure the ONDAM was respected. However, even after the establishment of the Alert Committee, the government itself allows additional budgets within the year and the principle of setting a cap on health care expenditure remains strongly opposed by professional organizations, notably physicians' associations.

Once the overall ceiling has been set, the government splits it into six subtargets as shown in Table 3.18⁹:

1. care in private practice;
2. health care provided by hospitals paid on a DRG basis (including outpatient visits in the public sector);
3. health care in other hospitals (rehabilitation hospitals, psychiatric hospitals, and long-term care hospitals);
4. health and social care for the elderly financed by SHI;
5. health and social care for disabled people financed by SHI;
6. other types of care such as health care provided to French citizens abroad, social and health care not financed through the CNSA, health care networks, etc.

In 2007, expenditure was split as shown in Table 3.18. For 2008, the 2008 Finance Act set the overall target at a 2.8% growth rate split into the six subtargets. Since the ONDAM target was introduced, priority has generally been given to the health and social care sector over the health care sector. Indeed, between 1997 and 2008, health and social care sector expenditure grew to 111.5%, and the hospital and private ambulatory care targets rose by 56 and 77%, respectively. Further details about each subtarget are provided below.

⁹ Initially there were four subtargets (care in private practice, public hospital care, private profit-making hospital care and social and health care for elderly and disabled). In 2005, this number increased to six.

Care in private practice

Expenditure on health care in private practice covers payment for treatment provided by doctors, dentists, medical auxiliaries and biologists in private practice (mainly ambulatory care, but also private profit-making hospitals). This includes:

- the fees of all self-employed professionals and professionals employed by private institutions, together with the fees of doctors practising privately in public hospitals;
- medical goods prescribed in private practice;
- disability allowances paid for inability to work.

Since 2000, SHI has been in charge of defining a specific target for health professionals' fees (including health transport) within the subtarget of health care in private practice. SHI is responsible for ensuring compliance with the growth rates set by the government for these costs, which are included in the budget target agreed between the state and SHI.

During their annual negotiation with health professionals, SHI has the responsibility to define allocated expenditure targets specific to each profession and measures to enable the targets to be met. Since the 2008 Finance Act, in order to ensure the adequacy of the professionals' national agreements with SHI on statutory tariffs to meet the ONDAM target, the professionals' agreements are not implemented for a six-month period and the new tariffs negotiated only put into practice if the private ambulatory care target is not exceeded. Otherwise, previously negotiated tariffs come back into force.

The cost of medical goods prescribed in private practice is not regulated directly through the ONDAM. However, in the Social Security Finance Act, a maximum rate of increase of the overall turnover on reimbursable drugs produced by pharmaceutical companies is established: the K rate (*taux K*). The overshooting of this target leads to financial penalties for pharmaceutical companies. The companies have to pay back a proportion of any exceeding turnover: 50% of the excess if the growth rate is below $K + 0.5$, 60% up to $K + 1$ and 70% if above this. However, there have been frequent criticisms of the discrepancy between the K rate and the ONDAM growth rate,¹⁰ the K rate being far below the ONDAM (1.4% in 2008 when the ONDAM was 2.8%).

¹⁰ From 2004 to 2007 in *Avis au nom de la commission des finances, du contrôle budgétaire et des comptes économiques de la nation sur le projet de loi de financement de la sécurité sociale nos. 58, 71, 60 and 73* (Jégou 2004, 2005, 2006, 2007).

Since the implementation of ONDAM, private care sector actual expenditure has been above the target every year, with the exception of 2004 (see Table 3.19, below).

Health care provided by hospitals paid on a DRG basis

Hospital sector expenditures were subject to targets long before the creation of ONDAM. Since 1978, a hospital guiding rate (*taux directeur*) was set up as an indicator of what should be the correct level of public hospital expenditure. It was taken into account for defining per diem tariffs prior to the implementation of the hospital global budget prospective financing method in 1984. The growth in hospital budgets was then based on this rate. These measures and additional ones in the same period, such as the freeze of the growth of hospital wages in 1983 (Delors plan) were quite successful in containing expenditure until the early 1990s. However, since then, annual growth rates of real expenditure¹¹ have regularly been higher than 3%.

From 1991, an annual National Quantified Target (*objectif quantifié national*; OQN) set a target budget for private profit-making hospitals. If actual expenditure exceeded the target, tariffs were lowered; if expenditure was below the target, tariffs were increased. This marked the beginning of a period characterized by a very weak growth in expenditure in private sector hospitals.

When the ONDAM was first set, separate targets were defined for public and private hospitals. The implementation of the T2A case payment mechanism in 2005 introduced a common target. This reflects the goals of converging public and private sector financing methods (which had been different in the past) and cost-containment. The target budget is divided between regions, with the aim of reducing regional inequalities. The adjustment is made on the basis of a formula that takes into account three elements:

- a theoretical volume of hospital stays, derived by applying national occupancy rates to the region's demographic structure;
- weighting by a comparative mortality index (that is, the differential mortality of the region when controlling for age and gender);
- the productivity of hospitals in the region.

Overall, ONDAM can be considered as being quite successful in containing hospital costs (see Table 3.19).

¹¹ Deflated by GDP price indices.

Health and social care for frail elderly and disabled financed by SHI

Budgets corresponding to the targets for health and social care for the elderly and disabled are transferred to CNSA. The budget for the elderly is used to finance health care costs and a share of social care cost in nursing homes as well as long-term domiciliary nursing care. The budget for the disabled is used to finance nursing homes, long-term domiciliary care for the disabled and community nursing services.

Budgets are allocated to regional health agencies (ARSs) depending on service capacities in their geographical areas (see Section 4.2). The ARS allocates budgets to services following the same principle.

3.5 Purchasing and purchaser–provider relations

As already stated, SHI covers care provided by both public providers and private health care providers who contract with SHI. Patients who consult these providers are reimbursed for a share of the cost of care (see Section 3.2).

The relationships of independent private health professionals with SHI are defined at the national level in agreements called “conventions” signed between the UNCAM (SHI) and representatives of the profession (see Section 2.3.6). These agreements exist for doctors, nurses, physiotherapists, dentists, midwives, pharmacists, speech therapists, chiropodists, orthoptists, heads of biological laboratories, providers of transport and some medical devices suppliers (for example, opticians and prothesists). These “conventions” govern health professionals’ relations with patients who have public coverage and with SHI. The method of payment and the amount health professionals receive should, therefore, conform to the terms of these agreements or to the minimum contractual regulations that the government sets out in the absence of an accepted agreement.

Negotiations between SHI (UNCAM) and doctors tend to be very hard. Because of the power of the medical professionals’ associations, it is very rare that SHI manages to implement the full range of measures it would like. This was the case, for example, between 1998 and 2005, when the relationship between doctors and the government deteriorated after the 1996 reform. Specialists did not manage to work out an agreement with SHI, and minimum contractual regulations were, therefore, applied to specialists.

“Conventions” not only include agreements on statutory tariffs of health professionals but also details about the commitments of both sides. All professionals are under the agreement rules unless he/she clearly expresses the wish to opt out. In exchange, SHI pays a part of the professionals’ social security contributions.

Agreements for each profession are signed to cover a period of four or five years or renewed until a new agreement is signed. However, there are regular amendments (at least annual for doctors) that take into account changes following the yearly Social Security Finance Act and other new measures. It should be noted that the Ministry of Health takes a large role in the negotiation.

There are wide variations in the content of national agreements across professions. The first doctors’ agreement, which was set up in 1971, is the most complete. A single agreement applies to GPs and specialists.¹²

From 2002, developments have included several types of collective contract that aim to promote the quality and efficiency of the health system (see Section 4.1.3). In exchange for an increase in their official tariff for consultation, doctors collectively agreed to respect these contracts. Themes of the contracts can vary from prescribing less patient transportation or proton pump inhibitors to increased prescription of generic drugs. However, these collective contracts have been shown to be weak in controlling doctors’ practice. As a result, the 2009 Social Security Finance Act introduced a new category of individual contracts called “individual contracts for professional practice quality improvement” (CAPI) for GPs: the GP agrees on achieving specific goals such as management of chronic diseases, preventive health care, and level of prescribing of generic drugs and of defined categories of drugs. In exchange she/he is paid on performance by SHI (see Section 3.6).

Interestingly, the last nurses’ agreement signed in 2007 was used as a means of introducing control of the geographical distribution of health professionals for the first time in the history of the French health care system (apart from pharmacists, for whom the distribution has been regulated for a long time). A 2008 amendment set out the conditions for regulating the regional distribution of nurses’ activity. In particular, nurses’ freedom for setting up a new practice would be restricted in areas with high nurse density. In return, financial and

¹² There was an exception to this in the 1998 to 2005 period. The National Agreement for General Practitioners came into force on 7 December 1998 for a period of four years but since no agreement was made with specialists (as explained above) there were two different contractual arrangements, one for each group, even though the method of payment remained the same for both types of doctor.

material incentives were proposed for encouraging new practices in underserved areas. SHI expects to introduce the same type of measure for private doctors in the near future.

Purchasing relations with hospitals differ. Public and private hospitals are the responsibility of the Ministry of Health, which decides the value of the DRG tariffs. SHI reimburses hospitals on a case-payment basis in public hospitals, private non-profit-making hospitals, and profit-making hospitals with a SHI agreement (*cliniques conventionnées*) (see Section 3.6). For private profit-making hospitals with no SHI agreement (*cliniques non conventionnées*), which are very few, patients pay for their care directly and are reimbursed on the basis of specific statutory tariffs called tariffs without consultation (*tarif d'autorité*), which are very low and have not been raised since the 1960s.

3.6 Payment mechanisms

Payment mechanisms in the French health care system have long been based on fee for service for health professionals working on a private basis and on prospective budgeting methods for health services. However, since the mid-2000s there has been a move towards the implementation of activity-based payment methods for health services, which started with the implementation of DRG tariffs in hospitals and the introduction of a degree of pay for performance for doctors, without impairing the fee-for-service principle.

3.6.1 Paying for health services

Payment of hospitals

Until the beginning of 2004, public and non-profit-making private hospitals, which together account for about 80% of all hospital beds in France, were paid on the basis of global budgets. This prospective payment mechanism based on historical budgets was long considered a resource-allocation method that was poorly associated with or reflective of health needs and equity. Profit-making private hospitals (representing about 20% of all hospital beds) were funded on a per diem rate covering the hospital stay (this includes all accommodation expenses, nursing expenses, routine care of patients with overnight stays, drugs, etc.) and an additional fee for physician procedures and services.

However, introduction of T2A in both the public and the private sector for acute care (specifically the medicine, surgery and obstetric sector) was intended to improve efficiency and fairness in financing and also to enhance competition

between public and private sector by harmonizing public and private sectors financing methods. The scheme started in March 2005 for 100% of private profit-making hospital budgets. It has been gradually implemented from 10% of the public hospital budget in 2004, to 50% in 2005 and 100% in 2008.

With the exception of long-term care and psychiatry, all hospitals are funded on the basis of “rates per activity”, or homogeneous hospital stay groups (*groupes homogènes de séjours*; GHS). The Programme of Medicalization of Information Systems (*Programme de médicalisation des systèmes d’information*; PMSI) is used as a basis to calculate hospital reimbursement (see Section 4.2.2). Every patient stay is classified in one of the approximately 2200 homogeneous patient groups (*groupes homogènes de malades*; GHM) (which are equivalent to DRGs) and an associated GHS.

Currently, the funding models for public and private hospitals remain different and the tariffs of GHS are calculated differently. However, from 2018, the objective is to harmonize the payment method and tariffs of both sectors (see Section 6.4.3).

Within the T2A, there are two primary categories of hospital reimbursement: medical activity-based payment and non-medical activity-based payment.

Medical activity-based payment

The medical activity-based category covers three areas.

- **GHS tariffs** per hospital stay have no cost weights, other than regional weights that take into account variation in the production cost at the regional level.
- **Additional fees** are charged for ambulatory consultations, emergency ward visits and all hospital activities that are not inpatient care.
- **Additional payments for expensive technologies and interventions** include a defined list of expensive drugs and medical devices, which are mostly for cancer treatment, and intensive care activities (depending on the authorization given by ARSs). In order to avoid discouraging the use of expensive and typically innovative medical technologies, they are first allocated an additional payment beyond the GHS tariff. Under T2A, over time, all these technologies should be reimbursed and integrated into GHS tariffs.

Non-medical activity-based payment

The non-medical activity-based category also covers three main areas.

- **Block grants** provide annual lump-sum funding, such as for emergency treatment, organ retrieval and transplants.
- **Public utility missions**, also referred to as missions for general interest and assistance for contracting (*missions d'intérêt général et d'aide à la contractualisation*; MIGAC). These missions serve to fund coordination of care, research and teaching, plus epidemiological surveillance and expertise. Two separate lump sums are defined by the regional hospital authorities on a contractual basis: one is for education and research-related activities (*general interest missions*); the other is for activities carried out to meet national or regional priorities (for example, developing preventive care) or specific public missions (for example, providing care for vulnerable groups; contracting allowance).
- **Innovative medical technologies and procedures payments**, especially those awaiting registration on a positive list, are financed through two research programmes: the supporting funds for expensive innovative technology (*soutien aux technologies innovantes et coûteuses*; STIC) programme and the Hospital Clinical Research Programme (*programme hospitalier de recherche clinique*; PHRC) (main source of public funding for clinical research projects). As part of their remit, these research programmes finance the development of selected innovations, primarily via the support of clinical trials. From 2000 to 2008, 99 programmes for recent therapeutic innovations in oncology were conducted in the context of the STIC.

In the private sector, doctors' procedures and services (including MRI and other scanners) are paid on top of the DRG tariffs (GHS) as they were previously paid on top of the per diem rate, while they are included in the GHS tariffs for the public sector. Specific GHS tariffs are calculated for the private sector together with an individual "transition coefficient" that aims to avoid large changes in hospital budgets from year to year and takes into account each hospital's own historical costs/prices. However, the objective is for all of the coefficients to converge to "1" by 2012. Regional weights, similar to those of the public sector, are also used in the private sector, as well as a technical coefficient which applies to a number of hospitals offering high-technology services.

Since its implementation, there has been much debate surrounding the T2A system, although the introduction of the reform was generally supported by a variety of stakeholders: private hospitals, medical organizations and public institutions. Supporters maintain that the system has increased efficiency,

while concurrently enhancing competition between public and private entities. Conversely, others assert that competition will be weak between these sectors, as the private sector is, in fact, already specialized in certain types of treatment (for example, surgical and interventional procedures) that ensure a higher rate of return.

The T2A payment methods have also been implemented for PMSI-HAD (see Section 6.4.1) in 2005 and should be used for paying PMSI-SSR (see Section 6.7) after 2012.

Payment for mental health care

Public mental health care is mainly provided by mental health care areas (see Sections 3.3.4 and 6.11.1). It is paid on an annual prospective global budget basis, as are private psychiatric hospitals. The implementation of an information system, the “summary of medical information for psychiatry” (*recueil d’informations médicalisées en psychiatrie*; RIM-Psy), which is a type of DRG system for psychiatry, is planned. However, data are not collected exhaustively currently and there is no precise timetable for a change in the payment mechanism.

Outpatient care provided by self-employed GPs or psychiatrists is paid on a fee-for-service basis. Consultations for psychotherapy provided by other self-employed professionals are also paid on a fee-for-service basis, but tariffs are freely fixed by providers because there is no coverage by SHI.

Payment for pharmaceutical care

Outpatient pharmaceutical care is paid according to the official tariffs defined by CEPS (see Section 6.6.1). Prices and payments are made on a package basis for drugs and opening packages and making up part of the content into a prescription is not allowed.

Drugs that have AMM but are not listed on the LSPR (reimbursable drugs) or LSAC (special drugs) (see Section 3.2 on Definition of benefits) can be sold over the counter. In this case, patients pay for the full price of the drug, which is not regulated. Traditionally, VHI did not cover drugs that were not covered by SHI. However, as a result of market saturation (see Section 3.3.2), and depending on contracts, VHI has started to cover some of them, such as omega-3 fatty acids, for instance.

Inpatient pharmaceutical care is included in the hospital budget. For hospitals paid on a DRG basis, pharmaceutical care is included in the tariffs paid by SHI to the hospitals, with the exception of innovative expensive drugs, which are paid on top of the DRG tariffs if listed on the special agreed products list (see Section 3.6.1 on Payment of hospitals).

3.6.2 Payment of health professionals

Methods of paying health care professionals vary according to whether the professionals concerned are self-employed (that is, independent professionals engaged in private practice) or employed by institutions. However, some categories of professionals such as doctors can have mixed activities, so their total remuneration is likely to be a composite sum.

Health professionals working in the private sector

Fee for service

Self-employed professionals (GPs, specialists, dentists, nurses, physiotherapists, midwives, ambulance personnel, speech therapists, orthoptists and laboratory technicians) provide the vast majority of outpatient services and a large proportion of services in private hospitals. These self-employed professionals are paid directly on a fee-for-service basis for the services they provide. Questioning the incentives involved in this method of payment, particularly for the work of doctors, is a recurrent issue in France. Recently, new methods of payment for particular tasks have been introduced. For example, a capitation system is used to pay for doctors' management of patients with long-term diseases (ALD) (€40 per patient per year) and to pay doctors or nurses who are involved in a provider network coordinating the intervention of several health professionals for a given patient. However, the fee-for-service principle has never been challenged by any government.

In most cases, self-employed professionals are paid directly by patients at the time of the provision of the service; the SHI system usually only reimburses the patient at a later stage and usually only partially (see Section 3.2).

Since self-employed professionals are paid per service provided, their revenue is equal to the sum of the amount received for each service. Their gross income, therefore, reflects the number, type and price of the services they provide, minus their professional costs.

Health professionals are not free to fix the rates they charge for their services and are required to apply the statutory tariffs set out in the national agreements (conventions) (see Sections 3.5 and 4.1.3). However, there are notable exceptions,

particularly for doctors with a permanent right to exceed the official charges (extra-billing). Doctors with this right can apply variable fees under the national agreements. They are mainly those who have opted to work in “Sector 2”. This is in contrast to “Sector 1”, which comprises doctors who do not practice extra-billing. Doctors who opt for Sector 2 relinquish some of the social and fiscal advantages normally accorded to doctors under the agreements. Patients who visit a Sector 2 doctor are covered on the basis of the statutory tariffs regardless of the level of extra-billing. In 2008, a quarter of doctors were in Sector 2. However, this proportion varies greatly among specialties; for example, only 8% of GPs are in Sector 2 whereas 75% of surgeons are. Because extra-billing raises equity of access issues, access to Sector 2 is tightly controlled by SHI, and currently only doctors who had certain public hospital full time positions can request to access this sector.

The official tariffs per service provided are included in two lists (see Section 3.2):

- the general nomenclature of medical procedures (*nomenclature générale des actes professionnels*; NGAP), for clinical procedures carried out by doctors and procedures carried out by dentists, midwives and ancillaries;
- the common classification of medical procedures (*classification commune des actes médicaux*; CCAM) for technical procedures delivered by doctors.

The NGAP existed prior to the CCAM. It was partly replaced by CCAM from 2005 and, in the long term, it should be completely replaced by CCAM. However, this is still under consideration and being negotiated between providers and SHI.

In the NGAP, for each professional category a value (consisting of a key letter and a coefficient) is assigned to the various procedures reimbursed by SHI (Table 3.20). The key letters correspond to groups of procedures of a similar nature. In principle, the coefficients attached to key letters take account of the relative importance of the procedure within its group. A procedure’s official charge is calculated by multiplying the corresponding coefficient by the rate for the key letter (see Table 3.20). The charges for the different key letters are included in an appendix to the agreements made between health professionals and SHI.

Table 3.20

Examples of official tariffs in the General nomenclature of medical procedures (NGAP) on October 2008

Item	Key letter	Charge per key letter	Coefficient	Charge
General practitioner consultation	C	€2	1	€22
Specialist consultation	C+CPM	€3 + 2	1	€25
Metal dental prosthesis	PRO	€2.15	50	€107.5
Stammer speech therapy consultation	AMO	€2.4	12.2	€29.28

Source: Ministère de la santé 2008.

Agreements with some professions permit tariffs to be revised upwards or downwards in relation to ONDAM and targets that are introduced in the agreements. Indeed, since 2002, targeted agreements on good practice, signed by professionals and SHI, bind increases in medical fees to commitments of good practice and on “medically based cost-containment” goals from professionals. For example, the agreement signed with doctors offers increases in the fee for visits in return for commitments by GPs to prescribe fewer antibiotics, proton pump inhibitors and statins and to increase the rate of influenza immunization among the elderly (see Section 4.1.3).

The CCAM was established to modernize NGAP by improving the descriptions of the professional procedures concerned. It is a far more detailed classification (over 7000 procedures, while NGAP had only 1500).

Expert medical committees have assessed each of the procedures (time required, skills involved, level of stress incurred, capital investment required, etc.). The classification is made according to a medical logic based on anatomical area and not by medical specialties. There are 19 chapters starting with (1) the nervous system and (2) the eyes and associated structures; it continues to chapter 17, which groups procedures without a precise anatomical localization. These chapters are split in two sections: the first section is for diagnosis procedures, while the second section is designed for therapeutic procedures. Two additional chapters (18 and 19) group complementary procedures.

The CCAM is based on the rule of comprehensiveness. Each code and label implicitly contains all the components of a medical procedure. Each principal code is made up of seven characters (for example, HAMA007 for *reconstruction du philtrum par lambeau hétérolabial, pour séquelle d'une fente profaciale*). In order to better qualify the procedure, an optional code

for a complementary procedure described in chapter 18 can be added to this principal code. In addition, physicians must add some mandatory codes to the principal code:

- **activity code:** there are distinct codes for when several physicians or health professionals participate in an intervention; one code is used for the principal procedure or service (for example, HAMA007 1 code by the surgeon who first intervenes) and a further code for every added procedure or service run by different physicians or health professionals (for example, HAMA007 4 code by the anaesthetist, the fourth to intervene);
- **a stage of the procedure code:** there is one code for each stage when a procedure requires more than one stage (for example, HAMA007 1 1 code by the surgeon to show that he was the first practitioner for the first stage of the intervention involved).

Physicians can also add optional codes called “modifier(s)” (included in Chapter 19 of the CCAM) that give additional information such as for a “procedure realized in emergency by specialists, between 8 pm and 8 am”, which elicits an extra fee. A physician cannot add more than four modifiers for one procedure or service (Mousquès 2005a).

Until the CCAM was implemented, the claims for reimbursement submitted by patients or providers only mentioned the value of the procedure performed, and not its nature, which could not be known since two (or more) different procedures can have the same value. Currently, the nature of the procedure is stated in reimbursement claims, which is an improvement in the information collected by SHI.

Additional payment for performance

Since 2009, SHI offers individual contracts to GPs for practice improvement (CAPI), in parallel to the national agreement. This type of contract was introduced by the Social Security Finance Act for 2009 (Article L.162-12-21 of the social security code) and officially issued by the 9 March Decree, published 21 April 2009.

CAPI are signed on a voluntary basis for a three-year period and can be broken at any time on the doctor’s demand. They encourage GPs to develop prevention, to improve treatment and to follow patients with a range of chronic conditions (currently hypertension and diabetes) and to improve efficiency by increasing the rate of generic drug prescribing. These objectives are set

to address evidence of underperformance in these areas. They are based on public health priorities set by the parliament and recommendations issued by the Health Products Safety Agency (AFSSAPS) and HAS.

The GPs' agreement to this type of contract is dependent on an overall increase in their remuneration. They are offered additional remuneration on top of their normal fee-for-service income. The additional payment takes into account the size of the population treated by the doctor and a number of quality indicators related to the three areas (Table 3.21). Currently, there are 16 indicators on which final but also intermediate targets are defined. Depending on the initial level of a doctor's practice, either final or intermediate targets will be considered to calculate the level of remuneration. Overall, the amount earned can exceed €7000 per year for a doctor achieving over 85% of the targets and treating more than 1200 patients. There is no penalty for the GPs who do not achieve the targets.

Table 3.21

Final targets of quality indicators used in the individual contracts for professional practice quality improvement (CAPI) by area of improvement

Targets	Objectives
Improving prevention	<p>The objective is to achieve flu immunizations for 75% of patients aged over 65 years, and breast cancer screening for 80% of women aged 50 to 74 years.</p> <p>The aim is also to prevent the use of contraindicated drug combinations, which can result in adverse reactions in people >65 years. The objective is to reduce the prescription of vasodilators (which are overprescribed despite being proven ineffective) to a maximum of 7% of patients and of benzodiazepine (potentially dangerous and addictive) to a maximum of 5%.</p>
Consolidation of quality of care for patients with chronic diseases	<p>For diabetic patients, the objectives are to improve the proportion that is treated in line with current recommendations (65% eye examinations, 65% glycated haemoglobin (HbA1c) tests, etc.)</p> <p>For patients with high blood pressure, the target is to normalize blood pressure for 50% of patients over three years.</p>
Improving efficiency of prescribing	<p>There are seven groups of medicine for which "generic prescription" is encouraged, with varying final targets of the share of generic prescription in the overall number of boxes prescribed – antibiotics (90%), proton pump inhibitors (80%), statins (70%), antihypertensive drugs (80%), angiotensin-converting enzyme (ACE) inhibitors (65% of ACE inhibitors and angiotensin II receptor antagonists boxes) – or in the overall number of patients treated – aspirin (85% of patients receiving antiplatelet drugs).</p>

Performance against the targets is regularly monitored and doctors can check on their level of achievement on the SHI's web site. In order to help doctors to achieve the targets, they are provided with materials such as patient information leaflets on preventive health and generic drugs, with the aim of improving patients' acceptance.

CAP1 has been very successful in terms of numbers of doctors subscribing to the scheme (see Section 7.1.3). Despite being encouraged by the doctors' unions not to sign these contracts, 12 600 doctors had signed a contract by December 2009. In June 2010, after nine months of implementation, 55% of doctors were eligible for additional payment from this type of contract, which is, on average, an additional 5% of their income (€3000).

In the medium-term, SHI plans to extend this type of contract to others specialties.

Total income

Table 3.22 shows the total gross and net payments received in certain health care professions compared with general economic indicators. In 2007, the gross income of GPs was 4.2 times higher than the GDP per capita, and their net income after social contributions before tax was 40% above the average wages of managerial staff. For specialists, the situation varies considerably, depending on the area of specialization; the net revenue of surgeons can reach 2.6 times the salary of managerial staff and 7.3 that of workers,¹³ while the net revenue of paediatricians is about that of GPs.

Table 3.22

Annual remuneration of self-employed health care professionals in 2007

	GPs	Surgeons	Ear-nose-throat specialists	Paediatricians	Dentists	Nurses	Physiotherapists
Average gross income by profession (thousand euros)	125	235	173	129	217	67	72
Index (GDP per capita = 1)	4.2	7.8	5.8	4.3	7.2	2.2	2.4
Net income (before tax) by profession (thousand euros)	67	127	82	69	81	41	38
Index (gross income per capita = 1)	2.2	4.2	2.7	2.3	2.7	1.4	1.3
Index (average wage of managerial staff = 1)	1.4	2.6	1.7	1.4	1.7	0.9	0.8
Index (average wage of workers = 1)	3.8	7.3	4.7	3.9	4.6	2.3	2.1

Source: Eco-Santé 2010.

¹³ According to the International Standard Classification of Occupations in its 1988 version (International Labour Organization 1988), managerial staff refers to the occupational group "senior executives and intellectual professionals"; workers include people from the groups "service workers" and "shop and market sale workers", "skilled workers" and "non-skilled workers".

Physicians employed in public hospitals

Doctors working in public hospitals are state employees who benefit from conditions of employment similar to those of civil servants. The method and amount of payment varies according to category:

- university hospital doctors are categorized as state employees because of their teaching responsibilities; their pay is composed, in more or less equal parts, of a university salary for their teaching responsibilities and hospital fees that correspond to their treatment responsibilities; levels of pay correspond to grades on a scale of seniority;
- full- or part-time hospital doctors with tenure or on contract are paid on a monthly basis according to their grade (seniority) and the time worked; they also receive various allowances for being on call;
- *attachés* (external practitioners working in hospitals on an intermittent basis) are paid on a monthly basis in proportion to the number of sessions they undertake, with allowances for being on call.

Since 1958, in a measure aimed at attracting doctors to and retaining them in public hospital service, university hospital doctors have been authorized to devote a part of their working time to private practice within the hospital. Their fees are received by the hospital administration, which transfers them to the practitioner after withholding their own fees for use of facilities. Fees for the use of facilities vary according to the procedure involved.

The annual salary of a full-time hospital doctor (after social tax, before income tax and excluding allowance for being on duty) starts from €48 000 and may reach around €87 000 at the end of his/her career.

4. Regulation and planning

The French health care system was initially organized according to a Bismarckian model of provision and payment for health care. However, it has developed into a mixed Beveridge and Bismarck model, characterized by a single public payer, the increasing importance of tax-based revenue for financing health care and strong state intervention (see Section 7.1.1).

Providers of outpatient care are largely private and they are paid partly by SHI financed by employer and employee contributions, increasingly substituted by ear-marked income taxes. Hospital beds are predominantly public or private non-profit-making. In the context of increasing health care expenditure, the increasing deficit of SHI and the overall social security system, the role of the state (Ministry of Health and Ministry of the Budget, Public Accounts, the Civil Service and State Reforms) in planning and regulation has increased since the early 1990s.

Planning and regulation, therefore, involve negotiations among provider representatives (hospitals and health professionals), the state represented by both the Ministry of Health and Ministry of the Budget, Public Accounts, the Civil Service and State Reforms and SHI (see Section 2.3). The outcome of these negotiations is translated into administrative decrees and laws passed by the parliament. These include public health laws, social security funding acts and reform acts. Providers are paid by SHI (or directly by patients who are later reimbursed). The statutory tariffs are set through negotiations between providers and SHI and are approved by the Ministry of Health.

4.1 Regulation

The Directorate of Social Security, which is under the supervision of the Ministry of Health and the Ministry of the Budget, Public Accounts, the Civil Service and State Reforms (see Section 2.3.2), proposes an annual Social Security Financing Act, which is debated and approved by the parliament. This Act establishes the provisional health care budget, or rather the expected national ceiling for SHI expenditure (ONDAM). Because in France providers are mostly paid on a fee-for-service and a per-case payment on a retrospective basis, there is no way to ensure that the SHI health expenditure will match the (approved) national ceiling for SHI expenditure. In fact, spending has repeatedly exceeded these provisional budgets (*Commission des comptes de la sécurité sociale* 2007) (see Section 3.4). The government and SHI control unit prices but do not control volume, which explains why total expenditure is not regulated. The statutory tariffs for health care providers and prices for health technologies are set by the government after negotiation between the providers/manufacturers and SHI (see Section 3.2). The French health care system still guarantees freedom of choice and does not limit utilization of services. However, the 2004 Health Insurance Reform Act introduced regulatory mechanisms previously unknown in France: semi-gatekeeping with financial incentives (see Section 6.3.4) and non-refundable deductibles on physician visits, drugs and ambulance transportation (see Section 3.2). Both can be seen as attempts to regulate volume by using price sensitivity.

In August 2004, the Public Health Act defined the government's priorities for health over a five-year period. For the 2005–2009 period, a total of 100 health targets were defined. The Health Insurance Reform Act passed in the same month defined the new relationships between providers and SHI and created an obligation to define a basic benefit package for all chronic conditions eligible for 100% coverage (ALD, see Section 3.2).

4.1.1 Governance and regulation of third-party payers

The Ministry of Health controls a large part of the regulation of health care expenditures on the basis of the overall framework established by parliament. It is responsible for:

- dividing the budgeted expenditure among the different sectors and, where hospitals are concerned, among the different regions;

- deciding on the number of medical students to be admitted to medical school each year (*numerus clausus*), the number of hospital beds and the amount of major equipment, including expensive medical technologies;
- approving the agreements signed between SHI and the unions representing self-employed health care professionals;
- setting the prices of specific medical procedures and drugs on the basis of proposals from ad hoc committees;
- establishing safety standards in hospitals;
- defining priority areas for national programmes: these currently include, among others, cancer, AIDS, rare diseases, mental health, health and environment, unhealthy behaviour and addiction, and quality of life of people suffering from chronic illnesses.

SHI signs with the Ministry of Health a triennial contract defining the objectives, the management and the governance of SHI (*Convention d'objectifs et de gestion*, COG). The 2006–2009 objectives were to improve efficiency in the management of SHI, reduce inequities in access to health care services and develop risk management. The risk management programme is based on the following strategic options:

- the development of prevention, which is relatively new since traditionally SHI has paid for curative health care and left prevention to the state;
- the implementation of information systems dedicated to health professionals and to patients: an example of the deployment of prevention and information systems is the SOPHIA experiment, a call centre dedicated to diabetic patients and operated by SHI;
- the definition of a basic benefit package for all chronic diseases (which represent up to two-thirds of total SHI expenditure and over three-quarters of the annual increase in expenditure);
- setting contractual agreements with health professionals, such as individual contracts for the improvement of individual professional practice (CAPI) (see Section 7.1.3).

The 2010–2012 COG is currently under discussion.

Statutory health insurance

SHI in France is composed of several health insurance schemes. It is still governed by the Ordinance of 4 October 1945, and the legislative measures that have followed since then, which are included in the social security code (see Section 1.3).

The three main insurance schemes (the general scheme (CNAMTS), the agricultural scheme (MSA) and the scheme for self-employed people (RSI)) were federated by the Reform Act of 2004 into a National Union of Health Insurance Funds (UNCAM). This new federation has become the sole representative of the insured in negotiations with the state and health care providers. The director-general of UNCAM is also the director of CNAMTS. The director-general is appointed by the government, and the executive power of this position has been strongly reinforced at the expense of the board, whose role is now limited to strategic matters. Collective agreements with doctors and other organizations of professionals in private practice are now negotiated and signed by the director-general alone. This is a new step in the process of the withdrawal of employee and employer unions from the management of the health insurance system.

The 2004 Reform Act increased the role of the appointed SHI managers. SHI is now fully responsible for the economic consequences of the agreements that they negotiate and sign, for example with health professionals in private practice. SHI can also set the level of user charges, although this power is limited to a certain extent by the political acceptability of their proposals. In terms of hospital care and drugs, UNCAM is more involved in the decision-making process than previously, although the state retains a leading role (see Section 3.2) (Franc, Polton 2006).

The SHI schemes are under the supervision of the Directorate of Social Security of the Administration of Health and Social Affairs (see Section 2.3.2). Since 1996, they have carried out their function as managers of the SHI system within the framework of an agreement on targets and management drawn up with the state for a minimum period of three years (see the example of the 2006–2009 COG, above).

Voluntary health insurance

Governance

The 2004 Health Insurance Reform Act has taken into account the growing role of VHI in funding the system (Mossialos, Thomson 2004) by allowing VHI companies to participate in the governance of the health care system (see Sections 3.3.2 and 7.1.3).

The 1500 VHI companies were grouped under a national umbrella organization, the National Union of Complementary Health Insurance Organizations (UNOCAM). This organization covers the National Federation of Mutual Benefit Societies (*Fédération nationale de la mutuelles*; FNMF), the French Federation of Insurance Companies (*Fédération française des sociétés d'assurance*; FFSA), the Centre for Provident Institutions (*Centre technique des institutions de prévoyance*; CTIP), the local fund from Alsace-Moselle (*Groupement des entreprises mutuelles d'assurance*; GEMA) and the National Federation of Independent Mutual Benefit Societies (*Fédération nationale indépendante des mutuelles*; FNIM). UNOCAM has a 33-member board (17 FNMF, 8 FFSA and 7 CTIP). Its president is elected by the board and governs with a six-member executive committee.

The most important member of UNOCAM is another national umbrella organization, the FNMF, which covers roughly 1000 of the traditional employment-based benefit societies and commands a 60% market share of the complementary health insurance market. The FNMF has a president, an executive committee, a board and a general assembly of 1400 delegates, which elect the president. It is active in the field of health care but also in long-term care, hospices and retirement homes.

UNOCAM is consulted prior to the introduction of a new product in the public health benefit package. It can participate in the negotiation of national agreements with health care professionals. As a member of the Pricing Committee (CEPS), it also negotiates the price of drugs and medical devices together with representatives of several ministries and of SHI (see Section 3.2). Moreover, UNOCAM issues reports on the private health insurance position and on changes and trends in the health care sector (La Mutualité Française 2009).

In 2008, following the increase in VHI turnover (see Section 3.3.2), the government introduced an additional €1 billion taxation on VHI revenue for financing the SHI shortage of funds. As compensation, the government introduced strengthened coordination between SHI and VHI companies for the management of health care coverage and of health care financing. Regular tripartite negotiations between SHI, complementary health insurers and health professionals were initiated; significantly, in sectors where VHI companies cover a large share of the cost of care, they were given a key role in the negotiations on proposed reductions in co-insurance and decisions that would result in a reduction of the price charged above the statutory official tariffs (2009 Social Security Finance Act).

Regulation

The three types of French VHI companies operate under three different sets of regulation (see Section 3.3.2). The mutual insurance companies are regulated by the mutual insurance code, the commercial insurance companies are regulated by the commercial insurance code, and the provident institutions are regulated by the social security code. This difference in regulation was seen as generating inequality in competition and specialization, because each code differs with regard to the services that can be provided, the selection and payment of providers; in addition, favourable fiscal advantages were enjoyed by mutual insurance companies as their role is perceived to fulfil an important social function (Colombo, Tapay 2004).

Furthermore, the body responsible for regulation varies across categories of insurer. The watchdog for the mutual insurance companies and the provident institutions is the Directorate of Social Security in the Ministry of Health, while for the commercial insurers it is the Ministry of Economics and Finance.

Therefore, in 2003 the three types of operator were put under the control of the same institution, the Mutual Insurance Funds Control Authority (*Autorité de contrôle des assurance et des mutuelles*; ACAM). The mission of ACAM is to review finances, management and business practices in order to verify that these elements are in line with regulation and the interest of policyholders (that is, to ensure that VHI companies will be able to provide the benefits that they promised to their policyholders).

Changes resulting from EU directives

Article 2(2) of Directive 92/49 of 18 June 1992 on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life assurance is to be interpreted as meaning that social security schemes such as the French SHI schemes providing health and maternity insurance for the self-employed in non-agricultural trades, old-age insurance for those in skilled manual trades and pensions for those in industrial and commercial trades are excluded from the scope of Directive 92/49.

That provision quite clearly excludes from the scope of the Directive not merely social security organizations but also the types of insurance and operations that they provide in that capacity. Furthermore, the Member States retain their powers to organize their social security systems and, therefore, to set up compulsory schemes based on the principle of solidarity, which would be unable to survive if the Directive were to be applied to them, removing

the obligation to contribute. In the case of VHI, however, Directive 92/49 contributed to a homogenization of the rules that govern each type of provider, introducing more transparency and more equality in competition.

This homogenization of the rules that govern each type of provider, which gradually occurred after the 1970s, was of three orders: standardization of tax treatment between types of insurers, harmonization of financial rules and of the control of these rules, and specialization of all types of providers towards non-life insurance activities.

Standardization of tax treatment between types of insurer

Previously, mutual insurance companies and provident institutions benefited from preferential tax treatment because they were considered to respect the concept of solidarity more than commercial insurance companies and to have an influence on public health policy through health care centres and health prevention. In particular, mutual insurance companies, and provident institutions benefited from:

- an exemption from tax on insurance contracts (7% of the premium)
- an exemption from corporate tax
- a preferential rate for business tax.

In 1993, commercial insurance companies complained to the European Commission about these advantages, arguing that they induced a distortion in competition in violation of Article 92 of the Rome Treaty. As a result, in 2002, *contrats solidaires*, which benefit from an exemption in the tax on insurance contracts, were created. Under these contracts, adjustment of the premiums according to individual characteristics or health status, for example through health questionnaires and experience rating, is not permitted. Any provider can offer these contracts, meaning that the tax is no longer determined by the type of company, but on the type of product. In 2006, the exemption from corporate tax and business tax, which benefited mutual health companies and provident institutions, was removed.

Harmonization of financial rules and of the control of these rules

Following the Directive 92/49/EEC of 18 June 1992 on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life assurance, financial rules related to health insurance management (for example, provision, composition of assets portfolio and the solvency ratio) were integrated into the new mutual insurance code in 2001. Before this time, mutual insurance companies were held to much less strict norms, in particular

concerning provisions and solvency ratio. The introduction of these new rules led some mutual insurance companies to merge and others to disappear, partially explaining the concentration that is observed among this type of insurer.

As a consequence of this harmonization, financial and management control of mutual insurance companies, provident institutions and commercial insurance companies has been placed since 2003 under the supervision of a single authority, the ACAM.

Specialization of all types of provider towards non-life insurance activities

Article 8 of the first Council Directive 73/239/EEC of 24 July 1973 on the coordination of laws, regulations and administrative provisions relating to the taking-up and pursuit of the business of direct insurance, other than life assurance, led to a separation of health insurance activity from other types of activity through the following steps:

- in 1993, provident institutions were asked to separate their activity that concerned mandatory complementary retirement pensions from their activity that concerned health insurance and other provident benefits;
- in 2001, the new mutual insurance code introduced the principle of separation between insurance activity and the management of health centres.

These changes increased competition and contributed to diminishing the specificities of each type of provider.

4.1.2 Governance and regulation of providers

The responsibility for providing health services is shared between office-based physicians and hospitals. Office-based physicians are self-employed. Ownership for hospitals is shared between the government; non-profit-making organizations, which include charities and mutual benefit societies; and profit-making hospitals, which are increasingly concentrated in the ownership of large international groups.

Governance

In France, roughly two-thirds of practising health professionals are independent self-employed fee-for-service providers. The 2004 Health Insurance Reform Act established an umbrella organization for all health care professionals in private practice, the National Union of Health Professions (UNPS). This umbrella organization represents health professionals and sets the agenda for negotiations with SHI and VHI representatives at the national level. The main objective in its

formation was to create a single organization that could legitimately negotiate with the payers at the national level on behalf of all self-employed independent health professionals. However, it did not replace the existing professional organizations and unions at the regional level (see Section 2.3.6).

The UNPS is consulted annually by SHI and VHI representatives on matters related to the organization of the health care system and health professions, such as the relationship between office based and hospital physicians, demography of medical professions, access to care, continuing medical education (FMC) and regulation of health care expenditures.

Following the 2009 HPST Act, regional unions of health professionals (URPS), which extend to all types of health professional in a region, replaced the URML, and each union negotiates with its regional health agency (ARS) (see Section 2.4).

Regulation

Professionals

Professionals practice under the regulations of the public health code (see Section 1.3), which includes all regulations related to patient and professional rights in relation to medical goods and health services.

Before the ARSs became operational in 2010, the provision of health care in a given area was the sum of individual demands by patients rather than the result of a planned supply according to the regional needs. However, planning the provision of out-of-hospital services and ensuring coordination between hospital and ambulatory care has now been introduced as one of the missions of the ARSs (see Section 2.4).

Self-employed physicians and other health professionals in the private sector can freely choose their place of practice. A first attempt to limit this freedom of choice failed in face of medical students' protests and demonstrations in 2004. The 2009 Act reforming the organization of health care delivery (2009 HPST Act) has positive incentives for young physicians who elect to set up their practice in under-served areas (see Section 5.2.3).

The specialty case mix can be to a certain extent adjusted by the government, which decides on the number of positions opened for recruitment in each specialty (Ministry of Education and Ministry of Health). For hospital physicians and public health care professionals, however, it is interesting to note that promotion may not follow the health requirements of the population but rather the international excellence of a discipline as reflected by the impact factor of the individual's publications. Consequently, the case mix of senior

academic physicians may not be consistent with health targets and priorities. The relative lack of specialists, such as ophthalmologists for example, has been noted and led to experimentation with transferring competence from ophthalmologists to orthoptists and to optometrists in order to compensate for the scarcity of ophthalmologists.

There is no formal re-certification or relicensing process of doctors. However, all physicians must undergo continuous learning activities. Physicians practising high-risk specialties (for example, surgery, interventional cardiology or radiology) have to undergo a specific accreditation process by reporting and analyzing the adverse and potentially adverse events in their practice (see Section 4.1.4).

Hospitals

Two-thirds of hospital beds belong to either public or non-profit-making institutions, with the remaining beds belonging to private profit-making clinics. Both human and physical resources are controlled by the government through different mechanisms (see Section 4.2). The Ministry of Health, through the National Health Authority (HAS), is in charge of ensuring standards of competence among hospitals and physicians through the accreditation process that all hospitals (public and private) must undergo every fourth year (see Sections 4.1.4 and 6.4.2). There has been no hospital closure as a result of the first round of accreditation; however, many below-standard institutions closed down before undergoing the accreditation procedure, anticipating a negative outcome. Overall, the number of hospitals was reduced from 3260 to 2870 at the end of the first accreditation round in the end of 2006. The reduction resulted mostly not from hospital closures but from the transformation of small hospitals into long-term care facilities and from private-profit-making hospital mergers.

To further pursue hospital reform, the Hospital Plan 2012 (*Plan Hôpital 2012*; see Section 5.1.2) was launched in 2007 to cover the 2007–2012 period. The objectives are to reinforce the regional role (rather than national or local levels) in decision-making regarding the activities of hospitals and their opening and closure; to ensure safety and deploy an information system; to improve workplace conditions for hospital staff; and to ensure environmentally friendly buildings. This plan benefits from a €10 billion subsidy.

4.1.3 Governance and regulation of the purchasing process

For many years, financial regulation was restricted to the control of prices and tariffs. Fees charged by professionals were negotiated by agreement between professionals and SHI (UNCAM) in the framework of private practice, while

DRG tariffs in hospitals were determined by the Ministry of Health, and drugs and medical devices tariffs were set by an interministerial committee, CEPS (see Sections 3.2 and 6.6.1). However, the 1996 reform introduced a major change by subjecting SHI expenditure to a national ceiling (ONDAM), approved each year by parliament (see Section 3.4).

The method of regulating prices and tariffs for various medical goods and services depends on the form of payment. It is important to distinguish between the approved or official tariffs and the fees actually charged. The official tariffs provide a basis for coverage by SHI, while the fees actually charged may, in certain cases, be higher when extra-billing is allowed. Regulation affects official coverage rates by SHI. Setting official tariffs for treatment carried out by self-employed health care professionals relies on the following positive lists (see Section 3.2):

- NGAP for common medical procedures or CCAM, the common classification of medical procedures, for technical medical procedures;
- LSPR for reimbursable drugs;
- NABM for biological laboratory tests and procedures (*nomenclature des actes de biologie médicale*);
- LPP for medical equipment and devices.

For medical procedures and laboratory tests (NGAP, CCAM and NABM), the technical services of UNCAM suggest revisions in the tariffs that must be approved by the Minister of Health. The tariffs are decided by agreements between SHI (UNCAM) and the trade unions, which make provisions for the terms and conditions of increases over a period of five years (see Section 3.5).

For drugs and devices, the Pricing Committee (CEPS) decides on the official tariffs (see Sections 3.2 and 6.6).

The relationship between SHI and individual providers is contractual (see Sections 3.5 and 3.6.2). In the case of hospitals, contractual agreements are established by the ARS in each region (see Section 4.2).

SHI and individual providers interact on the basis of contractual national agreements (conventions) signed by UNCAM (SHI) and each professional union. These agreements apply to all professionals nationally and govern health professionals' relationships with patients publicly covered by SHI, in terms of issues such as fee increases, implementation of practice guidelines and prescription of generic drugs (see also Section 3.5). Additionally, collective

or individual contracts can be signed at the regional or local level by the local SHI with a small number of providers. If contracts have a scientific component (for example, guideline implementation), the scientific part is drafted by HAS.

Physicians' national agreements organize three different types of contract that aim to promote the quality and efficiency of the health system through professionals' collective or individual commitment: targeted agreements on good practices (*accords de bon usage des soins*; AcBUS) and individual contracts of two types, good practice contracts (*contrat de bonne pratique*; CBP) and public health contracts (*contrat de santé publique*; CSP), which physicians choose to join on a voluntary basis. The latter two focus on a specific topic and are more related to the organization of care.

Targeted agreements on good practices. AcBUS is a collective contract that can be signed at a national or at a regional level. The aim is to modify the behaviour of professionals for very specific interventions with a clear objective of cost-containment, and it concerns frequently prescribed drugs and frequently used services. As a reward to this commitment, professionals are entitled to higher fees. They are valid for the length of a national agreement. Overall, by 2010, eight national AcBUSs had been signed (five lasting until 2005, three starting in 2005) and several regional AcBUSs have been signed with GPs. As an example, in 2006, a national AcBUS on antiplatelet drug use after an episode of thrombotic disease focused on increasing the proportion of patients receiving aspirin, which is cheaper than other antithrobotic drugs.

Good practice contracts. The CBP sets detailed commitments pertaining to the improvement of practice and consists roughly of an audit feedback of the professional's practice, in exchange for a yearly bonus and additional contribution to the professional's retirement pension. For example, an appropriate professional practice contract for GPs in rural, mountain or deprived areas provides additional revenue to pay for a replacement in exchange for a minimum number of days spent in FMC. This contract addresses the difficulties of physicians who cannot easily leave their practice and ensures continuity of care in sensitive areas. However, the CBP has been little developed and its impact is estimated to be low, although there has been no formal evaluation (Cour des comptes 2005a).

Public health contracts. The CSP is signed by individual providers, who agree to provide additional prevention or coordination services, or to ensure continuity of care in deprived areas. For example, a CSP signed in 2003 by medical laboratories on the follow up procedures for patients taking anticoagulant medication specified the duties of the professional: recording

the drug's name, advising the patients on drug interactions and performing the appropriate number of six annual tests with a log confirming that tests have been made sent to the local branch of SHI. In exchange, the laboratory received a €15 bonus per patient.

All contracts include follow-up indicators. For example, the 2006 AcBUS on mammography indicates the quality requirements for the equipment and the procedure for mammography performed outside of the national screening programme.

Moreover, starting with the 2005 national agreements, doctors collectively committed themselves to annual medically based cost-containment goals (see Section 6.3.2 and 7.1.3 for definition of medically based cost-containment). In a yearly addendum, cost-saving targets that can be achieved through better practice are defined. The principal topics are mainly related to prescription of sickness leave and drug prescribing (for example, antibiotics, statins, proton pump inhibitors, psychotropic drugs, angiotensin-converting enzyme inhibitors, antihypertensive drugs and generic drugs): for instance, a 10% decrease in antibiotic prescriptions in order to save €91 million, and a 10% decrease in anxiolytic and hypnotic drugs in order to save €33 million. Doctors' fees are reviewed depending on how these goals are achieved over the year. In 2005, the prescribing targets were poorly achieved. The results significantly improved in later years but the savings were much lower than the targeted amount. The effectiveness of such commitments on prescribing practice is difficult to assess and to disentangle from other policies that target the same categories of drugs (HCAAM 2007).

Disappointed by the results of the collective negotiations within the framework of the national agreements, and following the example of the GP contract in the United Kingdom in 2004, which introduced financial incentives for GPs to achieve better performance, SHI has offered since 2009 individual contracts as part of a national agreement with GPs (CAPI; see Section 3.6.1).

In addition to the methods described above, SHI at national, regional and local levels can make use of the Medical Service Office (*service médical*), consisting of about 2550 doctors, pharmacists and dentists, in order to regulate providers. This service monitors claims by individual patients and health care professionals to verify the validity of treatment on medical grounds; it also carries out public health programmes aimed at promoting efficient medical practice.

In 2003, a new function was created to complement the role of the Medical Service Office and to counteract the influence of pharmaceutical representatives: SHI medical representatives (*delégues de l'assurance maladie*; DAMs). Their mission is similar to the “academic detailing” used in US health services to implement practice guidelines on drug prescription by physicians visited in private offices (Simon et al. 2005). The DAMs are health professionals employed by the SHI funds who visit individual physicians and provide feedback on their practice and prescription, in particular the use of expensive drugs in comparison with the average prescriptions in the region (see also Section 6.3.3).

4.1.4 Regulating quality of care

Quality of care is regulated at the national level by the Ministry of Health, mainly through HAS and SHI, while monitoring is at the regional/local level (Table 4.1). For the specific case of cancer care, standard setting and monitoring are the responsibility of the National Cancer Institute (INCa, see Section 2.3.3).

Table 4.1

Decentralization of functions and regulatory institutions in France

Function	Type of decentralization	Regulatory institution
Standard setting	Centralization	MoH, National Health Authority, National Cancer Institute, SHI
Monitoring	Decentralization	SHI local funds, regional health agencies
Enforcement	Centralization/decentralization for hospitals	National Health Authority (accreditation) and regional health agencies (contractual priorities)
	Decentralization for self-employed professionals	Professional societies (<i>conseils de l'ordre</i>) (professional practice appraisal) and local SHI funds (individual contracts)

Physicians

There is no formal re-certification or re-licensing process for doctors. However, physicians must undergo continuous learning activities. Until the 2009 HPST Act, learning activities consisted only of participation in continuous medical education (*formation médicale continue*; FMC) and evaluation of professional practice (*l'évaluation des pratiques professionnelles*; EPP). The Act changed the term “continuing medical education” (FMC) into “continuous professional development” (*developpement professionnel continu*; DPC).

FMC was first developed on a voluntary basis in the 1960s on the initiative of medical professionals; it was managed mainly by non-profit-making FMC associations and financed by the pharmaceutical industry. In the 1970s, special

funds to which doctors contribute (currently around €50 per year) were set up to finance professional education. Therefore, many medical doctors' unions with a shortage of funds developed FMC programmes in order to generate resources. Since the early 1990s, FMC has been part of the framework of national agreements signed by the medical doctors' unions and SHI (see Section 4.1.3), and as such it is used as a negotiation tool with the medical unions. SHI partly finances FMC programmes and ensures that doctors are paid an allowance for participating in such programmes. The 1996 reform made FMC mandatory for self-employed as well as salaried doctors, thereby providing the basis for its formal organization.

From 1999, EPP was developed in parallel to FMC. It is a form of medical audit, similar to formative assessments, that aims to improve the quality of care through the provision of peer feedback to doctors on their patterns of practice compared to practice guidelines issued or endorsed by HAS or the Health Products Safety Agency (AFSSAPS).

However, as relations between doctors on the one hand and the government/SHI on the other were not good at that time (see Section 3.5), doctors did not perceive EPP to be a beneficial activity that increased the quality of their practice; rather, they saw it as a time-consuming administrative task and, as such, participation was low. Therefore, the EPP process, which had been voluntary, was made compulsory in 2004. Nevertheless, for over 10 years, despite it being compulsory, the number of doctors participating in learning activities has remained very low, particularly for self-employed doctors. This is partly explained by the fact that the governance of both FMC and EPP has remained very weak (Chevreul, Durand-Zaleski 2009). For example, no information system exists to monitor the completion records and no budgets have been allocated to regional committees in charge of organizing learning activities, undermining their effectiveness. Moreover, although legislation states that non-compliance can lead to sanctions, these have never been defined and there are no effective penalties.

It was only in 2006 that the criteria for learning activity requirements were finally defined and activities were assigned a defined number of credits. There are currently four categories of activity that generate different credits for doctors: FMC sessions; EPP sessions; participation in education and research activities within representative bodies and activities for improving the quality and organization of care; and individual FMC-supporting activities, such as producing teaching materials in paper or electronic form, reviews, books, telemedicine and e-education activities. Doctors have to obtain 250 credits

in every five-year period: two-fifths have to be obtained from EPP and the remainder from the other three categories. Hospital-based physicians can validate their EPP at the time of the hospital's accreditation (see below).

Learning activities regional committees inform the Regional Council of Physicians Associations (*conseil regional de l'ordre*) when doctors do not comply, and the doctors can then be offered education programmes to help them to catch up with their FMC requirements. The law does not provide any information on the consequences of refusing to comply with the system. However, it can be assumed that the professional association could suspend a physician's licence.

An additional shortcoming is that this framework did not set priority topics or national policies and did not guarantee independence from the pharmaceutical industry. Indeed, the latter is still the main funder of FMC through financing or organizing sessions for doctors, and it is sometimes difficult to disentangle which activities are related to marketing and which promote medical education. While the overall level of FMC funding by the pharmaceutical sector is difficult to assess, it was estimated to be around €300–600 million in 2006, at least 2.5–5 times higher than the other sources of financing altogether (Bras, Duhamel 2008).

In order to address these problems, the 2009 HPST Act replaced EPP and FMC with the concept of “professional continuous development” (DPC), which is mandated for physicians, but also for dentists, pharmacists and midwives.

In order to improve governance, resources from SHI, public and professional education funds should be merged into a single fund, and a national committee representing multiple stakeholders has been established to define a list of priority topics. However, more detailed legislation setting out the organizational processes that will drive DPC has not yet been issued. It is still not known whether the new arrangements will build on what has already been achieved or if this further reform will start from scratch, changing FMC processes, organizational structures and compliance requirements. Another important question is whether the reform will be able to achieve better results without allocating any new resources to the overall process.

For a limited number of high-risk medical specialties, another mechanism, accreditation, was put in place by the 2004 Health Insurance Reform Act. Professional accreditation differs from EPP, which is mandatory for all licensed physicians. Accreditation is optional and concerns physicians or medical teams practising in hospitals. Medical specialties involved include obstetrics and

gynaecology (including ultrasound imaging), surgery, interventional radiology, anaesthesiology and other interventional specialties such as cardiology. Accreditation permits physicians to claim a deduction on the premium they pay for their professional insurance. The accreditation process includes a registry of adverse events or “near misses”, use of practice guidelines and review criteria, and participation in educational sessions in risk reduction. Accreditation is delivered for a four-year period and its results are made public. The first round of the process is to end by 2012. If the standards are not met, there can be sanctions, ranging from a list of aspects to be improved within a given time frame to the withdrawal of the licence.

Hospitals

An accreditation system was introduced in 1996 (Ordinance no. 96-346 of 24 April 1996 and decree no. 97-311 of 7 April 1997) to monitor the quality of care in hospitals. Since the 2004 health insurance reform, this is called certification. It is a two-step process. First, there is a self-appraisal conducted by hospitals based on guidelines produced by HAS. It involves the implementation of a certain number of procedures and requires the compilation of a large amount of information, particularly with regards to quality indicators. Second, a team of experts assigned by HAS visits the hospital and carries out the certification. The process lasts 10 months on average (see also Section 6.4.2). A follow-up process is defined in order to ensure improvement in the quality of services provided. Hospitals must be certified every four years. HAS is in charge of completing the process and the certification criteria and reports are publicly available via the HAS web site. Following increasing premiums for professional insurance of doctors practising high-risk medical specialties, the 2004 health insurance reform extended the accreditation process to high-risk practitioners and medical teams in hospitals, who should also be accredited every four years (see above).

Quality assurance and risk management in hospitals are monitored nationally by the Information Platform on Health Care Organizations (*plateforme d'informations sur les établissements de santé*; PLATINES). This information system is the responsibility of the Ministry of Health. PLATINES publishes online technical information, data on hospital activity and data on control of hospital-acquired infection. The Coordination for Hospital Performance and Quality of Care Measurement (*Coordination pour la mesure de la performance et l'amélioration de la qualité hospitalière*; COMPAQH) is another national programme collecting hospital quality indicators. COMPAQH started in 2003 as a joint development by the Ministry of Health, HAS and the French National Institute of Medical Research (*Institut national de la santé et de la recherche*

médicale; INSERM). Participation is voluntary and, as of 2008, a total of 42 hospitals routinely collect and report (anonymously on the COMPAQH web site) some of the 65 quality indicators used. There is currently no financial incentive associated with monitoring quality indicators, but an adaptation of the “pay-for-performance” programme in the United States is being seriously considered by the Ministry of Health.

Funds for the quality of ambulatory care

In addition to the contractual agreements described above and to the mechanisms of accreditation and EPP, SHI has allocated specific funding to quality assurance and coordination of ambulatory care. Funds are attributed at the regional level on the basis of a yearly call for proposals. These are called Quality and Coordination of Care Funds (*fonds d'intervention de la qualité et de la coordination des soins*; FIQCS) since 2008 (see Section 6.3.4). Proposals are reviewed by a committee of experts and representatives of both SHI and professionals' unions. Funds are attributed on the basis of scientific merit. The total amount of money attributed annually is around €200 million. An assessment of the programme was commissioned in 2006 by the Ministry of Health. Unfortunately, the authors of the report gave a very critical appraisal of the poor governance and overall absence of monitoring of the programme (Daniel et al. 2006). Later, the 2009 HPST Act transferred responsibility for the quality of ambulatory care to the regional health authorities.

International projects

HAS participates in the EU-funded project SIMPATIE (Safety Improvement for Patients in Europe) and is coordinator of the project EUNetPaS (European Union Network for Patient Safety (*Réseau de l'Union Européenne pour la sécurité des patients*)). EUNetPaS is a project funded and supported by the European Commission within the 2007 Public Health Programme. Its purpose is to establish an umbrella network of all 27 EU Member States to encourage and enhance their collaboration in the field of patient safety (culture, reporting and learning systems, declaration of adverse events, education and monitoring patient safety), thus maximizing efficiency of efforts at the EU level.

4.2 Planning and health information management

Prior to 2010, planning of health services, professionals and social and health care for the disabled was done by separate institutions and separate processes. The 2009 HPST Act introduced a “one-stop shop”, with ARS being in charge of planning and better coordination of ambulatory and hospital care, as well

as health and social care for the elderly and disabled (see Section 2.4). This is done through a regional strategic health plan (PRS), which is based on population needs.

Capacity planning

Hospitals

Since 1996, responsibility for planning health system resources and capacity has been shared by the central government (the Ministry of Health) and 26 regional hospital agencies (ARHs), replaced by ARSs in 2010. This partial devolution of the planning function aimed to enable regional authorities to meet the health needs of the population more appropriately. Other corporate actors such as the hospital federations (see Section 2.3.6) and representatives of the public also participate in the planning process and may play an important role during consultations. The regulatory framework for hospitals applies equally to private profit-making, private non-profit-making and public providers. Services provided by any hospital will be reimbursed by SHI as long as the related providers are authorized by the Ministry of Health.

Planning largely takes place at the regional level, involving the Regional Conference on Health and Autonomy (CRSA) and the ARS. The Ministry of Health has a stewardship role, establishing a catalogue of health services that the regions must incorporate in their plans. Based on a national assessment of need and (sometimes politically driven) priorities, the catalogue lists services in major areas such as general medicine, surgery, perinatal care, rehabilitation, intensive care, medical imaging, psychiatry, palliative care, care of defined population groups (for example, older people, children and adolescents) and care for selected conditions (for example, chronic kidney failure and cancer). The strategy is mainly implemented through a regional health organization plan (*schema régional d'organisation sanitaire*; SROS) developed by the ARH prior to 2010 and the ARS since then, in consultation with the stakeholders (including the Ministry of Health), who participate in the Regional Conference on Health and Autonomy.

Since its introduction in 2003, in each region the SROS has incorporated the function previously undertaken by a “national medical map” (*carte sanitaire*). This was a quantitative planning tool used by the Ministry of Health to divide each region into health care and mental health care areas and to set norms for bed/population ratios for major disciplines based on national data, including data for expensive diagnostic and treatment equipment in hospitals or elsewhere and for rehabilitation and long-term care. Developed every five years, the SROS aims to tailor health care delivery to local needs, in contrast to the

previous national planning norms. The SROS sets out overall strategic goals for health care delivery and defines priorities, objectives and targets, including quantitative targets and the distribution of local health care facilities. Strategic planning requires the ARS to assess population health needs based on regional health care utilization data and data on mortality and morbidity. Data are analysed by region and compared across regions to identify demand and over/undercapacity. Assessments also consider expert estimates of future trends in demand and technological change; these are largely based on epidemiological data and trends observed in other countries.

The SROS also forms the legal basis for target contracts (*contract d'objectifs et de moyens*) between hospitals and the former ARH, introduced in 2005. Target contracts set out the responsibilities of each hospital and the volume of services to be provided. Typically negotiated for a period of three to five years, they require hospitals to obtain authorization from the ARS for the services they provide (including expensive health technologies). They also require an evaluation of existing capacity and service volumes, which must be undertaken at least 14 months before the existing contract expires.

Target contracts have been criticized by the hospital federations on the grounds that the definition of service volumes restricts the flexibility of hospitals to respond to changes in demand (for example, if there is a closure of a hospital in the vicinity). Hospitals can be penalized for not adhering to target contracts, with a financial penalty of up to 1% of total revenue. The ARS may also suspend the authorization for the service for which the target was not reached. However, so far no hospital has been penalized. A new model contract was negotiated by the Ministry of Health and the hospital federations for the SROSs for 2006–2010 and took effect in April 2007. Since the ARSs took over the remit of the ARHs in 2010, the SROSs are to incorporate the objectives of the regional strategic health plans (PRSs).

Health and social care services for the frail elderly and disabled

Prior to 2010, planning of health and social care services for the elderly and disabled, such as nursing homes (for example, residential care homes for disabled frail elderly (*établissement d'hébergement pour personnes âgées dépendantes*; EHPAD) and long-term homes (*foyers logements*), or community nursing services (see Section 6.8.1), was done by both the subsidiaries of the state at the regional level and the general councils at departmental levels. These two processes of planning have sometimes led to discrepancies or inadequacies.

Since the creation of ARSs, planning is done through an organizational pyramid.

1. At the top of the pyramid, a regional scheme of health and social care sector organization (*schéma régional de l'organisation médico-sociale*; SROSMS) is established by the director of the ARS, on the advice of a dedicated ARS commission, the coordination committee dedicated to the health and social care sector (*commission de coordination dédiée au secteur médico-social*) composed of representatives of the state, of the general councils and of the social security schemes involved in financing the sector, and of the head of the general councils. This regional scheme should meet the objective of the PRS.
2. In the middle is the inter-departmental programme for the disabled and for the loss of functional autonomy (*programme interdépartemental d'accompagnement des handicapés et de la perte d'autonomie*; PRIAC), which translates the regional scheme for health and social care sector organizations into authorization for capacity building. It is established by the director of the ARS and the head of the general councils.
3. At the bottom of the pyramid, the heads of the general councils (who previously took the lead in capacity planning in health care) design departmental schemes for the disabled (*schémas départementaux relatifs aux personnes handicapés ou en perte d'autonomie*), the objectives of which are to set departmental planning of health and social care services in conjunction with the ARS commission, the representatives of health and social care services and service users living in the departments.

These organizational developments are raising questions of clarity and coherence. How will ARS schemes and departmental schemes be articulated? Will the two levels of organization agree or will they advocate contradictory planning decisions? The answers to these questions will mainly depend on whether the ARS commission will genuinely be able to take the lead in dialogue and collaboration (Desmarescaux 2009).

Once this planning process is finished, a call for proposals is made by an ARS selecting committee to choose capacity-building projects that meet the local priorities that have been set out through the pyramid planning process described above (the mechanism for calling for proposals is still in development).

Health professionals

The National Observatory of Health Professionals (*Observatoire national de la démographie des professions de santé*; ONDPS) was created in 2003 to provide figures and guidance to the Ministry of Health. Its annual reports provide information on weaknesses in information required for the steering of

human resources in the French health care system by the Ministry of Health. It also identifies gaps in strategic planning at the national and regional levels (ONDPS 2008).

At the national level, the numbers of doctors, and to some extent their areas of specialization, are regulated by the *numerus clausus*, which controls access to the second year of study in medical schools. This *numerus clausus* is then applied at the regional level, taking into account current inequalities in the geographic distribution of doctors (see Section 5.2.3). There is also a *numerus clausus* limiting the number of students in other health professions, such as nursing, midwifery, dentistry and physiotherapy (see Sections 5.2.4 to 5.2.8).

For doctors, the distinction between specialists and GPs is determined by the number of posts for internship open in different areas of specialization in the national competitive examination that medical students undertake after six years of study (*epreuves classantes nationales*; ECN) (see Section 5.2.3). These posts are divided into the main branches (medicine, surgery, psychiatry, biology and public health), but until recently, there was no system of regulation by specialty within medicine and surgery, so choice of specialty was dependent on vacant hospital training posts and students' preferences. In recent years, the lack of interest in certain specialties (anaesthesiology, intensive care, gynaecology and obstetrics and paediatrics) has led the government to reserve a number of places for these specialties in the national examination.

After graduation, there is no restriction on the areas where professionals are allowed to practise. Hospital work is dependent on posts offered by institutions but self-employed professionals can set up their practice wherever they want. As a result, there are wide regional disparities in the distributions of self-employed doctors and other health professionals (see Sections 5.2.3 and 5.2.4).

Two policy approaches can be viewed as attempts to plan the provision of health services to tackle the relative deficiency in the number of physicians (see Section 5.2.3) and to tackle regional disparities in the distribution of doctors.

One policy favours task transfer between physicians and other health professionals. First, the 2004 Social Security Finance Act permitted experimentation in this area. HAS assessed these experiments and found that, although successful in general, they have so far been quite limited in scope and concern only a dozen tasks usually performed in hospitals. It stated that a full deployment would require a change in the law defining the task of each profession, changes in the fees and adaptation of the curricula. Later, in 2009, the HPST Act legalized the transfer of tasks between professionals beyond the

mere scope of these experiments and developed contractual agreements of care protocols between professionals under the control of HAS. It also set up a new system of organizing health care delivery by establishing a legal framework for providing health care using telemedicine and also encouraging the development of multidisciplinary and multiprofessional care centres.

The second policy develops tools for improving the geographic distribution of health professionals and for improving the organization of around-the-clock delivery of care in the hospital as well as the outpatient sector. In January 2006, a national demographic plan for health professionals was introduced. Among other things, this plan increased the *numerus clausus* in particular in areas with low density of doctors and high medical activity, known as “medically under-served areas”. It also developed financial incentives for doctors to practise in these areas by proposing measures for improving doctors’ working conditions, such as allowances for establishing a group practice. However, this has had a limited impact in reducing geographic disparities (see Section 7.1.4).

Later, the 2009 HPST Act developed a range of tools and incentives when reforming the regional planning of health care delivery in order to tackle the issue of the inequitable supply of physicians and to meet the objectives of the regional health organization plan, SROS. On the one hand, access to medical specialties in each territory will now be regulated by quotas that will be set five years in advance. On the other hand, the Act introduced a system of financial incentives to work in under-served areas:

- the public service commitment contract (*contrat d’engagement de service public*) can be offered to medical students and residents; under this contract, students and residents will receive a monthly allowance during their studies in return for the commitment to work in an under-served area under the Sector 1 agreements;
- from 2013 onwards, ARS directors can offer physicians who work in medically over-served areas a health and solidarity contract (*contrat santé solidarité*) in which they would agree to participate in health care delivery in under-served areas in exchange for an allowance.

The Act states that those refusing the solidarity contract or not fulfilling the contract terms will have to pay a lump sum fine to SHI. However, this financial incentive was dropped in June 2010 by the Minister of Health (see Section 7.1.3).

For nurses, a first attempt to implement a tighter form of planning was implemented following the 2007 national agreement of nurses with SHI. This includes financial and material incentives for nurses to settle in under-served areas and prohibition of settlement in over-served areas unless a retiring or leaving nurse is replaced (see Sections 5.2.4 and 7.1.4).

4.2.1 Health technology assessment

Health technology assessment (*évaluation des technologies de la santé*; HTA) governance and organization are defined by the government and SHI. The major HTA body in France is HAS, which has in-house expertise and also the capacity to commission assessments from external groups such as academic centres or professional societies.

All medical procedures and technologies (drugs, devices, equipment, reagents and tests) are assessed on the request of manufacturers, or professional learned societies in the case of medical procedures. For technologies, a first assessment concerns safety and can be supranational, for example the European Agency for Evaluation of Medicinal Products (*Agence européenne pour l'évaluation des médicaments*; EMA). The second assessment is specific to the French health care system.

Assessments are performed by ad hoc committees. Drugs are assessed by the Transparency Commission (CT), devices by the National Commission for the Evaluation of Medical Devices (CNEDIMTS) and procedures by the National Commission for the Evaluation of Medical Procedures (CEAP) (see Section 3.2). The last two have now merged and have one chairman. Stakeholders such as patients, professionals (via their learned societies) and manufacturers are members of the assessment committees.

In order to be listed in one of the positive lists and covered by SHI, all new drugs, devices and procedures must undergo an assessment. This assessment is prior to market launch and is used directly to determine the coverage rate and less directly the price (statutory tariff). For new technologies, assessment is based on the documents provided by the manufacturer. The studies are critically appraised by two reviewers and discussed by the committee. There is a two-tier procedure.

- **Is the technology efficacious at all?** Assessment of the level of medical benefit of the technology reflecting its clinical efficacy, the severity of the disease it is indicated to treat and the public health relevance of the technology (*intérêt de santé publique*), which includes epidemiological

aspects and quality of life. The degree of medical benefit or therapeutic value is represented by an SMR (*service medical rendu*) level for drugs and devices and SA (*service attendu*) for medical procedures. The assessment determines the coverage rate, from 0 to 100% (see Section 6.6.1).

- **Is the technology more efficacious than the available comparators?**

An assessment is made of the relative medical benefit of the technology in comparison with similar available treatments, termed the improvement in the relative medical benefit (*amelioration du service medical rendu*; ASMR) or the improvement in expected benefit (*amelioration du service attendu*; ASA). There is an explicit pricing decision based on the figure given by the drug or the device committee (CT or CNEDIMTS) to grade the improvement in medical effectiveness over the existing comparators (rated on a scale of 5 for no improvement to 1 for major improvement, usually assigned to life-saving technologies; see Section 6.6.1). Both the conclusions on the level of medical benefit and the relative medical benefit are published on the HAS web site.

Old technologies are re-assessed every five years based on the documents provided by the manufacturer and on systematic reviews of the literature. Manufacturers have an incentive to provide sufficient data to assess drugs and devices because of the pricing objective.

Following the 2008 Social Security Finance Act, an economic evaluation is added to the assessment in the case of re-assessments of old technologies. A specific committee, the Commission for Economic Evaluation and Public Health (*Commission d'évaluation économique et de santé publique*; CEESP), has been set up within HAS to advise the three committees mentioned above on how to include economic evaluation in their assessments and to define a societal benefit measure (*service rendu à la collectivité*; SERC) (see Section 7.1.3).

For other technologies, such as the equipment required for a procedure, reports are commissioned by the Ministry of Health. The HTA report can recommend waiting until additional information is available or can commission surveys or observational studies. The manufacturer is usually required to fund the studies, but the investigators have to be independent from the manufacturer. Manufacturers can appeal the decisions of the drugs and devices committees and request a second hearing.

Additionally, HAS can undertake evaluation of health programmes (such as screening programmes), medical practice or strategies. HAS can either define the topic it wants to work on itself or work at the request of the Ministry of Health and SHI. Topics are prioritized according to their public health and policy relevance, and priorities are published on the HAS web site. For example, 2009 priorities are safety, alternatives to conventional health care, cardiovascular diseases, obesity and care for the elderly.

HTA in France is conducted by well-trained professionals with a tradition of HTA and a good level of international integration. Its current challenge is to move from assessment to appraisal and consider nonmedical aspects that affect the deployment of new health technologies, such as cost-effectiveness (Chevreul, Durand-Zaleski 2009) (see Section 7.1.3).

4.2.2 Information systems

There are currently two coexisting types of information system in France: one for hospital admissions (the PMSI), which is used by hospitals to bill SHI using the French DRG system; and one for patient reimbursement claims for ambulatory and hospital care. For the first, all PMSI data are grouped at the national level by the Agency for Information on Hospital Care (ATIH, see Section 2.3.3); for the second, there are several systems attached to different SHI schemes that, from late 2009, are merged in a single database. Both types of information end up with the SHI schemes, and both are used for reimbursement claims and not for medical purposes. In order to connect these two types of system into one comprehensive system, the SHI inter-schemes system (*systeme national d'information interrégimes de l'assurance maladie*; SNIIR-AM) was set up in 2003. In addition, limitations for research concerning the above systems have led to the setting up of permanent samples of SHI beneficiaries. These information systems are described in more detail below.

The Programme of Medicalization of Information Systems for hospitals

Introduced in France in 1983, when the hospital global budget payment method was implemented, the PMSI developed significantly during the 1990s for the acute care sector (PMSI-MCO) and became exhaustive only by the end of that decade (after the 1996 reform). Data are kept from the implementation date of the system and a patient's hospital stay can be followed over the years.

Following the 1991 Hospital Reform Act (no. 1991-748 of 31 July 1991), public and private hospitals were required to evaluate their operations. For hospital stays involving medical, surgical and obstetric procedures, this evaluation is based on the production of a standard discharge summary

(*résumé standardisé de sortie*; RSS) for each hospital stay. The RSS contains information on the nature of the treatment and examinations carried out in the course of the patient's stay, the diagnosis that led to the hospital admission and associated diagnoses or possible complications. The RSS is then integrated into "homogeneous patient groupings" (GHM) for classification of hospital stays, adapted from the DRG classification system in the United States.

More recently, PMSI has been introduced for hospital at home (*hospitalisation à domicile*; HAD: PMSI-HAD) (see Section 6.4.1), which is also paid on a DRG basis for the rehabilitation sector (*soins de suite et de réadaptation*; SSR: PMSI-SSR) and for the psychiatric sector (RIM-Psy). All of these systems keep data from their implementation date, and a patient's course can be followed over the years and across systems.

Additionally, a national baseline for costs per stay in the acute care sector has been constructed from a voluntary sample of public and private hospitals, with a detailed accounting system producing an evaluation of the total cost of each stay, the national cost scale for the acute care sector (*échelle nationale des coûts communes*, ENCC-MCO). For each GHM, the median cost of all stays in the sample is taken as a reference point. Then a national scale of relative costs is constructed by positioning each GHM in relation to GHM 540 (childbirth, normal delivery without complications) (see also Section 3.6). Similarly, national cost scales exist for hospital at home (ENCC-HAD) and rehabilitation services (ENCC-SSR).

Reimbursement claim systems

Reimbursement claim systems include data on patients such as age, gender, place of residence, affiliation number, eligibility for 100% coverage and reasons for eligibility (such as CMU and ALD) and data on type and quantity of care consumed for which a patient has claimed for reimbursement.

For instance, the ERASME (*extraction, recherches et analyses pour un suivi medico-économique*) system collects data on health care consumption in the general scheme. Data are kept for the previous two years plus the current running year. Older data are discarded.

From October 2009, most of these systems have been merged into a single one: the interscheme consumption datamart (*données de consommation interrégime*; DCIR). The DCIR includes information on ambulatory care usage for the vast majority of the population for the previous two years plus the current running year. Only the systems of a few small SHI schemes (such as the miners' scheme) are not included.

The SHI inter-schemes system

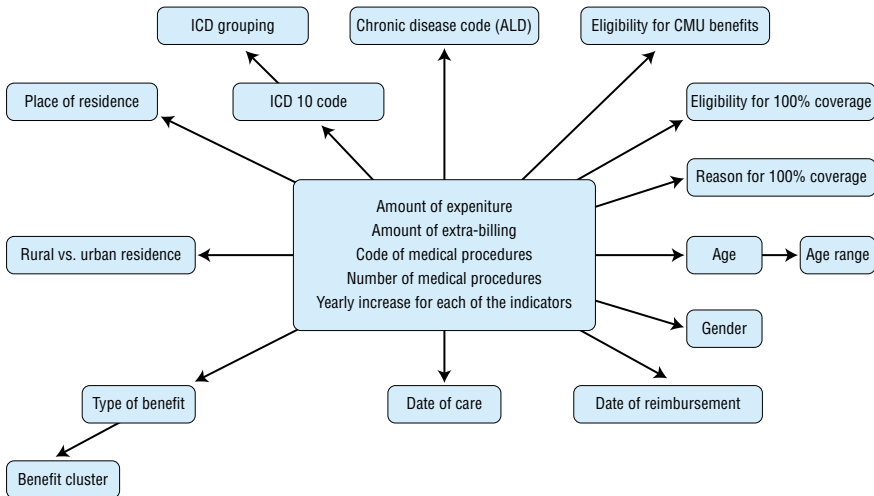
The 1999 Social Security Finance Act established a national information system for SHI (SNIIR-AM) primarily to provide information and feedback on professional practice for office-based physicians and public and private hospitals. The SNIIR-AM exhaustively regroups information from information systems of most SHI schemes in the DCIR and PMSI for the previous two years plus the current running year. It provides detailed information on all claims submitted to SHI and hospital stays. The level of detail is as fine as permitted by the coding system. Table 4.2 and Fig. 4.1 summarize the information collected.

Table 4.2
Data available in the SHI inter-schemes system

Patient data	Prescriber data	Prescriptions
Age	Specialty	Date
Sex	Extra billing	Procedure code
Place of residence		Drug code
Urban/rural		Test code
Type of benefit (CMU or ADL)		Number of prescriptions

Notes: ALD: list of long-term illnesses; CMU: universal health coverage.

Fig. 4.1
Information available in the SHI inter-schemes system



Source: WHO 1994; Lenormand, 2005.
Notes: ALD: Long-term illness; CMU: Universal Health Coverage Act; ICD: International Classification of Diseases.

The unit of analysis is the prescribing physician and the patient, so information can be linked to study a patient's care pathway or a physician's practice profile. However, access to SNIIR-AM for research and studies is currently difficult. Therefore, one of the objectives of the coming contract (COG) between SHI and the state is to facilitate access to data (see Section 4.1.1).

Moreover, SNIIR-AM is not a convenient tool for conducting research or studies when the information required is on trends, because only two complete years of data are available, or when rapid answers to management issues are required, because of the large size of the database.

Samples of beneficiaries

Because the SNIIR-AM is based on reimbursement claims, it does not contain any information on beneficiaries who do not consume any care covered by the SHI. In order to overcome these shortcomings, samples of beneficiaries have been established.

The permanent sample of beneficiaries (*échantillon permanent d'assurés sociaux*; EPAS) has been set up and in operation since the early 1980s. This is a 1/600th random sample of beneficiaries of the SHI general scheme from which all the information described above is collected and stored in a database that can be used by researchers beyond SHI and the Ministry of Health. It has the advantages of containing data for a long time period (not restricted to two years) and good accessibility.

In order to improve representativeness, the enlarged general sample of beneficiaries (*échantillon généraliste de bénéficiaires*; EGB) was set up in 2003 and replaced the EPAS in March 2010. This is a 1/97th sample of SHI beneficiaries and currently includes 500 000 people affiliated to the general scheme; in the short term it will cover all schemes' beneficiaries over a 20 year period.

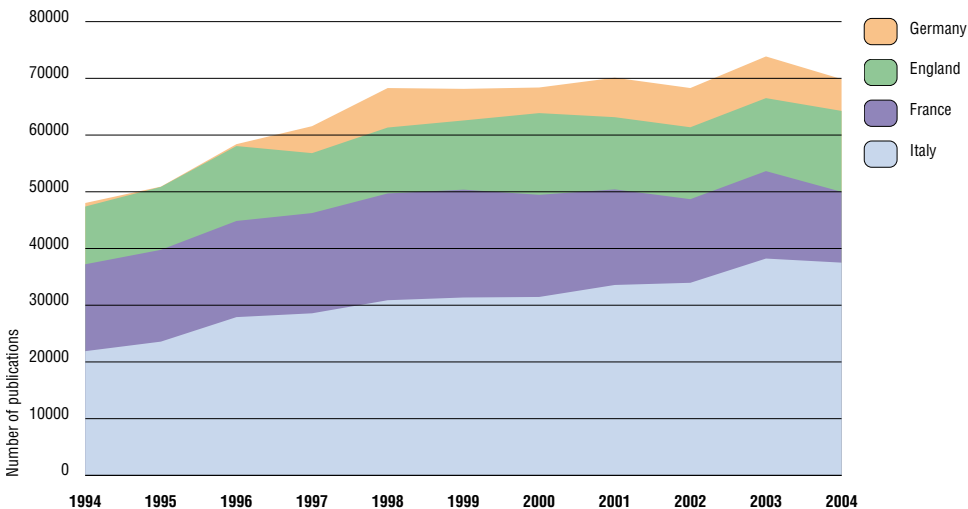
Following the creation of the electronic patient record (*dossier médical personnel*; DMP) project (see Section 5.1.4) and in order to improve the interoperability of existing systems and monitor the creation of one single patient identifier, a dedicated information systems agency was created in late 2009: the Agency for Health Information Systems (*Agence des systèmes d'information partagés de santé*; ASIP Santé).

4.2.3 Research and development

Biomedical research in France is funded by both public and private institutions. Universities and research institutes undergo performance assessments as required by the organic act (organic laws supplement constitutional provisions for purposes of implementation) that defines what should be included in the annual finance acts (*loi organique relative aux lois de finances*, Act no. 2001-692 of 1 August 2001). The number and impact of publications and the number of patents and clinical trials are indicators that have been widely used. Fig. 4.2 shows that Germany and England dominate in European biomedical research. France has increased its publications following a trend parallel to that of England, Germany and Italy. When the comparison is restricted to most cited articles, France remains third behind England and Germany.

Fig. 4.2

Number of biomedical publications for Germany, England, France and Italy



Source: INSERM 2005.

It is very difficult to produce precise estimates of the French funding commitment in biomedical fields because budgets within this area are highly dispersed. Funding sources are distributed among the following research organizations: INSERM; part of the grants for the departments of life sciences of the National Centre for Scientific Research (*Centre national de la recherche scientifique*; CNRS) and the French Alternative Energies and Atomic Energy Commission (*Commissariat à l'énergie atomique*; CEA); some departments

of the French National Institute for Agricultural Research (*Institut national pour la recherche agricole*; INRA); the hospital clinical research programme (*programme hospitalier de recherche clinique*; PHRC); and the university hospitals (*centre hospitalier universitaire*; CHU). Additionally, in university hospitals, new budgeting procedures have incorporated funding for clinical research activities into a budget attributed in addition to the DRGs in order to compensate for expenses incurred for public health activities, teaching and research. Funding from certain health agencies (for example, the National Institute for Public Health Surveillance; InVS) is also increasing for research activities at the frontiers of clinical research and public health. Some subjects such as cancer, AIDS and hepatitis are also supported by specific agencies, for example the National AIDS and Hepatitis Research Agency (*Agence nationale de recherche sur le sida et les hépatites*; ANRS) and more recently, the National Cancer Institute (INCa). Finally, the contribution that the National Research Agency (*Agence nationale de la recherche*; ANR) funding dedicates to biomedical research is not identified since funding goes to multidisciplinary programmes. Patient associations, leagues and foundations also play a very important role. Overall, total biomedical research funding in France can be estimated to be about €2.5 to 3 billion. In March 2008, INSERM underwent an important reorganization, creating eight themed institutes to plan and coordinate research. The eight themes are (1) circulation, metabolism, nutrition; (2) public health; (3) neurosciences; (4) cancer; (5) genetic and development (reproduction, ageing, rare disorders); (6) communicable diseases; (7) biotechnologies; and (8) immunology.

Despite evaluation difficulties, all of the available studies highlight that this investment is relatively low. For example, in terms of expenditure by population, France spends five times less in the biomedical field than the United States, while in 2004 the United Kingdom Medical Research Council's 2004 budget (€665 million) was 25% greater than that of INSERM (approximately €500 million) and it was allocated an additional 20% increase over the following three years (Medical Research Council 2005).

Current initiatives are aimed at creating consistent development of university research and clinical research in hospitals and strengthening local/regional initiatives such as competitive networks, research and higher training networks (*pôle de recherche et d'enseignement supérieur*; PRES) or cancer networks.

The ANR was established on 1 January 2007 to coordinate the existing publicly-funded research institutes and universities and to respond to the recurrent criticisms of lack of funding, flexibility and coordination. Its

budget is €840 million to fund four-year research projects that involve multidisciplinary teams. No assessment of its effectiveness is yet available. In 2007, the ANR called for proposals focused on six themes: biology and health; ecosystems and sustainable development; sustainable energy and environment; engineering, processes and security; information and communication sciences and technologies; and humanities and social sciences; as well as non-thematic actions. International cooperation at the institutional level resulted in original calls for proposals launched by the ANR together with Germany, the United Kingdom, China and Taiwan; the ANR also participated in two new ERA-NET (Networking the European Research Area) schemes, which develop the coordination and cooperation of European national and regional research programmes (Agence Nationale de la Recherche 2007).

Academic researchers are involved in policy-making in various ways, including as committee/panel members in research-commissioning and priority-setting bodies or in the development of guidelines; as reviewers of proposals for studies; writing reports or overviews of research and policy issues in particular areas of expertise; and as recipients of government grants from the Ministry of Health or a national agency where they are expected to identify policy implications of their work. Occasionally, academics advise the Ministry of Health or the president in a personal capacity.

5. Physical and human resources

This chapter addresses the planning and distribution of physical resources, including hospitals, health care facilities and medical devices. It then deals with the human resource input into the health system, focusing on planning, training, licensing and career paths.

The scope of the chapter will be limited to the health care sector (for information on the health and social care sector, see Section 6.8).

5.1 Physical resources

5.1.1 Infrastructure

This subsection deals with two main issues: the planning and distribution of infrastructure and the capital investments needed.

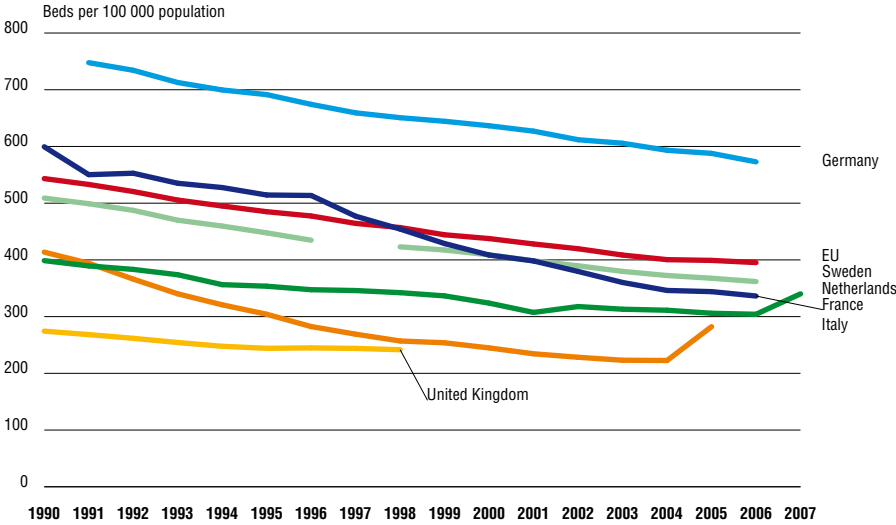
Planning and distribution of infrastructure

Since 1996, responsibility for planning health system resources and capacity has been shared by the central government (the Ministry of Health) and the 26 regional hospital agencies (ARHs), replaced in 2010 by the regional health agencies (ARSs). Representatives of health care providers and the public participate in the planning process through regional and national health conferences, which contribute to the assessment of needs and may, therefore, play an important role during consultations (see Section 4.2 on Capacity planning).

Following the general trend in European countries, the number of hospital beds in France has been declining since the late 1980s (Fig. 5.1), steadily decreasing at an average rate of 1.5% per year between 1990 and 2005.

Fig. 5.1

Beds in acute hospitals per 100 000 population in France, selected countries and EU average, 1990 to latest available year



Source: WHO Regional Office for Europe 2010.

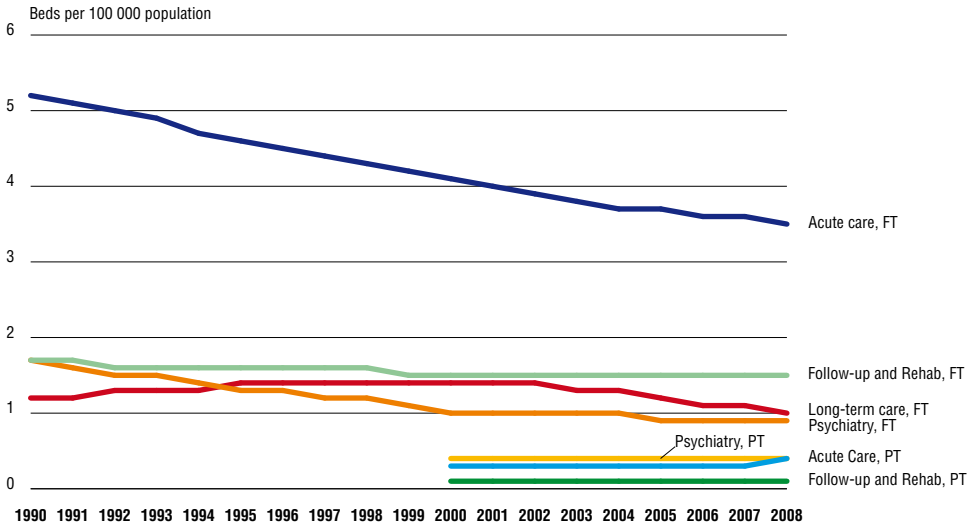
In 2008, France had an average of 6.9 full-time hospital beds (referred to henceforth as hospital beds) and 0.9 part-time hospital beds¹ (referred to henceforth as places) per 1000 inhabitants, with half the beds and two-fifths of the places dedicated to acute care. In addition, 0.2 places for home hospitalization services were available per 1000 inhabitants, 90% of which were dedicated to acute care (see Section 6.4.1).

This trend has diversely affected the different areas of care (Fig. 5.2). Since the late 1980s, acute and psychiatric care facilities and, to a lesser extent, follow-up and rehabilitation hospitals have seen their full-time hospitalization capacity reduced. Meanwhile, part-time hospitalization capacity has been increasing in the acute care and the follow-up and rehabilitation sectors. By comparison, the number of long-term care beds in the health care sector increased during the 1990s. Since 2001, however, some long-term care beds have been progressively closed and transformed into residential care for the disabled and frail elderly (EHPAD). This is in order to keep only the patients that need intensive medical assistance in the health care sector, and to transfer the other patients to the health and social care sector for elderly and disabled (see Section 6.8.1).

¹ Part-time hospital beds encompass beds for outpatient procedures and ambulatory care, including day or night care, provided in the mental health sector.

Fig. 5.2

Mix between beds in acute care hospitals, follow-up and rehabilitation hospitals, psychiatric hospitals and long-term care hospitals, 1990 to latest available year



Source: Eco-Santé 2010.

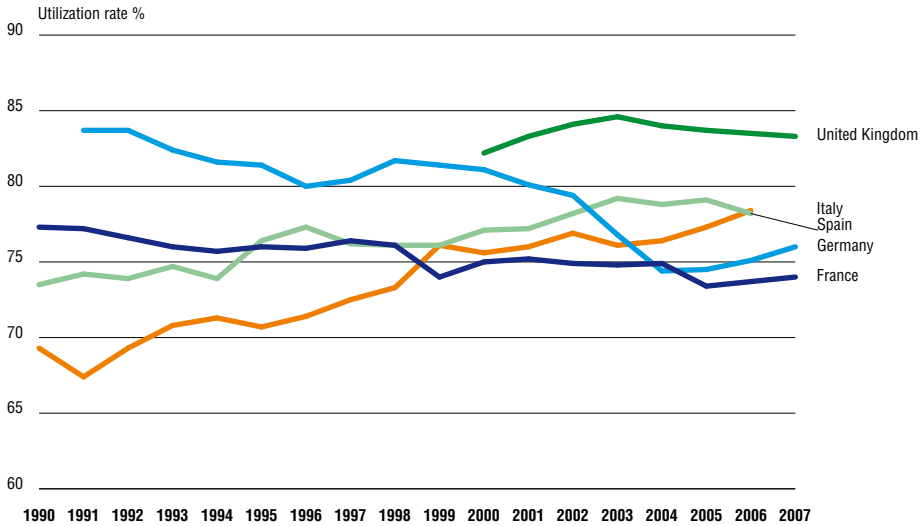
Reduction of excess acute care capacity was one of the major goals of the 1996 reform and, specifically, one of the missions of the ARHs created by the reform. The directors of the ARHs were to implement and oversee the transformation of excess beds into rehabilitation and long-term care units. In addition, policies have supported the replacement of full-time hospital beds by alternatives such as day-care surgery or home care: authorizations to open places for such outpatient activities have been granted in return for closing down acute beds (Cour des comptes 2008). Accordingly, part-time hospitalization capacity has been increasing in the acute care and follow-up sectors since 1994 (see Section 6.7).

Recent trends in the nature of hospital activity show that the French health care system continues to move towards increased efficiency. The development of day care in France follows international trends: the percentage of outpatient care has risen from 48% in 2001 to 53.4% in 2006, mostly through an increase of day cases in acute care (from 30.9 to 39.2%) and in the follow-up and rehabilitation sectors (60.3 to 67.4%). The average length of stay in acute care

decreased from 5.7 days in 2001 to 5.4 days in 2006. However, the utilization rate in the acute care sector, 73.4% in 2005, is relatively low compared with neighbouring countries (Fig. 5.3), indicating overcapacity.

Fig. 5.3

Utilization rate in the acute care sector, France and selected countries, 1990–2007



Source: Eco-Santé 2009; OECD 2009a.

In the psychiatric sector, the proportion of ambulatory stays is at a historical high, as a consequence of a de-institutionalization policy that started in France more than four decades ago (see Section 6.11). The proportion of part-time stays was 89% in 2008 and had been stable over the previous years.

5.1.2 Capital stock and investments

At the end of 2007, there were approximately 2840 hospitals in France. Two-thirds of these hospitals were non-profit-making organizations, equally divided between the public and the private sector, and one-third were private hospitals operated for profit.

Public hospitals account for a third of all hospitals (around 1000 out of 2840) and two-thirds of inpatient beds (around 290 000 out of 446 000). They are legally autonomous and manage their own budget. There are three main types of public hospital:

- 31 regional hospitals (*centres hospitaliers régionaux*), with the highest level of specialization and the technical capacity to treat more complex cases. Most are linked to a university and operate as teaching hospitals;
- 603 general hospitals (*centres hospitaliers*): 89 of these are known as *centres hospitaliers spécialisés* (CHS) and specialize in psychiatric care; the remaining 529 provide a range of services covering mainly acute care (medicine, surgery, obstetrics) (93% of their activity), but also follow-up care and rehabilitation and long-term care; they may also provide psychiatric care;
- 343 local hospitals, which tend to be small (160 beds on average) community-level structures that fulfil a health and social care function, offering acute medical care, follow-up care and rehabilitation, and long-term care; they are not equipped to carry out surgery or deal with childbirth.

Private hospitals fall into two categories: non-profit-making or profit-making. Non-profit-making hospitals are owned by foundations, religious organizations or mutual insurance associations. They account for around 30% of hospitals (780) and 15% of inpatient beds (62 000). Two-thirds of private non-profit-making hospitals perform public service duties such as emergency care, teaching and social programmes for deprived populations; they are known as “participants in public hospital service” (*participant au service public hospitalier*; PSPH).

The range of services provided by non-profit-making hospitals varies. In total, they account for a third of follow-up and rehabilitation capacity but fewer than 10% of acute care beds. There are 20 non-profit-making private hospitals specializing in cancer treatment, with a broad remit that includes prevention, screening, treatment, teaching and research. In order to improve coordination of care, they adopt a particular model of internal organization in which there are no wards by specialty as there are in general hospitals.

The private profit-making sector plays an important role in the French health care system. The share of hospitals that are operated for profit is higher than in most developed countries: private profit-making hospitals account for 35% of all hospitals (1050) and for 20% of all inpatient beds (94 000) in France, whereas they represent only 12% of the beds in the United States, and 10% in the United Kingdom and Germany (Cour des comptes 2006). They also account for 20% of part-time hospitalization places. They tend to specialize in areas where profit opportunities are higher (see Section 6.4).

Finally, it should be noted that the role of the profit-making sector may well be further increased as a result of the 2009 HPST Act. The Act suppressed the concept of public service hospitals and extended the list of public service duties that ARSs can now attribute to hospitals through individual contracts, thus introducing the possibility for profit-making hospitals to perform public service duties for which they will be paid similarly to public and non-profit-making hospitals. In addition, a new type of contract, the sanitary cooperation groups (*groupements de coopération sanitaire*), has been created in order to allow cooperation between public and private hospitals.

The market for hospital care is becoming more and more concentrated. The number of hospitals has been declining since 1990, mainly because of hospital closures and mergers occurring within the private sector. These mergers can be partially explained by the necessity to rationalize the organization of facilities for quality and safety reasons (see Section 4.1.2). Concentration of the hospital care market should continue to increase during the next years: reorganization of the hospital care supply was a major goal of the ARSs (Cour des comptes 2006), and the HPST Act contains provisions to foster cooperation between hospitals.

The main source of information on hospital facilities is a national annual statistical survey of health establishments conducted by the Ministry of Health (*statistique annuelle des établissements de santé*; SAE), which provides only limited information on hospital buildings (number of buildings, surface used and type of ongoing estate investments). Each year, the Ministry of Health also organizes a more detailed survey covering safety issues; results are transmitted to ARSs and used for regulatory purposes but are not publicly available. In addition, an assessment of whether the hospital complies with building safety standards (such as water and energy safety standards) is included in the mandatory auditing procedure, known as the certification process, that is performed every four years; its results are available on the web site of HAS (see Section 6.4.2).

Investment funding

Overall, the public and private non-profit-making sectors are known to have suffered from a lack of investment between 1983 and 2003, because of the tight financial constraints imposed by the global budget payment system.

Depending on the specific sector and public health priorities, capital investments in the health care sector are either covered by reimbursements for service delivery or funded by specific national or regional programmes. Despite the fact that reimbursements for service delivery have become the rule for the acute care sector (see Section 3.6.1), two nationwide investments

programmes have been launched since the start of this century, Hospital Plan 2007 (*Plan Hôpital 2007*) and Hospital Plan 2012 (*Plan Hôpital 2012*), to support the achievement of current quality and safety standards.

The first investment plan, the Hospital Plan 2007, was launched in 2003 as part of an ambitious reform of the hospital sector; €6 billion was invested over five years for selected projects that were submitted by public and private hospitals. The plan was to be entirely funded by SHI, partly by direct funding of the investments (€1.5 billion), and partly by 20-year loans contracted by the hospitals (€4.5 billion).

Previous attempts at stimulating hospital investment had been hampered by a lack of expertise and coordination at the national level. In order to address this difficulty, a governmental institution, the National Mission for Hospital Investment (MAINH), was created to assess investment projects, approve those that were consistent with the national health care strategy and to monitor their implementation. To achieve these goals, the MAINH developed a network of regional offices that assisted hospitals in the development and implementation of their projects. Since October 2009, the activities of the MAINH have been taken over by a new agency, the National Agency to Support the Performance of Health and Social Care Organization (ANAP). This organization was created by the 2009 HPST Act and supports and audits hospital investments and reorganizations in the health and social care sectors; it also provides expertise to the central administration and to ARSs (see Section 2.3.3).

The Hospital Plan 2007 reform also introduced two new types of legal contract for investment in hospital capital. The first was a new form of public tender that called for projects that included both the design and the realization of new facilities (and, optionally, the maintenance of the building). This type of contract seems to have reduced the length and unplanned costs of construction. Importantly, the reform also introduced long-term leases (*bail emphytéotique hospitalier*, BEH) as a type of public-private partnership for new hospital facilities. In a typical BEH, the (public) owner leases land (or a hospital facility), for a guaranteed period of 18 to 99 years, to a private partner, who will be responsible for building (or restoring) the facility during the lease. As a result, the contract effectively transfers the financial risks of construction and maintenance to the private partner.

In practice, Hospital Plan 2007 effectively induced around €16 billion of investments on top of what could be expected from previous trends, and has accordingly been hailed a success by the Ministry of Health. Nevertheless, an evaluation of the investment plan conducted in 2009 criticized the plan for

failure to select the most efficient investments and warned that the additional expenditures, which had to be self-financed, were degrading the financial accounts of the participating hospitals (Cour des comptes 2009).

The second investment plan, Hospital Plan 2012, was introduced in 2007 in order to extend the previous investment cycle. This new plan involved an initial endowment of €7 billion, financed again by SHI, through direct funding (€5 billion) and through access to public lending at preferential interest rates (€2 billion). The new plan has three major priorities: hospital information technology systems, restructuring of hospital facilities at the regional level (for example, collaborations and mergers between hospitals) and improvement of compliance with safety standards (for example, seismic compliance and asbestos removal).

Apart from these two major investment projects, national or regional health care reform plans may include specific budgets for capital investment. For instance, the mental health plan launched in 2006 included a €750 million budget for capital investment that was allocated mainly to public and private non-profit-making hospitals and served as an auxiliary source of funding, the total volume of investments for the selected projects amounting to €1.6 billion.

Capital investment controls

ARSs (previously ARHs) are generally responsible for planning services and for the authorization of hospitals; they also oversee any change to the existing hospital infrastructure, including restructuring and mergers. The only exception is the construction of (new) hospitals (private and public) and comprehensive emergency centres, which have to be authorized by the Ministry of Health. The ARSs also deliver authorizations for the implementation of major medical technologies (see Section 5.1.3).

The overall strategy for capacity and investment planning is mainly implemented through regional health organization plans (SROSS) and the related target contracts (*contrats d'objectifs et de moyens*) (see Section 4.2). Target contracts form a regulatory framework that is explicitly designed to implement changes; this framework applies equally to all hospital facilities that fall within the health care sector.

There is a large body of legal rules controlling the building and operation of hospital facilities, covering infrastructure and equipment; all the relevant texts are referenced in a guide that is published by the Ministry of Health (Mission nationale d'appui à l'investissement hospitalier, direction de l'hospitalisation et de l'organisation des soins 2005).

5.1.3 Medical equipment, devices and aids

Major medical equipment

Purchase of major medical equipment is subject to authorization from the ARS. In 2006, five types of equipment required such authorization: computed tomographic scanners, magnetic resonance equipment (spectroscopy or tomography imaging) used for clinical purposes, positron emission tomography devices, decompression chambers and cyclotrons used for medical purposes (that is, cancer therapy). Authorization is granted for five years, according to needs that are defined in the SROS. This regulation applies equally to the private and public sectors, and to outpatient and inpatient settings.

In spite of Hospital Plan 2007 intentions for investment in hospital infrastructure and major equipment, the number of major pieces of medical technology was still lower in 2007 than in many comparable countries, relative to population size (Table 5.1).

Table 5.1

Items of functioning diagnostic imaging technologies (MRI units, CT scanners, PET) per 1000 population, France and other European countries, 2007 or latest available year

Item	France	Germany	Spain	Italy	UK
MRI units	5.7	7.7 ^a	9.3	18.6	5.4 ^b
CT scanners	10.3	16.7 ^a	14.6	30.3	7.5 ^b
PET units	1.0	1.0	0.7	0.6	0.5 ^b

Sources: Eco-Santé 2009; OECD 2009a.

Notes: ^aData from 2006; ^bData from 2005; MRI: Magnetic resonance imaging; CT: Computer tomography; PET: Positron emission tomography.

Medical devices

Medical devices form a wide and heterogeneous group of medical equipment that contributes substantially to the expenditures of SHI. More than 60 000 medical devices and aids are at least partially covered by SHI. Invasive devices (such as coronary stents or intra-ocular lenses) fall into this category, as well as glasses, hearing aids, medical beds and wheelchairs. Annual expenditures for medical devices amount to €19 billion – 55% of the pharmaceutical market. Moreover, the medical devices market is growing at a faster rate than the drugs market (increase of 10% per year between 2000 and 2006, versus 6%).

The market for medical devices is nevertheless more loosely regulated than the markets for drugs or major medical equipment. In particular, quality and safety standards are less stringent than for drugs. Compliance with quality

and safety standards is assessed by the provider for devices that present a very low risk for the patient (medical beds, stethoscopes, etc.). Other devices must be assessed by an independent body. Monitoring of the market is under the responsibility of the French Health Products Safety Agency (AFSSAPS).

5.1.4 Information technology

Since the late 1980s, the French health care sector has seen a slow but continuous development of its information technology infrastructure. Recently, development of information technology systems has become a priority on the political agenda, mainly because it is seen as a way to improve the efficiency of the sector.

In France, the development of the Internet has been rather slow compared with other European countries, but has been improving during recent years. In June 2007, 55% of people aged 12 years or more had access to the Internet at home, with a 10% increase over 12 months. In addition, the Internet was often used for health-related purposes: in the same study, 74% of people aged 12 or more reported having looked for health information for themselves or one of their relatives on the Internet (Bigot, Croutte 2007).

Inpatient classification system

Within the health care system, the major information technology project over the last 15 years has been the development of a hospital activity information system, the Programme of Medicalization of Information Systems (PMSI), which is the backbone of the DRG-based prospective payment system that has been in use since 2004 (see Section 3.6). At the national level, the project has been overseen by the Agency for Information on Hospital Care (ATIH).

Electronic billing

Simultaneously, an electronic billing system has been gradually developed and implemented in the ambulatory care sector since the mid-1990s. An individual health insurance electronic card (*Sesam-Vitale carte*) was provided to all individuals enrolled in one of the three major health insurance funds. On the provider side, the billing system relies on an electronic identification card for health care workers (*carte de professionnel de santé*; CPS); the CPS was initially deployed to ambulatory care sector professionals (mainly physicians and pharmacists), in conjunction with the development of the electronic billing system; it has now been extended to inpatient care professionals and all categories of health care personnel. In 2009, 84% of billing in the ambulatory care sector was transmitted electronically.

Electronic patient records

Electronic patient records were introduced in French law by the 2004 Health Insurance Reform Act. The aim was to create an electronic patient record (DMP) to group medical information gathered in ambulatory and hospital settings. The decision to use the DMP will be made by patients on a voluntary basis, but there will be financial incentives to promote it (for example, increased co-payment rates for patients not opting for the DMP). National deployment of the system was initially planned for mid-2007, but that schedule appeared to be unrealistic given the technical complexity of the project and the sensitivity of the issue for patients and professional associations. The former demanded, for example, that patients be allowed to hide parts of their record from some health care professionals, in such a way that the professional would not be aware of it, but professional associations argued that such limitations may prevent them from providing accurate treatment.

In April 2008, the “mission to relaunch the electronic medical record” (Gagneux et al. 2008) reported its recommendations to the Ministry of Health. The overall message of the report was that actually producing the DMP was the top priority. The report announced six principles to achieve this, which in some cases differed from the previous project. It was recommended that the DMP should (1) be useful for professionals (initially the project focused on the DMP’s usefulness for patients, which in part explains professionals’ initial lack of interest. For example, the patient could choose the web site where the record would be kept; this has now been withdrawn); (2 and 3) be modular and incremental, based on emerging requirements; (4) be deployed according to an agreed-upon time frame; (5) balance information requirements and the protection of patients’ privacy; and (6) be subject to clear governance, which had not been the case and may again explain the difficulties encountered. A full chapter was dedicated the question of governance. It pointed out that various ministries had pushed their interests, meaning there was no clear leadership and direction for the project. It stated quite bluntly that the Ministry of Health did not have the competence, the means and the legitimacy to steer (govern) the project. It recommended the creation of a high level committee, chaired by the Minister of Health and comprising members of the parliament and representatives of all stakeholders. It also recommended the creation of a government agency in charge of shared information systems in the health care sector.

In 2009, the Minister of Health re-scheduled the project. The development of the DMP now falls under the responsibility of a newly created agency dedicated to the development of information systems in the health care sector, the Agency for Health Information Systems (ASIP *Santé*). A first version of the DMP should be available by the end of 2010.

Simultaneously, the Pharmacists Association has proposed that a pharmaceutical file be created for every patient. The file would be created and accessed with the patient's consent only and would allow pharmacists to check a patient's prescriptions within the last four months, thus preventing unnecessary prescriptions as well as contraindicated drug combinations. The system was successfully piloted in several departments between 2007 and 2008 (Cases, Le Fur 2008). From January 2009, the system has been progressively rolled out on a national scale and half of all pharmacies had installed the necessary equipment by October 2009.

5.2 Human resources

5.2.1 Overview

In January 2005, there were about 1.8 million health care professionals in France, accounting for approximately 7.6% of the working population. Nurses and nursing aides form the two largest groups of professionals, each of these professions accounting for 25% of the health care workforce (see Section 5.2.4). Apart from nurses, registered health professions in France include medical care professionals (physicians, dentists, midwives), pharmacists, professionals involved in rehabilitation (physiotherapists, speech therapists, vision therapists, psychomotor therapists, occupational therapists and chiropodists) and technical paramedical professions (hearing aid specialists, opticians and radiographers). The other professions usually identified as contributing to health care include clerical and technical staff working in hospitals, laboratory technicians, paediatric auxiliaries, dieticians, psychologists and ambulance drivers.

Trends

The density of physicians and nurses in France is currently very close to the European average (Fig. 5.4). The health care workforce has been steadily increasing since the late 1980s (Table 5.2). In 1990, the number of health care professionals was 1.3 million; the average annual growth rate of health care personnel between 1990 and 2005 was 2%, a figure higher than the corresponding 0.7% growth rate of the working population. This overall growth,

however, was mainly the consequence of the young age of the health care workforce, resulting in a low retirement rate. With large waves of professionals starting to retire, the health care sector will be confronted in the next decade with a reduction in the number of professionals, which is likely to create or exacerbate access difficulties to some categories of professionals.

Table 5.2

Health care personnel in France per 100 000 population, 1990 to latest available year

	1990	1995	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Physicians	305	323	329	330	332	334	336	337	338	337	335	335
GPs	162	163	161	162	163	164	164	165	165	165	163	163
Specialists	143	159	168	168	170	171	171	172	173	173	172	172
Dentists	67	69	69	68	68	68	67	67	67	67	67	66
Midwives	19	21	24	25	25	26	27	27	28	28	29	30
Pharmacists	–	93	99	102	104	106	107	111	113	114	116	117
Nurses	537	590	649	669	687	703	721	741	764	783	768	794
Physiotherapists	67	79	88	91	93	95	97	99	101	101	104	107

Source: Eco-Santé 2010.

At the regional level, the density of health care professionals is characterized by wide disparities that are roughly similar across the different health care professions, although of different magnitude. The Parisian and the south-eastern regions (Île-de-France and Provence-Alpes-Côte-d'Azur) are the two regions with the highest density of health care personnel, followed by the other southern regions, while the northern and eastern regions suffer from a lack of such professionals. These regional disparities are not related to population needs and, therefore, raise equity issues that may become prominent during the years to come, since they are likely to be exacerbated by the anticipated demographic shortage (HCAAM 2007).

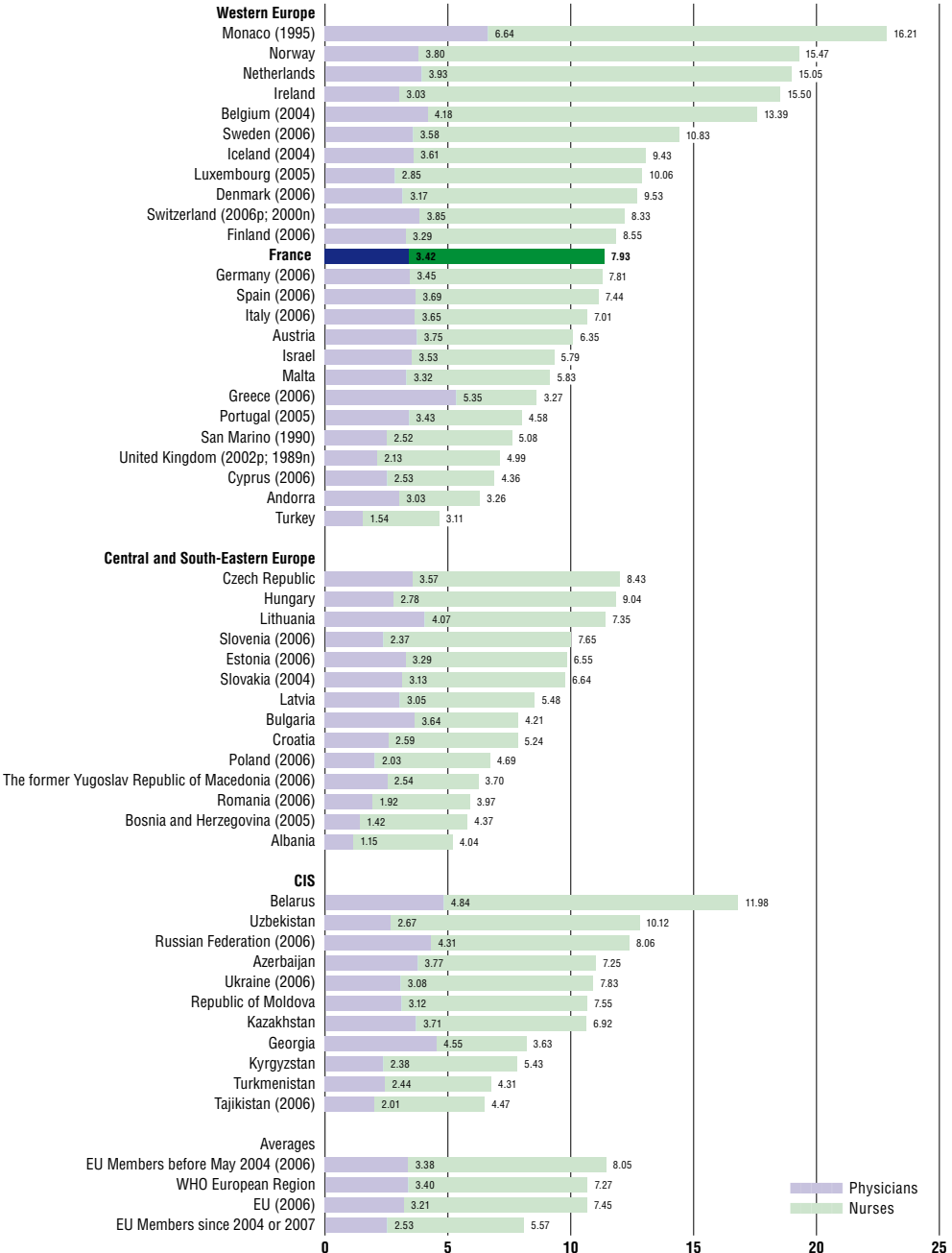
Overall, the French health care system will be increasingly confronted with difficulties in access to care, which will certainly be acute in the regions that are already suffering from a lack of health care professionals.

Planning of health care personnel

There have been several attempts to address the difficulties in access to care. In the short term, the shortage of professionals in some regions is alleviated by the recruitment of foreign professionals (mainly from Belgium, Algeria, Germany, Morocco and, since 2007, Romania (Lebreton-Lerouillois et al. 2007). In the long term, several policies are being tested or implemented in order to address this problem.

Fig. 5.4

Number of physicians and nurses per 100 000 inhabitants in France, the EU and selected countries, 2007 or latest available year



Source: WHO Regional Office for Europe 2010.

Notes: PP: Physical persons; Eur-A,B,C: Regions as in the WHO list of Member States, last available year.

First, the government has sought to increase the inflow of professionals by raising the *numerus clausus* for several professions (see Section 5.2.3). While appealing at first sight, this policy carries major drawbacks: its effect is delayed by the length of the training period; it does not address geographical disparities in a specific way, partly because self-employed doctors are free to establish their practice wherever they wish; and large variations in the quotas are the source of lasting discrepancies between the number of graduating and retiring professionals.

The second solution that has been advocated is to create incentives for young professionals to work in under-served areas and to prohibit settlement in over-served areas. A number of pilot projects using positive financial incentives to work in under-served areas have been conducted during the past few years, with limited success (for example, the 2006 national demographic plan for health professionals, see Section 7.1.4). However, attempts to restrict freedom of settlement have faced strong opposition from professional associations. Nevertheless, such restrictions were implemented for nurses in 2007 in the national agreement for nurses. Recently, the 2009 Hospital, Patients, Health and Territories Act (HPST Act) introduced financial incentives for attracting doctors in under-served areas (see Sections 4.2 and 5.2.3).

Finally, it may actually be the case that new methods of health care organization that redistribute the role of different health care professionals and improve their coordination or efficiency will decrease the need for some categories of professionals and thus solve accessibility problems. International comparisons of the physician-to-nurse ratio show wide discrepancies between European countries with similar health care systems (for example, in the Netherlands, the number of nurses is more than three times higher than the number of physicians, whereas this figure is close to two in France), suggesting that there is considerable scope for changes in the professional skill mix (Fig. 5.4).

The 2004 Health Insurance Reform Act has permitted experimentation of task transfer between professionals and some such transfers have already taken place (for example, between ophthalmologists and vision therapists). In 2008, a recommendation regarding the professional skill mix between doctors and other health care professionals was issued by the National Health Authority (HAS) and the National Observatory of Health Professions (ONDPS). The proposed changes include a transfer of some tasks from physicians to other health care professionals, an improvement of the education and training of nurses, and a regulatory and financial framework for developing cooperation.

These proposals are supported by the current Ministry of Health but are yet to be implemented. Finally, the 2009 HPST Act went further in encouraging the transfer of tasks and cooperation between categories of health professionals (see Section 4.2). The ARSs, which are in charge of organizing health care for the regions for the ambulatory care sector, may, therefore, play a key role in improving coordination and efficiency of care in the years to come (see Section 2.4).

5.2.2 Public health professionals

In France, public health professionals do not form a clearly recognizable professional group (Cassou 2006). The general consensus is that France is facing a shortage in public health specialists, but data are lacking and no definite planning is conducted at the national level. Most of the professionals that define themselves as public health specialists are physicians who have specialized in public health either at the end of their initial training (as a medical specialty) or later in their career, by becoming civil servants, medical inspectors in public health (*médecins inspecteurs de santé publique*; MISP). Apart from these two specific training paths, French universities offer a number of public health diplomas at the postgraduate level, which mostly focus on epidemiology and biostatistics.

The 2004 Public Health Act triggered the creation of a new institution in the academic field of public health, the School of Higher Education in Public Health (*Ecole des hautes études en santé publique*; EHESP). The EHESP has incorporated the duties of the previous National School of Public Health (*Ecole nationale de santé publique*; ENSP), which was dedicated to the professional training of administrative staff in the health care and public health field, such as managers of public hospitals, inspectors of health and social affairs (*inspection générale des affaires sociales*; IGAS) and MISP. In addition, EHESP is expected to contribute to the development of education and research in all fields of public health at an international level (Dufourcq et al. 2004). As a first step towards this goal, the school started offering an English-taught Master of Public Health (*master de santé publique*; MPH) in autumn 2008. It has also created a doctoral school and set up academic centres.

5.2.3 Physicians

In 2008, there were a total of 208 000 doctors in France, almost equally divided between GPs (49%) and specialists (51%). Self-employment, which averages 59%, is more frequent for GPs (68%) than for specialists (51%) (Eco-Santé 2010).

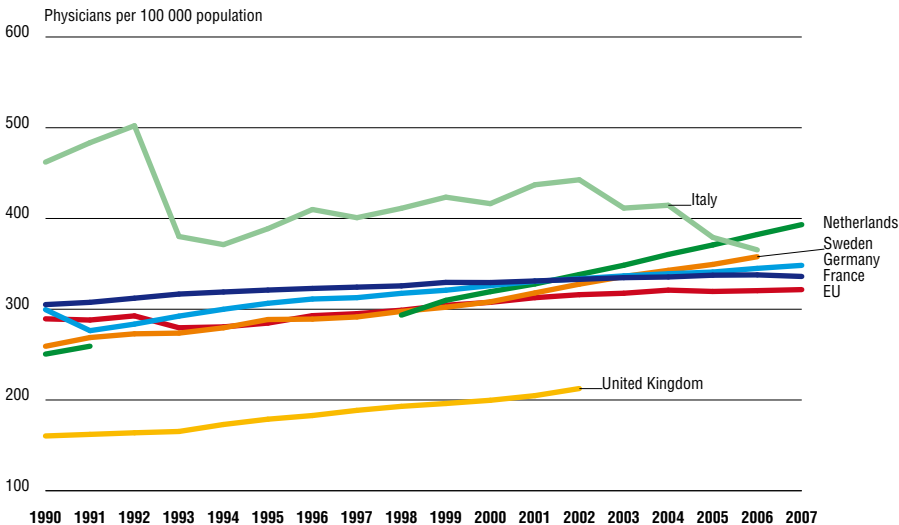
More than half of all salaried GPs work in hospitals (55%); 17% work in preventive services (such as occupational medicine and specialized services at the department level for pregnant women and children); other GPs are employed in health centres, in social services or in the pharmaceutical industry. Salaried specialists mainly work in hospitals (82%); others work in preventive services (89%), the pharmaceutical industry and laboratories (Sicart 2009).

The annual growth rate of the number of physicians has been progressively decreasing from 4% per year in the beginning of the 1980s to around 1% per year at the end of the 1990s, mainly because of a reduction in the number of students allowed to enter medical school (*numerus clausus*) (see Section 4.2).

International comparisons suggest there is currently no overall shortage of physicians in France: with a density of 3.4 physicians per 1000 inhabitants, the number of doctors is currently similar to that of neighbouring European countries such as Germany and Italy, and relatively close to the EU average (Fig. 5.5).

Fig. 5.5

Number of physicians per 100 000 population in France and selected countries, 1990 to latest available year



Source: WHO Regional Office for Europe 2010.

Nevertheless, simulations conducted for the Ministry of Health (ONDPS 2010) show that the number of active physicians peaked in 2007–2008 and will start decreasing in 2009–2010, when the large cohorts of physicians who started working before the quota was implemented (in the early 1970s) begin to retire. Despite the recent increase of the *numerus clausus*, the number of active physicians is predicted to decrease to a low of 195 000 in 2015 (best-case scenario) or a low of 185 000 in 2025 (worst-case scenario); in the latter case, the density of physicians will be reduced to roughly 2.85 physicians per 1000 inhabitants.

Within the country, the geographical distribution of physicians is characterized by wide disparities in regional doctor:population ratios, ranging from 2.4 and 2.59 doctors per 1000 inhabitants in overseas departments and Picardy, respectively, to 4.16 and 4.24, respectively, in Île-de-France and Provence-Alpes-Côte-d'Azur. The differences are greater for specialists than for GPs (from 1.09 to 2.39 per 1000 inhabitants for overseas departments and Picardy, respectively, and 1.31 to 1.93 per 1000 for Île-de-France and Provence-Alpes-Côte-d'Azur, respectively).

Planning

Consequently, the two major concerns regarding the physician workforce are the geographical disparities between French regions and the decrease of physician density that will occur during the next decade. The two problems are intertwined, since the latter is likely to exacerbate geographical disparities and create a shortage of physicians in some specialties. Regarding geographical disparities, tensions may arise, for example in rural areas, where several GPs may want to retire but be unable to find replacements, or in underprivileged areas, where doctors may be reluctant to set up practice because of the burdensome social content of the workload. Some specialties are already registering a decrease in the number of doctors. This is the case for anaesthesiology, for example, which is associated with heavy responsibilities and numerous obligations.

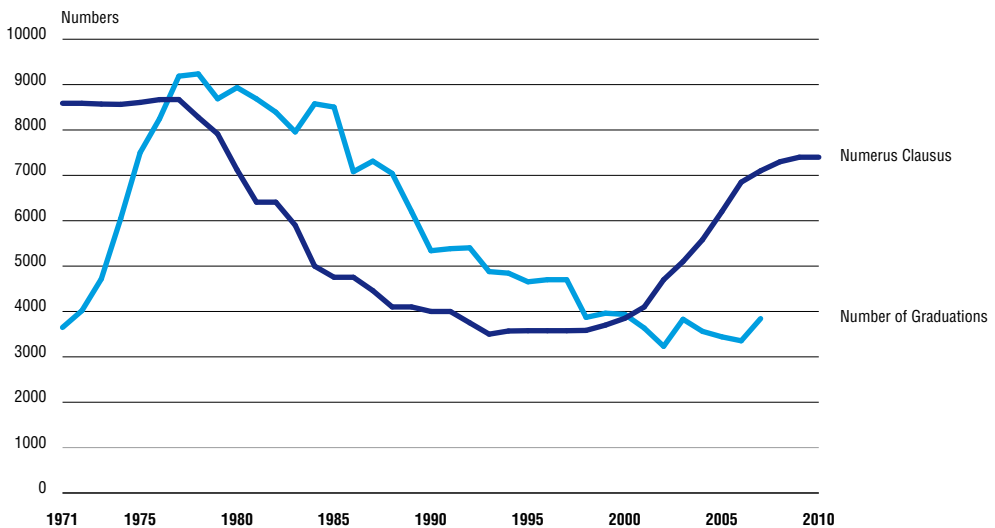
Historically, public authorities have tried to remedy geographical disparities through differentiation within the *numerus clausus* system (see Section 4.2) and the number of places open for internship, giving priority to regions with a low ratio. However, after graduation, there is no restriction on the areas where doctors are allowed to practise. Therefore, although regional disparities have been reduced over the past 30 years, policies intended to influence the regional numbers of medical students have not always had the expected results. In fact,

only 69% of doctors practise in the region where they did their training, and many specialists find internships in regions where there are fewer doctors and then return to their region of origin to practise.

Recently, a number of measures have also been instigated to address the anticipated shortage in physicians. At national level, the *numerus clausus* has been increased (from 4700 in 2002 to 7100 in 2007; Fig. 5.6), and financial as well as non-financial incentives (for example, professional building amenities, personal housing) have been introduced in order to attract young physicians to medically deprived areas. In addition, a number of programmes have been developed locally. Preliminary evaluations suggest that financial incentives alone are less effective than measures including organizational changes aimed at increasing satisfaction at work (Bourgueil et al. 2006) (see Section 4.2).

Fig. 5.6

Planning of physician workforce in France: *numerus clausus* and number of diplomas delivered, 1971 to latest available year



Source: Eco-Santé 2010.

Training

Medical training is divided into three phases. The first phase (*premier cycle d'études médicales*; PCEM) takes place over two years. Any student who has the qualifications to register with a university may enrol for the first year, which is common to students of medicine, dentistry and midwifery. A competitive

examination limits access to the second year. Every year, a ministerial decree specifies the number of places available (*numerus clausus*) for each of the 33 education and research units (37 including overseas departments).

The second phase of medical training takes four years and includes both theoretical and practical training.

Since 2004, all sixth-year students attend a national competitive examination (ECN) and subsequently choose a third-phase training programme according to their ranking. Previously, only students who intended to specialize had to take the competitive examination; students intending to become GPs automatically entered a general practice training programme in their region. The new organization is part of a process aimed at upgrading primary care, and the GP diploma is obtained after four years of internship as with specialists, for whom the internship lasts four of five years depending on speciality.

Although continuing medical education has been compulsory in France since 1996, physicians' participation in learning activities has remained relatively weak until the last few years. The 2009 HPST Act seeks to clarify the requirements and funding of these activities, which may improve physicians' participation (see Sections 4.1.2 and 6.3.2).

Registration and licensing

Physician registration by the Physicians' Professional Association (*Ordre des Médecins*) is usually granted upon request after the initial training and has permanent validity. It is mandatory for practising physicians.

There is not a formal re-certification or re-licencing process of doctors in France. Instead, the participation of doctors in learning or self-evaluation activities form part of a revalidation process that focuses on updating and improving physicians' medical knowledge and skills (see Sections 4.1.2 and 6.3.3).

5.2.4 Nurses

Trends

In 2008, there were 477 000 nurses in France: 14.6% of them were self-employed and provided ambulatory care. The remaining nurses were employed as salaried staff, mainly by hospitals (public and private hospitals employed 56% and 17% of nurses, respectively). Other institutions employing nurses include long-term care institutions, local communities, schools, temporary recruitment agencies and private firms.

In 2005, there were also 456 000 nursing aides assisting in caring for patients in health care institutions, providing routine nursing care such as maintaining personal hygiene and assistance with essential bodily functions.

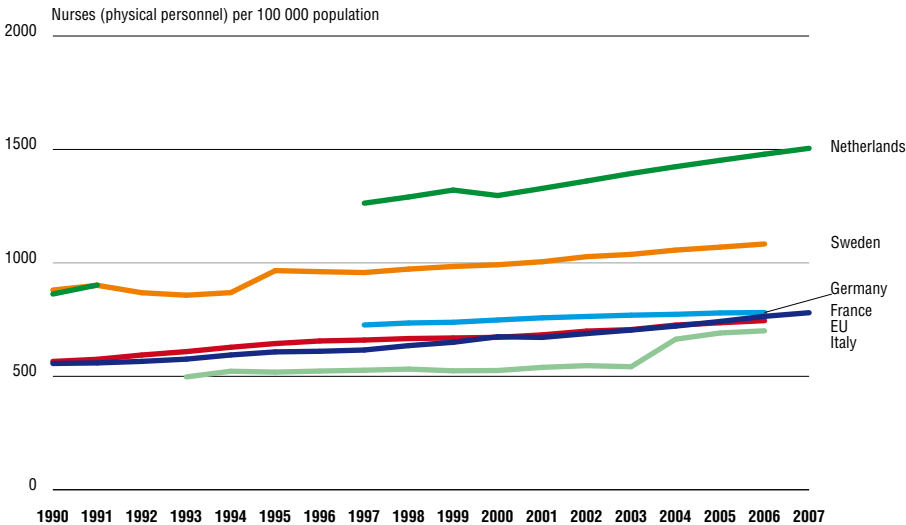
Their involvement remains marginal in outpatient settings and takes place under the specific services that employ them. The rest of this section refers to nurses only.

The number of nurses steadily increased between 1990 and 2008 at an average growth rate of 3.2% per year, following a progressive increase in the *numerus clausus* since 1993. However, this increase in the workforce has not been sufficient to meet the more rapidly increasing demand (see below). There are large persisting geographical disparities in the density of nurses, which parallel those observed for physicians. In 2008, there was a twofold difference between the region with the lowest density of nurses and that with the highest (from 6.34 in the Centre Region to 10.52 nurses per 1000 inhabitants in the Limousin region). In disaggregated figures for self-employed nurses only, the difference is fourfold, with a gradient directed more favourably towards the south of France.

With 7.1 nurses per 1000 inhabitants in 2006, the density of nurses is relatively low in France compared with neighbouring European countries (Fig. 5.7). However, this fact is difficult to interpret given the differences in the scope of tasks that are performed by nurses and nursing aides in different countries.

Fig. 5.7

Number of nurses per 100 000 population in France and selected countries, 1990 to latest available year



Source: WHO Regional Office for Europe 2010.

Planning

The number of students entering nursing schools each year has been limited by a *numerus clausus* since 1983. However, France is currently facing a shortage of nurses. This mainly reflects a sharp increase in demand that is related to the ageing of the population, but it is also caused by structural changes in the tasks that are performed by hospital nurses (for example, new protocols for quality and safety of care) and increase the amount of work required per patient. In addition, the enforcement of the employment laws of 1998 and 2000 restricting the working week to 35 hours has had a negative impact on the supply of nurses.²

In order to meet the increased demand, the government has significantly increased the number of places available in nursing schools since 1999 (from 18 270 in 1999 to 30 000 in 2004 and 2005), but the number of applications has not been sufficient to fill all positions, raising questions about the attractiveness of the profession. Additionally, the government and hospitals are encouraging nurses who had quit the profession to return and are attempting to recruit nurses from other countries (notably Spain and Lebanon).

In June 2007, a new general agreement was signed between SHI and the union of self-employed nurses. The agreement gives self-employed nurses more autonomy in the management and coordination of care for the elderly and calls for more stringent regulation of the geographic coverage of nurses, in order to address disparities (Naiditch 2007). The implementation of the agreement commenced in September 2008 on an experimental basis; it includes a 10% overall pay rise, financial and material incentives for nurses to settle in under-served areas and prohibition of settlement in over-served areas unless a retiring or leaving nurse is replaced (see also Section 7.1.4).

Training and registration

Access to nursing schools is regulated by a competitive examination that can be attempted after successful graduation from high school or after several years of professional experience. The basic training takes three years, with subsequent optional specializations in theatre nursing, paediatric nursing and anaesthesia, taking 18, 12 and 24 months, respectively. It is estimated that for each 100 students admitted for study, 75 will eventually work as nurses. In addition to their initial training, nurses need two years of clinical experience in a hospital setting in order to qualify for self-employed status. Registration by the National Nurses Association (*Ordre national des infirmiers* created in 2006; Act 2006-1668 of 21 December 2006) is granted after graduation and is valid for life.

² These laws have been applied much more flexibly to physicians, and the impact on health care organizations has been much lower than for nurses.

After years of negotiations, the nursing diploma should eventually be recognized as a university degree in 2012, at the bachelor level, which, in turn, will lead to increased salaries for nurses working in the public sector. This may alleviate the overall lack of recognition that the profession seems to suffer within the health care sector and that may contribute to its low attractiveness.

5.2.5 Midwives

Midwifery is a medical profession, with an area of competence restricted to physiological situations. There were 18 000 midwives practising in France in 2008. Around 77% of midwives work in hospitals with childbirth facilities, where a large proportion of antenatal care takes place; 17% of midwives opt for self-employment, while 5% work for local communities or for mother and child health services.

Since 1943, a quota has been used to limit entrance to midwifery schools. The quota, which was stable between 1991 and 1998, was gradually raised between 1999 and 2004 (from 663 to 975 places) in order to comply with minimum quality and safety standards regarding obstetric care.

As a result, the number of midwives has been steadily increasing since 1990, with an average growth rate of 3.8% per year between 1990 (when there were 10 705 registered midwives) and 2008. Recent years have seen an increase in the share of self-employed midwives. At the same time, hospital midwives have been complaining about an increased workload, and the National Midwives Association (*Ordre national des sages-femmes*) has expressed concerns about a shortage of midwives, in spite of a stable number of births per year. While there are plausible explanations for this concern, such as the new task transfers from physicians to midwives, the impact of the 2000 reduction of the legal number of hours worked and the increased proportion of midwives choosing to work part-time, there is currently no hard evidence of a shortage (ONDPS 2004).

Midwives undergo four years of training, the first year being common with physicians (meaning that the midwifery qualification is also recognized as a university degree) and admission to the second year being limited by a *numerus clausus*. The practitioner's licence is granted by the National Midwives Association.

Geographic disparities are less of an issue among midwives than among physicians and nurses because midwives are mostly not self-employed and, therefore, have less choice in terms of location of practice.

5.2.6 Dentists and dental auxiliaries

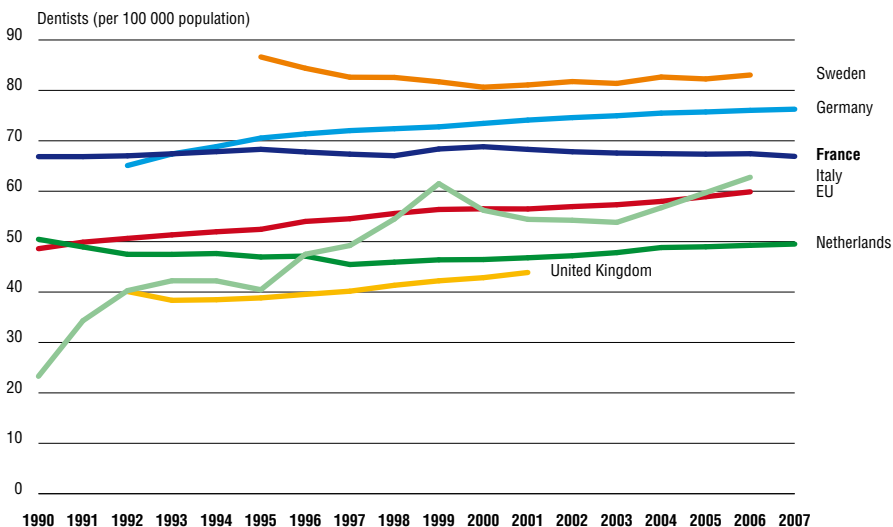
There were 41 400 dentists in France in 2008. Almost all of them (91%) were self-employed; most of those in salaried posts worked in health centres or for social security bodies. Dentists share their first year of study with medical students. Some procedures carried out by dentists – notably orthodontic processes and the fitting of prostheses – are also performed by stomatologists (specialist doctors). The area of expertise of the stomatologist is more extensive, however, also covering surgical operations on the mouth and teeth. Most (84%) of the 1400 stomatologists in France are self-employed.

The number of dentists has been relatively stable over the last years, compared with other medical professions: between 1990 and 2008, the number of dentists in France rose by 9.2%, which corresponds to a 0.5% increase per year.

The resulting density of dentists is high compared with other European countries (Fig. 5.8); nevertheless, this profession is subject to the same geographical disparities as the other health care professions.

Fig. 5.8

Number of dentists per 100 000 population in France and selected countries, latest available year



Source: WHO Regional Office for Europe 2010.

Dentists undergo five years of training. As with midwives, the first year is common with physicians, and admission to the second year is limited by a *numerus clausus*. The practitioner's license is granted by the National Dentists Association (*Ordre national des dentistes*).

5.2.7 Pharmacists

Compared with other European countries, France has a relatively dense network of pharmacies. In January 2007, there were 22 500 pharmacies in France, corresponding to a density of 37 pharmacies per 100 000 population (or 1 pharmacy per 2700 population), whereas the density in Germany and the United Kingdom was 26 and 18 per 100 000, respectively.

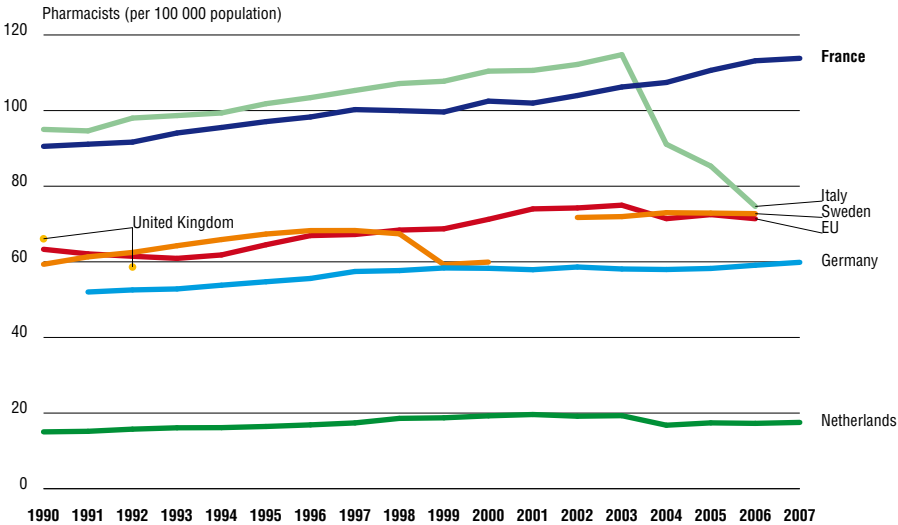
Although laws regarding installation of pharmacies have existed for more than 60 years, effective regulation of the number of pharmacies actually started only 10 years ago. Since 1941, the law specifies a limit to the density of pharmacies within each city (a rule referred to as the quorum, which was set to 1/2500 or 1/3000 citizens, depending on the size of the town). However, a possibility to overrule the quorum was built into the law in order to allow for flexibility under exceptional circumstances. This was extensively exercised until it was removed from law in 1999, resulting in significant overcapacity according to the quorum. Under the assumption that a reduction in the number of pharmacies would result in increased efficiency, the quorum was reduced to 1 pharmacy per 3500 citizens in 2008. Under this rule, 23% of pharmacies contribute to the overcapacity of the sector. The limit implies that no new pharmacy can be created if the limit is attained, but it does not insist that some pharmacies must be closed. Therefore, the government has tried to reduce barriers to restructuring and mergers of pharmacies. As a result, the number of pharmacies has been slowly diminishing since 2002, at a rate of approximately 0.2% per year (Cour des comptes 2008).

Ownership of pharmacies is restricted to pharmacists, but the possibility of removing this restriction is being currently discussed in France.

In 2008, there were about 72 000 practising pharmacists, corresponding to a density that is considerably higher than the EU average (Fig. 5.9). The vast majority of pharmacists (72%) work in retail pharmacies, either as the qualified title-holder or as an assistant. Other pharmacists work as directors of biological test laboratories (8%), as employees in health care institutions, administrators in mutual insurance associations or as officers responsible for blood products (15%).

Fig. 5.9

Number of pharmacists per 100 000 population in France and selected countries, 1990 or latest available year



Source: WHO Regional Office for Europe 2009.

The number of pharmacists has been steadily increasing since 1975, at a rate of roughly 4% per year before 1985, and 1.5–2.0% ever since, the slowing down being the result of the *numerus clausus* that was introduced in 1980. As in the case of other health care professions, the adoption of a *numerus clausus* to limit workforce growth has led to a progressive ageing of the pharmacist population, which, in turn, explains the decision by the government in 2001 to raise the threshold.

Initial training of pharmacists takes six years. From 2010 onwards, the first year will be uncommon with medical, midwifery and dental training. At the end of the fifth year, students must choose one among three available specialization areas: pharmaceutical industry, retail and hospital activities. The last is only accessible through a competitive examination and gives access to hospital pharmacy residency programmes as well as biology residency programmes, which are accessible to both pharmacists and physicians. Successful students enter these four-year residency programmes after their sixth year.

Pharmacists must be registered by the National Pharmacists Association (*Ordre national des pharmaciens*) in order to deliver regulated drugs.

5.2.8 Other health care professionals

Most of the other registered paramedical professionals undergo three years of training, often in educational institutions under the authority of the Ministry of Health. Exceptions to this are nursing aides and paediatric auxiliaries (who have one year of training), opticians, hearing aid specialists and dieticians (two years of training) and speech therapists (four years of training).

As for the other professions, limited admission in professional schools is the main instrument used for regulation of these professions. Quotas are set by the Ministry of Health.

5.2.9 Managerial staff

Public sector hospital directors are civil servants recruited mostly among students of public administration, after an initial training of four years. Successful applicants undergo additional training of two years in the EHESP before starting official duties.

There are roughly 3800 people who qualified as hospital directors in France; one-fifth of them are actually working as directors of a hospital, while the others have other administrative responsibilities either within a hospital or within the Ministry of Health or related agencies. Although not very large, this professional group is well organized and forms an influential group within the health care system.

6. Provision of services

Both public and private providers deliver health care to the French population. Primary care is mostly delivered in the ambulatory care sector by self-employed professionals while secondary care can be delivered in both the ambulatory and the hospital setting. From the late 1990s, GPs have gained a major role in the coordination of care, with the implementation of a partial gate-keeping system that provides patients with an incentive to visit their GP prior to consulting a specialist. Hospital care is delivered by public, private non-profit-making and private profit-making hospitals, and long-term care for the elderly and disabled is provided through both residential care and home care.

6.1 Public health

Public health policy and practice in France have historically been difficult to describe because they involve numerous actors and sources of funding, and large discrepancies exist between legislative texts and actual practice, which relies on the initiative of local actors.

Nevertheless, recent reforms have initiated a movement towards a clearer and more structured organization of the field. The 2004 Public Health Act has provided a new framework for public health policy. The Act firmly established the responsibility of the state in public health matters and emphasized the role of the regional level for organizational issues: regional groups for public health (GRSPs), involving representatives of the state, of the regional hospital agency (ARH) and of the Regional Union of Health Insurance Funds (URCAM), were created in order to plan and implement health promotion activities (see Section 2.4). In 2010, the missions and activities of the GRSP, as well as those

of the ARHs and URCAMs, were taken over by the regional health agencies (ARSs) created by the 2009 Hospital, Patients, Health and Territories Act (HPST Act).

The Public Health Act also created a quantitative assessment framework for health policies encompassing public health objectives for five-year periods that must be monitored on an annual basis and set five-year targets for most of the related indicators. For the 2005–2009 period, the Act defined 100 objectives. In order to meet some of these goals, several national plans have been set up, such as those related to cancer; violence, addictions and risky behaviours; environment and health; quality of life of patients with chronic diseases; and the provision of health care for patients with rare diseases.

Finally, the Public Health Act prompted the creation of the School of Higher Education in Public Health (EHESP) with the aim of strengthening public health education and research in France (see Section 5.2.2).

6.1.1 Environmental safety and infectious diseases

The current system for the management of health risks was created to overcome the deficiencies that came to light when several sanitary crises, such as the “growth hormone” and the “contaminated blood” cases,¹ emerged in the 1990s, giving rise to the concept of health safety in France (*sécurité sanitaire*) (Houssin, Coquin 2008). The different crises highlighted the lack of independence of hazard assessment from decision-making, so one of the key aspects of reforms was the development of evaluation and expertise capacity independent from the Ministry of Health.

At the national level, the current system involves a number of institutions that provide multidisciplinary expertise in the field of health safety (see Section 2.3.3 for more details on these institutions). On one hand, there are specialized agencies that provide expertise regarding specific types of risk and may also exert policy enforcement duties; on the other hand, two agencies have a broad remit that covers many aspects of health safety.

¹ The so-called “growth hormone” case refers to the ban on use of cadaver-derived growth hormone after it was identified as a vector of transmission of the Creutzfeldt–Jakob disease; the “contaminated blood” case refers to the transmission of the HIV through contaminated blood samples. In both cases, officials including members of the Ministry of Health were accused of a delayed and inappropriate response to new scientific information.

The specialist agencies include:

- the French Health Products Safety Agency (AFSSAPS), which evaluates the safety and overall quality of medical care products such as drugs and medical devices and delivers marketing authorizations; it also monitors side-effects of these products and controls the industrial sites that produce them;
- the Biomedicine Agency and the French Blood Agency have responsibilities similar to those of the AFSSAPS regarding all organ transplants plus assisted reproductive technologies, and blood transfusion, respectively;
- the French Food Safety Agency (AFSSA) evaluates nutritional quality and safety of food (including water); its remit extends to phytosanitary products (preventing the spread of pests of plants and plant products), animal feed and veterinary medicines, for which the agency supervises market entry;
- the French Agency for Environmental and Occupational Health Safety (AFSSET) provides expertise in the assessment of environmental and occupational risks;
- the Radioprotection and Nuclear Safety Institute (IRSN) provides expertise regarding all form of ionizing radiations, including health care products, energy-generating plants and natural radiations.

The two agencies with a broad remit are the Institute for Public Health Surveillance (InVS) and the National Institute for Prevention and Health Education (*Institut national de prévention et d'éducation pour la santé*; INPES).

- InVS has a mandate to monitor threats to population health, including known threats such as infectious and chronic diseases and environmental and occupational health, as well as emerging threats of unknown origin, which implies continuous monitoring of health outcomes. The institute gathers information from various sources, including national monitoring systems that rely on networks of professionals, mandatory reports of some diseases by health professionals, as well as a network of regional epidemiology units (*cellules interregionales d'épidémiologie*; CIRE). The institute also investigates all new epidemiological threats and informs the Ministry of Health.
- INPES has a major role in all issues related to communication and health, including strategies for dissemination of health alerts to the various population groups (for example, for avian flu).

The General Directorate of Health of the Ministry of Health supervises the activity of the health agencies on a regular basis, issues regulations based on the advice provided by the agencies and deals with all emergencies regarding health safety.

At the local level, municipal services are legally responsible for monitoring and purifying the water supply, controlling air and noise pollution, waste disposal, protection against radiation, hygiene in residential areas, food hygiene and industrial hygiene. Municipalities that do not have the necessary resources to carry out these functions were, until April 2010, backed up by the directorates of health and social affairs at the regional (DRASS) or departmental (DDASS) levels, which have now been replaced by the ARSs and their territorial delegations.

6.1.2 Primary prevention, health education and health promotion

Historically, the French health care system has been more oriented towards curative than preventive medicine. Nevertheless, the country has seen a progressive development of health education activities since the 1970s.

Early initiatives were promoted by private non-profit-making associations that were mainly funded by state subsidies such as the French Committee for Health Education (*Comité français d'éducation pour la santé*; CFES). Since the mid 1990s, the government has progressively played a more active role in the field. Regional health programmes introduced in 1996 included preventive and health education programmes. In 2001, a national programme for health education was launched, and regions were asked to develop corresponding regional health education plans (*schémas régionaux d'éducation pour la santé*; SREPS) to organize health education activities. In 2002, the Act on Patients Rights and the Quality of the Health Care System created INPES (see Section 2.3.3), which took over previous activities implemented by the CFES. INPES runs large-scale health education programmes and provides resources for regional and local actors. It is assisted by 117 local committees, at the regional and departmental level, which carry out field activities. Finally, the 2004 Public Health Act introduced some objectives related to health education and created regional public health plans that incorporate health education activities.

Despite these attempts to provide a unified framework for health promotion policy, responsibilities for the different areas of prevention are still split between different actors. For example, the departments are responsible for control of alcohol and drug abuse, but a large part of individual prevention, primary and secondary prevention in this area is carried out by self-employed doctors, by

institutions and by various associations: regional and local SHI funds are the principal promoters of preventing home accidents; the Minister of Transport tackles the prevention of road accidents; and the Ministry of Education runs school health services and carries out systematic interventions in schools. In addition to a dilution of responsibilities and the fragmentation of actors, prevention and health promotion also continue to suffer from a multiplicity of sources of funding, further impairing their global efficacy (Gagneux, Strohl-Maffesoli 2003).

Finally, it must be noted that the 2009 HPST Act includes a chapter dedicated to health prevention. The Act notably restricts the sale of alcohol and tobacco to people under 18, and introduces the concept of “therapeutic education” in the public health code; therapeutic education is a particular type of health education directed towards patients having chronic conditions, with the aim of developing the autonomy of the patients in the management of their treatment.

Immunization

Each year, the national immunization programme is determined by the General Directorate of Health of the Ministry of Health on the basis of proposals made by the Technical Committee on Immunization of the High Council on Public Health (described in Section 2.3.7); the policy and the associated recommendations are then published jointly by InVS (InVS 2010).

There are only three obligatory immunizations for the general population: tetanus, diphtheria and poliomyelitis. All three must be performed before the age of 18 months. Municipalities offer free immunization sessions and are responsible for controlling the immunization status of all children of the city. Immunization is also controlled at entrance into day-nursery and schools. Since 2007, vaccination against tuberculosis is no longer mandatory. Following international guidelines for low-incidence countries, immunization is now highly recommended for at-risk populations, as part of a nationally coordinated programme. Recommended immunizations include immunization against whooping cough, *Haemophilus influenzae*, pneumococcus, measles, German measles, mumps and hepatitis B. In addition, immunization against human papilloma viruses is recommended for teenage girls over 14 years and immunization against the flu is recommended for all people aged over 65.

Most of the immunizations are performed by self-employed GPs. Mandatory and recommended immunizations are covered by SHI.

Finally, there are a number of additional mandatory and recommended immunizations for health care workers, depending on their specific exposure.

Perinatal care

Antenatal and postnatal care for mothers and infants is fully covered by SHI and can be provided by office-based self-employed doctors or by institutions. In addition, the mother and child health services (PMI) offer free consultations for children up to the age of six, paying particular attention to families in difficulty, and run preventive health and social care interventions for children.

6.1.3 Secondary prevention/screening

The current cancer screening policy in France has been shaped by the 2003 national cancer plan. Responsibility for mass cancer screening, which was formerly held by general councils, is now held by the Ministry of Health, which decides on programmes to be implemented. Responsibility for implementing the screening programmes is jointly held by the Ministry of Health and the National Cancer Institute (INCa), a national agency created by the 2004 Public Health Act that is responsible for funding research on cancer and developing and coordinating expertise in this field (see Section 2.3.3). The Act created 90 local structures, mainly at the departmental level, in order to carry out mass screening programmes; 90% of these structures are private non-profit-making associations. Around 50% of the local structures are funded by general councils (if the latter have signed a contract with the state in order to retain responsibility for the implementation of cancer screening), while the rest are funded either directly by the state or SHI. Tests and related physician visits are funded by SHI.

Two mass national screening programmes have been deployed in France. Mass screening for breast cancer first developed at the local level on the initiative of professional and patient associations in the 1980s; following this, a national screening programme was set up in 1994 and progressively implemented at national scale, such that the whole territory was covered in 2004. All women aged between 50 and 74 are invited by mail to undergo a clinical examination and a mammography every two years.

Mass screening for colorectal cancer was first implemented in 2003 as a pilot programme in 21 French departments and it was implemented on a national basis in 2008. All people aged between 50 and 74 are invited by mail, every two years to go to their GP for free screening material, a faecal occult blood test, and explanations on the programme and on the process to use the test. If people do not go to their GP in the next three months, they receive a second letter of invitation. After two letters of invitation, the centre sends them the test material at home expecting that people will do it and mail it back for interpretation.

In addition, a mass screening programme for cervical cancer is currently being pilot-tested in 13 departments. In the remaining departments, screening for cervical cancer is still performed on an individual basis, by the gynaecologist or the GP. HAS recommendations are to perform one test every three years between 25 and 65 years, after two consecutive (annual) normal results.

Table 6.1 shows the budget allocated by the state and SHI for national screening programmes

Table 6.1

Budget allocated by the state and SHI for national screening programmes

	All screening programmes (euros)		Breast cancer (euros)		Colorectal cancer (euros)	
	SHI	State	SHI	State	SHI	State
2005	39 680 451	12 134 891	22 410 097	9 041 644	17 270 354	1 374 408
2006	47 087 526	23 973 319	26 928 058	19 308 420	20 159 468	4 664 899
2007	60 575 160	23 999 420	30 269 844	12 969 039	30 305 316	11 030 381
2008 ^a	107 000 000	40 000 000 ^b	36 000 000	21 000 000	71 000 000	19 000 000

Source: Chevreur 2010 (Ministry of Health data 2008).

Notes: ^aValue for 2008 are estimations; ^bIn 2008, €900 000 of state expenditure financed the pilot cervical cancer screening programmes in four departments.

The responsibility for evaluating these screening programmes has been given to InVS. The 2009–2013 cancer plan, launched on 2 November 2009, includes measures to further develop cancer screening programmes in France. Specifically, proposed measures aim at tackling inequalities in access and take-up of screening, improving the coordination of existing programmes, enhancing participation of GPs in screening programmes, improving and standardizing the screening techniques used across the country, and developing and evaluating screening strategies for other types of cancers (INCa 2009).

Finally, the state is also responsible for the prevention and diagnosis of HIV infection. Free and anonymous tests are available to the population in at least one centre in each department. Some of these centres also offer to diagnose other sexually transmitted diseases. All these centres are funded by SHI.

6.1.4 Occupational health

Employers are responsible for ensuring compliance with hygiene and safety standards through a Committee for Hygiene, Safety and Working Conditions (*comité d'hygiène et de sécurité des conditions de travail*; CHSCT) and occupational health services (*services de santé au travail*) in companies.

The CHSCT is a board that represents the company's employees in all issues regarding work conditions and safety. The board has a remit to check that regulation is correctly applied and to make proposals to improve working conditions.

Occupational health services, which are run by occupational physicians, have a general remit to check that employees' health is not altered by their work. They are responsible for checking employees' ability to do their job, monitoring their health and ensuring that the exposure to risks at the workplace is within regulatory standards. Occupational physicians may be assisted by occupational nurses. In addition, since 2002, it is mandatory for occupational health services to gather all necessary technical expertise (for example, in engineering, epidemiology, toxicology and ergonomics) to assess occupational risks, either by hiring additional staff with expertise on these topics or by contracting out with firms or associations that are specialized in these issues. Large firms finance and host their own occupational medical service, whereas smaller firms must be affiliated to external occupational health services, which are non-profit-making associations. There must be at least one occupational physician per 3300 workers.

Since 2005, two consecutive national programmes for the promotion of occupational health have been launched. The 2005–2009 occupational health plan (*plan de santé au travail*) extended the scope of the Agency for Environmental Health to cover occupational health and renamed it AFSSET (see Sections 2.3.3 and 6.1.1). The plan also contributed to raising awareness about occupational health issues and fostering research in this field (*Ministère du travail, des relations sociales, de la famille; de la solidarité et de la ville* 2009). The 2010–2014 second occupational health plan, which was announced in January 2010, aims to reduce morbidity and mortality rates from exposure to occupational hazards and diseases. It is too soon to assess whether the stated objectives are likely to be met or not.

6.1.5 Health inequalities

Although France has long shown some of the widest socioeconomic and gender-related health inequalities in Europe, until recently, policies directed towards the reduction of health inequalities have had a rather narrow perspective.

Despite the growing body of scientific evidence showing the progressiveness of the link between better socioeconomic status and better health status, which was emphasized by the 2000 report on health inequalities published by the

French Institute for Medical Research (Leclerc et al. 2000), until 2004 policies directed towards socioeconomic inequalities in health were mainly focused on access to health care (culminating with the implementation of universal medical coverage, CMU, in 2000) and the fight against precarious living conditions (Jusot, Polton 2005).

The Public Health Act passed in 2004 suggested a change in public health policy by explicitly introducing the reduction of socioeconomic inequalities in health as a major goal. It included two objectives directly related to health inequalities; the first directed towards financial access to health care, the second towards the reduction of the gap in life expectancy between socioeconomic groups. The Act also specified a number of targets that did not explicitly refer to socioeconomic inequality issues but were mainly relevant to people with lower socioeconomic status (for example, the objectives related to alcohol and tobacco consumption, obesity and occupational health) (Jusot, Polton 2005).

The objectives of the Act were to be assessed after five years, before new recommendations would be made in a new Public Health Act. In 2010, the High Council of Public Health (HCSP) reported that, for the first objective of tackling socioeconomic inequalities in access to health care resulting from financial status, available indicators had not shown a favourable trend. No data were available to assess the second objective regarding life expectancy in different socioeconomic groups (HCSP 2010). In order to promote public health policies aimed at reducing these inequalities, HCSP suggested, in the same report, the inclusion of two ambitious objectives regarding health inequalities in the next Public Health Act, which is planned for the end of 2010: reducing socioeconomic and geographic health inequalities (through action on most determinants of health, including financial barriers) and evaluating most of the objectives of the coming Act by socioeconomic groups.

6.2 Patient pathways

This section describe a typical patient pathway that could occur in the French health care system.

In France, a 70 year-old woman in need of a hip replacement because of arthritis would typically visit her GP first. The GP would prescribe radiography of the hip in order to confirm the diagnostic. The x-ray would typically be performed in a private ambulatory radiology practice, but could also be

performed as an outpatient examination in a hospital. The GP would then send the patient to an orthopaedic surgeon working either in the public or in the private sector.

Alternatively, the patient could visit an orthopaedic surgeon directly, thus bypassing the gate-keeping procedure (see Section 6.3.4). In 2010, for a surgeon who follows the Sector 1 agreement, the co-insurance rate would then be increased from 30% to 70%, and the surgeon would be allowed to charge up to €8 on top of the official tariff, both leading to a maximum overall increase of €18 of the patient's out-of-pocket expenditures. That additional expense would not be covered by the patient's VHI, since insurers have strong financial incentives not to cover these fees.

The patient is free to take an appointment with any orthopaedic surgeon she wishes, even if the GP has referred her to a specific one. The patient may have to pay more than the SHI tariff if she goes to a surgeon working under the Sector 2 agreement, or if she wishes to improve comfort during her stay (for example, a single room). The additional fee may be completely or partially covered by VHI depending on the patient's contract. The patient would only stay for a few days in the surgical department before being either transferred to a rehabilitation hospital or discharged home, where she would receive home visits by a physiotherapist. HAS recommends home discharge in uncomplicated cases, when the patient is not socially isolated at home. In practice, both possibilities (being transferred to a rehabilitation centre and being discharged home) were equally frequent in 2007. In the rehabilitation centre, improvements over standard amenities, such as accommodation in a single room, would again typically be charged over the SHI tariff and may be covered by the patient's VHI.

Finally, all information regarding the acute and follow-up stays would be transmitted to the GP, who would be responsible for further care.

6.3 Primary and secondary ambulatory care

Primary and secondary health care that does not require hospitalization is delivered by self-employed doctors, dentists and medical auxiliaries (including nurses and physiotherapists) working in their own practices, and, to a lesser extent, by salaried staff in hospitals and health centres. The range of services

available in ambulatory care is large, covering the majority of medical and auxiliary services that can be provided in such settings, including biological and radiological examinations.

Almost all self-employed health care professionals practise within the framework of the national agreements signed by the professionals' representatives and SHI (see Sections 3.5 and 4.1.3). These agreements cover a period of four or five years and include a number of provisions concerning conditions of practice and list (in an appendix) the rates professionals are allowed to charge. Nevertheless, a quarter of doctors within the agreement are authorized to charge prices that are higher than those indicated (extra-billing); these are mainly doctors who have opted for a sector where they can apply variable fees, called the Sector 2 (see Section 3.6).

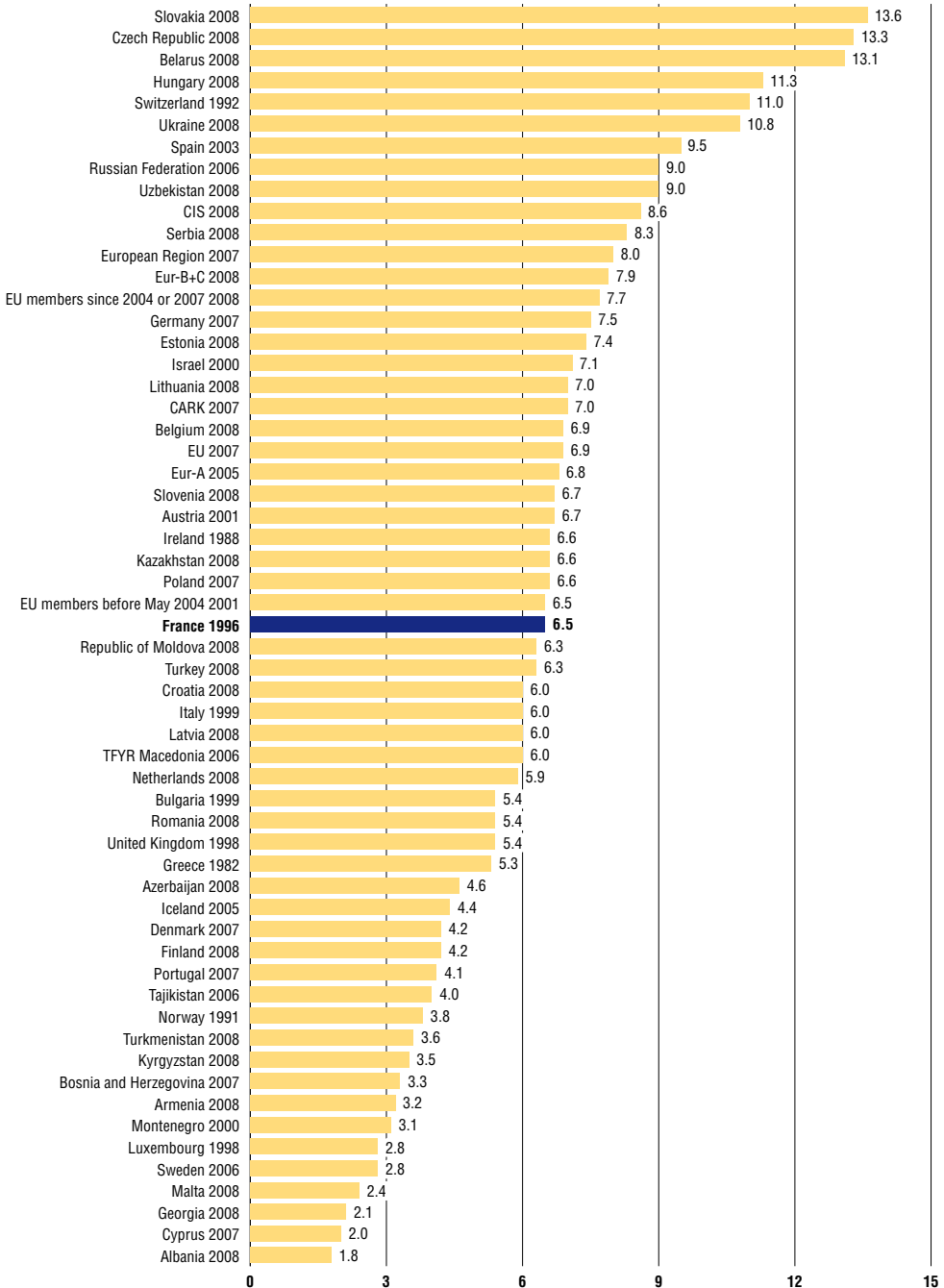
6.3.1 Ambulatory care by physicians

Outpatient medical care is largely provided by self-employed doctors (both generalists and specialists) in their own practices. In 2009, 122 500 self-employed physicians were active in France. Physicians involved in group practice usually do not share a common patient list but aim to ensure continuity of care and mutualize extensive capital investments. About 40% of self-employed physicians are involved in such practices.

Office-based consultations form the basis of GPs' work, but home visits are also significant, representing about 15% of their work. In one year, a GP sees, on average, 1400 different patients and carries out around 5000 consultations and visits. French people have an average of 4.7 contacts with a GP per year (they can visit several GPs). Fig. 6.1 shows that the number of outpatient contacts per person per year in France (6.5 in 1996) is equal to the EU15 average (2001). The percentage of GPs allowed to charge fees above the agreed tariffs is currently low (in 2008, 8.5% of GPs involved only in general practice and 12.7% of all GPs including the ones practising complementary and alternative medicine such as acupuncture or homeopathy) and is declining, through limitations to entrance into Sector 2 (see Section 3.6).

Fig. 6.1

Outpatient contacts per person in the WHO European region, last available year



Source: WHO Regional Office for Europe 2010.
 Notes: Eur-A,B,C: Regions as in the WHO list of Member States, last available year.

Outpatient care provided by self-employed specialists is more difficult to describe because it varies greatly by specialization. Consultations account for 55% of specialists' work, with the rest consisting of diagnostic and treatment procedures (notably surgery in private profit-making hospitals). The percentage of specialists working under Sector 2 rules is roughly 40% (40.7% in 2008) and is rising.

Regarding access issues, doctors benefit from total freedom to choose where they wish to practise, and geographical disparities in the distribution of doctors have existed for a long time (see Sections 4.2 and 5.2.3).

6.3.2 Quality of care and evaluation of medical practice

Promoting the quality of care and the evaluation of medical practice only became visible issues in the 1990s. Until then, medical practice was only subject to partial control exercised by the SHI Medical Service Office, which was responsible for detecting substandard care (see Section 4.1.3).

Since then, as in many countries, the quality of care has become more of a concern for health care system actors faced by the increasing numbers of treatments available, clinical uncertainty and the evidence on medical practice variations (Saltman et al. 1997). A new approach called the “medically based cost-containment concept” was developed. It aims to tackle the loss of efficiency in the system through medical practice variations (see also Section 7.1.3). As a result, many measures were implemented to improve medical practice and thus quality of care. The measures employ both coercive and non-coercive tools and include an increasing emphasis on learning activities; good practice commitments in national agreements between SHI and health professionals; the development of practice guidelines; involvement of SHI in the diffusion of clinical guidelines; and SHI medical representatives. These are discussed below.

Increased emphasis on learning activities

The development of learning activities through continuous medical education for doctors was one of the first tools used. It first developed in the 1960s and became compulsory from 1996. Additionally, audit of doctors' medical practice (EPP) developed in the early 2000s and became compulsory in 2004. However, very few doctors fulfilled the obligation of these learning activities. The failure of their implementation was mainly a governance problem and the lack of transparency in the relationship with the pharmaceutical industry. In order to balance these shortcomings, the 2009 HPST Act introduced the concept of continuous personal development and extended it to other medical professionals.

This aims to audit professionals' practice and to improve knowledge, quality and safety of care in the framework of the priorities of health policy and of medically based cost-containment (see Section 4.1.4 for more details).

Good practice commitments in national agreements between SHI and health professionals

Between 1993 and 1999, a first attempt was made to enforce, through financial penalties, recommendations that aimed to rule out ineffective or possibly dangerous practice. The Teulade Act of 1993 (Act no. 93-8 of 4 January 1993) introduced the principle of mandatory clinical guidelines (*référence médicale opposable*; RMO) within the national agreements signed between SHI and physicians' unions.

RMOs are scientific criteria that define useless, redundant or even dangerous care and prescription and aim to decrease medical practice variations (Allemand, Jourdan 2000). They are, therefore, forced to be expressed in a negative way, indicating what should not be done because it is unnecessary and/or dangerous or useless. An example is the following: "There is no need and it is dangerous to associate two systemic non steroidal anti-inflammatory drugs". Not following these guidelines can lead to sanctions.

However, the recommendations faced strong opposition from physicians and at the end of 1999, because the method used to compute penalties was related to physicians' income and not just to the severity of the non-compliance, the Council of State abolished these penalties. Despite initial evaluation that showed these measures had a positive effect in the short term (Cours des comptes 1998), over a longer period doctors' knowledge of RMOs was poor, and the effects on physicians' practice were not measured (Durieux et al. 2000).

Facing the declining interest in RMOs and of the more general deterioration of the relationships between doctors on the one hand and SHI and the state on the other (see Section 3.5), a new contractual framework for agreements between health professionals and SHI was enacted on 6 March 2002. It organized three types of contract with the aim of promoting the quality and efficiency of the health system through professionals' collective or individual commitment: targeted agreements for good practices, good practice contracts and public health contracts. Additionally, from 2005, as part of the national agreement, doctors were asked to annually commit themselves to medically based cost-containment goals (see Sections 4.1.3 and 7.1.3).

The logic behind all these agreements is to obtain professionals' commitment to improve their practice in return for higher fees or specific lump-sum payments. Additional individual pay-for-performance contracts were offered to GPs in 2009 (known as CAPI), with a seemingly large success in the numbers of participating doctors, although the majority of professional associations have been wary of these contracts for fear that they could distort the quality of care (see Sections 3.6 and 7.1.3).

Development of practice guidelines

The National Health Agency (HAS), the AFSSAPS and the INCa are the three bodies responsible for elaborating and disseminating recommendations and practice guidelines. More than 250 practice guidelines are currently available, relating to the diagnosis, treatment and supervision of specific conditions (including around 60 practice guidelines for long-term conditions).

However, a global strategy to implement these guidelines does not exist. It is currently almost impossible for doctors to get to know and to understand all of the guidelines produced. The main formal attempts to diffuse these guidelines have been made by SHI.

Involvement of SHI in the diffusion of clinical guidelines

Within the framework of their risk policy management programme (*programme national inter-régime*, PNIR), the SHI funds and organizes interventions aimed at improving the clinical management of defined diseases. These actions, which include education, information and promotion, are led by the SHI Medical Service Office (see Section 4.1.3) and are targeted at health care professionals and/or the population. These long-term public health programmes combine audits of practice, feedback and interventions in order to change practice patterns and assessments of their effectiveness. These campaigns are usually tested first at the regional level and, if successful, then scaled up to all of France. This was the case for national campaigns on type 2 diabetes, hypertension and the use of antibiotics based on the national agencies' guidelines. These interventions, based on collaboration with physicians rather than on the usual control and sanction approach, are usually well accepted by health professionals. However, their effectiveness is mixed: fairly positive results for the type 2 diabetes and antibiotics programmes and no effect for the hypertension campaign. Their cost-effectiveness has never been assessed.

The SHI medical representatives

A new function was created in 2003 to complement the role of the Medical Service Office and counteract the influence of pharmaceutical representatives: the SHI medical representatives (DAMs) (see Section 4.1.3). Since 2005,

the DAMs have focused on medically based cost-containment goals (see Sections 4.1.3 and 7.1.3) agreed between SHI and the representatives of doctors in national agreements and national targeted agreements for good practices. The DAMs' mission is to quantify and explain information. In other words, they are in charge of using a pedagogic approach for reminding doctors of the prescribing objectives fixed in the frame of the national agreement (such as a decrease of X% in the rate of prescribing of health transports, Y% in the rate of prescribing of statins, an increase in the rate of generic prescribing). Moreover, in order to inform doctors of their practice status, they present each doctor with their individual prescribing profile compared with the average profile of the doctors of the area. Finally, in the frame of targeted campaigns, the DAMs remind doctors of the clinical guidelines on defined topics. However, they do not provide any advice on drugs (results of clinical trials, scientific news, or comparison of drugs).

The number of DAMs increased from 638 in October 2005 to 904 in May 2007, and it was forecast to reach 1200 by the end of 2009. The first evaluations of this measure show a positive impact on doctors' prescribing as well as a relatively good acceptance by doctors, who in 2006 declared that they changed their practice after the DAM's visit (Bras et al. 2007).

6.3.3 Coordination of care and the gate-keeping reform

A weakness of the French health care system lies in the lack of coordination and continuity of care provided by often isolated professionals. This can lead to over-prescription and waste, but also inadequate care pathways and insufficient quality. The lack of coordination is not limited to self-employed professionals: the interface between hospital care and ambulatory care on one hand, and between health care and social care on the other hand (especially for disabled or elderly people), is also often a problem.

Two types of reform have been set up to try to address this situation: the development of provider networks and giving a gate-keeping role to GPs.

The development of provider networks

The 1996 reform opened up the possibility of experimenting with different forms of provider networks at the local level. The aim was to try out new forms of coordination between professionals providing ambulatory care or between ambulatory care and hospital care.

The idea was not new; a first set of networks had been set up in the 1980s to improve the coordination of care for patients with AIDS, and the same model had been extended to other fields (care of drug addicts, deprived populations, etc.). What was new about the 1996 Act was that it opened up the possibility for these networks to experiment in terms of financial rules (for example, tariffs, services covered and remuneration of professionals). This innovation permitted lines of funding that were not considered in the current system of payment (such as paying additional fees for professionals' coordination and management time, and financing information systems for sharing access to medical records) and the introduction of new benefits, such as joint consultations. The 1996 Act also allowed networks to focus on a specific chronic disease (for example, diabetes or asthma), a specific population (for example, the elderly), a specific type of care (for example, palliative care) or they could target the general population. The objective was to stimulate creativity and promote new forms of organization.

Although the process was slow to take off, in 2002 the regional level was permitted to take part and new funds were made available for this purpose. The 2002 Patients' Rights and Quality of Care Act brought together diverse provider network initiatives under the simple concept of "health networks", which are defined as a form of managed care that aims to strengthen the coordination, continuity or interdisciplinarity of health care provision, with particular focus on selected population groups, diseases or activities. The diversity in type, scope and regional distribution of health networks across regions is a legacy of the 1996 reform, which introduced mechanisms aimed at stimulating experiments with different provider networks at the local level. The 2001 Social Security Finance Act extended experimentation with provider networks for an additional five years (allowing specific payment for health professionals for the coordination of care) and gave the authority to evaluate the experiments to the regional funds of SHI. The 2002 Social Security Finance Act introduced specific budgets dedicated to provider network experiments. Currently, funding is provided by two major sources, the National Network Funding Scheme (*dotation nationale de développement des réseaux*; DNDR) under the main control of the Ministry of Health (and the ARSs) and the Health Insurance Fund for Improvement of Ambulatory Care (*fonds d'aide à la qualité des soins de ville*; FAQSV) under the main control of SHI. The Social Security Finance Act of 2007 unified these two funds into a single one aimed at quality and coordination of care (FIQCS), which is controlled by representatives of the state and of the social insurance funds, achieving global financial management of coordination of care policies (see also Section 4.1.4). In 2008, over 80% of the total budget was used to finance provider networks (FIQCS 2008) and

only 3% for the development of a uniform computerized medical record, the electronic patient record (DMP). The relative share of the FIQCS allocated to DMP is expected to increase with the re-launch of the project beginning in 2010 (see Section 5.1.4). There were about 300 networks by the end of 2008.

A gate-keeping role for GPs

The idea of introducing a gate-keeper into the health care system had been advocated since the early 1980s as a means to increase the efficiency of the health care system. The first attempt was made in 1998, when one GP professional association signed an agreement with SHI that introduced the status of “referring doctor”. GPs who volunteered for this scheme could then invite their patients to sign an individual contract. By signing the contract, the patients committed themselves to visiting their GP first whenever they needed care (except in case of emergency), while the GPs committed themselves, in exchange for a per capita annual payment (€46 in 2001, more than two times the price of a visit) to a number of rules: applying the prices listed in the agreement, using the third-party payment system (to protect patients from direct payment), keeping patients’ medical records (not a legal requirement in France), participating in public preventive programmes, complying with practice guidelines, and prescribing cheaper drugs (as defined in a list by SHI). The scheme was however opposed by most of the physicians’ associations, against the backdrop of very tense relationships between health care professionals on the one hand, and the government and SHI on the other hand (see Section 3.5); finally, it was adopted by only 10% of GPs and 1% of patients.

Following this, the 2004 Health Insurance Act introduced a new gate-keeping structure into the health care system, the “preferred doctor scheme”, and the “referring doctors” system was abolished. Under the new system, each patient is asked to choose the physician that would become his/her first point of contact with the health care system (*médecin traitant*; MT), which we refer to here as the “preferred doctor”. Exceptions to this rule include direct access to specialists that French patients tend to visit directly: gynaecologists, obstetricians, ophthalmologists, psychiatrists and neuropsychiatrists. In addition, children under 16 are exempted from the gate-keeping pathway, and direct access to paediatricians is accordingly not discouraged.

The system is backed by financial incentives that are mainly directed towards patients; doctors’ commitments and incentives are far lower than in the previous system. If a patient has not registered with a preferred doctor, has registered with a preferred doctor but nevertheless visits another GP or visits a specialist without a GP referral, the rate of coverage he/she is entitled to from

SHI will drop from 70% to 30%. In all these three cases, Sector 1 doctors applying the national agreement tariffs (as opposed to Sector 2 doctors, who practise extra-billing; see Section 3.6.2) are allowed to charge a supplemental fee of up to 17.8 to 19.1% of the official tariff. On the physician side, no per capita payment is offered, except for patients registered by SHI as suffering from long-term diseases (ALD; see Section 3.2). Physicians taking care of these patients receive an annual per capita payment of €40 for drafting a coordinated care protocol (see Section 3.6).

In order to keep incentives effective, VHI providers have been offered tax deductions for providing contracts that do not cover the additional fees (*contrats responsables*; see Section 3.3.2).

Most French patients have chosen a preferred doctor (80% by May 2006), which is almost always a GP (more than 99%). While the reform may succeed in improving the quality of care through better coordination of care pathways, the expected financial benefits have been partially offset by the additional payments offered to physicians (Naiditch, Dourgnon 2009). Moreover, concerns have been raised that the reform may increase socioeconomic inequalities in the use of specialist care, since it increases the overall cost of access to specialists (Com-Ruelle et al. 2006) (see also Section 8.2).

6.3.4 Ambulatory care by other providers

A wide range of services are available in ambulatory care.

Nursing care is mainly provided by self-employed nurses. There were 70 000 self-employed nurses in 2008. Nursing and home care of patients makes up two-thirds of the work of these nurses; the last third is devoted to technical activities (such as performing injections or intravascular perfusions). On average, each nurse has 275 patients. Additionally, community nursing services (*services de soins infirmiers à domicile*; SSIAD) have been developing since 1981 in the health and social care sector for disabled. They are mainly staffed by wage-earning nursing auxiliaries and nurses participate to the delivery of care to a lesser extent (see Section 6.8). Demographic issues for self-employed nurses are prominent and lead to substantial geographical inequities of access to nursing care (see Section 5.2.4).

Almost all dentists are self-employed in ambulatory practices (see Section 5.2.6). The majority of physiotherapists (75%), speech therapists (80%) and orthoptists are self-employed professionals working in an ambulatory setting.

Diagnostic procedures are mainly performed within private laboratories owned by specialized physicians or specialized pharmacists or in imaging centres owned by specialized physicians. About 4000 privately owned laboratories carry out biological diagnostic procedures. These procedures may also be carried out in hospitals, particularly when they have been prescribed by a hospital doctor.

Finally, there are some 22 500 pharmacies, which provide drugs, small medical devices and bandages (see Sections 5.2.7 and 6.6).

A small part of outpatient care is provided by salaried professionals working in public sector hospitals or health centres. Outpatient care and examinations in hospitals represent about 15% of all outpatient consultations. Around 1700 health centres, usually run by local authorities or mutual insurance associations, along with some organizations offering free treatment to disadvantaged groups, are also active, albeit more marginally, in the delivery of outpatient care. These centres are either specialized centres involved in nursing (40%), dental care (25%) or general practice (about 5%) activities or integrated centres providing all kinds of ambulatory care (about 30%).

6.3.5 Conclusions

While concerns regarding the health care sector have long been dominated by efficiency issues, the current decrease in the health care workforce (see Section 5.2.1) has also raised to prominence issues of access in the ambulatory care sector. In order to deal with these issues, the government is taking a more active role in the regulation of this sector, which historically has been regulated through agreements between SHI and provider associations (see Section 4.1.3). The 2009 HPST Act created a new institution at the regional level, the ARS (see Section 2.4), which is in charge of both issues; however, there is concern that ARSs will not be very successful in gaining control over the medical ambulatory care sector, since professionals in this sector still oppose stricter regulation.

6.4 Inpatient care

Acute medical, surgical and obstetric care is provided by public as well as private hospitals, with different areas of specialization.

Acute medical care is mainly provided by public hospitals, which account for three-quarters of acute medical care capacity (80% of medical beds and 70% of day-care beds) and performs 75% of full-time episodes and 55% of day-care

episodes. Private profit-making hospitals account for 10% of full-time beds and 20% of day-care beds, and they provide 15% of full-time episodes and 40% of day-care episodes; they specialize in a small number of technical procedures for which there are profit opportunities, such as invasive diagnostic procedures (for example, endoscopy or coronarography). The rest of the acute medical activity is performed by the private non-profit-making sector, which are the main providers in the area of cancer treatment (see Sections 5.1.1 and 5.1.2).

In contrast, surgical care is mainly delivered by private profit-making hospitals, which perform more than half of all surgical procedures, including 75% of the surgical episodes performed in day-care settings. Surgical care accordingly represents more than half of the acute care activity of the private profit-making sector. These hospitals tend to specialize in procedures that can be performed routinely within a short stay with a predictable length; for example, they perform three-quarters of surgery for cataracts and varicose veins, and two-thirds of surgery for carpal tunnel syndrome. Public hospitals perform a third of surgical procedures, with a much wider scope than profit-making hospitals, including the most complex procedures. Surgical procedures performed in the private non-profit-making sector are mostly related to cancer treatment, as for medical stays.

Finally, two-thirds of obstetric procedures are performed within public hospitals, while the private sector accounts for the remaining third, mainly within profit-making hospitals (one-quarter of all obstetrical stays). Two 1998 decrees define hospitals' roles in providing perinatal care on the basis of their technical capacity and promote cooperation between them. There are four different levels of hospitals providing obstetric care. Hospitals at the first level only conduct antenatal consultations, while those at the fourth level are capable of providing neonatal intensive care. Departments that are able to deal with obstetric (maternal or newborn) emergencies belong almost exclusively to the public sector, whereas the private profit-making sector accounts for 40% of the departments that deal with low-risk pregnancies.

Public hospitals are under the control of the Ministry of Health and the ARS for decisions regarding investments in infrastructure as well as in human resources (see Section 4.2 and 5.1.2). Nevertheless, reforms of the hospital sector since the 1970 Hospital Reform Act consistently support a move towards greater managerial autonomy of public hospitals. The 2009 HPST Act is no exception to this trend: it has increased the autonomy of public hospitals and their organizational flexibility. Importantly, it has also clarified their internal decision rules. Executive responsibilities, which were previously held by the administrative board (*conseil d'administration*) of the hospital (comprising

representatives of the state, local authorities, hospital staff, patients and qualified personalities), are now held by the hospital director; accordingly, the remit of the administrative board (which has been renamed the monitoring board (*conseil de surveillance*) has been reduced to the definition of the hospital strategy and the control of its implementation. Decisions directly relevant to the quality and safety of patient care will be jointly taken by the director and the president of the hospital's board of physicians (*commission médicale d'établissement*).

Regional disparities regarding acute care human resources are a concern, while disparities in acute care capacity are less so. The number of acute care beds per 1000 inhabitants shows a 1.4-fold variation between regions (it ranges from 3.2 in Haute-Normandie to 4.4 in Limousin), which is much lower than the more than two-fold variations that are observed for physicians (see Section 5.2.3). Quality of the facilities is also of concern (see Section 5.1.2).

6.4.1 Day care and other alternatives to full-time inpatient care

Because of long-lasting concerns about excess acute care capacity (see Section 5.1), alternatives to full-time inpatient care have been promoted since the late 1980s. Specifically, authorizations to develop “hospital at home” (or home hospitalization) (HAD) units (see below), as well as ambulatory care places, have been granted in return for closing down acute beds.

HAD units have existed in France for about 50 years. However, they only acquired an official status concurrent to ambulatory surgery following the 1991 Hospital Act (Act no. 91-748 of 31 July 1991; Decrees no. 92-1101 and no. 92-1102 of 2 October 1992). Their precise function as an alternative to hospitalization was recently redefined in two Ministry of Health circulars (Ministère de la santé 2000, 2006). The purpose of HAD units is to send medical or paramedical staff to the patient's home on a daily basis in order to provide continuous and coordinated care in cases where a hospital stay would have been necessary otherwise.

According to the Ministry of Health (Ministère de la santé 2000), “hospital at home” (HAD) concerns patients with serious, acute or chronic, progressive or unstable disease who need technical medical care of a certain degree of complexity and/or intensity. In the absence of such a service, these patients would be hospitalized in a health establishment. HAD aims to avoid, shorten or delay in-patient stays in acute wards or in follow-up and rehabilitation wards, whenever an admission into HAD is considered feasible.” This definition underlines three main notions: substitution (inpatient admission avoided,

delayed or shortened), the global care plan (global management of all types of graduated care: short-term, continuous, palliative, rehabilitation or functional therapy) and care coordination (external with hospitals; internal between health personnel, health workers and home helpers) (Chevreul et al. 2005). Hence, HAD can be seen as a small care network embedded in a larger one (Com-Ruelle, Afrite 2008).

Administratively, HAD units are either hospital departments or private mainly non-profit-making associations. Each unit is led by a physician, who takes responsibility for the overall coordination of medical care, while nurses coordinate individual treatments; actual care is provided by salaried staff from the hospital or self-employed professionals. HAD care is mainly provided in the areas of palliative care, cancer treatment and perinatal care (Afrite et al. 2009). Evidence shows that HAD provides cheaper care than acute and rehabilitation inpatient services (Afrite et al. 2007).

In 2008, there were about 233 HAD units in France, which were allowed to take in charge a maximum of 8400 patients simultaneously. Non-profit-making associations are the main actors in the HAD sector: during the same year, they provided 60% of the 112 600 HAD episodes that were organized; the other stays were mostly provided by the public sector, whereas the private profit-making sector accounted for only 2% of stays. In response to the growing demand of the ageing population, the supply of HAD is increasing rapidly: HAD capacity doubled over the eight years from 2000 to 2008. It has increased particularly rapidly from 2006 to 2008 (+25%) after the implementation from 2005 of a new payment method based on DRGs (see Section 3.6.1). However, further development is slower than expected: less than 10 000 places will be available by the end of 2010, whereas 15 000 were initially expected. The government has, therefore, set the objective of 15 000 places by 2015.

Alongside HAD, structures for part-time hospitalization have been set up (see Section 5.1.1). In particular, surgery in an ambulatory setting has been steadily developing since 2000: during the first semester of 2008, it accounted for 54% of surgical procedures performed in France, in comparison to 36% in 2000. While the growth of this sector was primarily led by the private profit-making sector at the beginning of this decade, the public sector is progressively catching up: 49% of surgical procedures in the public sector are performed in an ambulatory setting (versus 58% in the profit-making sector).

Since 2004, in order to promote the development of ambulatory care, SHI is progressively increasing the incentives to switch to an ambulatory setting for a short list of procedures for which ambulatory surgery has been deemed highly

suitable by learned societies (for example, cataract surgery, varicose veins surgery and carpal tunnel surgery) (see Section 3.6.1). While the difference between the full-time and ambulatory tariffs for each of these procedures has been greatly reduced, since 2008, hospitals with a lower share of ambulatory procedures than the national average for each of the listed procedures can be put under a specific reimbursement scheme, under which SHI can deny reimbursement of full-time hospital episodes for the given procedure if the hospital has not previously requested an authorization for it, justified by the patients' health status.

Early evaluations show that this measure leads to a dramatic increase in the share of ambulatory procedures in the hospitals to which the scheme has been applied. However, in spite of the incentives available, the rate of ambulatory surgery is still lower than in neighbouring countries: for example, the share of ambulatory procedures was 61% in Germany and 78% in Denmark in 2003. SHI is, therefore, expected to maintain strong incentives to shift procedures towards ambulatory settings.

6.4.2 Promoting quality of hospital care

The 1990s saw a rapid expansion in the evaluation of health care in hospitals in France. Quality of care became a matter of concern to public authorities, who were influenced by hospital rankings published by the popular press on the basis of rather crude indicators. It was promoted within hospitals and in the organization and restructuring of hospital facilities.

Hospital-acquired (nosocomial) infections still currently affect 7% of those admitted to hospital, making this a key priority within hospitals. Committees for combating hospital-acquired infections were set up in 1988, first in the public sector and then in the private sector. The first set of mandatory quality indicators that was released for French hospitals and clinics is related to the organization of the fight against hospital-acquired infections.

Since 1996, the HAS has carried out a periodic auditing procedure in all hospitals and clinics. This process, named *certification* (formerly *accréditation*), is an external evaluation of the quality and safety of the infrastructure and of the processes of care within the hospital, but it includes almost no evaluation of quality of care outcomes (see also Sections 4.1.2 and 4.1.4). The second wave of certification procedures started in 2005 and will be completed in 2010.

Finally, an optional audit process was introduced by the 2004 Health Insurance Reform Act that covers a limited number of high-risk medical activities (see Section 4.1.4).

6.4.3 Recent reforms

Recent reforms regarding the inpatient care sector have focused on efficiency issues. In order to promote efficiency in the public sector, the reform plan Hospital 2007 introduced a common financing structure for public as well as profit-making hospitals (see Section 3.6). While the stated objective was common tariffs for the non-profit-making and profit-making sector by 2012, the large discrepancies observed between costs in the private profit-making and public sectors has led to vigorous debates about the appropriateness of common tariffs. As a result, this objective has been recently postponed to 2018 by the 2009 HPST Act. Additionally, the 2009 HPST Act allows more flexibility in the management of public hospitals and also extends the possibility for private profit-making hospitals to perform public sector duties. Overall, these reforms are directed towards a gradual homogenization and a more structured cooperation between the public and private sector (see Section 5.1.2).

6.5 Emergency care

The scope of French health policy for emergency care encompasses the regulation of pre-hospital emergency care, the organization of hospital emergency departments, as well as the availability of appropriate hospital beds for patients admitted by emergency departments.

6.5.1 Pre-hospital care

The ability of the health care system to deal with pre-hospital emergency care relies on two types of measures: medical emergency call centres (*services d'aide médicale urgente*; SAMU) and the continuity of care system (*permanence des soins*; PDS).

Since 1986, SAMU have been freely accessible nationwide from any phone (by dialling 15). The centres share information with the police (dial 17) and fire brigade (dial 18) emergency call centres, so that medical emergencies are appropriately addressed. The European emergency number “112” is answered either by the medical or the fire brigade call centres, depending on the department.

Emergency calls that reach the medical call centre are treated by specialized call receptionists who are supervised and backed up by physicians. Several types of action can be taken, according to the level of emergency of the situation. If first-aid is needed on the site of the emergency, the SAMU can send a mobile intensive care unit (*services mobiles d'urgence et de réanimation*; SMUR), a first-aid team from the fire brigade or a primary care physician who is on call at that time, if one is available. Otherwise, the patient can be advised to go to the nearest emergency hospital and an ambulance can be sent to transport him/her, if necessary. Finally, the patient may be advised to call back after a few hours in order to confirm the symptoms or to visit his/her GP within the next days.

The PDS refers to the ability of the health care system to provide a timely and appropriate answer to patients' requests when ambulatory practices are closed. This activity was historically organized by the local centre of the Physicians Association, which scheduled on-call rounds. However, self-employed GPs, whose number is scarce in certain areas and whose workload is increasing, became increasingly reluctant to participate in the system. The system was, therefore, eventually reformed between 2003 and 2005. The new system fell under the responsibility of the representative of the state in each department (*préfet de département*), who is in charge of organizing it with the help of the local Committee for Emergency Care, Continuity of Care and Transportations (*comité départemental de l'aide médicale urgente, de la permanence des soins et des transports sanitaires*; CODAMUPS).

SAMU call centres deal with patient requests and direct them depending on the demand to on-call physicians, hospital emergency departments or a doctor's appointment. The system relies on doctors who are on-call on a voluntary basis, towards whom financial incentives are directed. Between 2004 and 2007, the SHI budget dedicated to PDS increased from €270 million to €350 million (that is, 4.4% of the total SHI fees of self-employed physicians), showing a relative success in developing the system (Bonnet, Pavillon 2009). Nevertheless, the system is still facing difficulties in several regions, mainly through the reluctance of physicians to participate in under-served areas. As a response, the 2009 HPST Act developed measures to improve PDS, which now falls under the responsibility of ARSs (see Section 6.5.3).

6.5.2 Emergency care in hospital

The 630 hospital emergency care units in France are the cornerstone of the French emergency care system. Emergency care activity must be authorized by the ARS. Units that have been granted an authorization were until 2006 classified into three categories, depending on the gravity and specificity of the cases that are taken care of:

- General emergency care units (*services d'accueil des urgences*; SAU) have the necessary resources to deal with all kinds of emergency. The public sector accounts for almost all of the SAU (97%). Overall, these units receive 55% of all emergency visits.
- Local emergency care units (*unités de proximité, d'accueil, de traitement et d'orientation des urgences*; UPATOU) have more limited technical and human resources. They may receive all types of emergency but must organize the transfer of the most complex cases. Two-thirds of the UPATOU belong to the public sector. They receive 40% of emergency visits.
- Specialized emergency units (*pôles spécialisés d'accueil et de traitement des urgences*; POSU) deal with specific pathologies or types of patient. Half of them are in the public sector, the majority of them dealing with paediatric emergencies. In contrast, private sector specialized emergency services are highly specialized units dealing with a limited range of pathologies (for example, heart attacks (Box 6.1) and hand trauma requiring surgery). POSU account for 5% of emergency visits.

However, since 2006 the SAU and UPATOU have the same administrative status as emergency structures (*structure des urgences*).

6.5.3 Recent reforms

Recent concerns regarding the system of emergency care have focused on the difficulty for hospital emergency departments to deal with an increasing workload. The overload of these departments has been related to the lack of access to primary care ambulatory services as well as to a lack of available hospital beds for emergency admissions (Gayrard 2005). Accordingly, the 2004–2008 Emergency Care Reform included half a billion euros of investments directed towards the recruitment of medical and paramedical staff in emergency wards, as well as the creation of hospital beds for acute geriatric care (an increase of 900 beds in 2004), intermediate care (an increase of 915 beds in 2004) and hospital-at-home care (an increase of 300 places in 2004). The plan also

Box 6.1**Patient pathway after a heart attack**

In France, someone feeling an unusual and worrying pain in the chest after a violent effort (that is, a typical symptom of a heart attack) and wishing to seek care would take one of the following steps:

- call the emergency regulation centre (SAMU, Centre 15)
- call the fire brigade (dialing “18”)
- call his or her GP
- call a cardiologist
- go direct to a general emergency unit.

While the majority of patients would call their GP, the most appropriate action would be to call the Centre 15 (some regional studies have reported that only between one-sixth and one-third of patients do so (Beer et al. 2002)). The subsequent sequence of events that would typically occur is described briefly here.

Given the nature of the symptoms, the specifically trained call receptionist receiving the call will immediately transfer it to a physician at the call centre. The physician will ask a few specific questions to get a better understanding of the symptoms. Given the likelihood of a heart attack, a mobile medical unit will be sent to take care of the patient; a first-aid team from the local fire brigade may also be sent to precede the medical unit.

The first-aid team will reach the patient first and will check the patient’s vital signs. They may start cardiopulmonary resuscitation, if necessary.

The mobile medical unit will arrive a few minutes later, start monitoring the patient’s heart rate and perform an electrocardiogram that will confirm the diagnosis of myocardial infarction. The physician of the unit will then call the emergency regulation centre to confirm the diagnosis and ask for instructions about which hospital the patient should be directed to. The call centre will check available places in the regional cardiology emergency centres, choose the most appropriate place for hospitalization, inform the centre of the imminent arrival of the patient and inform the mobile unit to which hospital to take the patient. In the meantime, the nurse of the mobile unit will give the patient necessary drugs according to the heart attack treatment protocol.

The mobile unit will then transport the patient to the designated centre. Depending on current protocols, expected delay before reaching the hospital and the availability of a catheterization and angioplasty ward, the patient may receive curative pharmacological treatment (thrombolysis) during transportation.

Upon arrival in the hospital, the mobile unit will bring the patient directly to the designated unit and ensure continuity of care when replaced by members of the unit.

promoted the development of ambulatory care centres (*les maisons médicales de garde*; MMG) that would be accessible during nights and weekends, in order

to guarantee continuity of access to care; this attempt has been only partly successful, mainly because of difficulties in hiring physicians for night shifts (Grall 2006).

Overall, the difficulties faced by the emergency care system are linked to the difficulties of the primary care sector, which are currently exacerbated by the increasing geographical disparities of the health care workforce (see Sections 5.2 and 6.3). The 2009 HPST Act attempted to tackle this issue: the responsibility for providing continuous access to health care services now falls under the ARSs, which can contract with ambulatory care physicians in order to meet these goals. In addition, call centres dedicated to primary care issues have been created in order to reduce the burden of calls received by the SAMU call centres.

6.6 Pharmaceutical care

The French population is among the biggest consumers of pharmaceutical drugs. While the price of drugs, as in most OECD countries, is set administratively for all drugs covered by SHI, the large size of the market makes the country the third largest market for pharmaceutical drugs, representing 6% of the annual worldwide drug expenditures (against 45% for the United States and 9% for Japan).

6.6.1 Market entry and public coverage

All drugs must obtain market authorization (AMM) before being put on sale. Authorization may be obtained through three different procedures:

- a centralized procedure within the European Medicines Agency (*Agence européenne des médicaments*; EMA), through which an EU AMM may be obtained
- a decentralized procedure for mutual recognition aimed at granting an EU AMM once a drug has already received an AMM in one Member State
- a national procedure, through which the AMM may be given by EMA or by AFSSAPS (see Section 2.3.3).

In order to obtain an AMM, a drug has to meet three criteria: pharmaceutical quality, safety and effectiveness. All drugs that have entered the French market since 1972 have been given an AMM, with the exception of the following: homeopathic products (which can sometimes be exempted), preparations made up in pharmacies, and drugs for which a temporary authorization for use has

been issued.² Drugs that were already on the market before 1972 had to follow a specific procedure to gain AMM; since 1997, all pre-1972 drugs have followed this procedure.

The AMM specifies the conditions for the prescription and supply of drugs for which a medical prescription is mandatory, singling out drugs that should be the object of special prescriptions (narcotics) and those that are in the restricted prescription category (drugs reserved for use in hospitals, drugs that can only initially be prescribed in hospitals and drugs that require particular supervision).

In contrast to the AMM procedure, the process leading to the coverage of a drug by SHI is strictly national. In order to qualify for SHI coverage, a drug must be included in the so-called “positive list” of reimbursable drugs established by ministerial decree on the advice of the Transparency Commission (CT; from the HAS) and the Pricing Committee (CEPS) (see Section 3.2).

In order to be included on the positive list, evidence must be supplied of the drug’s medical benefit or therapeutic value (SMR). The CT then assesses the SMR according to five criteria:

- the effectiveness of the drug and its possible side-effects;
- its place in the therapeutic process, in relation to the alternative therapies available;
- the seriousness of the condition in question;
- the curative, preventive or symptomatic properties of the drug;
- its importance in terms of public health.

The SMR is evaluated in absolute terms, for all different types of use. If the SMR of a product is “major or considerable”, “moderate” or “low but nevertheless justifying reimbursement”, it can be included in the positive list. The level of coverage is determined by the SMR and the seriousness of the condition, in accordance with Table 6.2. However, SHI retains the possibility to modulate this rate by plus or minus 5%. If the SMR is evaluated “insufficient” or “of low medical benefit” (SMR_i), the drugs are not covered by SHI.

² Note that this procedure is reserved for drugs that have not yet undergone all regulatory steps but are used to treat a serious or rare ailment for which there is no pre-existing treatment.

Table 6.2

Rate of coverage of drugs according to the seriousness of the pathology and the evaluation of the medical benefit (SMR)

	Medical service rendered	Rate of coverage (%)
	Serious illness	Illness usually benign
Major or considerable	65	35
Moderate	35	35
Low but justifying reimbursement	15	15
Insufficient	0	0

Notes: Some ambulatory drugs are recognized as irreplaceable and particularly expensive by the Ministry of Health, in which case they are covered at a 100% level. The 15% rate of coverage was added in 2010 (Decree no. 2010-6 of 5 January 2010). It was previously 35%.

The vast majority of drugs are covered at a 65% rate. In 2009, among the 109 new drugs reviewed by the CT, the vast majority of new drugs were evaluated with major or considerable therapeutic value (90) while only 10 were deemed insufficient.

The CT has the mandate for re-evaluating all drugs in accordance with these new criteria. A re-assessment of all covered drugs was conducted between 1999 and 2001, which led to 835 products being classified as providing SMRi (that is, 18% of those that were included on the positive list at that time). In principle, these drugs should have been removed immediately from the positive list, but the unpopular nature of such decisions has slowed the process down. In practice, the 1999 evaluation led to a reduction of the drugs' prices and of their coverage rate (from 65% to 35%), and new assessments of these drugs were scheduled to start between 2002 and 2006, in three waves:

- the first wave of re-assessment was conducted in 2002 and led to 60 drugs being excluded from the positive list in 2003, following the HAS recommendations;
- the second wave (in 2005) led the HAS to classify 245 drugs as offering an SMRi; the government decided to exclude 152 of them from the positive list and for 61 of them to create and apply a specific coverage rate of 15% prior to exclusion from the positive list in January 2008;
- the third wave (in 2006) led to 89 drugs being classified as SMRi: for 48 of them, the government decided to lower their price (up to 20%) while keeping them on the positive list; the remaining 41 drugs were applied a temporary special 15% coverage rate and were excluded from the positive list in January 2008.

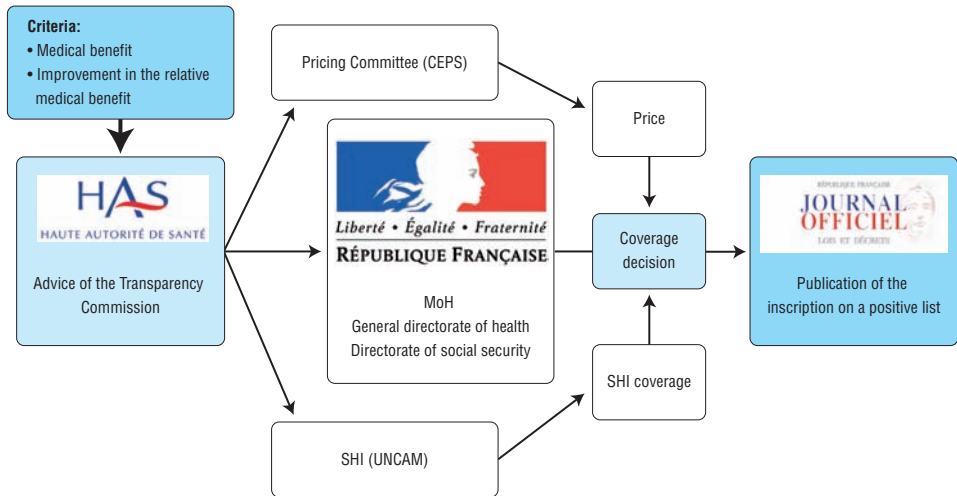
Following the creation in 2010 of the 15% rate of coverage for drugs with low SMR, the reimbursement rate of 171 additional drugs has been lowered from 35% to 15%.

In addition to the SMR, the CT evaluates the relative medical benefit of the drug in comparison with similar available treatments (ASMR) or drugs already available for the same pathologies. There are five levels of ASMR, from 1 (major therapeutic advance) to 5 (no therapeutic advance). The majority of new drugs are classified as providing no therapeutic advance: between 2000 and 2005, around 1000 drugs were evaluated by the CT; two-thirds of them have been classified in the ASMR group 5. In 2009, among 109 drugs reviewed by the CT, 36% showed an improvement in the relative medical benefit (ASMR between 1 and 4) and 10 showed a major therapeutic advance (ASMR 1).

The drug price, which is equivalent to the statutory tariff, is then set either as a result of a bargaining process between CEPS and the manufacturer or through an international benchmarking procedure. According to the social security code, the price must be set according to the ASMR, the price of other drugs with same therapeutic indications and the estimated volume of sales. Drugs offering a therapeutic advance can get a price higher than the reference, whereas drugs classified as ASMR group 5 will get a statutory tariff (and thus be subsequently covered) only if its price is lower than that of its alternatives. Since 2003, a new procedure has allowed the manufacturer to propose a price that is consistent with prices already defined in four other European countries (the United Kingdom, Germany, Spain and Italy); the procedure was initially limited to ASMR groups 1 and 2 products but has now been extended to ASMR 3 and 4 drugs as well; it is worth noting that the manufacturer may nevertheless opt for the standard bargaining process. Drug coverage and pricing processes are summarized in Fig. 6.2.

Fig. 6.2

Process for deciding SHI coverage and official tariffs for drugs



Source: HAS 2010.

Notes: HAS: National Health Authority; MoH: Ministry of Health; SHI: Statutory health insurance; UNCAM: National Union of Health Insurance Funds.

There are two exceptions to these rules. First, when sales volumes through unauthorized prescriptions are expected to be important, CEPS may ask the manufacturer to sign a price-volume agreement such that the manufacturer will pay rebates to SHI if the sales of the product are higher than expected. Second, CEPS may set a common price for a whole class of similar drugs when the class includes a generic substitute that is rarely prescribed. There are also specific cases:

- **conditional approvals** may be granted for certain indications, patient populations, treatment settings and therapeutic positioning to restrict use;
- **risk-sharing agreements** are employed between governments and providers or manufacturers, whereby the “good performance or use” (across cost-effectiveness, costs, volume, market share) of a product is associated with different reimbursement terms;
- **coverage with evidence development** links coverage to requirements for further clinical research.

Once SHI has fixed a coverage rate and the pricing committee has given a price the drug is available for use. For new and expensive hospital drugs that are listed separately from the DRGs (list T2A) and paid on top of the DRG tariffs (see Section 3.4 for more details on T2A), hospitals have to sign an appropriate use contract for a period of three to four years (*contrat de bon usage*) with the ARS. Hospitals can claim for full reimbursement of the drug if they follow the indications stated in the contract. Reimbursement will be linked to evidence of appropriate use.

6.6.2 Production, distribution and consumption

Since 1995, France has been the largest European producer of pharmaceutical products. In 2007, the French pharmaceutical industry included 325 firms and employed around 100 000 people. It had a turnover of €45 billion from drugs. Exports accounted for 45% of that turnover, while reimbursable drugs represented 75% of the industry's turnover in the national market.

Like production, the distribution of drugs is closely regulated, both for wholesalers and for pharmacies. Some 78% of the industry's turnover on drugs is distributed by wholesalers; 6% is sold directly to retail outlets and 15% to public and private hospitals.

The wholesalers form a very concentrated sector, involving 11 firms in 2004, three of which accounted for 95% of the turnover. They obtain their income on the basis of statutory margins, which have been regularly reduced during the last decade in order to limit profits of wholesalers. Since March 2008, the margins are 9.93% for producer prices below €22.90, 6% for prices between €22.90 and €150, 2% for prices between €150 and €400, and 0% for prices above €400. In addition, wholesalers pay an annual tax to social security, which is roughly proportional to their turnover; in 2006, that tax amounted to almost €379 million or 1.9% of their turnover. In addition to wholesalers, 28 firms distribute drugs on behalf of the producers; they are either subsidiary companies or independent companies that producers have contracted with for some of their products.

Pharmacies have a monopoly on the dispensing of medicines. As a general rule, retail pharmacies must be owned by a qualified pharmacist or by a group of pharmacists associated in a company; these pharmacists or companies cannot be proprietors of more than one pharmacy. As an exception to this rule, mutual insurance associations and the SHI scheme for miners may also own retail pharmacies.

There were about 22 500 retail pharmacies in 2007. This number is regulated by a *numerus clausus* that takes into account both the size of the population to be served and the distance involved in getting to the nearest pharmacy (see Section 5.2.7).

Since January 2000, pharmacists have been paid on the basis of a mixed system linking a fixed-sum component (€0.53 per item, with an additional €0.30 for some drugs requiring a specific delivery procedure) and a sliding scale margin. Since March 2008, the margins are 26.1% for producer prices below €22.9, 10% for prices between €22.9 and €150 and 6% for prices above €150.

Public advertisement for drugs is restricted to specialties that meet three criteria: they can be delivered without physician prescriptions, they are not covered by SHI and no restriction on advertisement has been included in the AMM of the product. Vaccines are the only exception to this rule.

For a long time, the general system for obtaining drugs involved the patient paying for the drug, being covered by SHI and then covered for the remainder of the drug's cost by complementary VHI. Recently, the third-party payment system has become more common, involving direct payment to the pharmacist by SHI or VHI, so that the patient does not incur any direct cost. This system of payment applies to about two-thirds of drug purchases.

France is a country where pharmaceutical expenditure accounts for a large share of GDP (in 2008, expenditure for pharmaceutical and non-durable goods accounted for 1.8% of GDP, compared with 1.9% in the United States, for example). In comparison with their European neighbours, the French are considered to be heavy consumers of drugs. In 2004, the turnover of sales to pharmacies amounted to €284 per capita (gross purchaser prices), higher than most neighbouring countries (Table 6.3). In 2005, drug expenditure per capita in France was 2.2 times higher than in Denmark, 1.8 times higher than in the Netherlands and Sweden, and between 40 and 80% higher than in Germany and the United Kingdom.

Table 6.3

Drug sales to pharmacies, as turnover per capita (euros, gross purchase prices) in 2004

Country	France	Germany	United Kingdom	Italy	Spain	Average
Per capita turnover, retailer sales	284	244	202	202	293	210

Annual per capita expenditure on drugs amounted to €544 in 2008, more than any other European country. Between 1995 and 2008, drug expenditure increased at an average rate of 5% per year, and it has been the largest contributor to the growth of health care expenditure. Therefore, despite regulated prices, the large volume of drugs purchased plus a relatively fast diffusion of new drugs has made France a rather profitable market for the pharmaceutical industry (Paris 2009).

6.6.3 Regulation of prescription patterns

In addition to policies directed towards the pharmaceutical industry, a number of measures have been taken to try to improve and limit the prescribing behaviour of physicians and as well as the consumption patterns of patients.

Regulation aimed at influencing prescribers has followed two different routes. First, in line with the aim of promoting the rational use of medicines, a system of practice guidelines was set up (see Section 6.3.3). Second, control of drug expenditure by doctors in private practice was increased by defining expenditure targets at the national and regional levels. In the reforms of 1996, the expenditure targets imposed on doctors made them responsible for the amount they collectively prescribed at the regional level. However, for legal reasons, it was not possible to define the sanctions applicable in cases where the target was exceeded, and this mechanism of collective responsibility was eventually dropped in 2000.

The promotion of generic drugs, largely non-existent until recently owing to the relatively low price of drugs in France (Lemorton 2008), first occurred in the 1990s. A ministerial order published in 1997 defined the concept of a generic drug. In 1999, regulatory changes gave pharmacists the right to substitute generic drugs for branded drugs, according to the parameters defined by SHI, while guaranteeing them, in cases of substitution, a profit margin equivalent to the margin that would have applied for the original product. In 2002, medical unions agreed to promote the prescription of drugs by their generic name (international non-proprietary name, INN) instead of their brand name, in exchange for a rise of the tariff for primary care visits. However, this has not been successful, and by the end of 2005 only 8.5% of all pharmaceutical prescriptions were made using the INN. Since 2006, agreements signed between SHI and pharmacists' unions define target rates of generic drug prescription. In 2008, 82% of drugs delivered by retail pharmacies were generic drugs, very close to the 82.9% target that had been set in the last agreement. Overall, the

generic drugs policy is considered to have been quite successful; it has been estimated that €500 million to €1 billion of savings can be attributed to the generic substitution policy between 2005 and 2007 (HCAAM 2008a).

Finally, in June 2008, the Ministry of Health decided to promote the development of self-medication and foster price competition in this market by allowing pharmacies to sell 216 non-prescription drugs on shelves that are directly accessible to the patient (“over the counter”). No evaluation of this policy has been published yet.

Overall, despite the number of reforms implemented since the end of the 1990s, the growth of drug expenditure remains high and stable. On the one hand, the government faces a difficult trade-off between two conflicting objectives, to contain health expenditures and to support the national pharmaceutical industry. On the other hand, physicians have been reluctant to modify their prescribing patterns. Reforms directed towards pharmacists seem to have been more successful.

6.7 Rehabilitation/intermediate care

Depending on a patient’s condition after acute treatment, rehabilitation care can be delivered in an inpatient or an outpatient setting.

Following a hospital stay for acute care, a patient would typically be transferred to an inpatient follow-up and rehabilitation unit (SSR) as soon as daily monitoring by acute care specialists is no longer necessary. The SSR unit might be a follow-up and rehabilitation unit or a specialized one (for example, in cardiology, neurology or orthopaedics), depending on patient needs. This SSR unit may be a single unit within a public hospital or a dedicated private hospital. The SSR unit then would discharge the patient home when she/he is able to perform daily life activities. Subsequent rehabilitation care would be performed by a physiotherapist working in an ambulatory setting and coordinated by the GP.

The private non-profit-making sector is historically the main actor in SSR, owning one-third of full-time and half of part-time SSR beds. The public sector represents 40% of full-time and 25% of part-time capacity. The private profit-making sector accounts for the smallest share (25% of both full-time and part-time capacities), but it has by far the fastest growing activity. Indeed,

between 2006 and 2007, the activity of the profit-making sector increased by 4.1% for full-time beds and by 3.4% for part-time beds, while the average growth in the sector was 2.1% and 1.4%, respectively (see Section 5.1).

The development of the SSR sector is associated with efficiency and equity issues (Larcher 2008). The development of follow-up units has been promoted since the late 1980s as a means to increase the efficiency of the health care system by allowing shorter stays in acute care hospitals. However, there are still wide geographical disparities, despite the continued growth of the sector: regional densities of full-time beds ranges from 0.9 to 2.1 per 100 000 inhabitants and disparities are even wider for part-time places, with densities ranging from 0.5 to 2.2 places per 100 000 inhabitants.

6.8 Long-term care

In France, long-term care for the elderly and disabled belongs to a specific sector of the social system that combines elements of medical and social care, and which is referred to as the “health and social care sector” or “third sector” (*le secteur médico-social*).

The sector was created in the 1970s, when it became clear that establishing a distinction between institutions belonging to the health sector and those belonging to the social sector, as required by the 1970 Hospital Act, would be impossible to implement, since many public hospitals hosted units that would provide both residential care and medical care to elderly or disabled people. An Act passed in June 1975, therefore, created a “health and social care sector”, which would primarily regroup institutions dealing with patients’ loss of functional autonomy.

The health and social care sector is split into two subsectors that encompass care for the elderly as well as for disabled people.

6.8.1 Residential care and treatment for elderly people

In January 2010, there were 14.6 million people aged over 60 in France (22.6%). In 2007, 8.1% of the people aged over 60 were receiving financial support for a loss of functional autonomy (see below); among them, more than 60% were receiving care in their homes, while less than 40% were receiving residential care.

Home care services

Home care is mainly provided by self-employed physicians and nurses and, to a lesser extent, by community nursing services (SSIAD), which deliver nursing care at home mainly using employed auxiliary nurses and to a lesser extent nurses, who are mostly self-employed. The authorization to run such a service (see Section 4.2) is given with a limit on the number of patients that the service is allowed to take charge of simultaneously, which is referred to as the number of “places” granted. In mid 2010, there were 2115 SSIADs, corresponding to a capacity to take charge of around 110 000 patients simultaneously (places). The vast majority of SSIAD places are dedicated to the elderly, and only a small share (5%) is reserved for disabled people. Two-thirds of SSIAD are private, mostly non-profit-making institutions; the remaining units are run by public institutions belonging to the health and social care sectors (see Section 3.3).

SSIADs are entirely financed by SHI funds that are managed by CNSA (see Section 3.3.1), who provide them a yearly prospective budget based on the number of places available (capitation method of payment). However, their payment method should be replaced from 2012 onwards by a case-payment method adjusted for the patient’s level of need.

Residential care services

Residential care for elderly people is provided by many types of institution offering different levels of service. These include:

- **Collective housing facilities** (*foyers logements*). These offer a range of nonmedical facilities (such as catering and laundry) and almost no medical care. In 2007, there were 3000 such establishments, offering 154 000 places.
- **Retirement homes** (*établissements d’hébergement pour personnes âgées; EHPA*). These accommodate the elderly but also offer medical care. In 2007, the total number of beds in these facilities amounted to 470 000.
- **Long-term care units** (*unités de soins de longue durée; USLD*). These accommodate people whose care requires constant medical monitoring. These units are provided in autonomous nursing homes or in hospital wards for very sick and dependent people. In 2007, around 70 000 beds were available in these institutions. These units do not belong to the health and social care sector for the elderly and disabled but to the health care sector. However, there is a plan to transfer a share of them (around two-thirds) into the health and social care sector and to transform them

into residential care homes for the disabled frail elderly (EHPAD; see below), where patients would not only receive medical care but also medico-psychological care.

There are great disparities in the distribution of these institutions. Some departments are also far better equipped than others, where capacity does not match population needs (the latter include, for example, Pas-de-Calais, Doubs, Landes, Hérault and Vendée) (Desmarescaux 2009).

Funding of these institutions is currently shared by the CNSA (through SHI funds) (see Section 3.3.1), general councils (*conseils généraux*) and users (see Section 3.3.4). On average in 2003, the monthly cost of a patient was estimated to be around €2550, payment being divided into SHI €750, general council €300 and patient €1500. However, there are great geographical disparities. In the Parisian region, out-of-pocket payment was estimated to be far higher, on average €2500 for the same year. The financial burden on patients is increasing and is estimated by the Inspector of Health and Social Affairs (*inspection générale des affaires sociales*; IGAS) to have risen to an average amount of €2200 and a minimum of €1500 in 2009 (IGAS 2009), resulting in great inequity of access across socioeconomic groups.

Intermediary services

In the early 2000s, intermediary services were created. These services receive, for a short period, the frail elderly not living in residential services. They care for patients on a daily basis (*accueil de jour*) or on a temporary basis (*accueil temporaire*). Their main goals are to offer respite care for families and day care for patients with Alzheimer's disease and other dementias. Following strong political support from the government, their capacities have reached 7500 for a daily care basis and 3600 for temporary care (out of which 1250 places are reserved for those with Alzheimer's disease) in January 2009. However, this is insufficient for the growing size of the population with Alzheimer's disease, and the 2008 Alzheimer's plan (see Section 6.8.3) forecasted a need to reach 11 000 and 5600 places, respectively, in 2012.

Evolution in financing

In order to meet the growing cost of care for the elderly, financing methods have changed over time, and allowances for the frail elderly to finance part of the services needed were created.

Until 1997, only two sources of funding existed for residential care: each bed was financed by the patient, who had to pay a daily fee (corresponding to the housing facilities), and SHI, which paid a daily fee according to complexity of

medical care that could be provided. Three different fees existed, corresponding to three different levels of care. In January 1997, a law introduced additional funding by general councils that was available in two forms (*loi de prestation spécifique dépendance*; Act no. 97-60 of 24 January 1997).

First, an individual dependency allowance (*prestation spécifique dépendance*; PSD) was set up. Funded by the general councils, it financed either the employment of people working at home to provide care and support or a share of care within institutions for heavily dependent people aged 60 and over. Evaluation of dependency levels and care needs was carried out by a joint health and social care team. The total allowance was means tested and subject to a fixed ceiling of €950 per month for a single person. It was established by decree. By the end of 2000, a total of around €60 million had been spent on the 140 000 people receiving this allowance, 53% of them living at home. The average PSD allowance was €414: €530 per month for those employing someone in their own home and €290 per month for those in institutions. However, the average PSD allowance varied widely between departments, irrespective of people's means, mainly because of differences in wealth between the general councils. Furthermore, the PSD did not develop as expected, as a great number of elderly did not want to benefit from this allowance because after their death general councils would retrieve the amount of the allowance from their estate.

Second, the 1997 Act modified the funding of residential care institutions. It introduced specific funding by the general councils for the costs associated with the loss of functional autonomy. Since then, all institutions have to sign a three-party-agreement for a five year-period (convention tripartite) with the general councils and the ARS (formerly DDASS) that specifies the details of the new financing scheme (by taking into account notably the level of complexity of medical care allowed). Institutions that have signed this agreement, EHPADs, agree to develop more advanced medical care and, as compensation, they receive additional funding. From 2006, the EHPAD financing method is of a capitation type adjusted for the average medical care needs and the average level of dependency of residents.

At the end of 2007, 515 000 residential care beds were funded according to this scheme, corresponding to 92% of the initial target. It is expected that facilities caring for elderly people with almost no loss of functional autonomy (mainly foyers logement) will remain outside of this scheme, as well as the long-term care units that take care of extremely dependent people, which will remain in the health care sector (see above).

In July 2001, as a response to the PSD shortcomings, a new individual allowance, the personal autonomy allowance (*allocation personnalisée d'autonomie*, APA) replaced PSD with the aim of increasing equity and eligibility to the allowance (Act no. 2001-647 of 20 July 2001). Unlike PSD, this is a uniform allowance throughout the country that cannot be retrieved from the person's estate. It is funded both by CNSA funds coming from the solidarity day and by CSG and general council funds (see Sections 3.3.1 and 3.3.4). It is managed by general councils. It is means tested and adjusted in relation to the individual's dependence level, living conditions and needs, as assessed by a joint health and social care team, but it does not depend on the wealth and priorities of the general councils. In practice, elderly people (aged over 60) who are dependent on support for daily activities could be entitled to an allowance of up to €1225 per month in April 2009.

By the end of 2009, 1136 million people were benefiting from APA – that is, eight times more than the number of people receiving PSD in 2000 – and 62% of APA beneficiaries were living at home. The average APA allowance was €441: €498 per month for those employing someone in their own home and €413 per month for those in institutions.

In 2008, the overall budget of APA was €4.9 billion, 33.4% of which was funded by CNSA funds and the remaining 66.6% by general council funds. Because of a growing number of beneficiaries, the CNSA share of total APA expenditure is decreasing overtime and provisional results for 2009 confirm this trend (Table 6.4). This has led to budget problems for general councils (especially the ones with a large elderly population and a low average level of wealth).

Table 6.4

Total personal autonomy allowance (APA) expenditure and National Solidarity Fund for Autonomy (CNSA) share, 2002–2009

	2002	2003	2004	2005	2006	2007	2008	2009 ^a
Total APA expenditures (million euros)	1855	3205	3591	3930	4243	4539	4860	5456
CNSA expenditure on APA (million euros)	798	1323	1338	1341	1411	1521	1599	1631
CNSA share of total APA expenditure (%)	43	41.3	37.3	34.1	33.3	33.5	32.9	29.9

Sources: Desmarescaux 2008, 2009.

Note: ^aProvisional results for 2009.

6.8.2 Residential care and treatment of disabled people

About 3.2 million people are registered as disabled in France, of whom 1.8 million are affected by a severe disability that limits their functional autonomy. Disability is measured in terms of an incapacity rate, which takes into account the degree of difficulty with daily living. Specific committees for children and for adults at the department level evaluate the rate of incapacity and determine the right to certain benefits. They also have the authority to refer the disabled person to a specialized institution.

Adults

Around 200 000 disabled adults are accommodated in 4800 dedicated facilities. Different types of institution provide services for disabled adults with different levels of functional autonomy. Broadly speaking, residential centres are linked to “centres for assistance through work” and take in people who are slightly disabled and who are capable of going to work during the day. Occupational centres take care of disabled adults who are not capable of working. They are split into different categories according to the severity of the disability and the need for care. There are four sources of funding for dedicated facilities for disabled adults (see Section 3.3.4); the health care part is paid by the CNSA on SHI funds while the costs of residential care are charged to the patient and/or to the general councils of the department. Institutions for the most heavily dependent people are financed entirely by the CNSA. Additionally, the state finances “helping through work” services (Table 6.5).

Table 6.5

Institutions of the health and social sector that provide services to disabled adults

Institution	Purpose	Funders^a
Specialized reception centres (<i>maisons d'accueil spécialisé</i>)	Cater for disabled adults who permanently need health care services	SHI
Medical reception centres (<i>foyers d'accueil médicalisé</i>)	Cater for severely disabled people who cannot work	SHI, general councils
Helping through work services (<i>établissements et services d'aide par le travail</i>)	Offer activities and help to disabled adults who have a below-average capacity to work	The state
Occupational rehabilitation centres (<i>centre de rééducation professionnelle</i>)	Offer professional training to disabled adult	SHI
Pre-orientation centres (<i>centres de pré-orientation</i>)	Used when a diagnosis is needed for further orientation in the system	SHI
Social support services for disabled adults (<i>services d'accompagnement médico-sociaux pour adultes handicapés</i>)	Devoted to severely disabled people, offering them care and support for professional and social integration	SHI, general councils

Companies for disabled people (<i>entreprises adaptées</i>)	Specific companies that are set up for disabled people but are included in the free market economy	The state
Break care health beds (<i>lits halte soins santé</i>)	Temporarily offering care and social support to the homeless	SHI
Temporary reception centres for disabled adults (<i>établissements d'accueil temporaire pour adultes handicapés</i>)	Respond to specific needs and support families	SHI
Experimental centres for disabled adults (<i>établissements expérimentaux pour adultes handicapés</i>)	Develop new forms of housing and care	SHI
Mutual aid groups (<i>groupes d'entraide mutuelle</i>)	Devoted to people with mental health-related disabilities and aim to bring new answers to their support needs	CNSA
Residential care homes (<i>foyers d'hébergement</i>)	Cater for disabled workers coming from the "helping through work services" or from companies for disabled people	General councils
Assisted living centres (<i>foyers de vie</i>)	Devoted to disabled people who are not able to work but who have some functional autonomy	General councils
Multipurpose reception centres (<i>foyers d'accueil polyvalent</i>)	Offer housing, care and activities to disabled people	General councils
Social life support services (<i>services d'accompagnement à la vie sociale</i>)	Facilitate access to community services	General councils

Note: ^aThe SHI funds presented in this table are managed by the National Solidarity Fund for Autonomy (CNSA).

Children

Nearly 130 000 disabled children are cared for in 2500 facilities. A large number of institutions offer treatment, special education and vocational training to children affected by motor, cerebral or intellectual disabilities. These institutions are mainly funded by the CNSA from SHI funds (Table 6.6).

Table 6.6

Institutions of the health and social sector that provide services to disabled children

Institution	Purpose	Funders ^a
Educational centres for children suffering from mental disabilities (<i>établissements d'éducation spéciale pour enfants déficients intellectuels</i>)	Aim to contribute to blossoming and social and professional autonomy	SHI
Institutions for children with multiple disabilities (<i>établissements pour enfants polyhandicapés</i>)	Offer adapted care and education to allow disabled children to become self-sufficient	SHI
Institutions for children with physical disabilities (<i>établissements pour enfants déficients moteurs</i>)	Offer care, education and general or professional training	SHI
Sensorial training centres (<i>instituts d'éducation sensorielle</i>)	Offer care and education to children with visual or auditory disabilities	SHI

Medico-psycho-educational centres (<i>centres médico-psycho-pédagogiques</i>)	Perform check-ups, diagnosis, screening for signs of potential disorders and provide care for children with mental health-related disabilities	SHI
Therapeutic and educational centres (<i>instituts thérapeutiques, éducatifs et pédagogiques</i>)	Offer therapeutic and educational support specifically adapted to each child or adolescent suffering from behavioral disorders	SHI
Home care and education services (<i>services d'éducation spéciale et de soins à domicile</i>)	Services delivered in disabled children's home environment	SHI
Early social activity centres (<i>centres d'action médico-sociale précoce</i>)	Offer early screening for motor, sensorial and mental disabilities	SHI, general councils
Temporary reception centres for disabled children (<i>établissements d'accueil temporaire d'enfants handicapés</i>)	Respond to specific needs and support families with disabled children	SHI
Experimental centres for disabled children (<i>établissements expérimentaux pour l'enfance handicapée</i>)	Develop new forms of housing and care.	SHI

Note: ^aThe SHI funds presented in this table are managed by the National Solidarity Fund for Autonomy (CNSA).

Disabled people may be eligible for monetary allowances that finance domiciliary staff or devices (see also Section 3.3.4). The disability compensation allowance (PCH), is an allowance that aims to finance the wages of people employed to provide assistance to disabled people or their families, or the necessary technical aids. It is funded by the general councils, the CNSA and the CSG funds and is not means tested. The general councils manage it. In 2008, PCH accounted for €550 million fully covered by CNSA funds; however, from 2010, general councils will contribute around a 10% share. This share should increase in the future because of the growing number of beneficiaries, which is increasing the burden of health and social care on general councils.

The special education allowance for children (AEEH) is an allowance funded by the Family Allowance Fund, which is a branch of the social security system; it is adjusted to the means of the parents. It aims to partially cover the costs of the child's education. Finally, expenses related to the disability can be partially or completely covered by the local authority once they have been agreed upon.

Additionally incapacity allowances (such as the *allocation aux adulte handicapé*; AAH) compensate the absence of income of disabled people who are unable to work, but they are not a health and social care sector benefit.

6.8.3 Challenges and recent reforms

Current challenges for the frail elderly sector are to provide enough services for meeting the forecasted needs of the ageing baby boomers without building excessive capacity and still ensuring equity of access. Therefore, recent reforms and future development mainly focus on three points:

- increasing the capacity of institutions to meet growing demand and developing new types of services;
- developing what is called the “maintaining at home” policy (*la politique du maintien à domicile*), which is based on “lighter” forms of care (such as family placements and assistance with care in the home), through promoting the development of home services, such as nursing home services and hospital at home services, and the creation of intermediate care services promoting better integration and autonomy between home and residential care services (see Section 6.8.1);
- financing such services and care and diminishing the economic burden of disability for frail elderly (out-of-pocket payment for the patient and their family).

In 2003, the French elderly population suffered a high death toll from the summer heat-wave; this became a turning point for the government, which has since then entered an active phase of policy development to address the three points described above (see Section 7.1.4).

Additionally, with the ageing of the population, a growing number of patients with dementia is expected. In order to face this challenge, an Alzheimer’s Disease Plan was issued in 2008 for a four-year period. It has three goals: improving the quality of life of patients and their relatives by developing appropriate treatment, care services and respite care for the relatives; improving knowledge of the disease by developing research; and informing the public about the disease.

In the early 2000s, challenges for the disabled sector were to provide sufficient capacity for residential care, to diminish out-of-pocket payment and to develop incapacity benefits that compensated the absence of income of disabled people who could demonstrate an inability to work. These were partly addressed by the 2005 Act for the “equality of rights and opportunities, the participation and citizenship of disabled people” (Act no. 2005-102 of 11 February 2005, *loi pour l’égalité des droits et des chances, la participation et la citoyenneté des personnes handicapées*).

Current challenges are to tackle the problem of financing transportation to care services and to improve further access to services for the disabled. Indeed, in 2005 in each department, a one-stop shop was created to inform disabled people on services and allowances available and to help them with administrative matters (*maisons départementales pour les personnes handicapées*; MDPH). However, MDPH are reported to be performing poorly and improvement is required (Desmarescaux 2009).

6.9 Services for informal carers

Rules governing the activity of informal carers are best presented in the overall legal framework for family support.

Although support within families is usually performed on a voluntary basis, France, as in other European countries, has a set of regulations that define the basic level of transfers among members of a family, such as the regulations governing inheritance.

Regarding informal care, the legal support obligation stipulates that basic support for daily living is expected between members of a couple and for all ascendants and descendants (but not between siblings). The law has a subsidiary function and is usually enforced by court when assistance will not be provided voluntarily, upon request from the person who is in need.

In contrast with this traditional perspective, concern about the growing burden of informal care for frail elderly people (especially those with Alzheimer's disease) has triggered the development of laws giving specific rights to the informal carers of dependent or disabled people. Eligibility for financial assistance in order to pay a salary to the carer depends on his/her relationship with the person in need. Financial assistance cannot be used for paying the carer when this is the spouse (or common law husband or wife) of the elderly person receiving APA or when this is the spouse, parent or child of the disabled person receiving PCH.

Finally, dedicated institutions at the city or local level (*départements*) or non-profit-making associations provide help to informal carers, such as information and counselling, psychological support and training.

6.10 Palliative care

Palliative care was officially recognized as part of the health care system in 1986. Palliative care structures have developed progressively since then, especially since the end of the 1990s, under the impetus of several national programmes. There are several types of inpatient and outpatient structures that contribute to palliative care.

Within hospitals, palliative care can be delivered within dedicated units, in dedicated beds in a given department or by a mobile palliative care team in any department of the hospital. Palliative care units are small specialized departments (with at least five beds) that must be able to provide continuous monitoring of the patient. They usually employ a multidisciplinary team with physicians, nurses and psychologists, as well as other paramedical staff. Some departments may develop their own palliative care capacity, under the responsibility of a referral physician and referral nurse, who must have received palliative care training; these palliative care beds may be accessible either for patients of the department or for all patients of the hospital. Mobile palliative care teams include at least one physician and one nurse, both with a palliative care degree, one psychologist and one personal assistant. The team may intervene in all departments of the hospital as well as in nearby hospitals; its mission is to assist and train personnel in all palliative care issues.

Palliative care networks are local associations that re-group physicians, nurses, psychologists and other professionals willing to assist GPs in palliative care issues. They visit patients at home upon the GP's request and help to coordinate care for the patient.

Volunteers who have been trained to support patients and their families can be involved in palliative activities, in accordance with the palliative care structure that is in charge of the patient's care. Such volunteers are present in most palliative care units as well as in some of the other structures.

In addition to these dedicated organizations, HAD units (see Section 6.4.1) contribute substantially to palliative care, with roughly one-third of patients in such units being at a palliative stage.

Palliative care capacity has been steadily growing since the late 1980s. By the end of 2007, French hospitals included 4000 beds dedicated to palliative care; there were 340 mobile palliative care teams in activity and 110 active palliative care networks. Nevertheless, palliative care capacity is still lower than the demand for these services and is very heterogeneous across regions.

The government has, therefore, launched two plans to develop palliative care during the last decade (in 2002 and 2008); accordingly, palliative care capacity is expected to continue growing in the years to come.

6.11 Mental health care

6.11.1 Mental health services and care

In France, services for mentally ill people are provided by both the health sector and the social and health care sector for the disabled. As in many other European countries during the second half of the 20th century, mental health care policy in France has been largely influenced by a general movement towards community-based organization of mental health care services – the so-called “deinstitutionalization” process.

Services and care provided by the health sector

Services provided by the health sector take the form of both public and private outpatient and inpatient care.

Adult public mental health care is provided within geographical areas of theoretically equivalent population size, called mental health care (*soins de santé mentale*; MHC) areas (*secteurs*). Care within each area is coordinated by a hospital (a public hospital in more than 90% of the cases) and includes a wide range of preventive, diagnostic and therapeutic services, which are provided in both inpatient and outpatient settings. In particular, ambulatory care centres (*centres médico-psychologiques*; CMP) are present in almost every MHC area; they provide primary ambulatory mental health care, including home visits, and direct the patients towards appropriate services.

In spite of the original planning process, the size and resources of MHC areas are quite heterogeneous. In 2003, the French territory was covered by 815 MHC areas. The average population covered by a MHC was 57 000 inhabitants, with significant disparities between the smallest and the largest areas regarding the size of population covered: the top 1% of MHC areas covered more than 133 000 inhabitants (two times the average) each, whereas the bottom 1% covered fewer than 33 000 inhabitants each (that is, half the average). Regarding available resources per inhabitant, a recent study showed that large differences exist between centres: for example, the number of beds for part-time care per inhabitant is more than 10 times higher in some areas than

in others; similarly, the number of full-time equivalent staff per inhabitant is between 3 and 10 times higher in some areas than in others, depending on the profession (Coldefy et al. 2009).

Public mental health care for children follows a similar territorial organization, with 321 areas covering an average of 46 000 people aged under 20 years (corresponding to an average of 210 000 inhabitants). These MHC areas for children show even wider geographical inequalities.

Overall, MHC areas account for 40% of psychiatric hospitals and 80% of psychiatric beds. With 11 000 hospital beds, the private profit-making sector accounts for 70% of the remaining full-time hospitalization capacity and is thus an important actor in the field of mental health care. Private profit-making hospitals are only marginally involved in outpatient treatment, but they account for 20% of cases involving inpatient care. They accept patients with psychiatric disorders on the same basis as public hospitals.

It should be noted that a large number of psychological disorders are dealt with on an outpatient basis by GPs (in 1997, 16% of GP consultations concerned a psychological problem or sleeping disorder) or private psychiatrists or psychologists, some of them practising psychotherapy and, occasionally, psychoanalysis. In 2004, there were around 13 500 psychiatrists in activity, and almost 50% of them were working in a private practice as their main professional activity. The density of psychiatrists was, therefore, slightly higher than 22 per 100 000 inhabitants in 2004, a figure that compares favourably with the density in Canada, in the United States and in the United Kingdom (with 12, 13.7 and 11 psychiatrists per 100 000 inhabitants, respectively), as well as with densities in Scandinavian countries (16–20 psychiatrists per 100 000 inhabitants). However, there is a shortage of psychiatrists in public hospitals in spite of this rather high density: in 2007, 25% of full-time permanent positions and 40% of permanent part-time positions were vacant. This shortage may be linked to the level of earnings or to the more difficult working conditions in the public sector, where the more seriously ill and potentially dangerous patients are treated and where administrative tasks may be higher (Milon 2009). Although no reliable figures are available, it is estimated that about 36 000 psychologists work in France, either as salaried employees or in private practice. Besides the psychotherapies mentioned above, they also offer psychological support and follow-up in the context of schools or as part of social welfare provisions.

Services provided by the health and social care sector for the disabled

People with severe mental illnesses that lead to disability also receive services from the health and social care sector for the disabled. Many organizations for the disabled (Tables 6.4 and 6.5 and Section 3.3.4) offer a wide range of services to mentally ill patients. These include housing, health care treatment, professional training, schooling for children and professional education. Only a

Table 6.7

Institutions of the health and social sector that provide services to adults with mental health related disabilities: overall capacity and share of the affected population served

Institution	Overall capacity (2006 or last year available)	Percentage of adults with mental health-related disabilities served (2006 or last year available)
Specialized reception centres (<i>maisons d'accueil spécialisé</i>)	19 622 ^a	10.60 ^a
Medicalized reception centres (<i>foyers d'accueil médicalisé</i>)	13 622 ^a	20.00 ^a
Helping through work services (<i>établissements et services d'aide par le travail</i>)	107 985	18.90 ^a
Occupational rehabilitation centres (<i>centre de rééducation professionnelle</i>)	9 833 ^a	10.40 ^a
Pre-orientation centres (<i>centres de pre-orientation</i>)	656	32.30 (2009) ^b
Social support services for disabled adults (<i>services d'accompagnement medico-sociaux pour adultes handicapés</i>)	1 675 ^a	20.00 ^a
Companies for disabled people (<i>entreprises adaptées</i>)	na	4.50(2001) ^c
Break care health beds (<i>lits halte soins santé</i>)	501 (beds; 2007) ^d	29.10 (1995) ^e
Temporary reception centres for disabled adults (<i>établissements d'accueil temporaire pour adultes handicapés</i>)	182 ^a	3.1 ^a
Experimental centres for disabled adults (<i>établissements expérimentaux pour adultes handicapés</i>)	3 994 ^a	27.9 ^a
Mutual aid groups (<i>groupes d'entraide mutuelle</i>)	na	100 ^a
Residential care homes (<i>foyers d'hébergement</i>)	38 526 ^a	15.7 ^a
Assisted living centres (<i>foyers de vie</i>)	42 944 ^a	16.5 ^a
Multipurpose reception centres (<i>foyers d'accueil polyvalent</i>)	4151 ^a	17.0 ^a
Social life support services (<i>services d'accompagnement à la vie sociale</i>)	24 434 ^a	18.0 ^a

Sources: Ministère de la santé 2005; ^aDREES 2006; ^bMinistère du travail, des relations sociales, de la famille et de la solidarité et de la ville 2010; ^cDREES 2001; ^dFNARS 2008; ^eMarpsat 2002.

few of them are fully dedicated to this population; otherwise these organizations provide services for patients with other causes of disability. Tables 6.7 and 6.8 show institutions of the health and social sector that provide services to adults and children with mental health-related disabilities and the share of the affected population for whom they provide services.

Table 6.8

Institutions of the health and social sector that provide services to children with mental health-related disabilities: overall capacity and share of affected population served

Institution	Overall capacity (2006 or last year available)	Percentage of children with mental health-related disabilities served (2006 or last year available)
Educational centres for children suffering from mental illnesses (<i>établissements d'éducation spéciale pour enfants déficients intellectuels (dont jardins d'enfants spécialisés, IME, IMP, IMPRO)</i>)	70 012 ^a	17.00 ^a
Institutions for children with multiple disabilities (<i>établissements pour enfants polyhandicapés</i>)	5 030 ^a	2.00 ^a
Institutions for children with physical disabilities (<i>établissements pour enfants déficients moteurs</i>)	7 352 ^a	2.00 ^a
Sensorial training centres (<i>instituts d'éducation sensorielle</i>)	8 409 ^a	1.90 ^a
Medico-psychoeducational centres (<i>centres médico-psycho-pédagogiques</i>)	2 644 000 (consultations, 2003) ^b	100 (2003) ^b
Therapeutic and educational centres (<i>instituts thérapeutiques, éducatifs et pédagogiques</i>)	14 962 ^a	93.90 ^a
Home care and education services (<i>services d'éducation spéciale et de soins à domicile</i>)	33 836 ^a	22.30 ^a
Early social activity centres (<i>centres d'action médico-sociale précoce</i>)	na	20.00 (2008) ^c
Temporary reception centres for disabled children (<i>établissements d'accueil temporaire d'enfants handicapés</i>)	284 ^a	6.00 ^a
Experimental centres for disabled children (<i>établissements expérimentaux pour l'enfance handicapée</i>)	593 ^a	17.60 ^a

Sources: ^a DREES 2006; ^b Coldefy 2005; ^c CNSA 2008.

6.11.2 Challenges and reforms

In spite of the deinstitutionalization reform in the second half of the 20th century in France, evaluation studies and reports that were produced during the 1990s created a general consensus that the mental health care system suffered from several shortcomings. Specifically, international comparisons on mental health care expenditures seem to suggest that France spends less on mental health than many other European countries, while mental health indicators for the French population do not compare favourably: in a 2004 study commissioned by the EU (Kovess et al. 2004), France ranked poorly for several indicators, such as positive mental health (8 out of 11), psychological distress (3 out of 11), depression and anxiety disorders (6 out of 6), suicide rate of males and females (14 and 15 out of 15) and consumption of psychiatric drugs (for which France ranks highest).

More precisely, critics of the MHC area system focused on the lack of coordination among the health and social care sector, self-employed medical professionals and specialists and the private profit-making sector; the important geographical inequalities regarding available resources; and the excess of full-time hospitalization capacity (resulting from the deinstitutionalization process, which is largely incomplete) (Couty 2009).

In order to respond to these recurring concerns, the government launched a quadrennial mental health plan in 2005, the Psychiatry and Mental Health Plan 2005–2008 (*le plan psychiatrie et santé mentale 2005–2008*). It had four stated objectives: improving coordination between psychiatric and preventive mental health care; reinforcing informal carers' rights; improving the quality of care and research; and introducing targeted programmes for specific diseases or patient groups. This plan, while well-received by most stakeholders, is believed to have been insufficiently funded in order to make a drastic change in the provision of mental health (Mousquès 2005b). The government has been considering a new mental health plan, but it has not been launch yet and measures are currently implemented in continuity with the 2005–2008 plan. Finally, it should be noted that a new system of activity-based financing for psychiatric hospitals and MHC areas is currently being considered in order to replace the current prospective global budget.

6.12 Dental care

Dental care in France is provided mainly by self-employed practitioners, who represent 91% of the roughly 41 000 practitioners in activity in 2009. The remaining 9% are salaried staff within health centres specialized in dental care (see Section 6.3.4) or in a hospital.

Oral health of children has improved during the last decades: the average number of impaired teeth (the aggregate decayed-missing-filled index) of 12-year-old children has decreased from 4.2 in 1987 to 1.9 in 1998 and 1.2 in 2006, which is similar to Italy and Spain but far below Germany and the United Kingdom. Moreover, substantial socioeconomic disparities remain, which can be related to the inequalities in access and the lack of comprehensive prevention programmes that prevailed until 2004.

The cost of dental care is substantial: expenditure related to dental care represents 20% of all ambulatory care expenditure. This expenditure is mainly covered by VHI (30–50%). SHI covers one-third of dental health care expenditure, with significant discrepancies depending on the type of care: 40% of expenditure for conservative dental care is covered, but only 33% of prosthetic care and 10% of orthodontic care. Accordingly, a substantial part of expenditure for dental care is financed by out-of-pocket payments, giving rise to substantial inequalities in access: in 2006, a survey estimated that 9% of the population had forgone dental health care during the past 12 months because of financial reasons, while 14% declared that they had forgone care of some type (Allonier et al. 2008).

Access to dental care services is indeed strongly related to socioeconomic status. The 1999 Social Protection and Health Survey showed that, while 5% of the population had seen a dentist during the month of the study, the probability of having received dental care increased with education level, income and health insurance coverage; for instance, managerial staff and senior executives were twice as likely to have received dental care than agricultural and unskilled workers (Rochereau, Azogui 2007).

Since 1999, the three major schemes of SHI have tried to reduce these access inequalities by offering free dental care examinations for teenagers. The programme was initially directed towards teenagers aged between 15 and 18; in 2003, it was extended to teenagers between 13 and 15. However this programme, which relied on invitation letters sent to people's homes, seems

to have improved the oral health of teenagers who were already likely to seek dental care but to have failed to do so among the target population that was in most need.

In 2004, the government introduced an objective related to dental care in the Public Health Act and in 2006 introduced a new programme of oral health examination for children: since 2007, an annual oral care examination is offered to all children aged 6, 9, 12, 15 and 18, and all subsequent care is fully covered by SHI; additionally, one-hour long oral health prevention sessions must be scheduled for all children in primary school. Initial evaluations show that the programme has been successful: from 2007 to 2009, participation in the free examinations has increased from 15 to 40% among 6-year-old children, and from 12 to 25% among the 18 year olds; overall, the rate of 6-year-old children visiting a dentist at least once a year increased from 25% to 50% between 2006 and 2009 (Caisse nationale d'assurance maladie 2010).

6.13 Complementary and alternative medicine

There is no general regulation and very few data regarding complementary and alternative medicines in France. Some of the drugs and practices that may fall under this category, such as homeopathy, acupuncture and, to a lesser extent, osteopathy, actually play a significant role in the French health care system. Recent debates have emphasized the need to monitor the development of diverse and mostly uncontrolled health-related practices in order to limit fraudulent activities.

France is the largest national market for homeopathic products and hosts the world's largest producer of homeopathic products. These products are regulated by the public health code, which provides a definition for homeopathic drugs and distinguishes between two types of homeopathic substance, which fall under different regulatory frameworks. First, products that are extremely diluted (so that they are considered innocuous), which are administered orally or by external application, and which are commercialized without any pre-specified therapeutic purpose, need only to be declared to the AFSSAPS before commercialization. They may be covered by SHI at 35% and, in that case, their price is regulated. These represent the vast majority of homeopathic products. Second, all other homeopathic products (notably those that are being sold with a specific therapeutic indication) must follow the AMM process for

new drugs before entering the market and are not covered by SHI. Distribution of homeopathic products is subject to the same restrictions as conventional drugs.

Acupuncture has been recognized as a medical activity in the common classification of medical activities for more than 20 years and is covered by SHI with a tariff that is currently half the tariff for a standard GP visit.

Finally, osteopathy sessions, while not recognized as a medical activity, are covered by a number of VHI contracts, often on an annual lump sum basis.

6.14 Health care for specific populations

In addition to the health care delivery structures outlined in the above sections, specific structures provide care for some populations.

Since 1994, the public health care sector is responsible for delivering care to prisoners. Each prison contracts with an acute care referral hospital from the public sector that will run an ambulatory care department within the prison walls. In addition, the hospital will provide inpatient care for the prisoners whenever needed. Mental health care is organized similarly. The transfer of responsibilities for the delivery of health care from the penitentiary administration to the health care administration has improved the quality of care delivered to prisoners; current concerns are related to access to mental health care in prison (Guérin 2003).

Hospitals in the military health care system are run by the Ministry of Defence. Although their primary aim is to provide care to military personnel, the general population also has access to these hospitals.

Illegal immigrants, refugees and asylum seekers usually receive emergency care in the mainstream health care system. In addition, they may be allowed temporary stay and working permits if they are facing a serious medical condition that cannot be treated effectively in their own country. Finally, a few private non-profit-making associations provide care to illegal immigrants, refugees and asylum seekers, regardless of their administrative status.

7. Principal health care reforms

7.1 Analysis of recent reforms

7.1.1 The defining characteristics and reforms of the French health care system

As noted in the previous sections, the French health care system combines elements of various organizational models:

- it lies between the Beveridge and Bismarck models, combining SHI and strong state intervention;
- it combines public and private health insurance, which finance the same services by the same providers for the same populations;
- it combines public and private care, including private profit-making hospitals;
- it is a publicly funded system characterized by a high level of freedom of choice and largely unrestricted access for patients and freedom of practice for professionals;
- it is complex and pluralistic in its management, with co-management by the state and SHI.

This mixed system of organization reflects a balance between different values, such as equity, freedom and efficiency, but it also generates structural difficulties that have provided the impetus for health care reforms since the late 1980s; major reforms are presented in Box 7.1.

Box 7.1**Major health care reforms and policy measures, 1990–2009****1990–1991**

- Evin Act (Act no. 91-32 of 10 January 1991) regulating direct and indirect advertising of alcohol and tobacco, prohibiting smoking in public places and excluding the price of tobacco from the general price index to allow it to increase more freely.
- Restriction of doctors' access to sector 2.
- Introduction of the General Social Contribution (CSG) to enlarge the social security financing base.
- Hospital Act (Act no. 91-748 of 31 July 1991) setting up regional health organization plans (SROS) as a tool for planning hospital equipment capacity at the regional level.

1992

- Introduction of quantified national targets setting expenditure ceilings in the medical sector, in nursing care and in private profit-making hospitals, with options for imposing penalties in cases where targets are exceeded.

1993

- Teulade Act (Act no. 93-8 of 4 January 1993) concerning relations between health care professions and SHI including, in particular: the setting of ceilings for growth in health care expenditure; the introduction of mandatory practice guidelines (RMOs); the establishment of a basis for the coding of medical procedures and of diagnoses; and the creation of regional unions of self-employed doctors (URML), with the intention that they should participate in analysing the health care system and its components, monitoring the quality of treatment and promoting public health action.
- Doctors' agreement with SHI of 21 October 1993 bringing the Teulade Act into force: ceilings for expenditure growth and setting out of mandatory guidelines (RMOs).
- Act on the Medical Safety of Blood Transfusions and Medicines (Act no. 93-5 of 4 January 1993) creating the Blood Agency and the Medicines Agency, which is now replaced by the AFSSAPS.

1994

- Creation of the French Institute for Transplants (Act no. 94-43 of 18 January 1994).
- Framework Agreement of 24 January between the government and the pharmaceutical industry, envisaging a revision of prices if consumption volume exceeds a fixed level.

1995

- Announcement of the Juppé Plan, 15 November.. Important stages in reform developments:

- institutional reforms and, in particular, the new role of parliament in regulating health expenditure, the establishment of regional hospital agencies, modification of the respective responsibilities regarding SHI governance of the government and of SHI;
 - measures aimed at greater equity through the extension of health insurance coverage to the whole population on the basis of residence in France;
 - improvement in the quality of treatment (lengthening the duration of medical training, compulsory continuing medical education, RMOs, and accreditation of hospitals);
 - possibilities for experimentation in new ways of delivering care.
- Act authorizing the government to legislate by ordinance to reform social protection (Act no. 95-1348 of 30 December 1995).

1996

- Constitutional Act (no. 96-138 of 22 February 1996) introducing annual legislation on social security finance (the Social Security Finance Act), estimating the receipts of social security bodies for the year to come and setting a growth target (ceiling) for total health care expenditure by SHI; the annual Act also approves the government's policy directions in health and social security.
- Following on from the Juppé Plan, three ordinances were adopted:
 - Ordinance 96-344 on measures concerning the organization of social security, defining the respective responsibilities of the state and the social security system;
 - Ordinance 96-345 relating to the control of the expenditure of health care professionals, introducing the possibility of separate agreements for GPs and specialists and providing for expenditure limits on treatment in private practice;
 - Ordinance 96-346 concerning the reform of public and private hospitals, with the creation of regional hospital agencies.
- The first Social Security Finance Act (Act 96-1160 of 27 December 1996) introducing the first stage of the transfer of earnings-related health insurance contributions to the CSG, fixing a national expenditure ceiling for health insurance (ONDAM) based on total resources, and setting priorities in public health.
- Creation of the Agency for Accreditation and Evaluation of Health Care (*Agence nationale d'accréditation et d'évaluation en santé* (ANAES), which became HAS in 2004).

1997

- The 1998 Social Security Finance Act: replacement of almost all earnings-related health insurance contributions with the CSG at the rate of 5.1% of earned income.
- The government divides up the total financial budget for hospitals between the regions, with the aim of reducing regional inequalities.
- Signing for the first time of an agreement on targets and management (*convention d'objectifs et de gestion*) between the government and SHI for a three-year period.
- Scheme for early retirement of self-employed doctors.

Box 7.1 (continued)**Major health care reforms and policy measures 1990–2009**

- Creation of an individual dependency allowance (*prestation spécifique dépendance*; PSD) for frail elderly.

1997–1998

- Innovation with regard to doctors' agreements with SHI: adoption of an agreement for GPs and minimum contractual regulations for specialists as a result of failure to reach agreement with specialists' professional representatives; introduction of the referring GPs scheme, targets for regional expenditure, new RMOs, promotion of generic drugs and use of information technology.

1998

- Act (no. 98-535, *loi relative au renforcement de la veille sanitaire et au contrôle de la sécurité sanitaire des produits destinés à l'homme*) reinforcing medical safety, with the creation of the National Institute for Public Health Surveillance (InVS), the French Agency for the Health Safety of Food Products (AFSSA), and the French Agency for the Medical Safety of Health Products (AFSSAPS).
- The 1999 Social Security Finance Act introduces payment of a penalty contribution by pharmaceutical companies, based on their turnover, in the event of pharmaceutical expenditure in excess of ceilings set.

1999

- Introduction of pharmacists' rights to substitute generic for brand drugs.
- Introduction of a reference to health care networks in the social security code.
- Clauses in the 1998 General Practitioners' Agreement with SHI concerning penalties in cases of failure to take account of RMOs are declared illegal (Decree of the Council of State of 10 November).
- Announcement by SHI of a proposed policy for "quality health care for all" aimed at a substantial reduction of SHI costs: definition of a 'basket of care' and adjustment of reimbursement rates in light of medical effectiveness. This policy was much disputed and was eventually rejected by the government, but debate continues, in particular on the basket of care.
- The 2000 Social Security Finance Act: restriction of the areas of expenditure managed by SHI, defining an allocated expenditure target covering treatment in private practice, excluding pharmaceutical costs; ONDAM growth rate set at 2.4%.

2000

- Implementation from 1 January of the Universal Health Coverage Act (CMU Act, no. 99-641 of 27 July 1999).

- The 2001 Social Security Finance Act: alignment of benefits for self-employed people with those of the general health insurance scheme; extension for five years of experiments with provider networks (allowing specific payments for coordination of care and delegation of the management of these experiments to regional level); creation of the Technical Agency for Hospital Information (ATIH); creation of a “fund for the promotion of medical and medical-economic information”.

2001

- New rules applied to the reimbursement of medical devices, according to their medical value.
- Introduction of a new allowance for frail elderly, the personal autonomy allowance (APA), to replace PSD.
- Reform of medical training, endowing general practice with specialty status.
- The 2002 Social Security Finance Act allowed doctors to prescribe drugs using generic names; introduces a specific budget for experiments with provider networks.

2002

- Act on Patients' Rights and Quality of Care (Act No 2002-303, 4 March 2002): enhancement of the collective and individual rights of patients (including improved access to medical records); development of continuing education for health care professionals and evaluation of professional practices; and compensation of patients for accidents occurring without any fault on the part of the health care professionals involved.
- A contractual convention reforming the agreement system between SHI and health care professionals (Act no. 2002-322 of 6 March 2002). The new agreement system comprised three levels: the first set up common rules for all professionals; the second contained specific items for each profession; the third allowed SHI to make contracts with individual professionals willing to engage in specific projects (networks, health promotion, etc.).
- Targeted agreement on good practice signed between GPs and SHI binding increases in fees to commitments of good practice (prescription of generic drugs and decrease of SHI expenditure for unjustified home visits).
- Introduction of the Hospital 2007 plan to be implemented over five years, comprising a payment per case system (a type of DRG system), an ambitious programme of investment and the simplification of the planning process.
- The 2003 Social Security Finance Act announced, among other things, the implementation of: a DRG system of payment for hospitals; reference prices for drug groups with generic drugs; the partial liberalization of prices for innovative drugs; the simplification of the hospital planning process; and budgets for investment in hospital facilities.

Box 7.1 (continued)**Major health care reforms and policy measures 1990–2009****2003**

- Ordinance no. 2003-850 (4 September 2003; *l'ordonnance portant simplification de l'organisation et du fonctionnement du système de santé*) simplified hospital and other medical facility planning by merging it into a single tool, the regional strategic plan. The ordinance also decentralizes almost all types of authorization for hospital activities, facilities and other medical equipment to the regional hospital agency.
- Creation of the High Council for the Future of Health Insurance (HCAAM). In order to propose solutions for the modernization of the health insurance system, it gathered all stakeholders to build a common diagnosis of challenges and problems and suggested solutions as a basis for a reform in 2004. It is still operational and it produces a yearly report with recommendations.
- Drug delisting and reduced reimbursement of pharmaceuticals following the Decree of 27 October 1999 reaffirming the idea of reimbursing pharmaceuticals according to the medical service rendered, with two objectives: first, to promote the use of the most effective and innovative treatments, and, second, to reduce national health expenditure on medicines.
- The ageing and solidarity plan followed the heat-waves, which were associated with the deaths of approximately 15 000 frail elderly people. It aimed to improve living conditions and care of frail elderly and disabled people.
- The 2004 Social Security Finance Act detailed the implementation of the DRG system payment per case for hospitals.

2004

- The Health Insurance Act (no. 2004-810, 13 August 2004) renews the organization and the management responsibility of SHI by increasing its competencies regarding the financial stewardship of the health care system, the definition of the health benefit package and the regulation of prices and tariffs, and the negotiation of collective agreements with providers. It also created the National Health Authority (HAS), which is an independent arms' length agency that replaced ANAES and is in charge of providing advice to the Ministry of Health and SHI on services, goods and procedures and auditing/accrediting health care professionals and firms.
- The coordination in health care policy was developed in order to improve the coordination and organization of the access and process of care for patients by introducing several financial incentives: a gatekeeping primary care system plus a referral system for access to secondary care (the preferred doctor scheme); and an electronic personal medical record (DMP) for the management of care, which was intended to be in place by 2007 but is currently still under development.
- The health insurance vouchers plan "*aide complémentaire santé*" was established. It aimed (1) to extend the population that might benefit from voluntary health insurance, (2) to offset the negative impacts of the threshold effect that occurred following the implementation of the universal Health Coverage Act dedicated to the poorest (that is,

people at the margin of the CMU income ceiling), and (3) to start regulating the voluntary health insurance market. The voucher is a grant aiming at lowering the supplementary insurance contract cost.

- A set of measures was adopted to regulate hospital drugs, aimed at containing expenditures while guaranteeing accessibility to costly innovative drugs; costly innovative drugs were excluded from the new DRG system method of financing hospitals and paid separately. The measures specified that, in order for hospitals to be fully reimbursed for the use of such drugs, drug use guidelines should be issued and hospitals would have to agree with the regional hospital agencies on contracts on the good use of these drugs. Moreover, the prices of these drugs would not be freely set between the hospital and the manufacturer; a ceiling price would be set by the government.
- The Public Health Act (no. 2004-806 of 9 August 2004) reformed the public health system. It defined the role and the responsibility of the state in public health policy at the national and regional levels, defined five-year term public health measures, and identified a set of 100 health-related issues as public health priorities for the 2005–2009 period. Five national plans were issued in order to help to achieve these aims: the Cancer Plan; the Violence Plan, Addictions and Risk Behaviours Plan; the Environment and Health Plan; the Plan for the Quality of Life of Patients with Chronic Diseases; and the Plan for providing Health Care to Patients with Rare Diseases. This law was the first attempt to transform the organization of public health in France since 1902.
- The Solidarity Act for frail elderly and disabled people created the national solidarity fund for autonomy (CNSA), which would be funded through the SHI budget devoted to this population together with the creation of a new tax called “solidarity and autonomy contribution”, which would be generated from the revenue of an unpaid working day for the French working population, the solidarity day (approximately €2 billion).

2005

- The psychiatric and mental health care plan was set for the period 2005–2008 with four aims: (1) to improve the mental health care supply; (2) to improve the involvement of patients, their families and health professionals in policy decisions concerning mental health care and to address challenges linked to stigma and discrimination; (3) to improve quality of care and research in this area; and (4) to implement programmes for specific disorders or population groups.
- The pharmaceuticals plan developed several measures with the aim of reducing drugs expenditure.
- The DRG payment financing method was implemented for private hospitals, which would be paid entirely through this method as of 1 March 2005, and would be gradually implemented in public hospitals. However, a transition period was allowed where “national prices” could be adjusted for each provider taking into account their own historical costs/prices.
- Introduction of flat co-payments in order to decrease SHI expenditure. These payments are €1 for every doctor’s visit, up to a ceiling of €4 per day and €50 per year for biological and radiography tests. This means that €1 is taken out of SHI participation towards the patient’s visit fee. Strong incentives were developed to discourage voluntary health insurance from covering these co-payments (*contrats responsables*).

Box 7.1 (continued)**Major health care reforms and policy measures 1990–2009****2005**

- A National Observatory of Health Professionals (ONDPS) was created in order to follow and supervise the evolution of the health professional work force. In a context of expected shortages, it aimed to provide information on current and future needs for health professionals in order to reform the planning and education of the health workforce as well as to promote coordination between the main stakeholders at national and regional levels.

2006

- The demographic plan for health professionals was introduced to improve access to health care and reduce existing geographical variations in the distribution of health professionals. It developed incentives for doctors to practice in medically deprived areas and proposed measures for improving doctors' working conditions and increasing the number of practising doctors.
- Exclusion of 152 drugs with low medical value from the SHI positive list.
- The Smoking Ban Act made smoking illegal in public areas from January 2007 and was extended to restaurants and cafés in 2008.

2007

- The 2007 nurses' agreement with SHI introduced for the first time territorial regulation (as opposed to merely incentives) for health professionals' geographic distribution in order to deal with regional shortages in nursing supply.
- The creation of a new insurance scheme for financing long-term care and increasing the revenue of the national solidarity fund for long-term care was announced by the government. For financial reasons, this reform was postponed many times to 2009 and then to an undefined date.
- The 2008 Social Security Finance Act introduced the use of economics in health technology assessments conducted by HAS.

2008

- Introduction of a €0.5 deductible for each package of drugs bought, with disincentives for complementary insurance to cover it.
- Creation of individual GPs' contracts (CAPI) with SHI, to be in place from 1 January 2009. These aimed to improve the quality of care for chronic diseases and to encourage preventive medicine and efficient prescribing. This can be considered as a step towards the introduction of pay for performance for GPs.

2009

- The 2009 Hospital, Patients, Health and Territories Act (no. 2009-879, 21 July 2009; HPST) aimed at: improving regional governance by creating regional health agencies (ARSs), which merged and replaced regional hospital agencies, regional health insurance funds and other regional state and SHI institutions. This move was intended to improve local access and quality of care, improve preventive medicine, and modernize the organization of hospitals by creating local hospital communities.

2010

- Introduction of a 15% coverage rate for drugs with insufficient relative medical benefit (SMRi), to replace a 35% rate.

In sum, the objectives of the reforms to the health care system since the end of the 1990s have been:

- to contain SHI expenditures without damaging equity in financial access to care;
- to increase geographic equity in access to care;
- to meet the increasing demand for long-term care.

Decentralization and a change in the balance of power between the state and SHI were the main instruments used to achieve these objectives.

7.1.2 A move towards a less centralized governance of the system

The institutional complexity of the French health care system and the conflicts of power and legitimacy associated with it are major issues, particularly with regard to the relationship between the state and SHI. Reforms, therefore, tend to search for institutional equilibrium.

Since the late 1980s, there has been substantial reorganization, with a process of decentralization at the regional level, an increase in the role of parliament and an attempt to clarify the respective roles of the state and SHI.

New governance: more power for SHI?

Before the 1990s, SHI was mainly responsible for the private sector (ambulatory care provided by self-employed professionals and treatment in private profit-making hospitals), which was regulated through professionals' national agreements with SHI. Public hospitals and the pharmaceutical industry

were regulated at the national level by the government. The state also took responsibility for hospital planning at the regional level (including private profit-making hospitals).

Since the 1996 reform, the state has assumed new responsibilities through:

- the annual Social Security Finance Act and the involvement of parliament in this Act; the focus of parliamentary debate is mainly financial, but it has gradually encompassed health policy issues;
- the allocation of the national ceiling for health insurance expenditure (ONDAM) (set by parliament) between different health sectors;
- the responsibility for negotiating with private profit-making hospitals (and, therefore, the entire hospital sector).

However, in spite of attempts to clarify the division of responsibilities in the system of governance between the state and SHI, the relationship has remained unclear and has been marked by periods of open conflict, with a trend towards increasing state control regularly denounced by SHI. This tension reached a critical point in September 2001, when employers withdrew from the boards of SHI.

The 2004 SHI reform renewed the organization and the management responsibilities of SHI by increasing its competencies in three areas: the definition of the health care benefit package and the regulation of prices and tariffs, the negotiation of the professionals' collective agreements, and the financial stewardship of the health care system.

- **Definition of the health care benefit package and the regulation of prices and tariffs.** Responsibility for the definition of the health benefit package was moved from the Ministry of Health to SHI in the case of medical procedures. However, the Ministry of Health kept in house the definition of the positive list for drugs and devices. SHI is also, since then, in charge of setting the tariffs for procedures and defining the coverage rate. SHI's decisions are informed by the advice of two newly created bodies independent from the state: the National Health Authority (HAS), which replaced the National Agency for Accreditation and Evaluation in Health Care (*agence nationale d'accréditation et d'évaluation en sante*; ANAES), and the National Union of Complementary Health Insurance Organizations (UNOCAM).

- **Negotiation of the professionals' collective agreements.** SHI was already in charge of negotiating with the representatives of the self-employed health professionals (the wages and working conditions of hospital staff are defined by the government). Since this reform, the result of the negotiations no longer needs to be approved by government, including the Ministry of the Budget, Public Accounts, the Civil Service and State Reforms. The agreements can only be invalidated on legal grounds. SHI, therefore, has full responsibility for the financial consequences of the agreements negotiated and bears the financial risk.
- **Financial stewardship of the health care system.** As a consequence of these changes, SHI's financial stewardship of the health care system has been increased. Prior to the reform, SHI was held accountable for the financial balance of the system but it did not have any possibility of controlling it in order to stay within the limits of the national ceiling for health insurance expenditures (ONDAM) defined by the parliament (see Section 3.4). Indeed, the Ministry of Health held control of all such financial mechanisms, including pricing, SHI coverage rate, positive lists, and so on. However, the reform has provided tools to SHI for more control of expenditure by giving more power to SHI in negotiating the collective agreements with providers, in defining the benefit package and in negotiating prices and tariffs.

The 2004 reform has clarified the respective fields of responsibility of the Ministry of Health and SHI. However, the shift of financial stewardship from the Ministry of Health to SHI is weaker than it could have been. As stated above, the Ministry of Health kept in house the decisions on coverage and pricing for drugs and devices. SHI's decision-making power on the rate of coverage of goods and procedures is further weakened because it is directly derived from the level of medical benefit assessed by HAS. Moreover, with regard to professionals' agreements, the government participates indirectly in the negotiation between SHI and professionals. Professionals' representatives continue to lobby the Ministry of Health, which retains a strong role in the negotiations (Ettelt et al. 2010).

Deconcentration at the regional level

Although some steps towards deconcentration in the health care sector at the regional level had already been taken, the 1996 reform introduced major changes, setting up three new institutions in each of the 26 regions (see Section 2.4 for full details):

- a regional hospital agency (ARH)

- a regional union of the SHI funds (URCAM)
- a regional health conference (CRS).

This trend towards decentralization contrasts with the policies of the previous two decades, which were characterized by a centralizing tendency. This first stage in decentralization was criticized for having created new actors without dismantling existing administrative and organizational structures, leading to a complex system with an increasing number of points of conflict.

Therefore, in March 2002, an Act created a regional council on health by merging several commissions; then in June 2009, the Hospital, Patient, Health and Territory Act (HPST Act) (see Section 7.1.3) constituted a further step forward in the deconcentration process. In each region, it merged and replaced several regional state and SHI institutions, such as the Regional Hospital Agency, the Regional Union of SHI funds and other bodies responsible for organizing and financing health and social care at the regional level, by creating regional health agencies (ARSs). These agencies, set up in April 2010, have the mission to define regional objectives to ensure fair access to quality care by, among other things, improving coordination among the hospital, ambulatory and health and social care sectors (see Sections 2.4 and 4.2).

In conclusion, decentralization in the French context is a form of deconcentration, where policies and frameworks are defined at the central level and implemented at the local level, adapted to local situations. Overall, despite reforms, the Ministry of Health and the government remain the main decision-makers in health care in France. Power at the national level is significant even when compared with other countries such as England, considered to be highly centralized (Ettelt et al. 2010). While the creation of ARSs in 2010, which are autonomous bodies, can be perceived as a step towards devolution, the Ministry of Health has retained the power to nominate the director of each ARS (see Section 2.4).

7.1.3 Containing SHI expenditures while maintaining equity in financial access

Cost containment: a permanent goal of the French health care system

Following the oil crisis of 1974, economic growth slowed and unemployment spread in France, making it increasingly difficult to sustain a system of health care funding that relied on wages. Cost containment thus became the main goal of the French health care system reforms that followed and remains a major objective.

Compared with national health systems, the organizational structure of French health care system makes the goal of cost containment more difficult to achieve. Indeed, controlling expenditure is a complicated task when the freedom of consumption by patients and of provision by providers is unrestricted, where care is largely publicly funded and retrospectively reimbursed and where local SHI funds do not have real financial responsibility but are often described as blind payers reimbursing care without having any information on its appropriateness and efficiency.

Not surprisingly, therefore, the French health care system is relatively expensive by international standards, and the slowing down of expenditure growth, which most countries achieved during the 1980s, has only occurred in France in the second half of the 1990s.

Although relatively high levels of expenditure on health care result in patient satisfaction (Boisselot 2006) and contribute to good health outcomes, cost-containment remains a permanent issue. First, many of the measures taken to reduce expenditure growth have focused on the control of provider tariffs, on volume of care provided and on decreasing the cost for SHI, without being genuinely effective. This was called the “strict accounting cost-containment policy” (*maitrise comptable des dépenses de santé*). It has been strongly opposed by professional associations, particularly among physicians, and has resulted in an ongoing conflict between physicians and SHI, which came to a peak in the early 2000s when doctors refused to sign an agreement with SHI for several years up to 2005 (see Section 3.5). In the meantime, a new concept called “medically based cost-containment policy” (*maitrise médicalisée des dépenses de santé*) was developed by the government. It is based on the reduction of financial and equity loss resulting from medical practice variations and aims to improve medical practice (see Section 6.3.3). Cost-containment measures that are currently being implemented belong to both types of policy. The following subsections present these trends.

Strict accounting cost-containment measures

Containing the volume of health care consumption: user charges and the coordinated care pathway

In France, the share of health care expenditure not covered by SHI (that is, co-insurance) is known as the “moderating ticket” (*ticket modérateur*). Attempts to contain SHI expenditure have often focused on increasing this. However, its ability to moderate patients’ health care consumption has always been very low because VHI, which covers over four out of five patients, pays for a broad range of care.

The 2004 reform attempted to make patients more responsible in their consumption of care by introducing higher co-insurance for patients consuming care outside of the coordinated care pathway (the “preferred doctor reform”) and deductibles for doctors’ visits, for some procedures and for drugs, with strong financial incentives for the VHI not to cover them (see Sections 3.2 and 6.3.4).

The effect of the introduction of deductibles on containing the volume of care has not been formally assessed, but what can be measured is the additional revenue (or non-expenditure) for SHI. In 2008, revenue from deductibles on nurses’ visits, drugs and patient transportation only shifted €850 million from SHI expenditure to household expenditure (HCAAM 2008a). Altogether in the same year, deductibles are estimated to have shifted €1.59 billion to households while the increase in co-insurance for consuming care out of the coordinated care pathway was estimated at only €135 million in 2006 (since then the level of co-insurance has increased from additional 20% to 40%; therefore, the latter amount will be higher) (HCAAM 2009).

Decreasing costs for SHI: a shift towards VHI coverage

For decades, cost-containment measures have resulted in a decrease in the SHI rate of coverage. The last of these was the creation of a 15% rate of coverage for drugs with low relative medical benefit in January 2010 (Decree no. 2010-6 of 5 January 2010) (see Section 6.6.1). This shift of financial responsibility for coverage of health care towards VHI has an impact on equity in financing and raises concerns about equity in access.

In order to ensure financial equity of access, several measures were implemented to increase VHI coverage for the less well-off. First, from 2000, public complementary universal health coverage (CMU-C) was offered on a voluntary basis to those whose monthly income was below a certain level: €627 for a single person in 2010 (see Section 3.2). The second is the “voucher scheme”, which entitles patients to a deduction in the price of the VHI contract if the household income is 1.2 times the CMU-C ceiling (see Section 3.3). This policy resulted in an important increase in the rate of the population covered by VHI, which has now reached around 93%. Consequently the revenue of VHI firms has increased. From 2004 to 2008, VHI profits increased by 25% while in the same period the number of people fully covered by SHI through the long-term illness (ALD) scheme (see Section 3.2) also rose and resulted in a transfer of expenditure from VHI to SHI. Therefore, in 2008, the government asked the VHI to pay a turnover tax of about €1.1 billion in 2009 to reduce the SHI budget deficit, which was estimated to reach €4.1 billion in 2008, and €7.6 billion in

2009. As compensation, VHI companies were given a place in the negotiation of health professionals' agreements with SHI where tariffs are agreed upon (see Sections 3.5 and 4.1.3).

Containing the price of care: HTA towards a new paradigm?

In the 1970s and the 1980s, strict control of tariffs was applied to the price of drugs and to medical procedures conducted by self-employed professionals, in particular self-employed doctors.

As in many European countries, France has established health technology assessment (HTA) to inform coverage and pricing decisions. For instance, since 1999, drugs are covered and priced according to their medical benefit and their level compared with available comparators. Since then, several hundred have been excluded from positive lists because of insufficient medical benefit (see Section 6.6.1).

However, in France, HTA is principally based upon clinical efficacy, not on cost-effectiveness or value to broader society. By not taking into account cost-effectiveness or “value for money”, the assessment does not allow for prioritizing public expenditure across different health technologies. This situation differs from some other European countries.

However, the situation in France may be changing. In 2008, the Social Security Finance Act introduced the use of economic evaluation in HAS reviews and recommendations (see Section 4.2.1). While this is considered a step forward, the precise way economic evaluation is going to be used and implemented in practice is uncertain and currently under discussion. A HAS Commission for Economic Evaluation and Public Health (CEESP) was established in July 2008 to oversee the integration of cost-effectiveness into public decision-making and in clinical practice. As currently envisioned, in the first instance the Commission will issue a recommendation on cost-effectiveness, which will be considered alongside the advice of the Transparency Commission when re-assessing drugs only (see Section 6.6.1). HAS is also currently developing a societal benefit measure (SERC), which would capture not only the medical and economic costs and benefits of health services but also important ethical, social and legal considerations. The SERC would more closely resemble a “full HTA”. While its use has been limited to screening programmes to date, there are plans to apply it to other interventions, such as pharmaceuticals.

Despite movement towards this new paradigm, there are several outstanding challenges to its development. First, there is mixed support for formal integration of economic evaluation into drug reviews. There will not be any

explicit decision mechanism following the consideration of cost-effectiveness (that is, a defined level of cost-effectiveness will not imply a defined decision as is the case for medical benefit (SMR) and the improvement in the relative medical benefit (ASMR; see Section 6.6.1)). Second, drug prices in France are currently comparable to European average prices and are often lower (Lemorton 2008), which does not favour a change in the current system. Third, the French system is favourable to the uptake of innovative products, so a focus on cost-effectiveness may hinder innovation.

In light of these concerns, it is unlikely (at least in the short term) that economic evaluation will directly influence coverage decisions. Rather, cost-effectiveness or considerations of value for money will be used to enlighten decision-makers and clinicians on the broader benefits of a given treatment.

Medically based cost-containment measures

As already stated, after several decades of cost-containment measures based on controlling volume and price of services and goods, the 1990s saw a move towards the concept of “medically based cost-containment” that focused more on prescribers’ behaviour and aimed to improve quality, efficiency and equity of care by decreasing medical practice variations (see Section 6.3.2). The main tools used are:

- physician lifelong learning (see Section 4.1.4);
- development of practice guidelines by national agencies (HAS, AFSSAPS, INCa (see Section 6.3.2));
- introduction of good practice commitments within professionals’ collective agreements with SHI (see Section 4.1.3).

Both lifelong learning activities and good practice commitments, through mandatory guidelines (RMOs) (see Section 6.3.2), were put into place to improve doctors’ knowledge and implementation of best practice. However, this coercive concept of improving practice was slowly abandoned for a move towards the development of incentives. The set of incentives developed were either non-financial incentives or collective financial incentives within the framework of the SHI national collective agreements with doctors. Collective incentives are targeted agreements on good practice (AcBUS) and, from 2005, collective commitments on medically based cost-containment goals, which are defined yearly in an addendum (see Section 4.1.3). For instance, in the addendum 2005 agreement, doctors collectively committed themselves on improving their treatment patterns with respect to some defined clinical

recommendations, on increasing their rate of generic prescription and on giving more attention to prevention and coordination of care. However, these commitments did not successfully change doctors' practice. Indeed, after three years with no visible improvements, generic prescription actually decreased from 2006 to 2008 and preventive medicine rates remained low. Moreover, a study of the Commonwealth Fund showed that France compares very poorly in terms of prevention of diabetes with some other developed countries¹ (Schoen et al. 2009). The French health care system continues to be confronted with common and well-documented malpractices: overuse (that is, antibiotics), underuse (that is, lack of screening or follow-up of chronic diseases including diabetes and hypertension) or misuse (that is, prescription outside of the official marketing authorization) (CNAMTS 2001, 2007).

The lack of success implementing the 2005 agreement may be associated with the history of tension between professionals on one hand and the government and SHI on the other hand. Negotiations around the signature of national agreements have typically been very tense and have led to tremendous conflicts. These reached a climax after the 1996 reform, where the collective prescribing budget (see Section 6.6.3) was introduced and hotly opposed, much like the RMOs. These circumstances have probably resulted in a global situation of doctors' non-acceptance of any proposals coming from both SHI and the government, regardless of the fact that some, such as developing practice guidelines and audit of medical practice (see Section 4.1.4), were implemented with the aim of helping doctors in their every day practice by reducing medical uncertainty or medical ignorance. This political context and the power of physicians may be the source of an underestimation of the theoretical effectiveness of the measures implemented. As such, it is important to note that the improvement in collective medical practice has been weak (HCAAM 2009). This explains the attempt to improve medical practice through individual contracts through the CAPI (see below).

Financial incentives: a step towards payment for performance for doctors

Most recently, in 2009, the introduction of CAPI, individual contracts with financial incentives on a pay-for-performance basis, represented a dramatic change in the relationship between SHI and doctors (until then, individual incentives for prescribing patterns existed only for pharmacists, who were encouraged to deliver generics) (see Section 3.6.2).

¹ Countries compared in this study are France, the United Kingdom, United States, Germany, the Netherlands, New Zealand and Australia.

Fee-for-service payment is often considered as a basis for supply-induced demand, in particular in areas with higher rates of professionals per capita without incentives for improving better care coordination and prevention. A recurring debate concerns the way in which doctors should be paid. However, because of the strong opposition of doctors' representatives, the fee-for-service system has never been reformed and remains the rule (see Section 3.6.2).

Disappointed by the results of the collective negotiations and following the example of the GP contract developed in the United Kingdom, which in 2004 introduced financial incentives for GPs for better performance, since 2009 SHI offers individual voluntary contracts in parallel with the national agreement to GPs. The contracts include good practice targets that, if achieved, secure additional revenue for GPs. Known as CAPI, these contracts were introduced by the 2009 Social Security Finance Act (Article L.162-12-21 of the social security code) and officially issued by the Decree of 9 March 2009 published 21 April 2009 (see Section 3.6.2).

All the numerous unions of GPs are against these contracts, with different degrees of opposition and different arguments. The Federation of Medical Unions has expressed their resistance to the individual aspect of the contracts and their wish to continue collective bargaining on all issues concerning quality and continuity of care in exchange for an increase in the basic fee for GP consultations.

The major left-wing union of generalists (MG France), while not completely against the objectives of the contract, expressed their concern that this type of results-based contracting might encourage patient selection. They argue that doctors will have less incentive to work in low-income zones where health outcomes are notably worse. The unions also have reservations about the quality of data provided by SHI, and they claim that the objectives set are unrealistic, that the administrative costs would be too high and that the bonus would not be high enough. The right wing union (CSMF) is totally opposed to the principle of controlling "medical practice" or "freedom of prescription" implied by these contracts. They have called on their members to refuse to sign the contracts.

Similarly, the National Council of the Physicians Association (CNOM) has sent strong messages describing CAPI as being non-deontological and has called for its withdrawal. However, CNOM and the unions seem to have had little impact on doctors' decisions. Indeed, three months after its launch, by August 2009, 8000 GPs (10% of GPs in the primary care sector) had signed an individual contract. This first step towards the introduction of payment for performance can be considered as a success in terms of doctors' acceptance.

SHI, which had initially forecasted 5000 signatures for the end of 2009, raised its target up to 10 000. Finally, 12 600 doctors had signed a CAPI contract by December 2009.

Future assessment will allow measurement of the impact of CAPI on the improvement of medical practice. Experience has shown that such individual financial incentives are powerful in changing professional behaviour, especially when the incentives support what would be considered good medical practice (Walley, Mossialos 2004). Therefore, the incentives introduced in CAPI are likely to be successful in delivering at least short-term change, since they are remunerative and support professionals' aims. However, in June 2010, after nine months of implementation, only 55% of doctors who signed a contract are eligible to additional payment from this type of contract, amounting, on average, to an additional 5% of their income (€3000).

Finally, it should be noted that the areas targeted cover only a small share of doctors' prescribing practice, and the question of how to improve overall prescribing practice remains high on the policy agenda (HCAAM 2004, 2009). However, in the medium term, SHI plans to extend this type of contract to others specialties.

7.1.4 Improving geographical access

Coping with geographical disparities in health professionals manpower

As a result of restrictions in the number of places available in medical schools (*numerus clausus*) starting in the 1970s, a significant decrease in the number of doctors is expected in the next 15 years. Moreover, the forecast of the required number of doctors did not take into account sociological changes in the profession, in particular the increasing proportion of women in the profession. Therefore, in spite of a relatively high ratio of doctors to people (336 doctors per 100 000 inhabitants in 2007), there is currently a shortage of doctors in some geographical areas and difficulties in recruiting doctors in specialties such as anaesthesiology or gynaecology and obstetrics (see Sections 4.2 and 5.2). The problem facing France is to cope with demographic change without having many tools with which to adjust for the geographical distribution of doctors.

Consequently, in order to improve access to care and reduce existing geographical variations in the distribution of health professionals, on top of raising regularly the number of new medical students admitted per year (see Sections 5.2.1 and 5.2.3), a national demographic plan for health professionals was introduced in January 2006 (see Section 4.2). This plan increased the *numerus clausus* for entry into medical school, in particular in areas with

low density of doctors and high medical activity. However, this does not address geographical disparities partly because self-employed doctors have no restrictions in where they choose to establish their practices. The plan, therefore, also developed financial incentives for doctors to practise in “medically under-served areas” (see Section 4.2).

However, focusing specifically on “medically under-served areas” limits the impact of these measures, since very few areas are concerned (the areas concerned represent about 2.6 million inhabitants or 4% of the total population and 1600 GPs or 3% of all GPs). Moreover, the plan used mainly financial incentives to encourage doctors to move to mostly rural areas, the effectiveness of which when weighed against doctors’ preferences in lifestyle is questionable (see Section 5.1.3).

Furthermore, in a system with fee-for-service payment, there is reluctance from doctors’ unions to delegate tasks to other health professionals such as paramedics, as this has the potential to have a negative impact their income.

In fact, this demographic plan appears to be a short-term measure with limited impact in the context of the need for primary care policies to facilitate structural changes in both medical education and the organization of care. Reforms in medical training are currently under investigation by the government. This policy is mainly focused on medical doctors but there are also problems in the geographical distribution of nurses and some areas face relative shortages in their number (see Section 5.2.4).

The 2007 nurses’ agreement with SHI was a first attempt to diminish the geographical freedom of health professionals in France. Indeed, there will be strict controls by ARSs over self-employed nurses’ settlement in areas where nurse density is already high. Moreover, the agreement offered a number of material and financial benefits to nurses who were already working or willing to work in areas defined as under-served (see Section 5.2.4). In order to make the profession more attractive overall, it also included a general pay rise for nurses (10% increase in their hourly wage over two years) and their diploma is from now recognized as a university degree. In implementing control over professional geographical settlement first among nurses, SHI hoped that it would be able to extend this control to other professions in the future, especially to doctors. Control over doctors’ settlement was, therefore, initially proposed as part of the 2009 HPST Act (see below), but subsequently these measures were abandoned by the government as they were strongly opposed by doctors. They were replaced by financial incentives. One of these was to impose a fine on doctors from medically over-served areas who refused to sign a health

and solidarity contract (*contrat santé solidarité*) to participate in health care delivery in under-served areas (see Section 4.2). However this was also strongly opposed by doctors and in June 2010, one year after the vote on the Act, while opening the Fourth National Congress of General Medicine, the Minister of Health announced that she would be dropping this financial incentive.

Improving access to secondary care: hospital planning

The implementation of the medical map (*carte sanitaire*) in the 1970s controlled the volume of beds and major medical equipment (“big-ticket” technologies) (see Section 5.1.3) and was decided at the national level. National standards such as bed and medical equipment to population ratios were used. As a result, the number of acute care beds decreased significantly, from 6.2 per 1000 inhabitants in 1974 to 5.2 in 1991.

The introduction of regional health organization plans (SROSs) in 1991 moved hospital planning to a more qualitative approach, taking population need into account, looking at geographical distribution and establishing networks of hospitals (see Section 4.2). A major goal of the 1994-1999 SROSs was to merge facilities and close small hospitals that were struggling to recruit doctors. The 1999-2004 SROSs have gone further, since hospitals are now explicitly classified according to their level of technical capacity in areas such as perinatal care or emergency care and have to work in cooperation with each other. As a result, the merging or closing of hospitals or hospital wards or their reorientation towards new activities (for example, from acute care to rehabilitation) has been conducted nationwide, and the number of acute beds per 1000 inhabitants fell to 3.7 in 2004. In 2006, the third generation of SROS moved towards more local planning. The medical map was abolished and “medical plans” were defined for local territories within each region. The plans identify local health needs, local objectives and specific health care services to be improved.

The 2009 Hospital, Patients, Health and Territories Act

In order to facilitate geographical equity in access to care, the newly adopted HPST Act reinforced local planning and simplified regional governance of the health care system.

The Act created a legal basis for the establishment of ARSs. From April 2010, ARSs have merged and replaced regional hospital agencies, regional health insurance funds and other state and SHI institutions (see Section 2.4). In addition to taking over responsibility for the regional hospital sector, these structures are also responsible for the ambulatory care sector and the health and social care sector for the disabled and the elderly. New tools have been developed in order to achieve better planning and coordination between

hospitals, ambulatory and health and social care sectors; better geographical spread of provision; and better cooperation between health care actors. The first of these is the regional strategic health plan (PRS), which should lead to a common approach of planning for the three sectors (hospital, ambulatory and health and social care) based on population needs, as in the case of SROSs (see Section 4.2). Each sector's planning process will have to comply with the PRS. This is a first attempt of regional planning of the ambulatory care sector.

For the first time, the term primary care has entered into the public health code (see Section 1.3), as it did not legally exist before. It has a recognized role in coordinating patient pathways. Transfer of tasks between professionals is made legal beyond the mere scope of the previously mentioned experiments, and contractual agreements of care protocols between professionals are developed (see Section 4.2). The regional medical *numerus clausus* is linked to needs. However, in order to optimize the distribution of doctors without impairing freedom of settlement, mapping of geographic needs has to be conducted, and opportunities for increasing the attractiveness of underrepresented specialties and medically under-served areas are being developed. For instance, hospital doctors' wages will possibly increase in cases in which their specialties are needed and contracts with medical students and self-employed health professionals with financial incentives to practise in under-served areas will be implemented on a voluntary basis (see above and Section 4.2).

Many tools are still to be created and implemented in order to achieve the objectives of the Act, such as indicators for needs, utilization rates and quality indicators, as well as tools for cooperation between sectors that are not accustomed to having formal contacts and discussions with each other.

7.1.5 Taking account of the growing demand for health and social care of the elderly

The 2003 heat-wave was a shock for French society, given that 15 000 elderly died in this very hot summer, mainly because of a lack of timely reaction from the social and health sectors. Following this, the elderly and the projected growth in their number, expected from the Second World War baby boom and the extension of life expectancy, have become major concerns for policy-makers in France.

As a result, a first plan devoted to the elderly was issued: the Ageing and Solidarity Plan (*plan vieillesse et solidarité*, November 2003). This aimed at improving living conditions and care of elderly and handicapped people. A specific emergency plan was set up in each department for taking care of

the frail elderly and the disabled in the event of exceptional risks (such as a heat-wave). The idea was to identify disabled people who may need assistance at the local level for prevention purposes and to organize cooperation between health services and health and social care organizations at the local level in order to ensure a timely response to their needs.

The Solidarity Act for the Elderly and the Disabled (*loi relative à la solidarité pour l'autonomie des personnes âgées et des personnes handicapées*, no. 2004-626 of 30 June 2004) created the CNSA, which is funded through the SHI budget, and a new tax called the “solidarity and autonomy contribution” derived from an unpaid working day (solidarity day; approximately €2 billion) and a 0.1% share of the general social contribution (CSG) (see Section 3.3.1). It has three missions: financing “support services” (such as residential care, home care, helpers) (see Sections 6.8.1 and 6.8.2), ensuring equal treatment for all people with loss of functional autonomy, and providing information and analysis concerning the service needs of disabled people.

Additionally, many reports were ordered to gain an insight into the current and future French situation with regard to frail people. Three reports issued in 2005 and 2006 showed that, despite the implementation of the Ageing and Solidarity Plan, the provision and financing of long-term health and social care remain challenging issues for future generations (Centre d'analyse stratégique 2006; Commissariat général du plan² 2005; Cour des comptes 2005b). The reports stated that home care services and services devoted to people with neurodegenerative diseases (such as Alzheimer's and Parkinson's diseases), in particular, needed to be developed and that immediate action was necessary. Moreover, they raised the issue of financing, arguing that the CNSA would not have sufficient resources to cover the expected cost.

As a response, the Solidarity and Old Age Plan (*plan solidarité-grand âge*) was issued in June 2006 for the five following years (2007–2012). It reinforced the previous Ageing and Solidarity Plan and provided several service development targets in terms of capacity increase in residential care, as well as in home care settings, including in hospitals at home for the frail elderly. It also stated that 40 000 people per year should be recruited and trained in the health and social care sector. Furthermore, it encouraged research on neurodegenerative diseases; in synergy with the Brain Plan (*plan cerveau*), money was allocated for research in this area. However, the Solidarity and Old Age Plan does not have any new propositions for financing these new investments, although it sets up a mission to investigate this issue (see Section 7.2).

² *Commissariat général du plan* was renamed and replaced in 2006 by *Centre d'analyse stratégique*.

Overall, despite the genuine political will to develop services to respond to the needs of the frail elderly, current developments have not moved as quickly as expected. One of the reasons for this is the difficulty of finding property developers for residential care. This is especially true for intermediary services between the residential and home care services (see Section 6.8.1). A second reason is the heavy financial burden of residential care on general councils. A third reason is difficulty of enrolling skilled professionals in this sector because of the low attractiveness of working with the disabled frail elderly, relatively low salaries and poor career development. The Solidarity and Old Age Plan was, therefore, followed in 2008 by a Plan for Professions in Services for Those with a Functional Loss of Autonomy, the Disabled and Frail Elderly (*plan des métiers de la dépendance au services des handicapés et des personnes âgées dépendantes*), which attempts to increase the attractiveness of the sector.

7.2 Future developments

Financing long-term care

Demographic projections show a 1% growth per year until 2040 in the number of frail people with neurodegenerative diseases (such as Alzheimer's and Parkinson's diseases) or with functional loss of autonomy (Gisserot, Grass 2007). Expenditure on long-term health and social services of various kinds to meet these needs is estimated at around €16 billion in 2005 (0.94% of GDP) (Centre d'analyse stratégique 2006).

During the campaign for the presidential election in 2007, the mission set up by the Solidarity and Old Age Plan estimated that a 3 to 4% average increase in expenditure per year is expected until 2025 (resulting in a total expenditure rate of 1.5% of GDP). The difference in the projected growth rate of the population and expenditure figures mainly reflects the expected increases in the cost of staff working in this sector. Consequently, an extra €250 million to 430 million in addition to SHI funding would be required every year for the following 20 years, representing an increase of 0.5 to 0.9 points per year in the general social contribution rate (Gisserot, Grass 2007) (see Section 3.3.4).

Following this, the two main candidates announced that a “fifth branch” of social protection would be created in order to offer public coverage (see Section 2.2 for the other four branches). However, the resources that would be used to finance this branch were not described. After he was elected, the President Nicolas Sarkozy confirmed that a fifth branch of social protection

would be created in the beginning of the year 2008. An interministerial group was set up to work on this issue. However, the launch of the new reforms was postponed many times to 2009, and no dates are currently defined.

Several sources of revenue were envisaged. However, it appears that the government does not want to increase social contributions, which are already considered to be large, and local authorities, which are already financing a large share of long-term care (see Section 6.8), have strongly protested against increasing local taxes. Therefore, finding a long-term solution that is not unpopular is difficult and currently no acceptable position has been found.

8. Assessment of the health system

8.1 The stated objectives of the health system

According to the 2004 Health Insurance Reform Act (no. 2004-810 of 13 August 2004, Article L. 111-2-1), the stated objectives of the French health system are:

- universal coverage, independent of age or health status;
- equitable access to health care;
- equitable contribution to the costs of the health care system; every person is expected to contribute, to the extent of his/her capacity, to the appropriate use of the resources endowed by the nation to SHI;
- continuity, coordination, and effectiveness of care.

The French health care system has long enjoyed the reputation of being one of the best in the world (WHO 2000). It has become synonymous with universal health coverage and a generous supply of health services. This reputation comes in large part from success in meeting its goals of full coverage, access without waiting lists, patient choice and satisfaction. The combination of a basic universal public health insurance system and complementary VHI, which provides reimbursement for co-payments required by the public system as well as coverage for medical goods and services that are poorly covered by the public system, results in low out-of-pocket costs and high medical care utilization (Couffinal, Perronnin 2004). France's average life expectancy of over 80 years is in part testament to the strong combination of good health care and good public health policies in France. Despite these positives, there are also some criticisms (Docteur, Oxley 2003). Certain assessments have found the system overall to be inefficient and wasteful (Lenain 2000). Major problems include lack of coordination between hospital and ambulatory services, between private and public provision of care, and between health care and public health. Health expenditures per capita are also higher than the OECD average, ranking usually third or fourth after the United States, Germany and Switzerland, depending

on the data used and year. The high level of health expenditure has become increasingly important at a time when the public system is facing chronic deficits, which are likely to increase with the current economic downturn.

This chapter reviews the global performance of the French health care system, focusing in particular on the closely related topics of health care inequities and the disconnect between health care and public health.

8.2 The distribution of the health system's costs and benefits across the population

The OECD's assessment, although based on old data, stated in 2000 that: "The health system in France is regarded as delivering high quality services, with freedom of choice and generally no waiting lists for treatments. Access to medical services is equal among the population and, unlike in some other countries, people can get the treatments they need irrespective of their social status or work situation" (Imai et al. 2000). The strength of the French system was also reflected by the *World Health Report* (WHO 2000). In a comparative ranking of 191 health care systems worldwide on criteria including overall country health, distribution of services, fairness in financial contributions, and goal attainment, the WHO listed France as number one (WHO 2000), although the methodology used for ranking was subject to wide criticism. These positive assessments result from a number of factors, including freedom of choice, ease of access and full coverage of health care costs. These factors work together to enable relatively high health care utilization and, ultimately, better overall health.

Freedom of choice of health care provider is a traditional feature in France. It is usually considered that the 2004 Health Insurance Reform Act, which imposed financial negative incentives on patients who entered directly into any point of the system without prior approval from their "preferred doctor" (see Sections 3.2 and 6.3.3), restricted this freedom. However, this form of soft gate-keeping was generally well accepted, perhaps because a number of specialties were excluded from the referral system, for example gynaecology, dermatology, psychiatry, ophthalmology and paediatrics. Furthermore, adherence to the "preferred doctor scheme" mainly reflected existing patterns of access. Indeed, in 2006, 92% of the patients that had chosen a preferred doctor already had this doctor as their usual family practitioner (Allonier et al. 2008). Moreover, in 2007 after the implementation of the scheme, the share of patients consulting outside of the gate-keeping system was 20% on average for

all categories of specialists (Gouyon 2009) when it was only 30% prior to the implementation of the reform (Le Fur, Lengagne 2006). This shows that prior to the reform, French patients were already following a gate-keeping model, despite enjoying a large freedom of choice. Finally, freedom of choice of doctors has not actually been restricted at all, since patients are still able to choose which doctors they want to visit (having been referred or not) and they can very easily switch preferred doctors (by filling out a form with the doctor of their choice).

The number of physicians in France also contributes to giving patients choice of provider. While not particularly high compared with some other European countries (about 3.4 physicians per 1000 population), it is still higher than the OECD average (3.1) and in several other developed countries including the United States, Australia and Canada. A high level of choice plus relatively high numbers of physicians have resulted in good access to health care in terms of availability of services.

Another important feature of the French health system is financial access to health care. The 1999 Universal Health Coverage Act (CMU Act) allowed for universal health care coverage for people living in France (see Section 3.2). In 2009, roughly 80% of total health expenditure on health was publicly funded. The remaining 20% came from a combination of VHI and out-of-pocket payments (respectively around 13 and 7% each). In France, low-income groups are at increased risk for a number of diseases and, ultimately, death (see below). Reducing financial barriers for these groups in particular is important for maintaining a healthy overall population. This was partly achieved through the 1999 CMU Act by the provision of free VHI for low-income groups and through the implementation of the voucher scheme (ACS), which provides means-tested vouchers for supplementary VHI, thus removing the requirement for out-of-pocket expenditure (see Section 3.3).

High levels of accessibility and choice, combined with low out-of-pocket expenditure, have resulted in high system utilization. Among a number of countries, including Germany, Australia, Italy, Sweden and the United States, France ranked number one in hospital admissions and sales of pharmaceuticals per capita, and ranked among the countries with the highest number of physician visits per capita. High access and utilization of health care across socioeconomic groups has contributed to France ranking high in many key health measures such as life expectancy, burden of disease and infant mortality (WHO 2000). For example, total health expenditure on primary care by income does not vary between low- and high-income households (ranging from an average monthly income per person in the household of €534 to above

€1300) (Delvallée, Ventelou 2004). However, all things being equal, people in higher-income groups enjoy a greater number of specialists' visits, biologic diagnostic tests and eye and dental care, although people in the low-income groups are characterized by higher hospital expenditures (Piäser, Raynaud 2002). Inequities concern the utilization of preventive care, with evidence that persons in low-income groups have fewer cancer screening tests and fewer immunizations (Or et al. 2010).

The 2009 Health at a Glance OECD report found France rated in the top 10 countries among a group of 27 low-mortality European countries in categories such as overall life expectancy, infant mortality, cardiovascular diseases and prevalence of obesity (OECD 2009c). Women in France were rated well above average compared with the other countries, with an average life expectancy of 84 years, while French men were around the average with a life expectancy of 77.5 years. The general public also has a positive view of the system. The Eurobarometer 2002 (European Commission 2002) showed that almost 70% of the population was satisfied with the health care system, 42% of which considered that minor changes were required (see Section 2.5.7).

Inequalities in health and access to health care

While France has achieved a good level of equality in access, in particular in relation to primary care, there is concern that the full coverage policies introduced in the 1990s have not reduced other persisting areas of inequality: the seven year gap in life expectancy between lower and higher income groups persists and may be negatively affected by the economic downturn (Elbaum 2007a). The mortality ratio for less-educated/more-educated people is roughly 1.1 for men and 1.3 for women, which is the fourth lowest in OECD countries (Italy, Spain and Denmark performing better). Individuals in the highest income quintile are three times less likely to report very bad health than in the lowest income quintile, figures that are close to the OECD European countries' average (Elbaum 2007b). The average share of out-of-pocket spending on health in household consumption represents less than 2% of total household consumption in France, which is less than the OECD average. Despite the availability of health care coverage to the entire population and relatively low out-of-pocket expenditure, people in the lowest income quintiles are four times more likely to report an unmet need for a medical examination because of problems of access than people in the highest income quintile and seven times more likely where dental care is concerned (De Looper, Lafortune 2009). Explanations for this finding may be on the demand and/or the supply side. On the demand side, one could hypothesize lack of familiarity with the system, time costs or level of income. On the supply side, the absence of physicians who do not practise

extra-billing in certain areas is likely to play a role. More alarming is the refusal of some physicians to treat patients benefiting from CMU coverage; doctors appear to be prejudiced against these patients for whom there is a third-party payment system (physicians are directly paid by insurance) and no possibility to charge over the official tariffs (extra-billing) (Desprès 2010).

There is concern that the recently implemented deductibles (not covered by VHI) on doctors' visits, ancillary care, transportation and drug prescription will increase access problems. Because deductibles may harm the most vulnerable populations (sick people), they were combined with financial safety nets to preserve welfare benefits, and an annual ceiling for deductibles payment was established at €50 per person (see Section 3.2).

Evidence on the determinants of poor health status and reduced life expectancy among low-income groups in France is troubling: (1) the health gap between social groups has not decreased globally in the past 20 years despite periods of sustained economic growth and increase in the average household income; (2) the health gap begins early in life, as early as six years of age for obesity, dental health and vision disorders; and (3) poor health is significantly correlated with almost every possible marker of lower socioeconomic status: low education level, unemployment, poverty, homelessness, single parenthood, mental health, violence and substance abuse (Elbaum 2007b). In France, the seven-year gap in life expectancy between the lower and upper social classes is largely explained by the effect of alcohol and tobacco abuse (30%) as well as accidents and suicide (15% and 11%, respectively) (Elbaum 2007b).

An integrated and comprehensive policy has been argued to be the appropriate response for tackling interdependent health determinants (Elbaum 2007b). The 2004 Public Health Act was an attempt to improve coordination and consistency in public health policies, but this has proven difficult in the French context. The fact that population health is affected by both income and income distribution was not systematically recognized by the Public Health Acts, and, as noted by Elbaum (2007a), only two out of the 100 priorities in the 2004 French Public Health Act directly concern health inequities. Acting simultaneously upon several determinants of health requires cooperation between administrations and payers, both at local and national levels. Financing public health policies that deal with health determinants needs to cut across sectors (versus being directed only to the health care sector). However, in the French system, the number of stakeholders (administrative departments) involved at the national and, more importantly, at the local level is high, potentially making this a difficult task (Table 8.1). Nevertheless, these potential drawbacks may prove

an unexpected political advantage: because of the separation of health care and health promotion budgets, health care professionals may not identify increases in budgets for health promotion as a threat to their budgets (Evans, Stoddart 2003).

Table 8.1

Distribution of responsibilities for health care and health promotion in France

	Health care	Health promotion
National	Social security: SHI (several schemes and benefits)	Ministry of Health, other branches (for example, family, retirement, accidents); other ministries (for example, education, justice, finance, environment, family, youth; social security);
Local (regional), state health-related areas	Local branches of social security/ SHI funds	Local subsidiaries of each ministry; local branches of SHI
Professionals providing the services	Fee for service	Salaried
Reporting and indicators	Ministry of Health	–
SHI	Ministry of Health and other ministries (for example, for internal affairs, social security)	–
Legislation	Ministry in charge of social services, prime minister, ministry of Finance	Ministries of health, environment, finance, education, internal affairs, transportation, agriculture

In France, the state and social security budgets were debated and approved simultaneously by the French parliament for the first time in 2007. The justification was that there is little difference to citizens between taxes and social contributions and that the EU reporting regulations concern the expenditures of all public administration in total. The 2009 HPST Act enacted the merger of health care, public health and SHI funds at the regional level (see Section 2.4). This can be considered a major step towards the recognition that health needs should be identified and priorities established at the local level with the major stakeholders: hospitals, self-employed health professionals, public health decision-makers, patients' representatives, representatives of the state and representatives of SHI.

8.3 Efficiency of resource allocation in health care (across services, across inputs)

The national ceiling for SHI expenditures

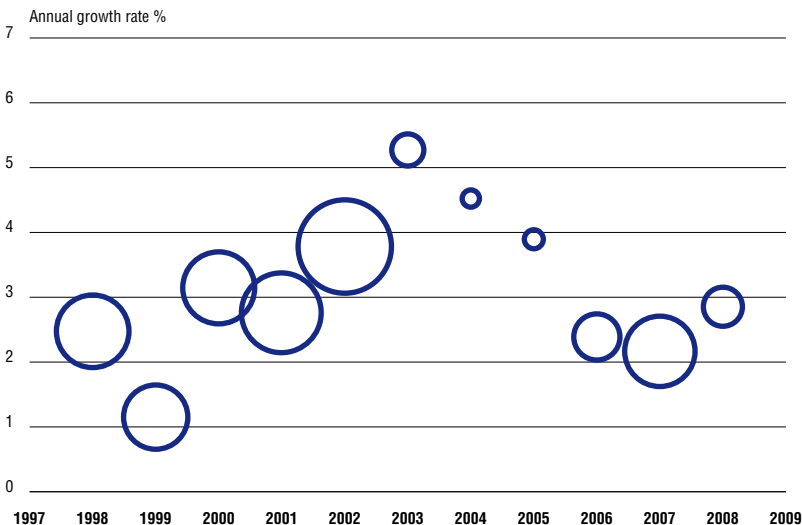
In France, there is no formal mechanism of resource allocation for the overall health care system and across sectors of care as there is in the United Kingdom NHS systems. The main resource allocation mechanism in place is the ONDAM,

which sets the overall level of SHI expenditure and its distribution across six subsectors of care (care in private practice, health care in hospitals paid on DRG basis, health care in other hospitals, health and social care for the elderly, health and social care for disabled people, and other types of care) (see Section 3.4).

Fig. 8.1 shows the ONDAM annual growth rate approved by the parliament and the ONDAM overrun actually incurred during the period 1998–2008. Since 1998, the ONDAM target has never been met. However, from 2003, the size of the overrun is decreasing, showing greater efficiency of this resource allocation mechanism after this year. The setting up of the Alert Committee in 2004 has insured greater credibility of this system. One can further expect that the newly created group for statistical monitoring of ONDAM (*groupe de suivi statistique de l'ONDAM*) in the Administration of Health and Social Affairs, which includes representatives of the Directorate of Social Security, the General Directorate for Health Care Supply (DGOS) and the General Directorate for Social Policy (see Section 2.3.2), will show even greater ability to forecast ONDAM overrun per sector of care and thus will be able to take appropriate and timely measures.

Fig. 8.1

Annual growth rate in the national ceiling for health insurance expenditure (ONDAM) and size of ONDAM overrun



Source: Eco-Santé 2010 (provisional results for 2007 and 2008).

Note: The size of the bubbles shows the size of the overrun as a percentage of ONDAM.

Coordination of planning and financing in different sectors of care and public health policies

There is a need for improved efficiency in resource allocation in France, in particular in the coordination of public health policies and the planning of health services and professionals. This is evidenced, for example, by OECD health indicators, which point to the poor results of the French system with regards to avoidable mortality in males (see Fig.1.2). Improvements in coordination between the different sectors have gradually taken place through initiatives led by the state at the general policy level and also by the Ministry of Health in the field of health and social services (see Sections 2.4 and 4.1.2).

Budget forecasting by programmes integrated across ministries at the national level

Moreover, there has been a move towards broader integration of health care and public health policies in organic laws, which supplement constitutional provisions for purposes of implementation, for both the State Finance Act and the Social Security Finance Act. In 2005, organic laws (Act no. 2005-779 of 12 July 2005, modifying the organic law no. 2001-692 of 1 August 2001 on State Finance Act, Act no. 2005-881 of 2 August 2005) dramatically changed the paths of resource allocation for both budgets. They ruled that budgets will follow policy objectives, cutting across traditional administrative boundaries. Solidarity and integration and response to health threats, for instance, became state objectives with dedicated budgets across ministries and administrations. Cross-cutting missions are solidarity and integration (several ministerial directorates), health (one directorate), health safety (several directorates) and social benefits and pensions (several directorates).

Each social security branch (SHI, work-related illness, family allowances and retirement pensions) had to determine programmes for quality and efficiency (*programme qualité efficacité*, PQE) in which precise objectives (targets) and indicators were set (Box 8.1). Targets aimed to balance access for the French population to social security benefits, adequacy of coverage to meet population needs, efficiency in benefits provision and financial sustainability of the system.

The organic law created an obligation to set a budget for each programme and to report on the spending and achievement of targets. A major shift from a spending to an investment model was thus initiated, and a framework that allowed allocation of resources that cut across the traditional boundaries of the state and SHI bureaucracies was created. SHI had historically been labelled a “blind payer”, which reimbursed providers without assessing the effectiveness

Box 8.1**Targets for the programmes for quality and efficiency (PQE) for SHI, 2005****Programme 1 Ensure equal access to health care**

- Identify and reduce the percentage of physicians who bill over the SHI statutory tariffs (for example, €22 for a GP visit) and reduce the average expenditure on extra-billing. In 2006, over 16% of the population lived in neighbourhoods where over 50% physicians engaged in extra-billing and these physicians billed on average 50% over the official rate. This means that patients who have no or limited supplementary insurance have in effect reduced access to physicians in their neighbourhood. The objective (not quantified) is to reduce both the number of physicians billing extra and the amount of extra-billing.
- Decrease the percentage of patients in the lower income group eligible for state financial help not seeking care for financial reasons compared with patients with commercial complementary coverage. In 2006, there was a 6% absolute difference.

Programme 2 Develop prevention

- Reduce the percentage of overweight and obese children (currently 15–20%).
- Reduce tobacco and alcohol consumption in the population aged over 15 years, from 25% of the population smoking in 2007 to 24% in 2010 and annual alcohol consumption from 12.2 litres in 2007 to 10.7 litres in 2010.
- Increase breast cancer screening from 60% of the targeted female population in 2007 to 65% in 2010, and cervical cancer screening from 65% to 80% for the same time frame.
- Increase the immunization rate in children under 24 months from 88 to 95%.
- Improve oral health and decrease the rate of children with decayed teeth by 30%.

Programme 3 Improve quality of care

- Increase the current 85% rate of patients with a referring physician and the current 85% rate of primary visits to this referring physician.
- Improve coordination between hospital and ambulatory care by increasing the percentage of areas where hospital-at-home care is available (currently 85%).
- Increase from 93% to 100% the areas with 24-hour emergency physician availability.
- Decrease waiting times for vital emergencies (no figure; the indicator has yet to be developed).
- Reduce to 0% from a current 2% the rate of hospitals that do not report hospital-acquired infections.
- All physicians (100%) must undergo professional practice appraisal by 2010.
- Increase the percentage (from a current 11%) of health care organizations with the highest accreditation level.

Box 8.1 (continued)**Targets for the programmes for quality and efficiency (PQE) for SHI, 2005****Programme 4 Improve efficiency and control health care expenditure**

- Control the rate of increase of drug expenditures.
- Increase the current 75% share of drugs with generic forms (in numbers of boxes) sold.
- Decrease the average number of drugs per prescription (currently 3) and the percentage of prescriptions with six drugs or over (currently 10%).
- Decrease prescriptions for discharged patients.
- Decrease the number of defined daily dose per 1000 patients for antibiotics below the current 31 (highest level in Europe).
- Decrease the amount of compensation for patients' sickness leave (currently 10% of all ambulatory care expenditures).
- For patients who are eligible for 100% coverage of health care expenditures in relation to a chronic condition (ALD), ensure that only expenditures in relation to that condition are fully reimbursed by SHI and that unrelated expenditures are reimbursed at the usual (65–80%) rate. It is expected that 75% of expenditures for patients with a chronic condition are related to that condition.
- Increase to over 50% the rate of hospitals signing contractual agreements to limit expenditures on drugs and ambulances.
- Decrease prescriptions by office-based physicians (antibiotics, statins, proton pump inhibitors, angiotensin-converting enzyme inhibitors, etc.).
- Increase to 85% in 2010 the proportion of ambulatory procedures for cataract surgery, knee arthroscopy, tonsillectomy, varicose veins and teeth extraction.
- Increase transfers and decrease waiting time from acute care to rehabilitation centres.
- Increase hospital productivity.

Programme 5 Ensure financial sustainability

- Reduce the current deficit.
- Increase non contribution revenues (fraud, abuse, unclaimed assets).

of interventions. The new laws impose an obligation to decide prospectively on the important issues in population health and to allocate resources accordingly. Programmes and targets for the health care system are presented in Box 8.1.

These objectives and indicators represent an endeavour to improve the fairness and efficiency of the system and financial sustainability without negative effects on health attainment and health equity. A criticism of the 2004 Public Health Act was that it did not necessarily tie resources to the 100 objectives defined in the Appendix of the Act: the public health targets did not constitute a binding obligation for financing organizations. This was identified as a weakness of the system and a cause of the disconnection between public health policies and health care planning and organization.

The objectives presented in the PQE can be seen as an attempt to improve consistency in response to the 100 health targets presented in the Appendix of the 2004 Public Health Act. Baseline figures and trends for health targets were clearly used to define the specific objectives of the Social Security Finance Act, not only for SHI programmes (Box 8.1) but also for other programmes of the social security branches (such as workplace safety and environmental safety). In addition to the PQE indicators, structured follow-up of the Public Health Act indicators included targets relating to air pollution, water pollution and lead poisoning, for example (not shown in Box 8.1). In this way, public health objectives can be used to allocate public resources for missions outside the health care system.

However, in April 2010 the High Council of Public Health (HCSP) published an assessment of the achievement of health targets (HCSP 2010). This assessment concerned only the effectiveness of the measures taken and not their efficiency. Out of the 56 targets that could be assessed, 10 had been achieved (for example, controlling childhood obesity) and 13 partly achieved (for example, increasing immunization coverage). Information on the amount of public resources that had been used to achieve these targets was not available, thus making it difficult to assess efficiency.

Coordination of planning and financing of the different sectors of care and public health policies at the regional level

Both the 2004 Health Insurance Reform Act and the 2009 HPST Act emphasized the lack of coordination in the French health care system and the expected financial (and health) gains from improved information, development of joint care protocols and regional planning based on the public needs of the local population. Gains in efficiency are expected from the merging at the regional level of all institutions involved in the planning and financing of health services and public health policies in a one-stop shop: the ARS (see Sections 2.4 and 4.2). Improvement in capacity planning and allocation of health care resources based on needs assessment is expected to result from this new regional governance.

The regional strategic health plan (PRS) should lead to a common approach of planning for the hospitals, ambulatory and health and social care sectors based on population needs (see Section 4.2).

Until then, planning and resource allocation according to need assessment is limited to hospital services and health and social services for the disabled. The trend since the late 1990s has been, as in most OECD countries, a reduction in the number of hospital beds concurrent with a reduction in length of stay. The development of ambulatory surgery has, however, remained limited and mostly confined to private institutions, which perform 75% of these procedures. The reduction in beds has also affected mental health, while beds in rehabilitation care remained stable (see Figs 5.1 and 5.2 and Section 5.1.1).

8.4 Technical efficiency in the provision of health care

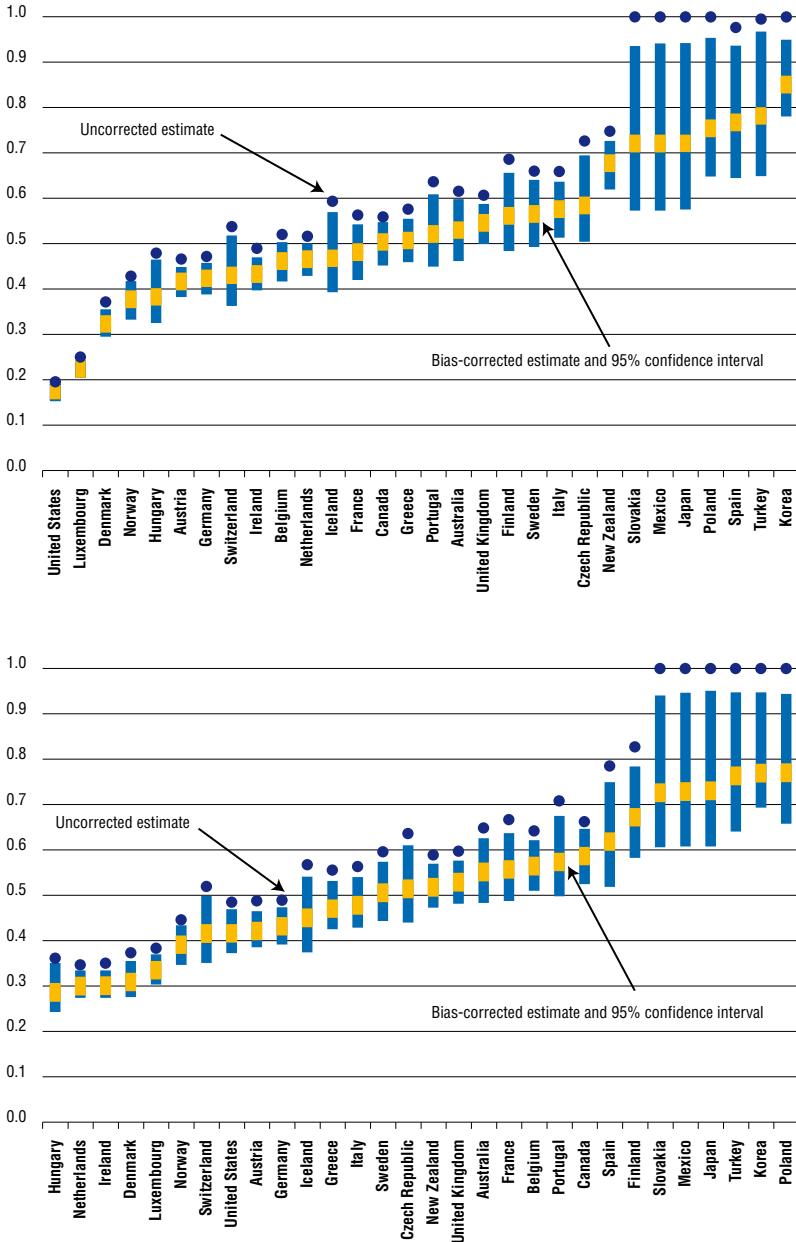
While the overall assessment of the French health care system is positive, the system is not without faults. Chief among the concerns is health care spending, which is high and has been rising over the past decades. In 2006, France ranked in the ninth place of OECD countries for the level of per capita health care expenditure, but in third place for health care expenditure as a proportion of GDP. France is above the regression curve that marks the average relation between the wealth of a country and the amount of per capita health care expenditure. Taking its wealth into account, France, therefore, spends more on health care than other OECD countries (see Section 3.1).

A report, published by OECD (Joumard et al. 2008), aimed to “shed light on the contribution of health care and other determinants to the health status of the population, and to provide evidence on whether or not health care resources are producing similar value for money across OECD countries”. With life expectancy as the output, efficiency varied depending on the economic input; in terms of health care spending, France was considered as moderately efficient; in terms of practitioner workforce, France ranked slightly below the average. Fig. 8.2 shows these results.

Fig. 8.2

(A) Health care spending versus life expectancy (cost efficiency)

(B) Health practitioners versus life expectancy (technical efficiency)



Source: Joumard et al. 2008.

Recent years have seen several attempts to improve the productivity of the system. In the community, the provision of health care has been traditionally physician centred, with a high physician to population ratio, but since 2000 there has been a decline in the number of medical graduates matched by an increase in the number of nurse trainees, signalling perhaps a shift in labour inputs and the will to develop task transfer (see Section 4.2).

The medically based cost-containment concept developed in the 1990s is an attempt to increase efficiency of care by diminishing medical practice variations and improving the quality of care. However, despite implementing a good range of tools, it did not seem to have a major effect in improving the collective practice of doctors (see Sections 6.3.2 and 7.1.3). The latest tool was implemented in April 2009; the individual contract for practice improvement (CAPI) uses a pay-for-performance incentive to achieve efficiency targets in primary care. Among these targets, the percentage of generic prescription and use of low-cost statins received much public attention. Initial assessment suggests that 55% of doctors are eligible for additional payment for achieving targets (see Section 3.6).

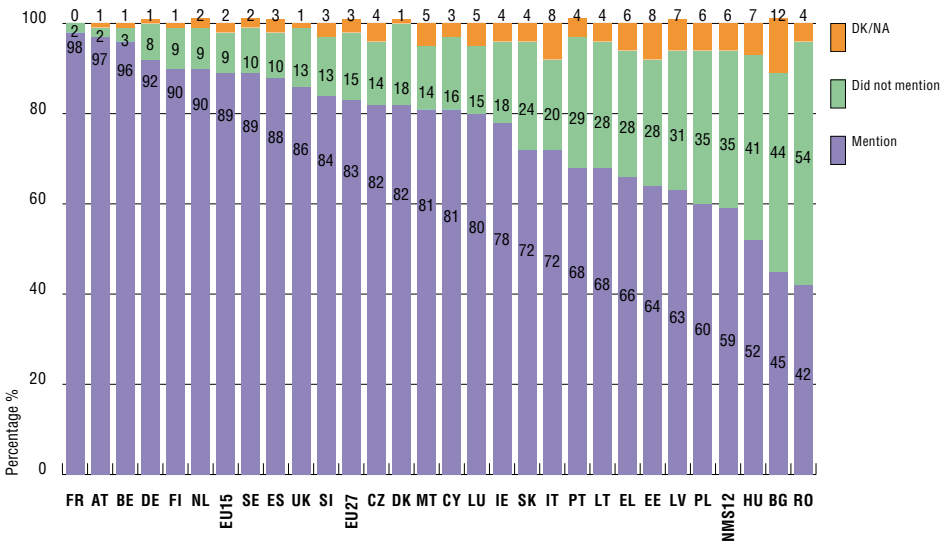
In hospitals, recent reforms regarding the inpatient care sector have focused on efficiency issues. The 2009 HPST Act reformed the governance of public hospitals to create a single manager in charge of strategic decisions and to allow more flexibility in the management of public hospitals. In order to promote efficiency in the public sector and increase competition between the private and public sector, the reform plan Hospital 2007 introduced a common financing structure for public as well as for private profit-making hospitals. While the stated objective was adopting similar DRG tariffs for both the non-profit-making and profit-making sectors by 2012, the large discrepancies observed between costs in the private profit-making and the public sectors has led to vigorous debates about the appropriateness of common tariffs. As a result, this objective has been recently postponed to 2018 by the 2009 HPST Act, although ongoing negotiation might result in adopting unified tariffs for a selected number of DRGs before that date (see Section 6.4.3).

8.5 Quality of care

The French population has a relatively high level of satisfaction with health care. For example, in a *Eurobarometer* survey, 98% of the French respondents stated they would not travel to another country in order to receive health care because they had a high level of satisfaction with the health care they receive at home; this compared with 89% in the EU15 and 83% in the EU27 (Fig. 8.3).

Fig. 8.3

Satisfaction with health care received in respondents' own country



Source: European Commission 2007.

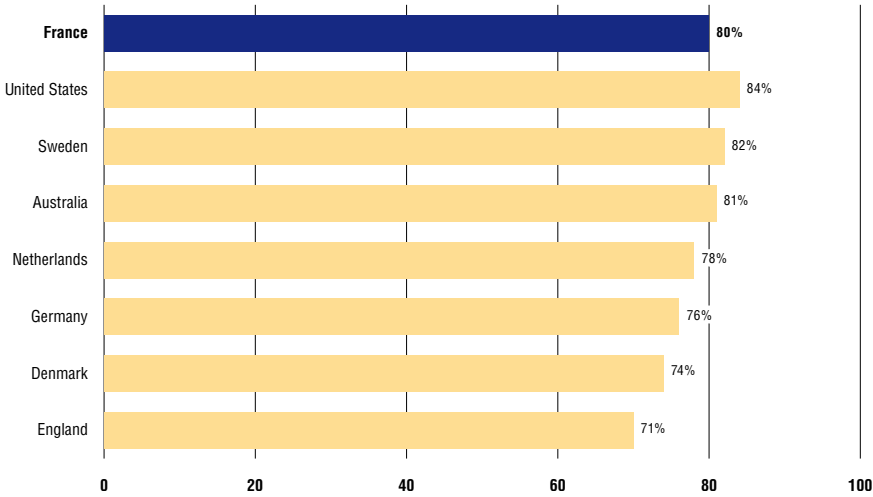
Notes: The question asked was "For which of the following reasons would you not travel to another country to receive medical treatment"; results given as percentage of all respondents by country. DK/NA: Don't know/not applicable; Mention: Respondents mentioned a high level of satisfaction with the health care they receive at home as a reason for not travelling to another EU country; Did not mention: Respondents did not mention this as a reason for not travelling to another country; NMS12: 12 new Member States. Columns may not total 100% due to rounding.

There have been many recent initiatives to improve health care quality and its measurement in France (see Section 6.3.2). However, systematic information on the quality and safety of health care remain partial, inconsistent and not easily accessible. Nevertheless, some assessments and comparisons across countries can be made (Or, Com-Ruelle 2008).

Cancer survival rates, which are highly linked to the quality of cancer care and the efficiency of screening policies, show good results for breast and prostate cancers, which are the two most frequent cancers in the French population (Figs 8.4 and 8.5).

Fig. 8.4

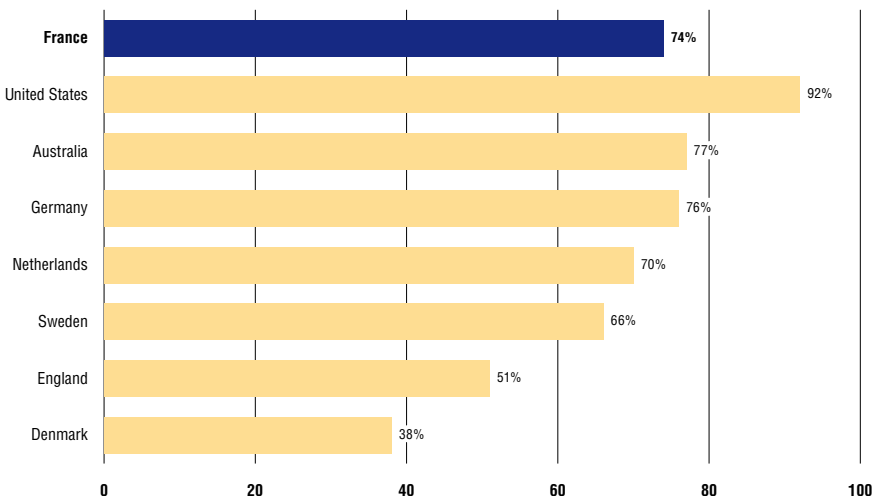
Breast cancer five-year survival rate (%)



Source: Coleman et al. 2008.

Fig. 8.5

Prostate cancer five-year survival rate (%)

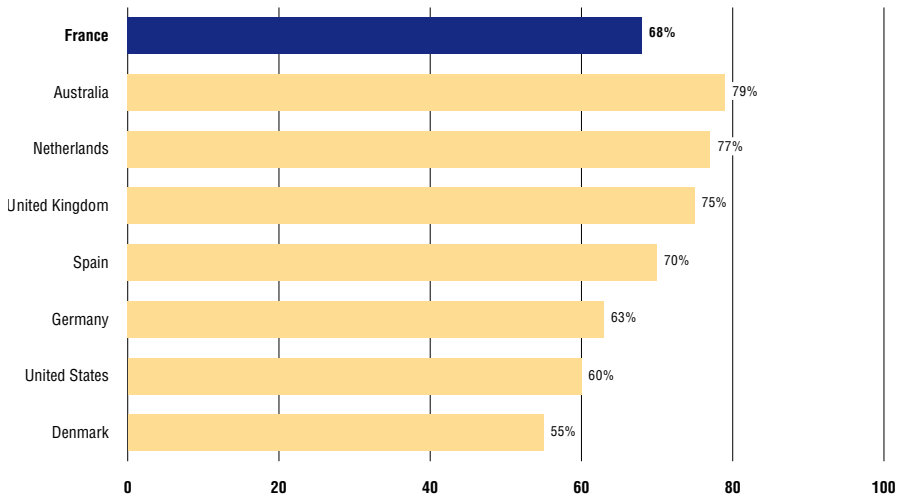


Source: Coleman et al. 2008.

Influenza immunization and cervical cancer screening rates, which can also reflect the quality of the prevention policy, are also good compared with several other OECD countries (Figs 8.6 and 8.7).

Fig. 8.6

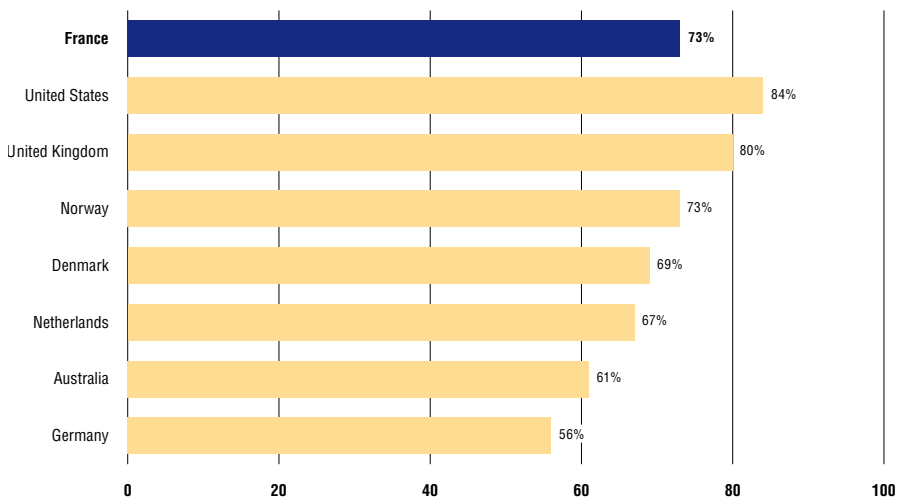
Influenza immunization rate in people over 65 years (%)



Source: Or, Com-Ruelle 2008.

Fig. 8.7

Cervical cancer screening rate in women aged 20 to 69 years (%)



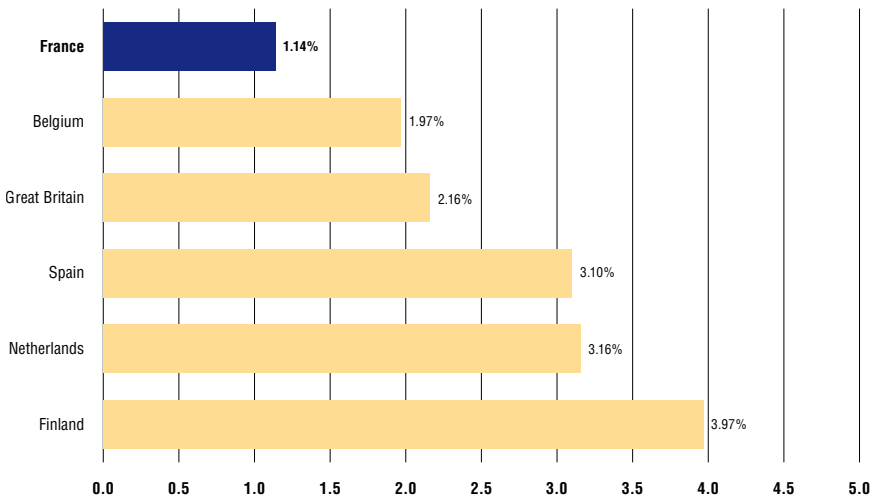
Source: Or, Com-Ruelle 2008.

However, quality of prescribing practice and management of chronic conditions are areas where major improvement can be made. For instance, France compares very poorly in the management of diabetes when compared with some other developed countries (Schoen et al. 2009), and unnecessary antibiotic prescription remains high (see Section 7.1.3).

Safety of inpatient care is gradually improving, with the prevalence rate of hospital-acquired infection decreasing from 7.5% in 2001 to 5.4% in 2006 (Or, Com-Ruelle 2008). Comparative data on local infection of the surgery site for hip replacement and caesarean section show that France is performing well (Figs 8.8 and 8.9).

Fig. 8.8

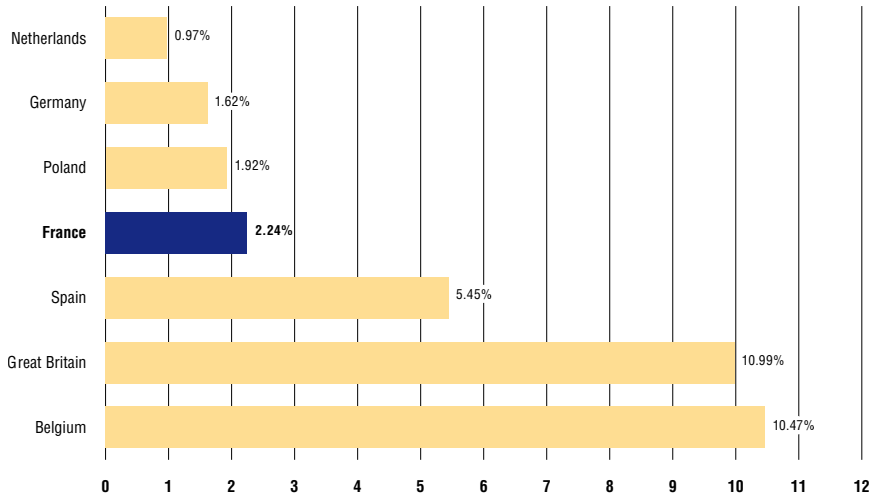
Local infection rate of the surgery site for hip replacement (%)



Source: Or, Com-Ruelle 2008.

Fig. 8.9

Local infection rate of the surgery site for caesarean section (%)

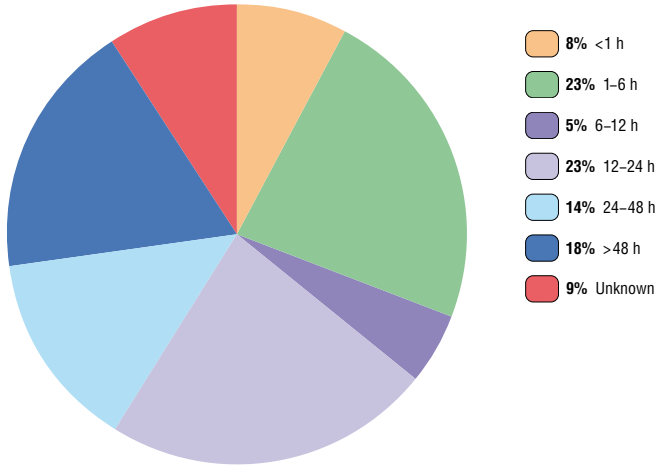


Source: Or, Com-Ruelle 2008.

Finally, the quality of the delivery of care is partly reflected by waiting times. A 2004 survey of the French population found that waiting times for visiting a doctor varied across specialties and were higher for specialists (median, 25 days) than for GPs (median, 24 hours). The population is generally satisfied with the latter waiting time; only 11% would have wished to have an appointment with their GP faster (Fig. 8.10) (Or, Com-Ruelle 2008). However, very few data are available on timelines for other types of care, such as emergency care and planned surgery, as well as time spent in waiting rooms of doctors' practices.

Fig. 8.10

Waiting time prior to getting a GP consultation appointment



Source: Or, Com-Ruelle 2008.

8.6 The contribution of the health system to health improvement

While the overall health of the French population is good and health care ensures relatively long life expectancy after 65 years in France compared with other high-income countries, avoidable mortality from violence and lifestyle factors is higher in France than in most EU countries (WHO 2000). This important issue has been recognized at the government level which has resulted in effective policies to reduce road traffic accidents: the combination of enforced controls and high taxes on petrol was accompanied by a halving of deaths over a 10-year period.

Similarly, smoking ban policies were fully implemented in all public places in 2009. This was followed by a decrease in smoking rates as well as a yet to be confirmed decrease in cardiac accidents in the younger population.

With regards to healthier diet, the Ministry of Health launched in 2005 the National Health Nutrition Programme (*programme national nutrition santé*; PNNS); this enlisted support from other ministries, most notably the Ministry of Agriculture, which in 2007 developed a food policy “to incite the agricultural and agrifood industries to launch varied, high-quality foods that meet consumer expectations and public health objectives”. However, one of the obstacles to

the adoption of a healthier diet with at least five different fruits or vegetables per day was the relative high price of those products compared with starch and fat. The programme also focused on encouraging people to exercise more. Another objective concerned salt intake. The average daily consumption was 10 g/person. In a 2002 report, the Food Safety Agency set a target of 20% reduction in salt intake (AFSSA 2002). Therefore, the 2006–2010 national health nutrition programme introduced contractual partnership between public health stakeholders and food industries to achieve a reduction in salt intake. In 2008, the Ministries of Health, Agriculture and Consumers Affairs set up an Observatory of Food Quality with the remit of monitoring the salt content of processed foods. A recent evaluation from the HCSP (HCSP 2010) shows that an improvement in childhood obesity occurred between 2004 and 2009 and that people exercised more, although the empirical design does not allow for conclusions on a causal relationship.

Overall, the HCSP assessment of the effectiveness of public health policy defined through the health targets in the 2004 Public Health Acts (see Section 6.1) (HCSP 2010) shows that out of the 56 targets that could be assessed, 10 had been achieved (for example, decrease in cardiovascular death, stable incidence rate of chronic renal failure) and 13 had been partly achieved (for example, increasing immunization coverage). Despite the continued need for improvement, this highlighted the positive role of public health policy on the improvement of the health of the population.

9. Conclusions

The French health system has achieved success in meeting its goals of full coverage, access without waiting lists, patient choice and satisfaction. However, major problems include lack of coordination between hospital and ambulatory services, between private and public provision of care and between health care and public health. Furthermore, the relatively high level of health expenditure is increasingly of concern at a time when the public system is facing chronic deficits, which are likely to increase with the current economic downturn.

In light of these issues, the health care system in France is undergoing a series of structural reforms with regards to both its organization and its financing. In 2004, the Health Insurance Reform Act introduced new relationships between providers, patients and payers through the implementation of the preferred doctor scheme and a new governance system for SHI. The Public Health Act in the same year proposed public health objectives for the 2005–2009 period, which were partly assessed in 2010 and are expected to serve as a basis for future public health plans and for public health objectives for the 2010–2014 period. Putting both public health and health care financing on the same legislative agenda was an important step in improving coordination in the health system. However, the two Acts were not entirely complementary, and public health and financing were essentially managed as separate issues. For instance, the Public Health Act reorganized governance of learning activities (FMC) without taking into account the audit of medical practice (EPP) process that was made compulsory by the Health Insurance Reform Act in the framework of the medical cost-containment policy, while the public health objectives did not constitute a binding obligation or even a framework for use of resources by financing bodies. This illustrates the need for further integration of health policy at the national level.

The 2009 Hospital, Patients, Health and Territories Act (HPST Act) aimed at a further integration of public health, health care delivery and financing by creating a one-stop shop at the regional level, the regional health agency (ARS). The ARS governs all these aspects of the health system and has a fundamental role in articulating the ambulatory, hospital and health and social care sectors. At the time of writing, this authority had just been established in each of the 26 regions, and further assessments will help to identify remaining issues and challenges.

The financial sustainability of the system is fragile. The need to control SHI expenditure has led to several measures attempting to contain demand, to increase SHI resources or to decrease SHI expenses, frequently leading to an increase in patient out-of-pocket payments. In acknowledgement that such measures may have negative effects on equity of access, counterbalancing measures have been introduced. These include the creation of safety nets for given populations, such as free public complementary health insurance for low-income groups and financial aid for purchasing voluntary health insurance contracts for households with an income just above the ceiling for free complementary health insurance. Despite these measures, socioeconomic disparities in access to health care are increasing and, as a consequence, disparities in health status remain broad. This challenge should be better addressed with new public health objectives for the 2010–2014 period, but substantial policy efforts still need to be made. There is also scope for health services research in this field in order to identify barriers to access to care, including non-financial barriers, thus enlightening the policy-making process.

Despite three decades of cost-containment measures, the debt accumulated by SHI was estimated to be around €135 billion in 2009. Following the economic downturn, the 2009 annual deficit reached €11.5 billion, whereas it was around less than half of this in previous years. France only recently implemented a budget cap for SHI expenditure by creating the national ceiling for SHI expenditure (ONDAM) in 1996. Formerly, this budget was of a very soft form, with parliament voting an expected target. However, the parliament, SHI, and government were unable to control expenditure along the course of the year. Indeed, statutory tariffs for self-employed professionals, medical devices and drugs are negotiated on a pluriannual basis and, therefore, fixed for a given period of time, and there is not *a priori* control of the volume of care consumed. However, recent measures have attempted to make ONDAM into a harder form of budget. The first measure was creating the Alert Committee in 2004 and the group for statistical monitoring of ONDAM in 2010, while the second gave the head of the Directorate of Social Security the power to present a financial rescue

plan when the overrun is above 0.75% of SHI expenditure (which corresponded to €1.22 billion in 2010) or to introduce correcting interventions during the year. These interventions include, for example, a decrease in hospital DRG tariffs set by the Ministry of Health and a freeze of a share of budgets dedicated to the Quality and Coordination of Care Fund (*fonds d'intervention pour la qualité et la coordination des soins*; FIQCS), to the social and health care sector and to the hospital block grant for public utility mission (MIGAC). However, what is striking is that these measures hardly concern services and goods delivered or prescribed on a private basis by self-employed professionals, when in fact this is the area where the overrun is the greatest. For instance in 2008, of the €930 million that was spent in excess of the overall target, €800 million came from the private practice subarea of expenditure, while only €130 million came from the hospital sector. Meanwhile, the targets of the health and social care sector and the other types of care, which includes FIQCS, were respected.

This suggests that, in addition to traditional measures that remove certain goods and services from SHI coverage and structural reforms that reduce duplication and inefficiencies, reorganization of health care delivery and financing needs to be considered, in particular with regards to private practice. One important structural aspect of the French health care system is fee-for-service payment for self-employed professionals based on the national agreements they establish with SHI. In June 2010, SHI announced the implementation of individual payment for performance contracts (CAPI) for GPs, as a first step in reforming the fee-for-service model. However, this is an extremely challenging policy area. One important issue is the significant role of the Ministry of Health in the decision-making process and whether any government would have the required political power to defend these types of reform. This difficulty was illustrated recently by the Minister of Health's reversal of the negative financial incentives set in the 2009 HPST Act for doctors who refused to sign a contract to deliver care in under-served areas. Controlling expenditure in the private practice sector, therefore, remains a major concern.

10. Appendices

10.1 References

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10.2 Useful web sites

AFSSA:

<http://www.afssa.fr/>

AFSSAPS:

<http://www.afssaps.fr/>

AFSSET:

<http://www.afsset.fr/>

AMELI:

<http://www.ameli.fr/>

ANAP:

<http://www.anap.fr/>

ANESM:

<http://www.anesm.sante.gouv.fr/>

ARH:

<http://www.parhtage.sante.fr/re7/site.nsf>

ATIH:

<http://www.atih.sante.fr/>

CHG:

<http://www.cphweb.info/>

CMH:

<http://www.cmh-hopital.org/>

CNSA:

<http://www.cnsa.fr/>

Conseil de l'ordre des médecins:

<http://www.conseil-national.medecin.fr/>

CSMF:

<http://www.csmf.org/>

EHESP:

<http://www.ehesp.fr/>

FEHAP:

<http://www.fehap.fr/>

FHF:

<http://www.fhf.fr/>

FHP:

<http://www.fhp.fr/>

FMF:

<http://www.fmfpro.com/>

FNMF:

<http://www.mutualite.fr/>

Fonds CMU:

<http://www.cmu.fr/site/index.php4>

French social security:

<http://www.securite-sociale.fr/>

GMSIH:

<http://www.gmsih.fr/>

HAS:

http://www.has-sante.fr/portail/jcms/j_5/accueil

HCAAM:

<http://www.securite-sociale.fr/index.html>

HCSP:

<http://www.hcsp.fr/explore.cgi/accueil?ae=accueil>

Health agencies:

<http://www.sante.fr/>

INCa:

<http://www.e-cancer.fr/>

INPES:

<http://www.inpes.sante.fr/>

InVS:

<http://www.invs.sante.fr/>

IRSN:

<http://www.irsn.fr/FR/Pages/home.aspx>

MG France:

<http://www.mgfrance.org/>

Ministry of Health:

<http://www.sante-sports.gouv.fr/>

MSA:

<http://www.msa.fr/>

OECD health data:

[http://www.ecosante.org/index2.php?base=OCDE&langh=ENG&langs=ENG
&sessionid=](http://www.ecosante.org/index2.php?base=OCDE&langh=ENG&langs=ENG&sessionid=)

ONDPS:

[http://www.sante-sports.gouv.fr/observatoire-national-de-la-demographie-
des-professions-de-sante-ondps.html](http://www.sante-sports.gouv.fr/observatoire-national-de-la-demographie-des-professions-de-sante-ondps.html)

RSI:

<http://www.le-rsi.fr/>

SML:

<http://www.lesml.org/>

SNAM-HP:

<http://www.snamhp.org/>

UNPS:

<http://www.unps-sante.org/>

URCAM:

<http://www.urcam.fr/portail.0.html>

URML:

<http://www.urml-idf.org/Public/>

10.3 HiT methodology and production process

The HiT profiles are produced by country experts in collaboration with the Observatory's research directors and staff. The profiles are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources and examples needed to compile HiTs. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. The most recent template is available online at: [http://www.euro.who.int/en/home/projects/observatory/publications/
health-system-profiles-hits/hit-template-2010](http://www.euro.who.int/en/home/projects/observatory/publications/health-system-profiles-hits/hit-template-2010).

Authors draw on multiple data sources for the compilation of HiT profiles, ranging from national statistics, national and regional policy documents to published literature. Furthermore, international data sources may be incorporated, such as those of the OECD and the World Bank. The OECD Health Data contain over 1200 indicators for the 33 OECD countries. Data are drawn from information collected by national statistical bureaux and health ministries. The World Bank provides World Development Indicators, which also rely on official sources.

In addition to the information and data provided by the country experts, the Observatory supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the European Health for All database. The Health for All database contains more than 600 indicators defined by the WHO Regional Office for Europe for the purpose of monitoring Health in All Policies in Europe. It is updated for distribution twice a year from various sources, relying largely upon official figures provided by governments, as well as health statistics collected by the technical units of the WHO Regional Office for Europe. The standard Health for All data have been officially approved by national governments. With its summer 2007 edition, the Health for All database started to take account of the enlarged EU of 27 Member States.

HiT authors are encouraged to discuss the data in the text in detail, including the standard figures prepared by the Observatory staff, especially if there are concerns about discrepancies between the data available from different sources.

A typical HiT profile consists of 10 chapters.

- 1 Introduction: outlines the broader context of the health system, including geography and sociodemography, economic and political context, and population health.
- 2 Organizational structure: provides an overview of how the health system in the country is organized and outlines the main actors and their decision-making powers; discusses the historical background for the system; and describes the level of patient empowerment in the areas of information, rights, choice, complaints procedures, safety and involvement.
- 3 Financing: provides information on the level of expenditure, who is covered, what benefits are covered, the sources of health care finance, how resources are pooled and allocated, the main areas of expenditure, and how providers are paid.

- 4 Regulation and planning: addresses the process of policy development, establishing goals and priorities; deals with questions about relationships between institutional actors, with specific emphasis on their role in regulation and what aspects are subject to regulation; and describes the process of HTA and research and development.
- 5 Physical and human resources: deals with the planning and distribution of infrastructure and capital stock; the context in which IT systems operate; and human resource input into the health system, including information on registration, training, trends and career paths.
- 6 Provision of services: concentrates on patient flows, organization and delivery of services, addressing public health, primary and secondary health care, emergency and day care, rehabilitation, pharmaceutical care, long-term care, services for informal carers, palliative care, mental health care, dental care, complementary and alternative medicine, and health care for specific populations.
- 7 Principal health care reforms: reviews reforms, policies and organizational changes that have had a substantial impact on health care.
- 8 Assessment of the health system: provides an assessment based on the stated objectives of the health system, the distribution of costs and benefits across the population, efficiency of resource allocation, technical efficiency in health care production, quality of care, and contribution of health care to health improvement.
- 9 Conclusions: highlights the lessons learned from health system changes; summarizes remaining challenges and future prospects.
- 10 Appendices: includes references, useful web sites and legislation.

The quality of HiTs is of real importance since they inform policy-making and meta-analysis. HiTs are the subject of wide consultation throughout the writing and editing process, which involves multiple iterations. They are then subject to the following:

- A rigorous review process (see the following section).
- There are further efforts to ensure quality while the profile is finalized that focus on copy-editing and proofreading.

- HiTs are disseminated (hard copies, electronic publication, translations and launches). The editor supports the authors throughout the production process and in close consultation with the authors ensures that all stages of the process are taken forward as effectively as possible.

One of the authors is also a member of the Observatory staff team and they are responsible for supporting the other authors throughout the writing and production process. They consult closely to ensure that all stages of the process are as effective as possible and that the HiTs meet the series standard and can support both national decision-making and comparisons across countries.

10.4 The review process

This consists of three stages. Initially the text of the HiT is checked, reviewed and approved by the series editors of the European Observatory. The HiT is then sent for review to two independent academic experts and their comments and amendments are incorporated into the text, and modifications are made accordingly. The text is then submitted to the relevant ministry of health, or appropriate authority, and policy-makers within those bodies are restricted to checking for factual errors within the HiT.

10.5 About the authors

Karine Chevreul is a medical doctor, specialist in public health. She carried out her PhD research in the Department of Social Policy at the London School of Economics. She holds two Master degrees, one in Health Services Management from the London School of Hygiene & Tropical Medicine and one in Public Health in Developing Countries from Paris VI University. She has been a technical adviser to ministers of health and of social security, elderly, disabled and family. She is currently the deputy head of the Paris Health Economics and Health Services Research Unit and a researcher in the Public Health Department of the Henri Mondor Teaching Hospital in Créteil.

Isabelle Durand-Zaleski is a medical doctor, Professor in Public Health. She carried out her PhD research in economics and management at Paris IX University. She holds a Masters in Public Health from Harvard University and a diploma from the Political Study Institute of Paris (*Institut d'Etudes Politiques de Paris*). She has been the head of the Evaluation Department in the National Health Authority. She is currently the head of the Paris Health Economics and Health Services Research Unit and the head of the Public Health Department of the Henri Mondor teaching hospital in Créteil.

Stéphane Bahrami is a medical doctor, specialist in public health. He is currently conducting his PhD research in economics in Paris IX University. He has completed the doctoral courses in Health Economics and Policy from the Swiss School of Public Health. He holds a Masters in Health Economics from Paris IX University and a Bachelor of Science from the *Ecole Polytechnique*. He is currently a researcher in the Paris Health Economics and Health Services Research Unit and in the Public Health Department of the Henri Mondor teaching hospital in Créteil.

Cristina Hernández-Quevedo is Technical Officer at the European Observatory on Health Systems and Policies. She holds a PhD in Economics and MSc in Health Economics from the University of York, United Kingdom. Research interests include inequalities in health, equity in access to health care services and socioeconomic determinants of health, and she has published articles on these topics in internationally recognized scientific journals.

Philipa Mladovsky is a Research Officer at the European Observatory on Health Systems and Policies and at LSE Health. She holds an MSc in Health, Population and Society from the LSE. Research interests include comparative health policy, health financing, and health inequalities, including migrant health.

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When noted, they are also available in other languages:

^a Albanian

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