

# Health Care Systems in Transition

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## France

## 2004



The European Observatory on Health Systems and Policies is a partnership between the World Health Organization Regional Office for Europe, the governments of Belgium, Finland, Greece, Norway, Spain and Sweden, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

**Keywords:**

DELIVERY OF HEALTH CARE

EVALUATION STUDIES

FINANCING, HEALTH

HEALTH CARE REFORM

HEALTH SYSTEM PLANS – organization and administration

FRANCE

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**Suggested citation:**

Sandier S, Paris V, Polton D. *Health care systems in transition: France*. Copenhagen, WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004.

**European Observatory on Health Systems and Policies:**

WHO Regional Office for Europe

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Government of Finland

Government of Greece

Government of Norway

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Government of Sweden

European Investment Bank

Open Society Institute

World Bank

London School of Economics and Political Science

London School of Hygiene &amp; Tropical Medicine

# Contents

<b>Foreword</b> .....	v
<b>Acknowledgements</b> .....	vii
<b>Introduction and historical background</b> .....	1
Introductory overview.....	1
Historical background.....	5
<b>Organizational structure and management</b> .....	19
Organizational structure of the health care system.....	19
Planning, regulation and management.....	28
<b>Health care financing and expenditure</b> .....	35
Main system of financing and coverage .....	35
Health care benefits and rationing .....	38
Complementary sources of financing .....	43
Health care expenditure .....	46
<b>Health care delivery system</b> .....	57
Public health services .....	57
Primary and secondary ambulatory care .....	61
Secondary and tertiary inpatient care .....	68
Social care.....	79
Human resources and training .....	82
Pharmaceuticals .....	92
Health care technology assessment .....	97
<b>Financial resource allocation</b> .....	101
Third party budget setting and resource allocation .....	101
Payment of hospitals .....	104
Payment of health care professionals .....	109
<b>Health care reforms</b> .....	115
Why embark on reforms? .....	115
Reform objectives .....	115
Contents of the main reforms and related legislation .....	118
The implementation of reforms .....	128
<b>Conclusions</b> .....	133
<b>List of abbreviations</b> .....	137
<b>Bibliography</b> .....	141



## Foreword

**T**he Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of a health care system and of reform initiatives in progress or under development. The HiTs are a key element of the work of the European Observatory on Health Systems and Policies.

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

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

The HiT profiles are produced by country experts in collaboration with the Observatory's research directors and staff. In order to facilitate comparisons between countries, the profiles are based on a template, which is revised periodically. The template provides the detailed guidelines and specific questions, definitions and examples needed to compile a HiT. This guidance is intended to be flexible to allow authors to take account of their national context.

Compiling the HiT profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health care 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 WHO Regional Office for Europe health for all database, Organisation for Economic Cooperation and Development (OECD) Health Data and data from the World Bank. Data collection methods and definitions sometimes vary, but typically are consistent within each separate series.

The HiT profiles provide a source of descriptive information on health care systems. They 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 care systems. This series is an ongoing initiative: material is updated at regular intervals. Comments and suggestions for the further development and improvement of the HiT profiles are most welcome and can be sent to [observatory@who.dk](mailto:observatory@who.dk). HiTs, HiT summaries and a glossary of terms used in the HiTs are available on the Observatory's website at [www.observatory.dk](http://www.observatory.dk).

## Acknowledgements

The French HiT was written by Simone Sandier (ArgSES), Valérie Paris (IRDES) and Dominique Polton (IRDES). It was edited by Sarah Thomson (European Observatory on Health Systems and Policies) and Elias Mossialos (European Observatory on Health Systems and Policies). The Research Director for the French HiT was also Elias Mossialos.

The European Observatory on Health Systems and Policies is grateful to Martine Bellanger (National School of Public Health in Rennes) and Karine Chevreul (LSE Health and Social Care) for reviewing the report and to Yves Charpak (World Health Organization Regional Office for Europe) for his comments on the report.

The authors of the HiT would like to thank their colleagues and friends Agnès Couffinhal, Pierre-Jean Lancry, Thérèse Lecomte and Arié and Andrée Mizrahi, who reviewed all or part of the first draft of this report and thereby improved it. They also thank the reviewers mentioned above and the Observatory staff for their helpful comments. The help and support of the French Ministry of Health is much appreciated.

The current series of Health Care Systems in Transition profiles has been prepared by the research directors and staff of the European Observatory on Health Systems and Policies.

The European Observatory on Health Systems and Policies is a partnership between the WHO Regional Office for Europe, the Governments of Belgium, Finland, Greece, Norway, Spain and Sweden, the European Investment Bank, the Open Society Institute, the World Bank, 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, Head of the Secretariat, and research directors Martin McKee, Elias Mossialos and Richard Saltman. Technical coordination is carried out by Susanne Grosse-Tebbe.

Jeffrey V. Lazarus managed the production with the support of Misha Hoekstra (copy-editing), Susanne Grosse-Tebbe (proof-reading) and Shirley and Johannes Frederiksen (lay-out). Administrative support for preparing the HiT on France was undertaken by Uta Lorenz, Myriam Andersen and Anna Maresso. The Observatory is grateful for the financial support of AstraZeneca which helped cover parts of the production costs of the HiT report.

Special thanks are extended to the WHO Regional Office for Europe for its Health for all database, from which data on health services were extracted; to the OECD for the data on health services in western Europe, and to the World Bank for the data on health expenditure in central and eastern European countries. Thanks are also due to national statistical offices that have provided national data.

The report reflects data available in autumn 2003.



# Introduction and historical background

## Introductory overview

### Geography and demography

**O**n 1 January 2001, the French population totalled 59 million inhabitants of metropolitan (mainland) France and 1.7 million inhabitants of the French overseas departments of Guadeloupe, French Guyana, Martinique and Réunion.

Metropolitan France covers an area of about 545 000 km<sup>2</sup>, giving an average density of 107 people per km<sup>2</sup>, which places it in ninth position in the European Union (EU), far behind the Netherlands, the United Kingdom and Germany. However, average density conceals considerable variations; half of all French people live on 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 there has been a rapid catching-up process. By 1999, 76% of the population was living in urban areas. In the last ten years or so, this urban growth has mainly taken place in outer suburbs and rural areas surrounding towns, rather than in centres.

As a result of decreasing rates of fertility and increasing life expectancy, France's population is ageing. Today, one in six French people is over 64 years old, compared to 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 shows the most recent demographic indicators.

Fig. 1. Map of France<sup>1</sup>

Source: World Factbook 2003.

### 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.

<sup>1</sup> The maps presented in this document do not imply the 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.

**Table 1. Demographic and health indicators for metropolitan France, 2000**

Population on 1 January 2001	59 053 300
Distribution by age (%)	
– less than 20 years	25.4
– 20 to 64 years	58.5
– 65 years and over	16.1
Life expectancy at birth (years)	
– women	82.7
– men	75.2
Infant mortality (per 1000 births)	4.4
Mortality (per 1000 population)	9.1
Total fertility rate	1.9
Crude birth rate (per 1000 population)	13.2

Source: INSEE 2001, OECD 2001.

The President of the Republic is elected by direct universal suffrage. The President's term of office, until recently seven years, has now been reduced to five years. The government, led by the Prime Minister, who is nominated by the President of the Republic, determines and conducts policies. The Prime Minister is accountable to parliament, which exercises legislative power and is made up of the National Assembly and the Senate.

577 deputies elected by direct universal suffrage make up the National Assembly. 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.

The Senate consists of 321 senators elected for nine years by indirect universal suffrage, through an electoral college consisting of elected persons in each department (see below). 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 20 years, the civil service, against the background of its long tradition of centralizing policies, has undergone substantial changes. 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 elected assemblies with their own areas of responsibility and a certain degree of autonomy in relation to the central authorities.

The 36 679 municipalities<sup>2</sup> form the basic structure of France's administrative organization. They are run by a Municipal Council 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. Municipalities' areas of responsibility relate to local activities and are extensive in the economic and social sectors.

Departments, 96 of which are in metropolitan France and 4 overseas (Martinique, Guadeloupe, Réunion and French Guyana), are territorial communities with an elected assembly (the General Council) 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.

The 100 departments are grouped in 26 regions, 22 of which are in metropolitan France and 4 overseas (coinciding with the 4 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). Its specific jurisdiction mainly covers planning, development, economic development, vocational training and upper secondary educational institutions (*lycées*).

## Economic context

France's gross domestic product (GDP) has risen in 2000 to €1405 billion, which is an increase of 4% in value and 3.1% in volume in relation to 1999. These figures place France slightly below the EU average for per capita GDP. The budget deficit was 1.3% of GDP in 2000, as opposed to 1.6% in the preceding year.

In 2000, 26 million people were active in the labour market (that is, 45.3% of the population). Women represent 47% of the country's work force, and their participation in the labour market has increased dramatically in recent decades. The unemployment rate was 8.9% in July 2001, a decrease in relation to 1998. In the past 20 years, the structure of employment has moved away from agriculture (which today accounts for only 4% of the work force), manufacturing and construction (26% of the work force as opposed to 38% at the beginning of the 1970s), towards commercial activities and the services sector, which now involve 16 million people (69% of the work force).

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<sup>2</sup> This term is applied to all municipalities, irrespective of the size of their population (80% of them have fewer than 1000 inhabitants), which is why there are so many municipalities in France compared to many other European countries.

## Health status

Life expectancy increases regularly, by three months a year for men and by two months a year for women. The gap between male and female life expectancy remains high, although it is narrowing (see Table 1).

The overall picture of the state of health in France contains apparent contradictions. On one hand, indicators such as life expectancy and life expectancy without disability show that the health of the population is good. In terms of international comparison, women live longer and old people remain in better health. 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 mortality due to smoking and accidents, and social and geographical inequalities in health remain substantial (see Fig. 2).

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 west (Brittany and Normandy) 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 high rates of unemployment, etc.

The main causes of death in France are cardiovascular disease (31.1 % of deaths), cancer (27.7%), accidents (8.3%) and diseases of the respiratory system (8.1%).

## Historical background

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

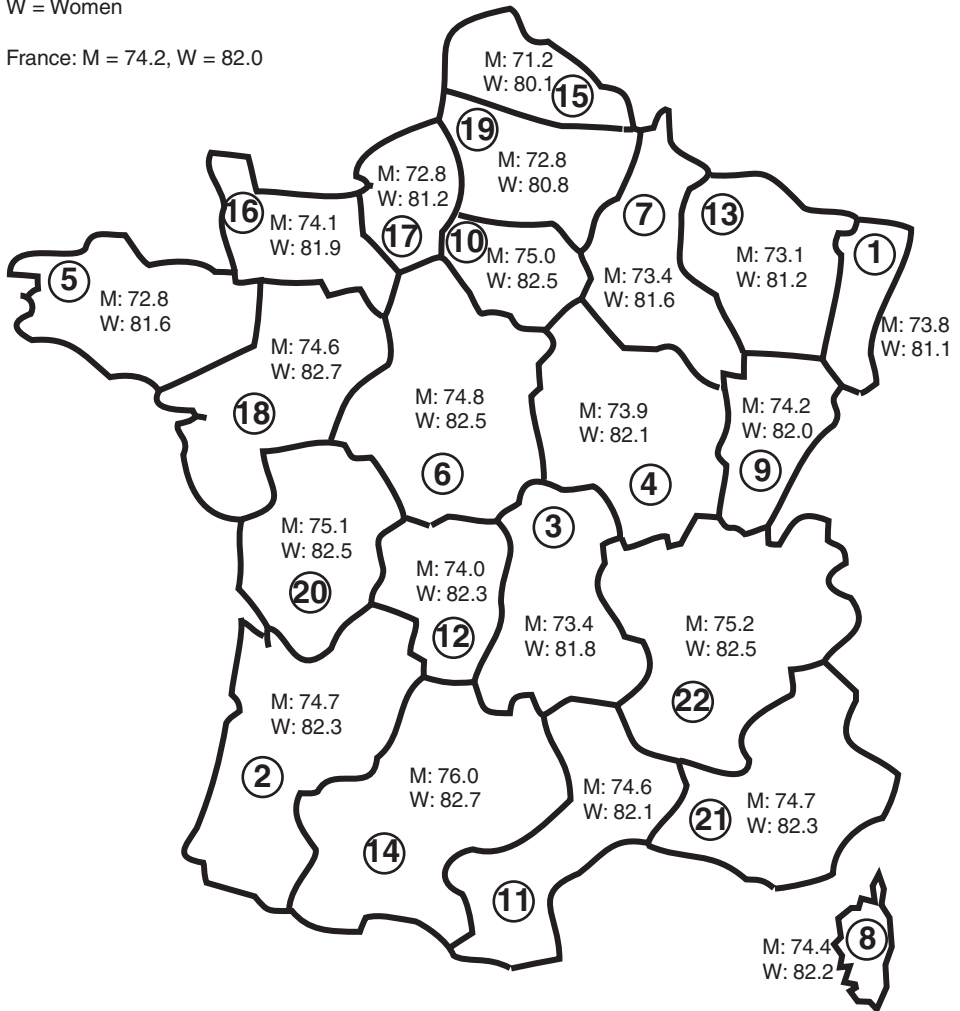
The present system of social security, including statutory health insurance, was established in 1945, at the end of the Second World War.

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.

**Fig. 2. Life expectancy by region, 1996**

M = Men  
W = Women

France: M = 74.2, W = 82.0



Sources: INSEE 2001, IRDES/DREES 2001.

- |                          |                                |
|--------------------------|--------------------------------|
| 1. Alsace                | 12. Limousin                   |
| 2. Aquitaine             | 13. Lorraine                   |
| 3. Auvergne              | 14. Midi-Pyrénées              |
| 4. Burgundy              | 15. Nord-Pas-de-Calais         |
| 5. Brittany              | 16. Normandy (Basse)           |
| 6. Centre                | 17. Normandy (Haute)           |
| 7. Champagne-Ardenne     | 18. Loire Valley               |
| 8. Corsica               | 19. Picardy                    |
| 9. France-Comté          | 20. Poitou-Charentes           |
| 10. Ile-de-France        | 21. Provence-Alpes-Côte d'Azur |
| 11. Languedoc-Roussillon | 22. Rhône-Alpes                |

**Table 2. Mortality by cause of death in 1998**

	Number of deaths	% deaths	Rate per 100 000 population
All causes	534003	100.0	914
Diseases of the circulatory system	166299	31.1	285
Malignant neoplasms	147681	27.7	253
External causes, poisoning	44108	8.3	76
Diseases of the respiratory system	43314	8.1	74
Undefined morbid conditions	33776	6.3	58
Diseases of the digestive system	26194	4.9	45
Endocrinal diseases	16070	3.0	28
Disorders of the nervous system	15531	2.9	27
Mental disorders	14568	2.7	25
Infectious diseases/parasites	7988	1.5	14
Diseases of the genital-urinary organs	7361	1.4	13
Diseases of the blood or haematopoietic organs	2981	0.6	5
Diseases of the osteo-articular system	2856	0.5	5
Diseases of the skin, cutaneous tissue	2481	0.5	4
Congenital abnormalities	1458	0.3	2
Perinatal conditions	1262	0.2	2

Source: IRDES/DREES 2001.

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 for employees in industry and business whose earnings fell below a certain level. It provided insurance 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 were covered for illness, with free choice of the organization providing coverage.

The social security system officially came into being with the Ordinance of 4 October 1945. In the early postwar days, priority was given to reconstruction, so the provision of social security was aimed primarily at workers and their families. 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 fact, statutory health insurance 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 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 to make a contribution on their behalf.<sup>3</sup> In practice, however, access to 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 system guaranteeing uniform rights for all. However, this goal could not be achieved due to opposition from certain socio-professional groups who already benefited from insurance coverage that had more favourable terms, 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 health insurance schemes are dominant: 95% of the population is covered by the general health insurance scheme (*régime général*), which covers employees in commerce and industry and their families, by the agricultural scheme and by the national insurance fund for self-employed non-agricultural workers (see the section on *Organizational structure and management*). 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 health insurance funds have never really had the management responsibilities accorded to sickness funds in the German health care system. The state rapidly took responsibility for the financial and operational management of health insurance (for example, setting premium levels and the prices of goods and services, etc.).

Difficulties arose in the 1980s, with a growing number of unemployed being deprived of their right to health insurance because the right was linked to professional activity. While the safety net of medical assistance for those with low incomes remained, the conditions under which it applied and the degree of generosity in its coverage depended on the resources and policies of the General Council in the individual’s department. Successive rounds of legislation have therefore softened the conditions governing access to compulsory insurance coverage and have 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).

An important reform recently took place in the form of the Universal Health Coverage Act (CMU), which was passed in June 1999 and came into force on 1 January 2000. This act, as its name suggests, establishes universal health

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<sup>3</sup> Based on an arrangement inherited from the principle of aid to the poor, which applied before the establishment of statutory health insurance.



coverage, opening up the right to statutory health insurance coverage on the basis of residence in France. Furthermore, those whose income is below a certain level (currently 1.8% of the population) are entitled to free coverage. 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), has now been replaced by a system based on the right to health insurance and the logic of social protection through insurance rather than state aid.

The CMU Act has 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, named after the Prime Minister of the time, which introduced two important changes:

- first, in the method of funding health insurance, by substituting part of the contribution based on earned income (wages) with a contribution based on total income, which was more like a tax on income;
- secondly, in the institutions responsible for operating health insurance, by giving parliament, from 1997 onwards, a role in the definition of health care and financial targets.

Three key lines of evolution can therefore be observed in the French health insurance system:

- universal health coverage based on residence;
- the substitution of a tax on income for wage contributions in the funding of the system;
- a more active role for parliament in determining policy directions and expenditure targets.

The CMU Act also contains other provisions that represent a major development in the French social security system: in addition to universal health coverage, those with incomes below a certain level have the right to complementary voluntary health insurance (VHI) coverage (see the section on *Complementary sources of finance*).

### **The management of social security and the division of responsibilities between the state and the health insurance funds**

The general social security system created in 1945 was associated with the idea of social democracy; it was made up of a network of health insurance funds headed by elected boards of directors comprising representatives of employees (a majority) and employers.

The first important reform of the organization of social security took place in 1967:

- first, establishing a separation into four branches: health insurance, pensions, family benefits, and insurance for work-related accidents and occupational illnesses;
- secondly, elections to the board of directors were discontinued and replaced by a system of appointment by trades unions, with parity between employers and employees, giving more weight to employers than previously.

In 1982, with the political left coming to power, the intention of restoring the original principles of 1945 was announced; that is, that there would be a return to elections and a majority of employees on the boards. In practice, however, such elections only took place once, in 1983. The 1996 Juppé reform returned to the principles of 1967 by appointing board members rather than electing them and by reintroducing parity between employers and employees.

This succession of reforms reflects an important debate concerning the legitimacy of the so-called “social partners” in the management of health insurance funds and their role in the health care system, particularly with regard to the role of the state. The division of power between the state and the health insurance funds has always been problematic. Traditionally, the compromise was to organize a division along sector lines; the state handled policy concerning public hospitals and drugs, while the health insurance funds took charge of independent (private) medical practice (including the services provided by self-employed professionals and private for-profit hospitals) on the basis of negotiated agreements. Decisions concerning the financing of the health insurance funds (conditions and levels of social contributions) were clearly within the state’s remit.

Over time, this balance has tended to shift towards increasing state intervention, particularly since the issue of balancing the public accounts, and thereby controlling public expenditure, has figured prominently on the political agenda. From the 1980s onwards, these conflicts and contradictions, arising from the complexity of the institutional structures, have become more and more visible. Since the beginning of the 1990s, experiments have been set up in certain sectors, with tripartite agreements between the state, the health insurance funds and the health care professions.

The 1996 Juppé reform involved a more radical reorganization of institutions and powers. To many, it was seen as giving the state control of the health care system, and it is true that some of its most significant measures explicitly increased the role of the state, for example the reinforcement of the role of parliament and the creation of regional hospital agencies (ARH). It also

established an “agreement on targets and management” between the government and the largest health insurance fund, the National Insurance Fund for Employed Workers (CNAMTS), which was intended to clarify the roles of each (see the section on *Organizational structure and management*).

A further attempt to clarify roles was made in 2000, with the Social Security Funding Act. According to the terms of this act, the whole hospital sector was to be the responsibility of the state (including private for-profit hospitals), but in return the government delegated to CNAMTS the dual responsibility of regulating the fees charged by all self-employed health care professionals and negotiating with them targets (ceilings) for expenditure. However, this reform was only applied in 2000 and was subsequently abandoned.

In spite of these attempts at clarification, the division of responsibilities remains unclear, and in recent years relations between state authorities and the health insurance funds have been marked by periods of open conflict, with the trend towards increased state control regularly denounced by the health insurance funds. This tension reached a critical point in September 2001, when employers withdrew from the boards of the health insurance funds. As a result, the institutional issue of who should be in charge of statutory health insurance is more central to the debate than ever before.

### **Confrontation between health care professionals and the state**

The implementation of statutory health insurance after the Second World War made it necessary to enter into negotiations with health care professionals in order to define a fee schedule. The medical unions were extremely hostile to negotiations concerning the fees they charged patients, which they viewed as an attack on one of the fundamental principles of independent medical practice— that of direct agreement with the patient on the fee to be charged. The negotiations were originally intended to take place between the regional health insurance funds and the local medical unions in each department, but the latter refused to take part. As a result, many departments were not able to finalize agreements and doctors continued to set their own fees. For their part, the health insurance funds reimbursed fees on the basis of “official” rates, which were well below the rates being charged in practice.

This conflict was the first in a long series of conflicts that has punctuated relations between medical unions, health insurance funds and state authorities over the last 50 years. Unlike in Germany, where doctors have agreed to co-manage the system with the sickness funds, the majority of French medical unions have tended to maintain an attitude of dispute, if not opposition, towards

the managers of the health insurance system. However, this has given rise to internal divisions within the medical profession, causing successive splits in their unions and resulting in some fragmentation of medical representation.

In 1960, the government put an end to the first phase of conflict, initiated in 1945, by imposing ceilings on charges and setting out the conditions under which these ceilings might be exceeded. Furthermore, although the possibility of negotiating collective agreements at the department level continued to exist, such agreements were now to follow a standard, nationally defined form. Importantly, doctors were offered the possibility of joining this national agreement on an individual basis, which considerably reduced the unions' power of veto.

The arrangements governing health service contracts with doctors were put on a national footing (*conventionnement*) in 1971. They applied to all doctors, except in cases of explicit refusal. In return, doctors were granted social and tax advantages<sup>4</sup> and gained reaffirmation, in the agreement, of the principles of independent medical practice: free choice of doctor, freedom to prescribe, professional confidentiality and direct payment of fees by the patient. National agreements (*conventions*) were subsequently signed in 1976, 1980, 1985, 1990, 1993 and 1997–1998.

Rising concern about keeping health care expenditure under control made its mark on the negotiation of these agreements, which proposed successive measures aimed at controlling the costs of health insurance, in addition to fixing fees for treatment. These measures included:

- individual monitoring of the work of doctors (1971);
- the establishment of a 'second sector' (Sector 2), within which doctors were authorized to exceed the ceiling on negotiated charges, but charges in excess of the ceiling would not be reimbursed by the health insurance funds (1980); doctors who chose this option lost their social and tax advantages;
- limiting the freedom to prescribe by introducing practice guidelines (RMOs), which doctors must respect or face sanctions (1993); however, this measure was partially annulled by the courts in 1999.

The 1996 Juppé reform introduced two major changes in relations between doctors and the health insurance funds. On one hand, the law aimed to delimit doctors' activity in terms of fees and prescriptions by setting an estimated target (ceiling) for expenditure, defined annually, with failure to respect this target giving rise to financial penalties. This "book-keeping control", as the most important medical union, the Confederation of French Medical Unions (CSMF), has called it, formed the focus for CSMF's strategy of opposition to agreements, and between 1996 and 2002 CSMF did not sign a single agreement.

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<sup>4</sup> For example, doctors' payroll contributions are paid for by the health insurance funds.

On the other hand, the reform has opened up a new breach in the unity of the medical profession by allowing the signing of separate agreements with general practitioners and specialists. Thus, in 1997 the health insurance funds signed an agreement with MG-France, a general practitioners' union leaning more to the left than other unions and in favour of a specific re-evaluation of the status of general practitioners in relation to specialists. The specialists' agreement was only signed by one union representing a minority of health care professionals.

It should be noted that most of the agreements signed by the medical unions and the health insurance funds have been contested in law, and a number of them have had some of their provisions annulled. The 1997 agreements were no exception, and although a new agreement with the general practitioners, signed in 1998, was a partial replacement, it has not been possible to reach any agreement with the specialists, to whom minimal contractual regulations, defined unilaterally by the government, have since applied. Until the beginning of 2002, the relationship between the medical profession on the one hand, and the government and the health insurance funds on the other, had consistently deteriorated. The arrival of a new government has facilitated further dialogue.

## **50 years of hospital development**

An act passed in 1941, which took effect from 1945 onwards, signalled an important stage in the evolution of hospitals in France. Until then, public hospitals had been autonomous institutions attached to a geographical community, usually the municipality or department. Public hospitals had also been institutions that treated poor people, but since 1945 they have been opened up to all types of patient, and the links between the hospital and the local community have loosened somewhat.

While hospitals' association with municipalities was preserved, with the mayor remaining president of the board of directors, new powers were given to the Minister of Health, including: approval of a general plan for hospital organization, foreshadowing current planning processes; fixing salary levels for a large section of hospital workers, who are now endowed with a unique status; a role in the appointment of hospital directors, who were assigned some of the responsibilities of the board of directors.

This important ministerial intervention marked the beginning of an increasingly centralist policy for hospital development, which has tended to remove public hospitals from the exclusive remit of the municipality and to reduce significantly their autonomy. The 1941 Act even modified the recruitment

procedures for medical staff in hospitals, who had previously been co-opted locally, but were subsequently to be appointed by the prefect, following a competitive regional procedure.

In 1958, reform of the hospital sector reinforced the powers of the Minister of Health, extending the Minister's control over hospital building programmes and the appointment of hospital directors, who became executive agents of the central authority, even though they remained subordinate to the boards of directors. Among the most important provisions of the legislation were:

- the establishment of teaching hospitals, by means of agreements negotiated between regional hospitals and faculties of medicine;
- the introduction of the principle of full-time employment of doctors in these university hospitals, and for certain specialties in all public hospitals; this integrated doctors with hospital organization, while excluding all external activity, and represented a genuine transformation of these institutions; to encourage doctors to abandon their external private practice, the possibility of private practice within the hospital was offered to certain categories of doctors, and this 'private sector' in public hospitals is a recurring source of controversy.

The 1958 reform also placed the private hospital sector under state supervision with regard to capacity and equipment. Hospital planning has become more stringent since 1970. Neither public nor private hospitals can increase bed numbers or equipment without prior authorization and until 2003, authorization could only be given if the proposed increases were in line with the 'medical map' (*carte sanitaire*), which set out target capacities by geographical area.

## **The development of regulatory policies**

The founding fathers of the social security system hoped that the access to health care provided by statutory health insurance would make it possible to maintain good health among the whole population, and that as a result, the need for treatment would diminish over time. In practice, the pattern of development has been quite different, with the concurrent dynamic of an increased supply of services and greater demand leading to unrelenting growth in expenditure on health care. The onset of economic difficulties in the 1970s marked a turning point in policies towards the provision of health care, which became increasingly influenced by financial constraints.

In the past 25 years a succession of cost containment policies (both on the demand side and the supply side) has attempted to balance the accounts of the health insurance system. However, it has not been easy to implement cost control policies in a system characterized by fee-for-service payment of doctors, retrospective reimbursement and unrestricted freedom of choice for patients.

Measures to limit demand had been anticipated from the outset, with consumer responsibility fostered through cost sharing. The portion of the costs of treatment not reimbursed by the health insurance system was named “*ticket modérateur*” precisely because of its intended aim of moderating demand. Over the years, the patient’s share of treatment costs has steadily increased, by means of progressive increments, the introduction of a daily charge in hospitals and authorizations for Sector 2 doctors and for certain services, such as dentures and artificial limbs, to exceed standard charges. The share of treatment costs reimbursed by health insurance diminished from the mid-1980s to the middle of the following decade, but has been stable since then.

Over and above the problems of equity and access to treatment posed by this financial burden on the patient, the theoretical effectiveness of this measure, in terms of reducing expenditure, has been severely impaired by the massive extension of complementary VHI coverage, which today applies to 85% of the population, not counting those covered by CMU. Two attempts, in 1967 and 1979, to limit the coverage of health care costs by the bodies responsible for complementary VHI, leaving 5% of the costs to be paid by the patient, met with strong resistance and were abandoned.

More recently, the debate has shifted towards steering demand and organizing channels of treatment to limit free choice. For example, general practitioners are provided with financial incentives to become ‘referring doctors’ (that is, a kind of gatekeeper, with voluntary registration of patients).

Policies relating to the supply of treatment have targeted capacity as well as professional practices and charges for goods and services. These policies have diversified over the last 30 years. Control of capacity was one of the first instruments introduced after 1970. Limiting supply rapidly came to be seen as an essential mechanism on the basis of the potential for “supplier-induced demand” in health care, where patients have a low level of information and do not have to bear the full cost of treatment.

This type of control has been exercised in two ways: by the medical map, which until 2003 made the provision of hospital beds and certain kinds of equipment subject to authorization and limited them on the basis of an agreed ratio of beds and equipment per head of population, and by the *numerus clausus* system, which regulates access to medical training.

The implementation of the medical map led to a 25% reduction in the number of acute beds between 1975 and 1998. Nevertheless, the policy of restricting the number of beds rapidly proved to be ineffective, from the point of view of controlling expenditure, because it only took account of the hospital-stay function and did not account for the dynamics of technical progress, which led to a greater number of staff and equipment per bed.

Introduced for medical studies in 1971, the *numerus clausus* system first began to make its effect felt on the number of graduates at the end of that decade. Since then, the growth in the number of doctors has slowed. However, the number of doctors almost trebled between 1975 and 2000, reaching a ratio of 3.3 doctors per 1000 inhabitants. Today, the total number of doctors is stabilizing and will decrease from 2010 onwards.

In order to reduce the number of doctors, a financial incentive to retire early was set up in 1988 and reinforced in 1996. Between 1996 and 1998 the incentive was fairly generous, but since 1988 the incentive has been much smaller.

Initially based on a quantitative framework, hospital sector planning has evolved in the last ten years or so, with the establishment of regional strategic plans for organizing the provision of health care that are more qualitative in character.

Since the 1970s, measures have also been put in place to influence the behaviour of health care providers. The agreement of 1971 (see above) foresaw individual analysis of doctors' activity, based on statistical profiles. This rather crude instrument was intended more as a means of identifying cases of extreme individual behaviour than as a means of affecting the evolution of behaviour generally. More recently, developments in medical evaluation have made it possible to engage in a more qualitative approach involving the introduction of a system of guidelines for medical practice. Looking back, it is possible to note that these measures have had a significant and lasting impact on prescribing patterns, without, however, having a clear macro-economic impact.

There have been extensive attempts at price control through the negotiations held with health care professionals on the level of charges, and through administrative regulation of the price of reimbursable drugs. In terms of international comparisons, both payments to doctors and drug prices have been relatively low in France for a considerable period of time. The evolution of prices for medical services and goods has been moderate in relation to inflation in the long term; between 1978 and 2000 the consumer price index rose by 280% (210% for ambulatory treatment and 150% for pharmaceuticals). France's high volume of consumption, particularly where pharmaceuticals are concerned, may be linked to the relatively low level of prices.

As a possible solution to the price/volume dilemma, restrictive budgets were introduced in different sectors of the health care system in the 1980s and 1990s. From 1984/85 onwards, the system of funding public hospitals using a per diem rate was replaced by a system of global budgets. At the beginning of the 1990s, targets for limiting the expenditure of a whole sector were negotiated with laboratories, private for-profit hospitals and freelance nurses. In the event



that these targets are not met, corrective mechanisms, such as lowering levels of charges and claiming refunds (as penalties) from practitioners, may be applied.

Most health care professionals have remained fiercely opposed to both the principle and practice of a restrictive total framework for expenditure *ex ante*. The Juppé reform clearly included doctors among those subject to the principle of such restrictive budgets, with refunds in cases of non-compliance with budget targets. However, this latter provision has never been applied, and cases where targets have been exceeded have never given rise to refunds by doctors.



# Organizational structure and management

## Organizational structure of the health care system

Jurisdiction in terms of health policy and regulation of the health care system is divided between:

- the state: parliament, the government and various ministries
- the statutory health insurance funds
- to a lesser extent, local communities, particularly at the department level.

The institutional organization of the system was profoundly affected by the Juppé reform of 1996. 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 the health insurance funds, the reform significantly reinforced the role of the regions, creating new institutions at the regional level (see Fig. 3).

### The state: parliament and the government

Every year since 1996, the parliament has passed an Act on Social Security Funding based on the reports of the Accounts Commission (*Cour des Comptes*)<sup>5</sup> and the National Health Conference (see below). This act:

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

For example, the 2001 Act improved the benefits provided by the health insurance scheme for self-employed people, aligning them with those provided

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<sup>5</sup> The Accounts Commission is an independent body responsible for monitoring state and social security bodies to ensure adequate control over and proper use of public funds.

by the health insurance scheme for salaried workers. It also set up specific funds for the modernization of hospitals and for developing pharmaceutical information (independently from pharmaceutical companies) for doctors. The 2002 Act has renewed an agreement between the health insurance funds and health care professionals' organizations.<sup>6</sup>

The Ministry of Health, which has recently been reorganized, includes the following structures:

- a general directorate of health, responsible for health policy;
- a directorate of hospital and health care, responsible for the management of resources; its scope, previously limited to hospitals, has been extended to the whole health care system;
- a directorate of social security, responsible for financial matters, and for supervising social security organizations (including the health insurance funds);
- a general directorate for social policy, which is responsible for the specifically social aspects of health care (such as care for disabled, elderly or vulnerable people).

The Ministry of Health also has external services at local level: directorates of health and social affairs in the regions and departments (DRASS and DDASS). Their operations will be described below.

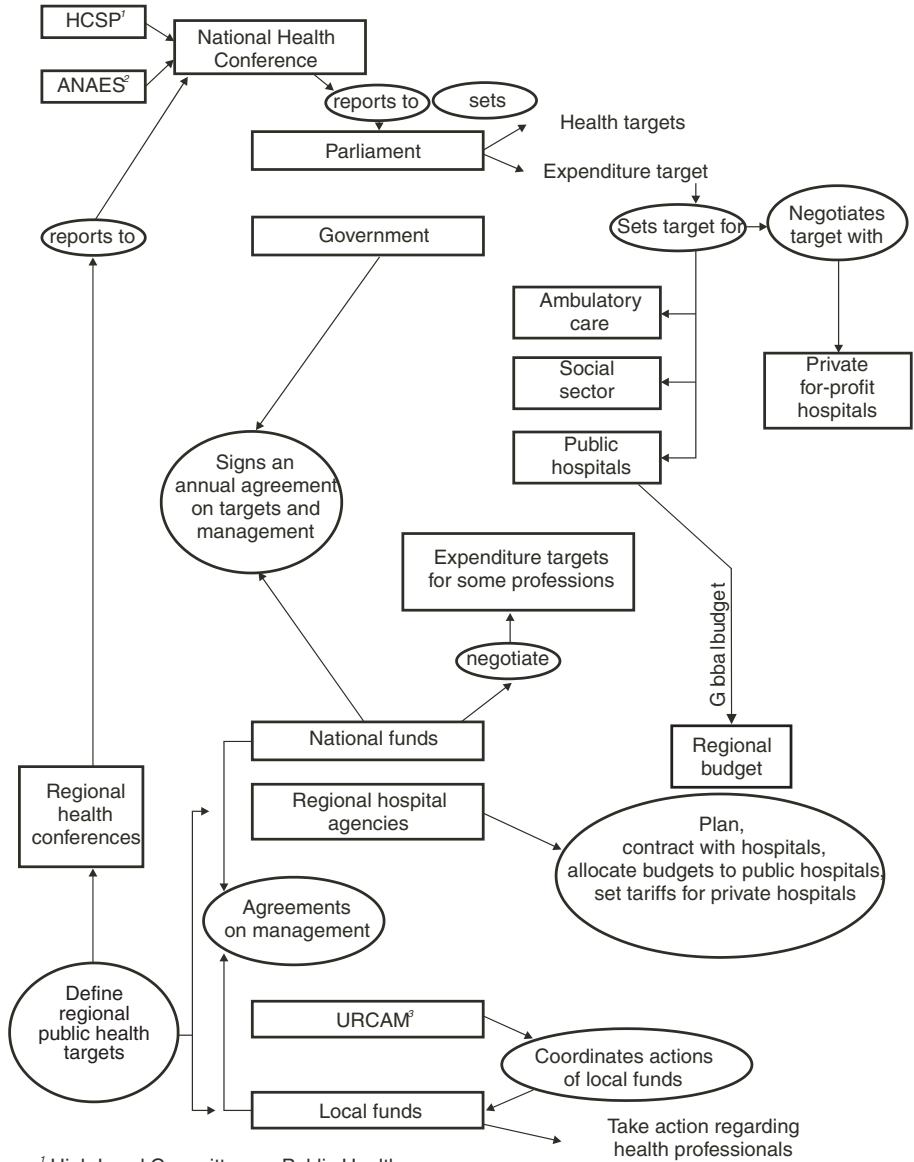
The Ministry of Health controls a large part of the regulation of health care expenditure, on the basis of the overall framework established by parliament. It is responsible for:

- dividing the budgeted expenditure between the different sectors 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 the health insurance funds 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 cancer, pain control and an anti-smoking campaign.

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<sup>6</sup> Replacing an earlier agreement that was originally deemed illegal by the courts.

Fig. 3. Organization of the French health care system



<sup>1</sup> High Level Committee on Public Health  
<sup>2</sup> National Agency for Accreditation and Evaluation of Health Care (Agence Nationale d'Accréditation et d'Evaluation en Santé)  
<sup>3</sup> Regional Unions of Insurance Funds (Unions Régionales des Caisses d'Assurance Maladie)

Source: various.

## Expertise and independent authorities within the administration

During the past ten years the state has established a number of committees and agencies to fulfil specific functions.

Set up in 1991 and located within the Ministry of Health, the High Level Committee on Public Health (*Haut Comité de Santé Publique*) 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. Since the Juppé reform of 1996, the committee has prepared an annual report for presentation to the National Health Conference and parliament.

With regard to medical safety, vigilance and warning systems, a new set of provisions has been put in place in the last few years, consisting of two agencies responsible for the safety of health products (AFSSAPS) and food products (AFSSA) and an Institute for Monitoring Public Health (see the section on *Health care delivery system*). Coordination of the activities of these three bodies is provided by a National Committee on Medical Safety, which brings together their respective directors under the chairmanship of the Minister of Health. More recently, in April 2001, the French Agency for Environmental Health and Safety (AFSSE) was added to this structure.

The National Agency for Accreditation and Evaluation of Health Care (ANAES) was created in 1997. Its functions are as follows:

- to elaborate and disseminate practice guidelines;
- to promote the development of clinical skills in hospitals and doctors' practices, by editing a guide and training professionals;
- to carry out an accreditation process for all hospitals (both public and private); this process is still in its infancy; by April 2002, 150 hospitals had been accredited;
- to provide guidance regarding the procedures that should be eligible for reimbursement by the health insurance funds; 381 procedures were examined when the fee schedule for physicians was recently reorganized.

ANAES is staffed by about 150 people (doctors, other health care professionals and economists etc). Its agenda is defined by a board of directors, taking into account requests from the Ministry of Health, the health insurance funds and the medical unions.

The Economic Committee for Medical Products (CEPS), an inter-ministerial committee, sets prices for drugs and medical appliances and monitors trends in spending on drugs in relation to the annual budget targets. It concludes long-term agreements with pharmaceutical firms, incorporating provisions for controlling growth in expenditure (see the section on *Pharmaceuticals*).

A technical Agency for Information on Hospital Care (ATIH) was recently set up to manage the information systematically collected from all hospital stays and used for hospital planning and financing.

A National Health Conference takes place once a year to propose priorities and suggest policy directions to the government and parliament. From 2002, the conference is also responsible for monitoring respect for patients' rights. The conference is made up of representatives from health care professionals' organizations and health care institutions. In future, patients' organizations will also be represented in the conference.

### The statutory health insurance system

The three main health insurance schemes are as follows:

- The **general scheme** (*Régime général*) covers employees in commerce and industry and their families (about 84% of the population) and CMU beneficiaries (estimated on 30 November 2001 to be 950 000 people or 1.6% of the population).
- The **agricultural scheme** (MSA) covers farmers and agricultural employees and their families (about 7.2% of the population).
- The **scheme for non-agricultural self-employed people** (CANAM) covers craftsmen and self-employed people, including self-employed professionals such as lawyers etc (about 5% of the population).

Other 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. Others 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.

Each of the three major health insurance schemes has a national health insurance fund and local structures corresponding to the degree of geographical distribution involved.

The general scheme includes:

- 129 local funds (*caisses primaires d'assurance maladie*) to affiliate members and reimburse the costs of treatment;

- 16 regional funds (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 preventive measures;
- a national fund for the insurance of salaried employees/employed workers (CNAMTS).

Fund offices at different levels can make use of a medical service consisting of about 2500 doctors, pharmacists and dentists. This service individually monitors the insured 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.

CNAMTS plays a supervisory role in relation to the general scheme's regional and local funds, although the latter have autonomy of management and their own boards of directors. The national, regional and local boards are made up of an equal number of representatives of employers and employees (appointed by the trade unions), between one and three representatives of the mutual insurance associations, and persons appointed by the Minister of Health.<sup>7</sup>

The health insurance schemes are under the supervision of the Social Security Directorate of the Ministry of Social Security. Since 1996, they have carried out their function as managers of the statutory health insurance system within the framework of an agreement on targets and management drawn up with the state for a minimum period of three years. The national funds of the three main health insurance schemes enter into this agreement with the Ministry of Health and the annual appendix to the agreement sets out the total target budget for the remuneration of self-employed health care professionals. The three national funds are responsible for managing this budget, known as the "allocated expenditure target" (*objectif de dépenses déléguées*). Within this framework they negotiate with the relevant professionals to ensure that these expenditure targets are met. In practice, however, this system was only implemented for a year, in 2000. In 2001, the government and the health insurance funds did not reach an agreement on the target budget. In 2002 the target was not defined.

The national funds of the three main health insurance schemes also conclude agreements with self-employed health care professionals practising privately: general practitioners, specialists, dental surgeons, nurses, physiotherapists,

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<sup>7</sup> CNAMTS' board of directors comprises 33 members: 13 representing employers, 13 representing salaried workers, 3 representing the mutual insurance associations and 4 people appointed by the Ministry of Health. For the regional offices, the respective figures are 8, 8, 1 and 4 and for local offices 8, 8, 2 and 4.



biologists, midwives, speech therapists, orthoptists<sup>8</sup> and ambulance personnel. These agreements concern the conditions and level of charges for treatment. Currently, they apply to all the professions, with the exception of specialists, who have not been able to reach an agreement with the health insurance funds. In the meantime, minimal regulatory conditions set by the Ministry of Health apply to specialists.

The scheme for self-employed people consists of regional funds and professional funds, comprising 31 bodies in all. Individuals can choose to be insured with any body listed that has an agreement with the regional fund and is authorized to receive contributions and reimburse treatment.

Wage-earners and self-employed people within the agricultural sector are insured by the agricultural scheme, which is organized on the basis of fund offices in the different departments, although funds tend to be grouped together on a wider geographical basis.

Most of the bodies concerned with health insurance have the legal status of private enterprises.

### **Institutions at the regional level**

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 directorates of health and social affairs in the regions (DRASS), which were given increasing responsibilities for hospital planning and budget allocations to hospitals. Later, in 1993 and 1996, new institutions were set up. Today, the regional structure is as follows:

The regional hospital agencies (ARH) are responsible for hospital planning (for both public and private hospitals), financial allocation to public hospitals and adjustment of tariffs for private for-profit hospitals (within the framework of national agreements). They bring together, at the regional level, the health services of the state and health insurance funds, which previously shared management of this sector. ARH directors are appointed by the Council of Ministers and are directly responsible to the Minister of Health.

The regional unions of the health insurance funds (URCAMs) bring together the three main health insurance schemes at the regional level. They coordinate the work of the funds and give impetus to a regional policy of risk management. In relation to the ARHs, whose role is operational, their function is more to influence and stimulate, and they do not have authority over the regional and local funds.

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<sup>8</sup> These professionals deal with visual rehabilitation.

Regional unions of self-employed doctors (URMLs) carry out functions in the following areas: analyses and studies regarding the functioning of the health care system, private medical practice, epidemiology and the evaluation of health care needs; coordination with other health care professionals; providing information and training for doctors and patients. These unions engage in dialogue with the ARHs and the URCAMs.

The regional health conferences bring together all the regional actors – institutions, health care professionals and patients – and are responsible for assessing regional health needs and setting regional priorities for public health. They prepare a report for the national health conference each year.

In principle, the regional level is now structured in such a way as to give it the capacity to direct the health care system in a strategic way and to manage it coherently. The 2001 Social Security Funding Act reinforced this trend by providing ARHs with a mandate to authorize experiments to set up networks of health care providers.

### **Institutions at the department level**

At the department level, several health and social services come under the jurisdiction of the general councils.<sup>9</sup> These include:

- institutions and services for elderly people and disabled people; non-medical facilities come under the authority of the general councils, who supervise them and finance them through social assistance budgets; 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 low-income elderly and disabled people in institutions and for financing assistance in the home;
- protection of children, particularly through the management of maternal and child health centres, which offer consultations and free health care;
- prevention of certain diseases, such as tuberculosis, sexually transmitted diseases and cancer;
- municipalities also have a public health and hygiene role (environmental health, sanitation, etc.).

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<sup>9</sup> General councils are elected bodies funded through local taxes and subsidies from the central

## Professional organizations

There are two types of professional organizations:

**Professional associations** for doctors, pharmacists, dentists and midwives are concerned with medical ethics and the supervision of professional practice.

**Trade unions** look after the interests of different professional groups. Union representation is very fragmented, not only due to the existence of different professions, but also as a result of differences in status, for example between salaried and self-employed professionals. Furthermore, health care professionals can often choose from more than one union. There are six unions for self-employed doctors that are considered to be representative and competent to sign agreements with the health insurance funds. Several unions represent both general practitioners and specialists: the Confederation of French Medical Unions (CSMF), the Union of Self-Employed Doctors (SML) and the Federation of Doctors in France (FMF). Other unions are more specific, such as the Union of French Surgeons and Specialists (UCCSF) and the French Federation of General Practitioners (MG France). In spite of this diversity, only 29% of general practitioners are union members. Fragmentation of professional representation is not exclusive to doctors. 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. The organizations representing self-employed professionals negotiate with the health insurance funds and the Ministry of Health on conditions of practice, particularly those conditions relating to payment.

Since 1994, the regional unions of self-employed doctors (URMLs), elected on the basis of union lists, have had the task of analyzing the functioning of the health care system, evaluating needs, coordinating training and providing information for doctors and health care users. These unions are funded by specific contributions from doctors.

Hospitals are represented by different organizations, depending on their status.

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

## Health care users

In recent years, the search for ways to take more account of health care users' expectations has been an important issue of public debate. The activities of certain patients' associations have been a factor in this development. The

AIDS epidemic was the source of 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 influence 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 patients' associations, there also has been a reinforcement of general-purpose organizations, such as consumers' associations.

Recently, associations related to health care have regrouped to form a collective unit (CISS), thereby increasing pressure to accommodate the interests of health care users. Legislation enacted in March 2002 reinforced the role of these associations.

## Planning, regulation and management

### Physical resources

Resource planning involves both human and material resources. 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*, fixed at national level, is then applied at regional level, taking into account current inequalities in the geographical distribution of doctors (the density of doctors varies from 1 to 1.7) and attempting to correct any imbalance by adjusting the flow of training.

The distinction between specialists and general practitioners is determined by the number of posts open for the entrance examination for hospital work (*concours d'internat*), which provides access to different areas of specialization. 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 entrance exams.

Today, the *numerus clausus* policy has resulted in an overall stabilization of the number of doctors, which will be followed by a notable decrease in numbers in the next few years. Regional disparities have diminished slightly over the last thirty years (the gap between regions has been reduced from 2.1 to 1.7). The ratio

of specialists to general practitioners is the subject of much debate in France; in the past there has been a tendency towards increasing specialization.

Self-employed doctors are free to work wherever they like, whereas hospital work is dependent on posts offered by institutions.

There is also a *numerus clausus* limiting the number of students trained as other professionals, such as nurses, physiotherapists, etc. (see the section on *Human resources*).

Until 2003, hospital planning involved a combination of two tools: the medical map as a quantitative tool and the Regional Strategic Health Plan (SROS) as a more qualitative tool. The medical map divided each region into health care sectors and psychiatric sectors. No health care sector could have less than 200 000 inhabitants, unless it consisted of an entire department.

Within the health care sectors or groups of sectors, the director of the ARH decides on the quantitative norms, in terms of bed/population ratios, for each discipline: medicine, surgery, obstetrics, psychiatry, follow-up care and rehabilitation and long-term care. All proposals for establishing new beds or changing the use of existing ones, whether in public or in private hospitals, are subject to authorization by the ARH, granted until 2003 in accordance with the norms set out in the medical map. In practice, today, most sectors are considered to be in excess of the targets set and authorizations essentially involve restructuring, conversions or mergers.

The medical map also applied to certain expensive diagnostic or treatment equipment, either in hospitals or elsewhere, such as dialysis apparatus, radiotherapy equipment, magnetic resonance imaging (MRI), scanners and lithotripters. In certain cases, norms for assessing needs had been specified, but in others authorizations were granted on the basis of a case-by-case evaluation of local needs.

For the past ten years or so, authorization from the Ministry of Health has also been required for certain very specialized types of care, such as organ transplantation, treatment of major burns, cardiac surgery, neurosurgery and medically assisted reproduction, or for more common procedures, such as the treatment of emergency cases, resuscitation and radiotherapy. The fact that authorization is now required not just for equipment, but also for certain treatment, indicates a change in hospital planning from quantitative quotas towards a more qualitative and medicalized approach to the organization of the supply of services.

In 2003 the government decided to abandon the medical map and to integrate all planning tools into the SROS, which can be considered as the instrument of a qualitative approach. It sets out the goals for the development of regional provision over a five-year period, in areas corresponding to national or regional

priorities. The SROSs defined for the 1999–2004 period were all concerned with the provision of emergency care, perinatal care and cancer. The focus on these three areas illustrates a recent trend in hospital policy – to promote networks of hospitals within a region, in which each hospital cooperates to provide care at the level most appropriate to its technical capacity. Overall, the network will be able to provide a comprehensive range of care, but individual hospitals will be responsible for more or less serious cases.

For perinatal care, all hospitals are classified in four levels, from the small local facility providing prenatal and postnatal consultations to highly specialized centres capable of providing intensive neonatal care.

For emergency care, only a few hospitals within each region have fully equipped emergency units. Smaller hospitals have basic emergency units. Hospitals enter into contracts with each other to enforce their cooperation (including, for example, the possibility of using a rotation of emergency staff in less busy locations).

Cancer treatment is another area in which cooperation between public and private hospitals is promoted as a means of ensuring that a full range of care is available to patients regardless of their point of entry into the system. Three levels are defined: proximity care, hospitals providing cancer treatment and referral centres.

Apart from these three areas, which are covered in all regions, each region has chosen specific issues, such as follow-up care and rehabilitation, palliative care, suicide, cardiovascular diseases, chronic renal failure and the development of outpatient or day care surgery.

The SROS for each health care area sets up objectives to improve the organization of care and proposes the development of activities, restructuring and cooperative measures.<sup>10</sup> It also provides the ARHs with a framework for granting authorizations, approving proposals submitted by institutions and negotiating the contracts that ARHs must enter into with every hospital in the region – whether public, private non-profit or private for-profit.

ARH contracts with public hospitals set out goals and commitments for the hospital for three to five years. Some commitments relate to the provision of medical services, which should be consistent with the SROS, but they may also concern the quality of care, information systems, management efficiency, etc. The contract determines the way in which hospital projects will be funded. If the hospital is not considered efficient enough, it will have to generate resources

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<sup>10</sup> By the end of 2001, more than 300 actions aimed at merging or closing hospitals and hospital wards or reorienting them towards new activities (for example, from acute care to rehabilitation) had taken place across the country.

by increasing its productivity; if it is considered to be very efficient, it will be allocated additional resources by the ARH.

There are no national standards for these contracts and their content can vary. For example, in some regions the financial implications of the contract (such as the additional resources that will be made available for hospital projects) are clearly specified, whereas in other regions contracts contain only general indications. The contract process itself proceeds at a variable pace. In some regions, contracts have been concluded with all hospitals, while other regions had still not begun the process by June 2001.

The scope of the contracts with private for-profit hospitals is more limited; basically, these are standard contracts whose main objective is to fix tariffs.

## Financial regulation and management

For a long time, financial regulation was restricted to the control of prices and tariffs, both those negotiated by agreement between professionals and health insurance funds in the framework of private practice and those determined administratively (such as drugs and per diem rates in hospitals). It has gradually been extended to include budget setting and budget targets (ceilings) to limit expenditure, at the level of the individual institution (public hospitals), the sector (private for-profit hospitals) or the wider interest group (fees of health care professionals working in private practice). Since 1996, these targets have been subordinate to the national ceiling for health insurance expenditure (ONDAM), voted each year by parliament (see the section on *Financial resource allocation*).

### Setting prices and charges

Regulation by setting prices and charges is linked to the forms of payment for different medical goods and services. At this level it is important to distinguish between the approved or official rates and the fees actually charged. The official rates provide a basis for reimbursement by the health insurance funds, whilst the fees actually charged may, in certain cases, be higher. Regulation affects the former.

Setting rates for treatment carried out by self-employed health care professionals relies on two instruments (see the section on *Payment of health care professionals*):

- official schedules (*nomenclatures*) organizing authorized procedures into a relative hierarchy and attributing to them a coefficient with respect to a unit of measurement, known as a “key letter”;
- setting the unit charge for key letters.

The technical services of CNAMTS prepare schedule revisions, but each revision has to be approved by the Minister of Health. The unit value of the key-letters is decided by agreements between the health insurance funds and the trade unions, which make provision for the terms and conditions of increases over a period of five years.

Drug prices are determined by CEPS (see the section on *Pharmaceuticals*).

Rates charged by private for-profit hospitals<sup>11</sup> – in addition to doctors' fees – are a national and regional matter:

- at national level, an agreement between the state and the private hospitals' associations sets an average figure for increases in rates by group of specialties, both at national and regional level;
- the figures for increases are then adjusted for each hospital within the region, in accordance with an agreement negotiated between the regional hospital agencies and the hospitals' representatives at regional level (this adjustment takes place within the limits of a range determined at national level).

The daily hospitalization charges for public hospitals are the result of a balancing calculation made when the general hospital budget was fixed. They are not, strictly speaking, "set".

### Overall financial framework

Each year since 1996, parliament has voted on a national ceiling for health insurance expenditure (ONDAM) for the year to come, in the context of the debate on the Social Security Funding Act. Although expenditure frameworks existed in different health care sectors before the creation of the ONDAM, now they should be consistent with the ONDAM.

Within the ONDAM, a separate budget is defined for public hospitals. It is then divided between regions by the Ministry of Health, and the ARH allocates individual budgets to each hospital in the framework of regional resource allocation.

Expenditure in private for-profit hospitals is subject, at the national level, to an annual maximum target set by the Minister of Health (and no longer negotiated, as it was before 2000). In the event of overspending, the state and the private hospitals negotiate measures to redress the situation, usually by lowering

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<sup>11</sup> Unlike the unit rates applied to self-employed health care professionals, the rates applied to private for-profit hospitals are not uniform across the country. In fact, there are important variations resulting from a previous period of decentralized management by the regional health insurance funds (CRAMs). Regional variations have been progressively reduced by a policy of national harmonization, although they have not yet been eliminated.



rates. If agreement cannot be reached, the state takes unilateral decisions. These measures take effect at the national level, but since 2000 adjustments can be made at the regional level.

Finally, the ONDAM also concerns outpatient expenditure. Under this expenditure category, a sub-category encompassing the fees of self-employed health care professionals is, in theory, isolated under the heading ‘allocated expenditure target’ (*objectif de dépenses déléguées*) and managed by the health insurance funds. In practice, however, as noted above, this delegation of responsibility was only effective in 2000. Nevertheless, the fees charged by self-employed health care professionals are subject to a target ceiling for most of these professionals (see the section on *Payment of health care professionals*).

### **Regulation of professional practice and the quality of care**

There are several bodies and levels of decision-making in the regulation of professional practice. Doctors, dental surgeons and pharmacists are self-regulating through their professional organizations at national and department level, in terms of professional ethics and the right to practise.

The Minister of Health stipulates norms for hospital care, while compliance is monitored by doctors at regional and department level, and by the medical service of the health insurance funds.

Institutions and health care professionals can also be involved in the procedures for quality control recently set up by ANAES, including the (compulsory) accreditation of public or private hospitals and the (voluntary) audit of self-employed professionals.

ANAES also prepares practice guidelines that are issued to the entire medical profession, most of which are voluntary in nature (see the section on *Health care delivery system*).

Recently, two sets of recommendations (for diabetes and hypertension) were used by the medical service of the main health insurance scheme to establish a diagnostic on the quality of outpatient care for these two conditions and to undertake action to improve medical practice. However, there is no systematic evaluation at the level of the individual health care professional, and malpractice giving rise to patients’ complaints are dealt with by professional associations and the courts.



# Health care financing and expenditure

**F**inancial responsibility for health care in France is mainly borne by the statutory health insurance system as a branch of the wider system of social security. Since 1 January 2000, statutory health insurance covers the whole population, although it only funds three quarters of health spending, so there is considerable scope for complementary sources of funding.

## Main system of financing and coverage

### The structure of the statutory health insurance system

The current structure of the health insurance system is based on its founding text, the Ordinance of 4th October 1945, and the legislative measures that have followed since then. The system 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). Statutory health insurance on a voluntary basis was introduced in 1978.<sup>12</sup>

Since 1 January 2000, the Universal Health Coverage Act (CMU) has completed this extension by offering basic health insurance coverage to all those legitimately resident in France. Under the CMU, people with a taxable income of less than €6600 per year are exempt from paying contributions.

Participation in the statutory health insurance system takes place on the basis of professional status, through the health insurance funds of the different schemes. In the context of the CMU, however, participation depends on

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<sup>12</sup> This voluntary health insurance scheme provided coverage to those who were not covered by statutory health insurance. Members of the voluntary scheme had to pay a fixed premium, which could be financed by the general councils for low income people.

residence in France and level of income. Any dependants of the insured person are also covered by his/her health insurance.

The three main health insurance schemes are as follows:

- The **general scheme** (*Régime général*) covers employees in commerce and industry and their families (about 84% of the population) and CMU beneficiaries (estimated on 30 November 2001 to be 950 000 people or 1.6% of the population).
- The **agricultural scheme** (*Mutualité sociale agricole*) covers farmers and agricultural employees and their families (about 7.2% of the population).
- The **scheme for non-agricultural self-employed people** (CANAM) covers craftsmen and self-employed people, including self-employed professionals such as lawyers, etc. (about 5% of the population).

Other 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 Alsace and Moselle regions benefit from a specific scheme offering better cover of medical goods of services in return for higher contribution rates.

The health insurance schemes are under the supervision of the Social Security Directorate of the Ministry of Social Security. Since 1996, they have carried out their function as managers of the statutory health insurance system within the framework of an agreement on targets and management drawn up with the state for a minimum period of 3 years.

## The financing of statutory health insurance

The financing of statutory health insurance varies from scheme to scheme. Health insurance schemes (see the section on *Organizational structure and management*) are subject to an adjustment mechanism on the basis of their demographic profile. Between 1946 and 1996, the financing of social security in general, and of health insurance in particular, depended almost exclusively on contributions from employees and employers as a proportion of wages and salaries, initially with a ceiling on contributions and then without a ceiling. Later, coverage was extended to those on benefits (retired people, those on early retirement benefit and unemployed people). The contribution rates for health insurance have steadily increased to cover spending on health care,

which has grown faster than the level of contributions. Between 1992 and 1997, contribution rates remained stable at 12.8% of gross earnings for the employer and 6.8% for the employee.

Since 1998, as a result of attempts to widen the social security system's financial base, contributions based on earnings have fallen from 6.8% to 0.75% of gross earnings. Contributions based on earnings are now accompanied by a 'general social contribution' (CSG) based on total income. The CSG rate varies depending on the source of income. According to the 2001 Social Security Funding Act, the rates for health insurance are 5.25% on earned income, capital and winnings from gambling and 3.95% on benefits (pensions and allowances). Health insurance funds' revenue has therefore been partially disconnected from earnings, making it less vulnerable to wage and employment fluctuations. However, while this change has widened the revenue base of health insurance, it has not increased the actual amount of revenue collected.

A reform of the conditions governing employers' contributions, which might relieve some of the burden on labour-intensive industries and promote increased employment, is still pending. One possible solution – that of basing employers' contributions on the added value of the firm – has been studied but has not yet been accepted. In an attempt to encourage the employment of people with low skills levels, the 1999 Social Security Funding Act decreased employers' contributions for low wage-earners (about two thirds of employees). The 1999 Act also created a tax levied on the profits of companies with a turnover of more than FRF 50 million and polluting activities. The 2001 Social Security Funding Act reduces the CSG rate for those on the lowest level of earned income.

Table 3 shows the structure of statutory health insurance funding in 2000. Employers' contributions, employee's contributions and CSG revenue account for 87.8% of total health insurance revenue. The remainder is provided mainly through state subsidies and earmarked taxes (on car usage and tobacco and alcohol consumption). The pharmaceutical industry is also required to contribute, largely through a tax on advertising. In comparison with health insurance funding in 1990, the most striking change is the substitution of most employee payroll contributions with a tax (CSG).

Changes in the revenue base of statutory health insurance (the extension of statutory health insurance coverage to almost the whole population, on the basis of residence rather than employment, and the near total replacement of earned income by total income as the basis for insured persons' contributions) are coherent with parliament's new role in defining health sector financing policies and the government's growing role in controlling certain aspects of the health care system. The enhanced involvement of parliament and government comes at the expense of involvement by the health insurance funds.

**Table 3. Revenue received by the statutory health insurance system (the general scheme) in 1990 and 2000**

	1990		2000	
	€ (millions)	%	€ (millions)	%
Employees' contributions	20.1	32.2	3.4	3.4
Employers' contributions <sup>a</sup>	39.3	63.1	49.8	51.1
Total contributions	59.4	95.2	53.2	54.5
CSG	0.0	0.0	33.8	34.6
Specific taxes (cars, tobacco, alcohol)	1.0	1.6	3.3	3.3
Taxes on the pharmaceutical industry	0.0	0.0	0.7	0.8
Total taxes	1.0	1.6	37.8	38.7
State compensation for the loss of contributions <sup>b</sup>	0.3	0.5	4.8	4.9
Adjustment between health insurance schemes	0.7	1.1	0.3	0.3
Other	1.0	1.5	1.5	1.6
Total revenue	62.3	100.0	97.6	100.0

Source: Commission des Comptes de la Sécurité Sociale 2001.

<sup>a</sup> this includes contributions paid by the health insurance funds on behalf of doctors; <sup>b</sup> the state compensates the health insurance funds for the loss of contributions directly related to economic policy decisions; a recent example is the reduction of employers' contributions for

## Health care benefits and rationing

### General rules for the reimbursement of health care costs

The reimbursement of health care costs accounts for 84.9% of statutory health insurance expenditure. Health care consumption is (usually partially) reimbursed through repayments to insured persons or payments to providers. The remaining 15.1% of statutory health insurance expenditure goes on cash benefits in the form of daily allowances paid to insured persons for maternity, illness or following an accident at work and disability pensions.

Although statutory health insurance covers the whole population for a wide range of medical goods and services, it only funds three quarters of the total expenditure on health care. The rules for reimbursement are based on several general principles:

- the health insurance system grants people access to the registered health care professional of their choice;
- in general, there is no limit to the volume of goods and services reimbursed;
- doctors have considerable freedom in prescribing, although they must comply with practice guidelines (RMOs) (see the section on *Outpatient care*).

In order to be eligible for reimbursement, 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 the statutory health insurance system;
- be listed on the positive lists currently in operation (that is, the official schedules of procedures for different health care professionals and the list of reimbursable drugs or materials).

The amount reimbursed by the statutory health insurance system is calculated for each good or service by applying a coverage rate (a percentage) to the negotiated charge.

As a general rule, patients are expected to pay the health care provider themselves and then claim (total or partial) reimbursement of their expenses from their health insurance fund. This rule does not apply in case of hospitalization (the hospital is paid directly by the health insurance fund), nor does it apply to any type of care received by CMU beneficiaries. Direct payment of providers by the health insurance funds is becoming increasingly common in ambulatory care, particularly in the pharmacist and laboratory sectors.

The following sections give details of the general principles set out above, describing which treatments are eligible or ineligible for reimbursement by the statutory health insurance system (the scope of reimbursement) and providing further information on the terms of financial coverage for different types of medical goods and services (the level of reimbursement).

### **The scope of reimbursement**

Medical goods and services qualifying for reimbursement by the health insurance system include:

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

Initially, health insurance funds were supposed to focus on the financing of curative care, in case of illness or accident. In practice, however, more and

more preventive care is eligible for reimbursement, particularly for preventive treatment provided in a doctor's practice, such as mammography, cervical smear tests, etc. Compulsory or recommended immunizations are also reimbursed, and care of pregnant women and newborn babies is free. There is no way of paying self-employed health care professionals for collective action to promote health or prevent ill health.

The range of services covered by statutory health insurance does not include cosmetic surgery or most types of thermal cure; nor does it include some services of uncertain effectiveness. The choices required by the allocation of scarce resources may result in non-reimbursement of 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 certain kinds of care, such as physiotherapy and thermal cures, prescription by a doctor is not a sufficient condition for reimbursement. Coverage by statutory health insurance is subject to the prior authorization of the doctors advising the health insurance funds, after examination of the patient's case history and possible interviewing of the patient.

### **The level of reimbursement**

Each type of good or service reimbursed by statutory health insurance has its own negotiated rate. This rate serves as the basis for calculating the total amount reimbursed to the patient, even if the prices actually charged in practice are higher than the official rate in question (excess charging).

A general principle of financial coverage by statutory health insurance is for the health insurance fund to retain a proportion of the total cost of treatment (partial reimbursement). This proportion must therefore be paid by the patient and is equivalent to a statutory co-payment. The patient's contribution to the total cost of treatment varies according to the type of treatment and is higher for outpatient care and drugs than for hospital treatment.

In certain circumstances patients are exempt from these co-payments and their health insurance fund then covers the total cost of treatment. There are three types of exemption:

- exemption linked to health status, in particular when the person insured is suffering from one of 30 specified long-term illnesses (such as diabetes, AIDS, cancer or psychiatric illness), or if the patient is suffering from one or several diseases that are incapacitating;
- exemption linked to the nature of the treatment provided, such as certain hospital treatments and infertility treatment;



- exemption linked to the person concerned, such as those involved in accidents at work, pregnant women, disabled children, etc.

Exemptions on economic grounds do not exist, although the CMU provides complementary VHI coverage for people with low incomes, which has the same effect as an exemption on economic grounds (see below).

Any difference between the amount actually paid by the patient and the amount reimbursed by the health insurance fund (the patient's co-payment plus any amount in excess of the official charge) remains to be paid by the insured person or, where applicable, by their complementary voluntary health insurer.

The amount of the patient's contribution is not sufficient information to establish the rate of total coverage of actual expenditure, since the latter also depends on the frequency of exemptions and possible charges in excess of official charges. Table 4 provides further details. For example, the health insurance funds normally reimburse 70% of a visit to a doctor, on the basis of the official tariff (column 1). Taking into account exemptions, the actual average rate rises to 81% of the same tariff (column 2). But given the fact that some physicians have a right to engage in balance billing, and that a few treatments are not reimbursed, the final average rate is 75% (column 3).

Before the CMU was implemented, low income people, who were also less likely to have complementary VHI coverage, could face relatively high expenses. In 1997, a person with an annual income below €5400 had, on average, €193 that was not covered by statutory health insurance in a year (Alignon et al, 2001).<sup>13</sup> If they did not have complementary VHI, they would be forced to incur this expense themselves.

### Third party payment

Although the general rule is that reimbursement by statutory health insurance only takes place after direct payment has been made by the patient to the provider of the good or service, 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 applies to CMU beneficiaries, those involved in accidents at work and patients admitted to hospital. It may also be used (for partial or total reimbursement) in laboratories, pharmacies, hospitals 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.

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<sup>13</sup> The equivalent amount, for the whole population, is €279.

**Table 4. Reimbursement of health care costs as a percentage of total costs, 1999–2000**

	Theoretical average reimbursement rate %	Actual average reimbursement rate %	Final average reimbursement rate %
Visits to a doctor	70	81	75.0
Dental care	70	73	34.9
Medical auxiliaries	60	92	79.0
Laboratories	60	77	73.3
Pharmaceuticals	35, 65, 100	73	61.5
Hospital care	80	–	90.2

Source: Social Security Agency (CNAMTS, Comptes de la Santé, DREES).

## Reimbursement of different types of care

### Inpatient care

Inpatient expenditure is financed by the health insurance fund on the basis of a per diem rate. In public hospitals, this per diem rate includes all services provided. In the private for-profit sector, medical fees and other items (for example, prostheses) are billed and reimbursed separately.

In principle, the reimbursement rate for hospital care is 80%, but it rises to 100% (that is, no co-payment) in a number of cases:

- after the 31st day of a hospital stay
- for treatment involving major surgery (such as appendectomy)
- maternity care

The third party payment system usually applies in these cases, but patients still have to pay a flat-rate fee of €10.67 per day for accommodation in hospital.

The health insurance system finances part of the cost of hospital care for elderly people living in institutions through flat-rate allowances.

### Outpatient care provided by self-employed doctors

The health care provided by self-employed doctors (general practitioners or specialists), dentists, medical auxiliaries, laboratories, etc. will be eligible for reimbursement if it is included in the official schedules established jointly by the representatives of the statutory health insurance system and the medical professions within the Standing Committee on the Official Schedule of Professional Procedures.

Health insurance funds and union representatives for each profession negotiate the unit value which is applied to the schedule to determine the tariff for each procedure (see the section on *Financial regulation and management*).

Reimbursement rates range from 70% for health care provided by doctors and dentists to 60% for medical auxiliaries and laboratory tests (see Table 4). The reimbursement of services provided by medical auxiliaries and laboratory tests is conditional on a doctor's prescription.

### **Pharmaceuticals**

In order to be eligible for reimbursement by statutory health insurance, pharmaceutical products must be prescribed by health care professionals (doctors, dentists and midwives) and must be included in one of the positive lists of reimbursable products established and updated by CEPS (see the section on *Pharmaceuticals*).

Most drugs are reimbursed at a rate of 65%, but the rate varies from 100% for non-substitutable or expensive drugs to 35% for drugs considered to be "convenience medication". Taking into account the respective weight of the different types of eligible drugs 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%.

Medical devices and prostheses are reimbursed if they figure on a special list (TIPS) established by inter-ministerial order. In many cases (for example, spectacles, dentures, hearing aids, etc.), actual prices tend greatly to exceed official charges and the levels of reimbursement are therefore particularly low.

## **Complementary sources of financing**

### **Voluntary health insurance (VHI)**

As a result of the general principles on which health care costs are reimbursed by the statutory health insurance system, there is usually a discrepancy between the actual amount paid by patients and the amount they are reimbursed by their health insurance fund. This discrepancy is either borne by patients or by the complementary VHI scheme to which they subscribe on a (usually) voluntary basis. In 2000, the statutory health insurance system accounted for 75.5% of total expenditure on health care, complementary VHI accounted for 12.4% and direct out-of-pocket payments by patients accounted for 11.1%.

In general, organizations providing complementary VHI coverage do so in order to compensate for the discrepancy between the amount patients pay for health care and the amount reimbursed by the statutory health insurance system. Depending on the terms of a particular contract, these organizations will pay patients an amount equivalent to some or all of this discrepancy (including costs in excess of official charges for goods and services).

Complementary VHI coverage is provided by three types of organization:

- mutual insurance associations
- private for-profit insurance companies
- provident institutions.

The mutual insurance associations are non-profit bodies, legally and financially supervised by the state through the Mutual Insurance Code; the insurance companies are commercial enterprises governed by the Insurance Code; and the provident institutions are run jointly by unions of employees and employers and governed by the Social Security Code.

Over the last few years, complementary VHI coverage has developed rapidly due to the demand for better coverage and the slow but significant erosion of the proportion of health care costs reimbursed by the statutory health insurance system. Complementary VHI coverage applied to 33% of the population in 1960, 50% in 1970 and 86% in 2000. In 2000, it also accounted for 12.4% of total expenditure on health care. These figures have increased since January 2000, when the CMU Act extended complementary VHI coverage to people with low incomes (those earning less than €550 per month for people living alone). In December 2001, CMU covered 4.3 million people.

43% of those who subscribe to complementary VHI do so as a result of individual initiative, but most coverage is purchased (voluntarily or not) in the context of employment, where the employer/professional organization enters into a collective (group) contract with an insurance provider on behalf of all its employees or a specific professional group.

As a general rule, the rate of complementary VHI coverage is linked to employment factors, for example those in employment and pensioners are more likely to be covered than the unemployed or other non-working persons, while unskilled workers are less likely to be covered than managerial staff or office workers (see Table 5). The quality of complementary coverage also varies with social status and level of income, as Fig. 4 shows.

The mutual insurance associations play a dominant role in providing complementary VHI coverage, providing 59% of all complementary VHI contracts and financing 7.5% of total health care expenditure, while private

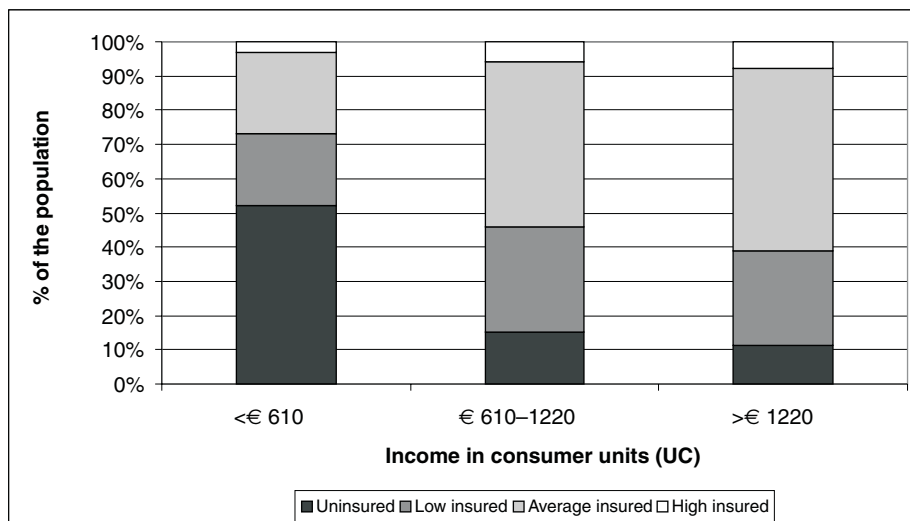
**Table 5. Complementary VHI coverage by social category (% of persons covered), 2000**

Social category	Mutual insurance associations	Provident institutions	Private insurance companies	Total
Farmers	42.8	2.2	44.5	89.3
Commercial craftsmen	43.3	11.9	24.5	82.0
Managerial, academic, professional	50.2	19.7	20.7	93.5
Intermediate categories (teachers, administrative)	58.5	15.3	18.4	94.4
Office employees, etc.	62.1	8.5	10.5	85.2
Commerce employees	43.4	5.1	14.2	69.2
– Skilled workers	47.9	17.1	14.6	84.0
– Unskilled workers	43.8	11.3	12.8	71.8
Total	50.4	14.0	17.6	85.7

Source: IRDES 2000.

Note: the total may be different from the sum of the figures in the three columns, partly due to multiple coverage and partly due to unknown type of contract.

**Fig. 4. Quality of complementary VHI coverage according to income level**



Source: Adapted from Bocognano et al 2000.

insurance companies account for 21% and 2.8%, and the provident institutions for 16% and 2.1%, respectively.

These three types of complementary voluntary health insurer have a clientele that varies in demographic and social terms. The mutual insurance associations' clientele is older and to a larger extent female, with a heavy representation of office employees and intermediate professionals. Farmers and independent professionals are more frequently associated with the private insurance companies, while unskilled workers and senior managerial staff more often turn to provident institutions (see Table 5).

Reimbursement policies vary according to insurance provider. Complementary VHI coverage expenditure varies by type of care in inverse proportion to the reimbursement rate of statutory health insurance; in 2000 it accounted for 3.7% of hospital treatment, but a much higher share of the cost of spectacles and prostheses (21.9%), drugs (18.6%) and dental care (35.9%) (see Table 9).

### **Out-of-pocket payments**

An individual's household income contributes to the financing of health care because patients usually make direct payments to providers and because reimbursement by the statutory health insurance system rarely covers the total amount spent by the patient. Patients are directly responsible for the cost of health care that is not covered by the statutory health insurance system (such as non-prescription drugs) and for meeting the discrepancy between the amount they pay providers and the amount they are reimbursed by their health insurance fund.

In 2000, direct out-of-pocket payments accounted for 11.1% of total health care expenditure. Out-of-pocket payments by patients account for a substantially larger proportion of expenditure on spectacles or orthopaedic appliances (35.7%), dental care (28.7%) and drugs (17.9%) than on hospital treatment (5.2%). In terms of the absolute value of the total amount paid by patients, drugs come first (€4.4 billion in 2000), followed by hospital treatment (€2.9 billion), prostheses (€2.3 billion) and dental treatment (€1.8 billion). When these figures are linked to the proportion of patients for each type of health care, it is apparent that, on average, patients (3.2% of the population in three months) pay most out-of-pocket for hospital treatment.

### **Health care expenditure**

Health care expenditure is subject to an annual evaluation validated by the Committee on Health Accounts. It should be noted that not all spending on

health care provided in institutions for elderly or disabled people is included in the health accounts.

### Health care expenditure in 2000

In 2000, total expenditure on health care in France was estimated at €140.6 billion or 10% of GDP (see Table 6). Health care consumption accounted for €122.2 billion or 86.9% of total health care expenditure, giving an average of €2020 per person. The figure for total health care expenditure also includes expenditure on prevention (2.4%) and activities related to research (4%), teaching (0.5%) and health administration (1.7%).

Again taking figures for 2000, 72.8% of total expenditure on health care was financed by social security, 12% by complementary VHI (7.8% by mutual insurance associations, 2.4% by private insurance companies and 1.8% by provident institutions), 9.7% by private households and 4.4% by the state and local authorities (see Table 8). 75.5% of health care consumption

**Table 6. Trends in health care expenditure, 1970–2000**

	1970	1980	1990	1995	1996	1997	1998	1999	2000
Value at current price level (billions of €) <sup>a</sup>	7.5	34.6	92.3	119.7	122.2	124.3	128.7	133.7	140.6
– as % of GDP	6.2	8.1	9.1	10.1	10.1	9.9	9.9	9.9	10.0
– per capita F (current values)	974	4212	10405	13218	13441	13632	14057	14544	15225
Index of value (relative prices) <sup>b</sup>	33.2	59.8	85.6	100.0	100.6	101.1	103.6	107.1	111.7
Share met by public finance (%)	78.5	80.2	77.8	77.2	77.2	77.3	77.2	77.2	77.2

Source: IRDES/DREES 2001.

<sup>a</sup> Billion = a thousand million; <sup>b</sup> value deflated by the general price index.

alone was financed by social security, 11.1% by private households, 7.5% by mutual insurance associations, 2.8% by private insurance companies, 2.1% by provident institutions and 1.1% by the state and local authorities. 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.

Total expenditure on health care consumption, by type of service, is divided as follows:

- 46.5% on inpatient care in health care institutions, of which 45% relates to hospital treatment in the public and private sectors and 1.5% to care provided in residential institutions for elderly people;
- 26.1% on outpatient care, of which 12.5% relates to care provided by doctors, 5.3% to dental care, 5.2% to services provided by medical auxiliaries, 2.3% to laboratory tests and 0.8% to thermal cures;
- 20.5% on drugs and 5.4% on other medical products (bandages and minor supplies, lenses, orthopaedic appliances, etc.).

Several arguments have been put forward to justify the objective of cost containment as a central element in plans for health care reform. As in other countries, health care expenditure in France grew more rapidly than national wealth for many years, even if this was no longer the case between 1997 and 1999.

According to OECD estimates published in 1998, France ranks in eleventh place for the level of per capita health care expenditure, but in fourth 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.

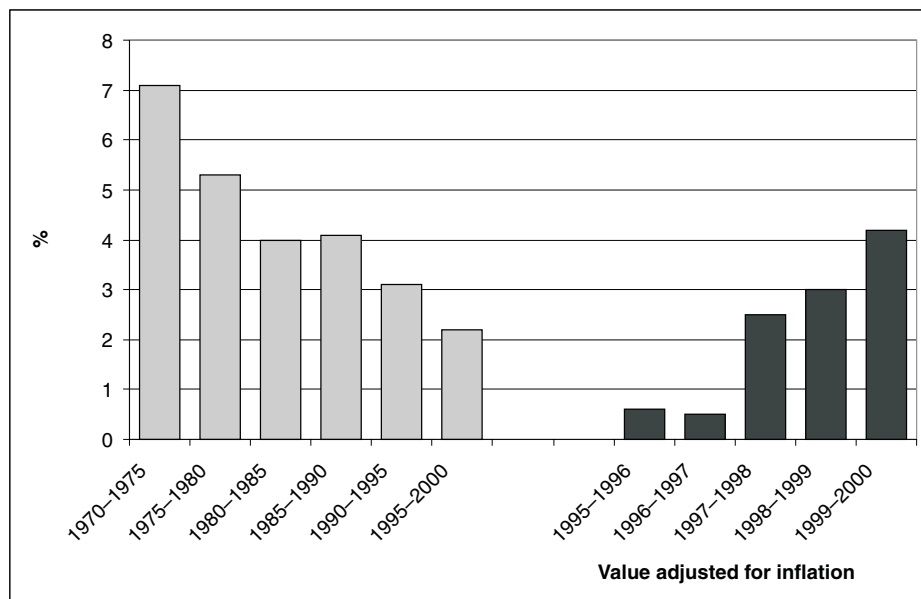
The evolution of health care expenditure results from growth in the volume of care provided and growth in the price of that care, which is in turn linked to general inflation and specific conditions governing the means of production. Overall, the health care price index has developed at a similar pace to the general price index, if adjustment is made for the relative price of different types of care (more rapid growth in hospital prices and slower growth in the price of drugs).

It should be stressed that, as an overall trend (see Fig. 5), the relative value of health care expenditure in France (that is, deflated by the general price index), has slowed down in the last 25 years, although there has been a stronger increase over the last three years, accompanying the return of more sustained economic growth.

Expenditure corresponding to different types of health care has undergone a different pattern of development, leading to a change over time in the structure of total health care expenditure (see Table 7). The hospital sector grew up to the beginning of the 1980s, but since then it has steadily decreased. This trend can be found in many countries, and does not only reflect France's policy of



**Fig. 5. Average annual rate of growth in the relative value of the consumption of medical goods and services, 1970–2000**



Source: IRDES/DREES 2001.

Note: Value deflated by the general price index.

controlling hospital budgets. It is also the result of technical developments that are conducive to growth in outpatient care.

Trends in expenditure in other areas have differed from trends in hospital expenditure. In 1970, expenditure on drugs accounted for 28% of total expenditure on health care, while in 1980 it accounted for 19.4%, and in 2000 for 25%. These movements reflect the growing role of drugs as substitutes for hospital treatment and the technological innovations that have led to the introduction of many new and effective but expensive drugs.

Expenditure on outpatient care has been relatively stable as a proportion of total expenditure on health care.

Trends in the proportion of total health care expenditure financed from different sources reflect changes in the rules governing health insurance coverage (see Table 8). On one hand, the state has shifted some costs to the statutory health insurance system. On the other hand, the rate of coverage of health care costs by health insurance has gone down (due to increases in patient cost sharing), leaving a larger role for complementary VHI coverage.

**Table 7. Health care expenditure by category as a percentage of total expenditure on health care, 1970–2000**

Type of care	1970	1980	1990	1995	1996	1997	1998	1999	2000
Inpatient treatment	41.9	53.0	49.7	49.2	49.3	49.0	48.2	47.3	46.4
Public <sup>a</sup>	30.3	41.2	38.0	38.4	38.4	38.1	38.2	37.8	37.3
Private	11.6	11.7	11.6	10.8	10.9	10.9	10.0	9.5	9.1
Outpatient medical services	29.0	26.3	27.4	26.5	26.5	26.4	26.5	26.4	26.1
of which:									
Doctors (private practice)	15.0	11.9	12.8	12.7	12.7	12.7	12.7	12.7	12.5
Dentists (private practice)	7.3	6.9	6.1	5.6	5.7	5.7	5.6	5.5	5.3
Auxiliaries (private practice)	3.0	2.8	4.9	5.1	5.2	5.0	5.1	5.2	5.3
Medical laboratories	2.5	2.5	2.7	2.3	2.2	2.0	2.2	2.3	2.3
Medical goods	28.0	19.4	21.6	22.9	22.9	23.2	23.9	24.9	25.9
of which: Medicines	25.9	17.5	17.9	18.7	18.6	18.8	19.3	19.8	20.5
Transport of patients	0.7	1.0	1.3	1.4	1.4	1.3	1.4	1.5	1.5
Spending on medical goods and care	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: IRDES/DREES 2001.

<sup>a</sup> public here includes public hospitals and private hospitals participating in the public hospital service.

**Table 8. Trends in the main sources of health care financing as a percentage of total expenditure on health care, 1970–2000**

	1970	1980	1990	1995	1996	1997	1998	1999	2000
Public	78.5	80.2	77.9	77.2	77.1	77.2	77.2	77.4	77.1
Social security	69.3	74.3	73.7	73.0	72.9	72.9	72.9	73.0	72.8
State and local authorities	9.2	5.9	4.2	4.2	4.2	4.3	4.3	4.4	4.3
Private	21.5	19.8	22.1	22.8	22.9	22.8	22.8	22.6	22.9
Private households				10.6	10.1	10.0	9.8	9.6	9.7
Mutual insurance associations			12.2	12.8	12.8	13.0	13.0	13.0	
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: IRDES/DREES 2001.

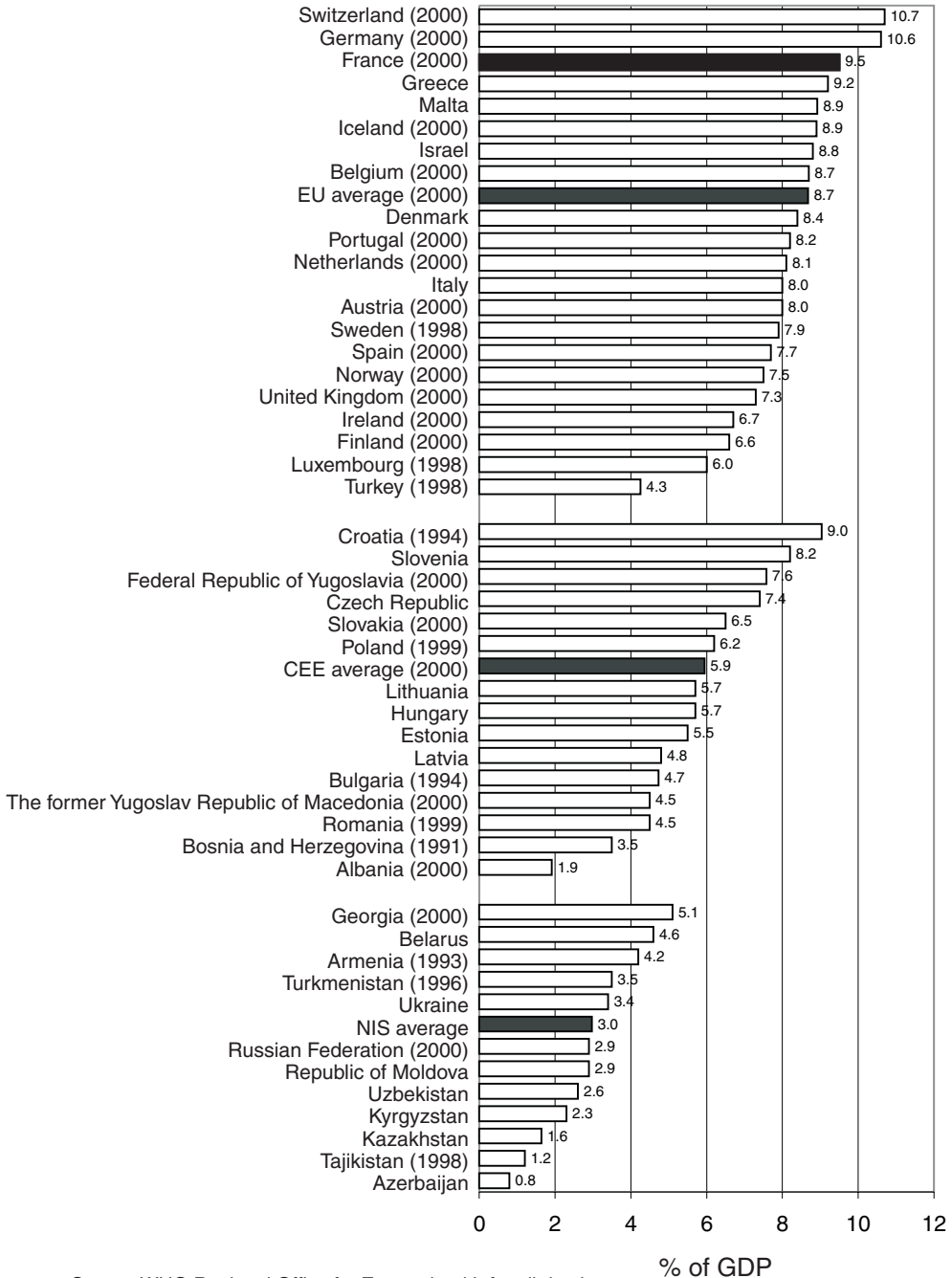
Note: prior to 1995, expenditure by voluntary health insurers was not listed separately in the national health accounts.

**Table 9. Health care financing by category, 2000**

	€ (millions)	%	Social security	State and local authorities	Mutual insurance associations	Provident institutions	Private insurance companies	Households
All medical goods and services	122 197	100.0	75.5	1.1	7.5	2.1	2.8	11.1
Hospitals and curative medical facilities	56 821	46.5	90.1	1.0	2.3	0.7	0.7	5.2
Public hospitals	44 286	36.2	91.1	1.2	1.4	0.4	0.5	5.4
Private hospitals	10 679	8.7	84.1	0.5	6.7	1.7	1.7	5.3
Ambulatory care	31 861	26.1	65.8	1.2	12.7	3.6	5.1	11.7
Medical care	15 324	12.5	74.2	1.4	12.5	3.1	4.8	4.0
Paramedical care	6 465	5.3	78.9	1.0	6.0	0.9	2.4	10.8
Dental care	6 430	5.3	34.7	0.6	20.0	7.5	8.4	28.7
Laboratories	2 789	2.3	72.9	1.3	13.6	3.3	6.1	2.7
Spas	853	0.7	25.1	1.3	9.1	2.7	1.8	60.0
Transport	1 873	1.5	94.5	0.1	1.6	0.3	0.7	2.8
Pharmaceutical products	31 642	25.9	58.1	1.0	11.7	3.3	4.2	21.6
Medicines	25 069	20.5	62.4	1.2	11.6	2.8	4.2	17.9
Other products goods	6 573	5.4	42.0	0.3	12.2	5.2	4.5	35.7

Source: IRDES/DREES 2001.

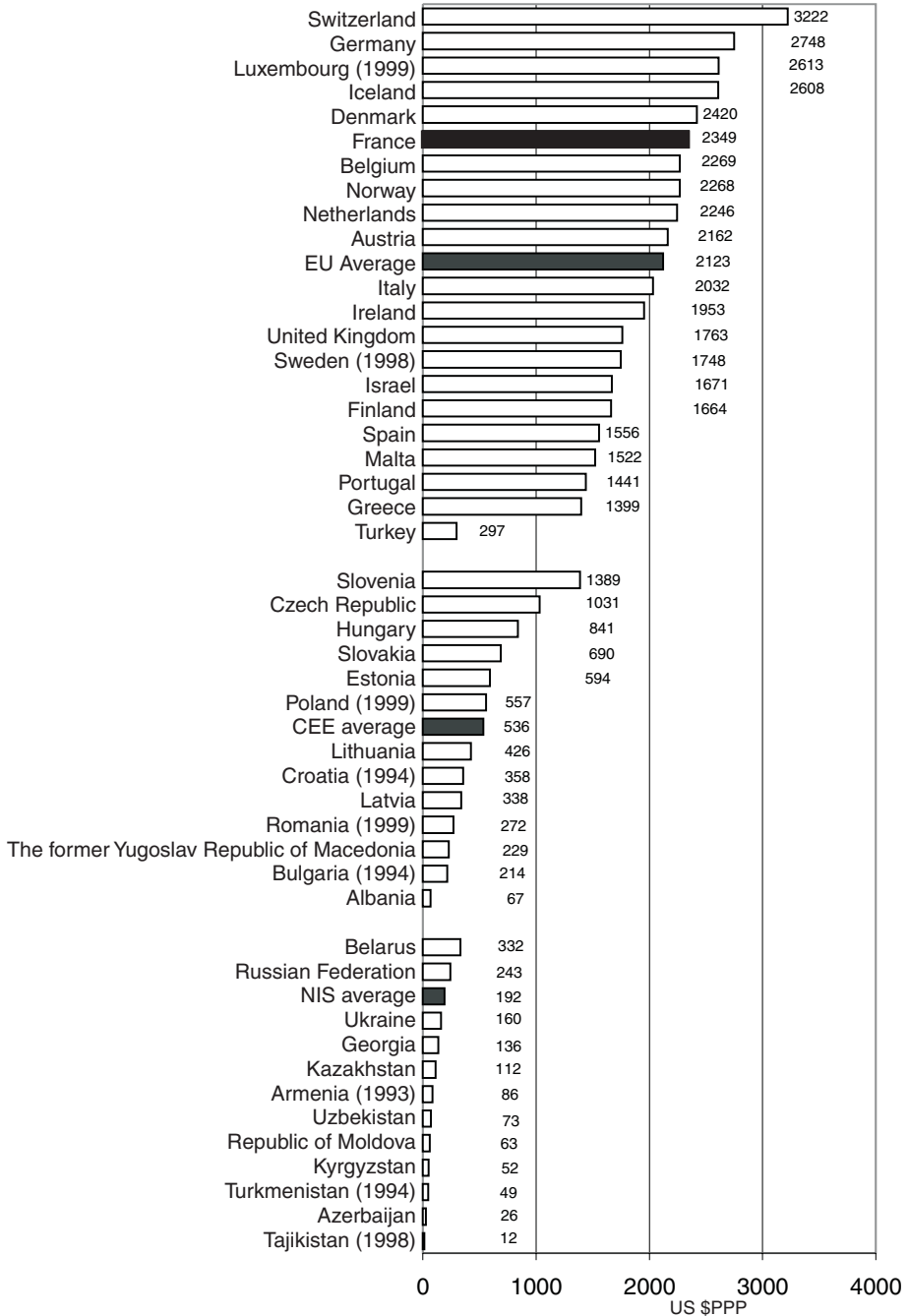
**Fig. 6. Total expenditure on health as a % of GDP in the WHO European Region, 2001 or latest available year (in parentheses)**



Source: WHO Regional Office for Europe health for all database.

Notes: CEE: central and eastern Europe; EU: European Union; NIS: newly independent states.

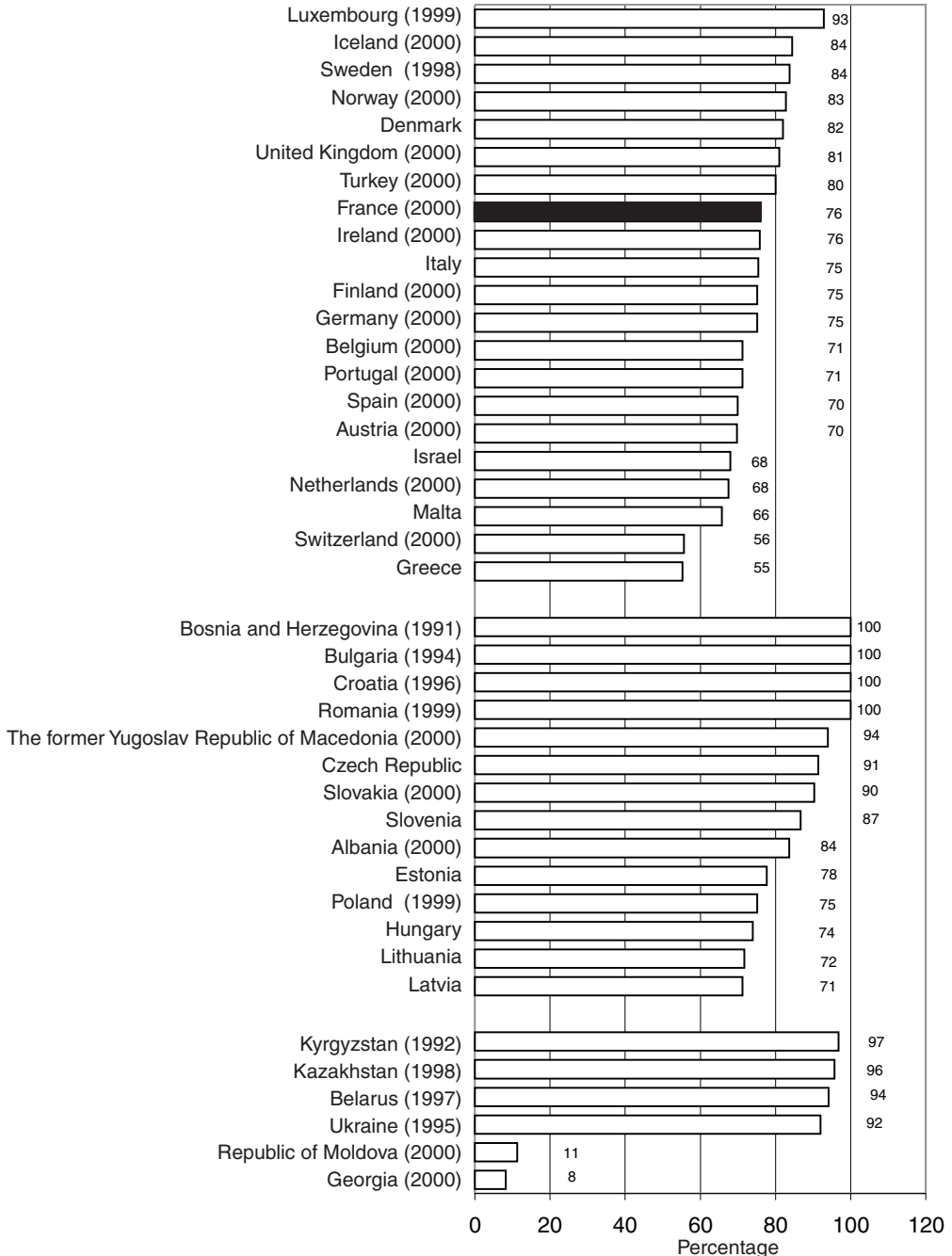
**Fig. 7. Health care expenditure in US \$PPP per capita in the WHO European Region, 2000 or latest available year (in parentheses)**



Source: WHO Regional Office for Europe health for all database.

Notes: CEE: central and eastern Europe; EU: European Union; NIS: newly independent states.

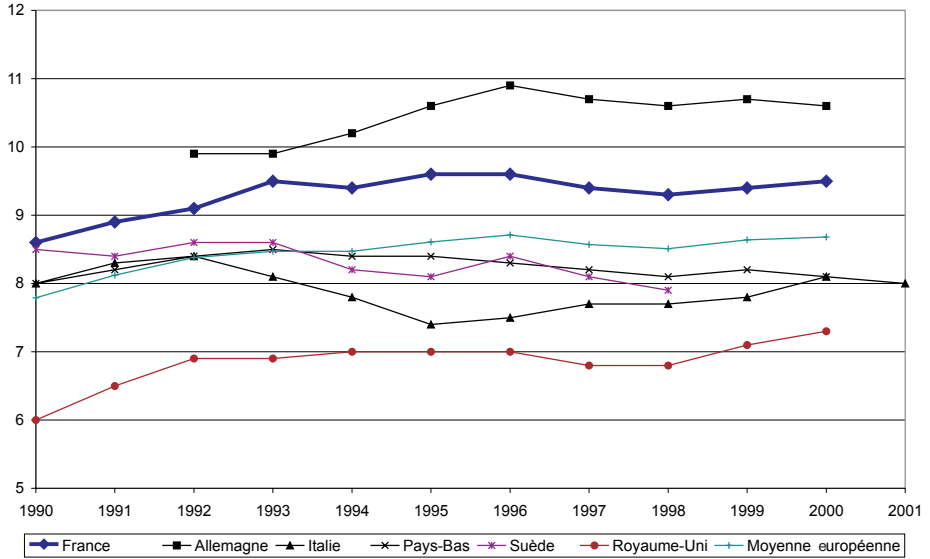
**Fig. 8. Health care expenditure from public sources as a percentage of total health care expenditure in countries in the WHO European Region, 2001 or latest available year (in parentheses)**



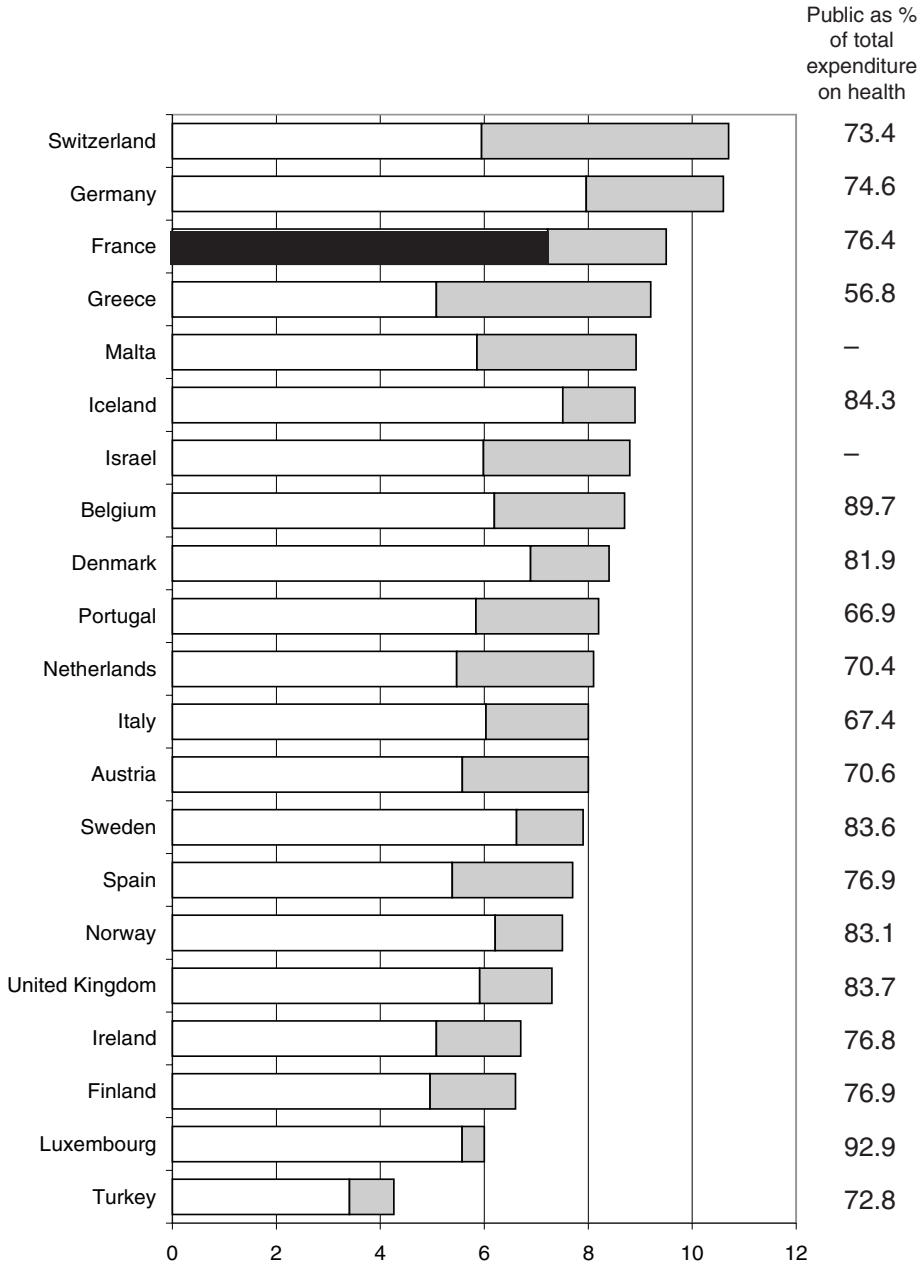
Source: WHO Regional Office for Europe health for all database.

France

**Fig. 9. Trends in total expenditure on health care as a percentage of GDP in France and selected countries, 1990–2001**



Source: WHO Regional Office for Europe health for all database.

**Fig. 10. Total and public expenditure on health as a % of GDP, 1998**

Source: WHO Regional Office for Europe health for all database; OECD 2000.



# Health care delivery system

## Public health services

Public health policy and practice in France are difficult to describe because they involve numerous actors and sources of finance. In addition, there is a real discrepancy between policy documents that allocate roles and responsibilities to various bodies (often local authorities) and actual practice, which is determined to a large extent by self-employed doctors, hospitals and other institutions. This is particularly evident in the area of individual prevention of ill health.<sup>14</sup>

On the advice of specialist agencies, the state issues basic regulations concerning environmental matters. Legally, municipal services at municipality level are 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. However, not all municipalities have the necessary resources to carry out these functions, and where this is the case, they are backed up by the Directorates of Health and Social Affairs at regional level (DRASS) or department level (DDASS).

Provision for the management of health risks was extensively reinforced by an Act of 1 July 1998, which set up three public bodies under ministerial guidance. The French Agency for the Medical Safety of Food Products (AFSSA) has a mandate to evaluate nutritional and health risks in foods and to conduct research activities in these areas. It is also responsible for supervising the market entry of veterinary medicines. The French Agency for the Medical Safety of Health Products (AFSSAPS) is in charge of scientific and economic evaluation of medicines and medical devices, of laboratory control and advertising control and of inspection of industrial sites. It also sets out recommendations for proper use.

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<sup>14</sup> This is related to the historic separation between health care on one hand (the responsibility of the health insurance funds) and prevention and public health on the other (the responsibility of the state).

The National Institute for Monitoring Public Health (InVS) monitors the population's state of health and developments in this area. It has a mandate to detect threats to public health and to inform public authorities of its findings, to collect, analyse and evaluate information about health risks and to participate in the collection of epidemiological data. Its field of responsibility involves communicable diseases, environmental health, health at work and chronic illnesses (monitoring of cancer, etc.).

Immunization policy is determined by the General Directorate of Health in the Ministry of Health on the basis of opinions given by the Technical Committee on Immunization and after consultation with the French High Council for public hygiene.

Some vaccinations are compulsory, while others are merely recommended.<sup>15</sup> The departments are obliged to offer free immunization against tuberculosis, but almost all vaccinations are carried out privately by self-employed doctors. As a result, rates of immunization are relatively low for recommended vaccinations in France (83% at the age of two for measles) in comparison with countries offering vaccination more systematically within their statutory health care systems (see Fig. 13). Compulsory and recommended vaccinations are reimbursed by the statutory health insurance system.

Antenatal and postnatal care for mothers and infants is fully reimbursed by the statutory health insurance system and can be provided by office-based self-employed doctors or by institutions. Maternal and child health services provided by departments are responsible for monitoring children's health, paying particular attention to families in difficulty. They are also responsible for consultations, preventive health and social care interventions for children up to the age of six, and establishing children's health records.

The Ministry of Education runs school health services, with systematic interventions in schools.

Prevention and diagnosis of sexually transmitted diseases comes under the authority of the general councils, at department level, who are obliged to offer free anonymous testing for certain diseases. In the case of HIV/AIDS, these tests are co-financed by the statutory health insurance system.

Departments are also legally responsible for cancer screening, but in practice tests are mainly provided within the health care system (mostly by self-employed doctors) and only marginally by department services. Nevertheless, systematic screening programmes have been organized for several

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<sup>15</sup> Compulsory vaccinations include: tetanus, diphtheria and poliomyelitis before eighteen months; BCG before nursery or school; specific vaccinations for risky professions. Recommended vaccinations include: measles, German measles, mumps and meningitis.

years to target populations that are less likely to initiate screening themselves. Until recently, these programmes for breast cancer (mammography every two years for women aged between 50 and 74) and colon cancer (blood culture after the age of 50) were limited to a few regions. There are plans to extend these programmes to the whole country (in 2002 for breast cancer). A new and ambitious cancer plan has been launched in 2003 and a National Institute of Cancer will be created to implement this new policy.

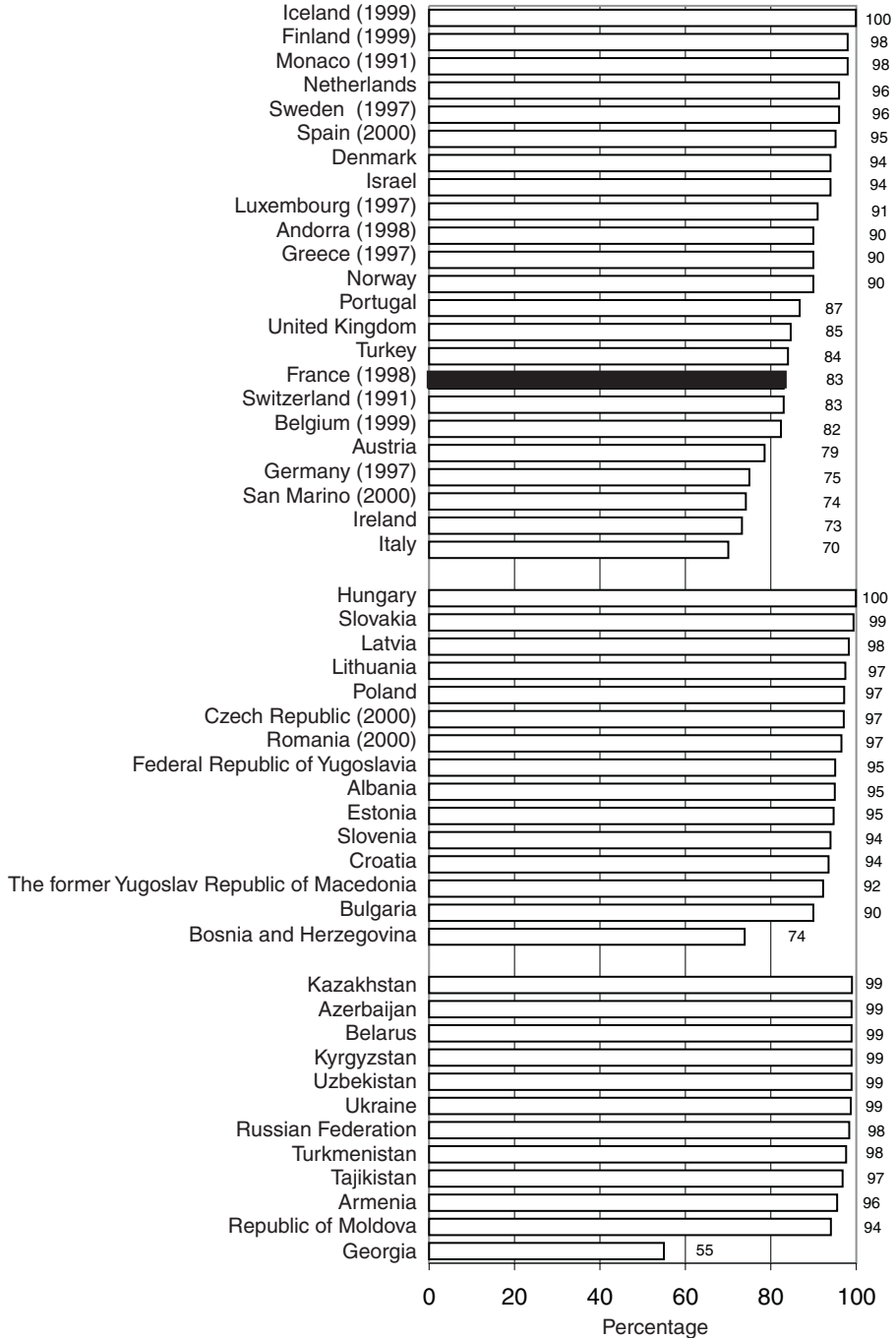
The degree to which different general councils have committed themselves to the task of prevention and screening varies considerably, ranging from a minimal service to active prevention programmes and campaigns.

The departments are also responsible for control of alcohol and drug abuse, but a large part of individual, primary and secondary prevention in this area is carried out by self-employed doctors, by institutions and by various associations.

It should be noted that in about 200 of the larger municipalities, the local health services have strengthened their efforts in the fields of immunization, health promotion and measures against alcohol and drug abuse. Where individual prevention is concerned, the health insurance funds offer medical examinations with priority for those at risk.

The state, the social security organizations and other relevant bodies define policies for the prevention of work-related health risks, taking guidance from the studies and expert advice of the National Agency for Improvement of Work, the National Institute for Research and Safety and other specialist bodies. The prevention of risks in the workplace involves three types of actors. The services of the workplace inspectorate (decentralized services of the Ministry of Labour) are responsible for ensuring compliance with regulations on hygiene, safety and working conditions. Within each business, the employer is responsible for ensuring that these regulations are respected, and the Committees on Hygiene, Safety and Working Conditions, which represent the employees of major enterprises, analyse risk in the workplace, giving their views on the working environment and the way in which work is organized. Compensation of victims is carried out by the section of the health insurance fund responsible for accidents at work and work-related illness. Finally, services providing doctors in the workplace are responsible for the systematic medical supervision of workers, preventive measures in the workplace and the adaptation of work to the needs of the worker. In 2000, nearly 6500 doctors were working in 1327 workplace services. These services either belong to the enterprise itself (if it is large) or are shared by several smaller firms.

**Fig. 11. Levels of immunization for measles in the WHO European Region, 2001 or latest available year (in parentheses)**



Source: WHO Regional Office for Europe health for all database.

Health promotion and health education involve a large number of actors. In the public sector, the Ministry of Health organizes national campaigns, while the DRASSs implement regional health promotion programmes. At department level, the DDASSs cover mental health, alcoholism and AIDS. The French Institute for Prevention and Health Education (INPES; previously the French Health Education Committee) contributes by implementing prevention programmes on a national scale. INPES is assisted by 117 committees in the regions and departments who carry out activities in the field. The Ministry of Health's High Level Committee on Public Health, set up in 1991, is responsible for developing the monitoring of health status and of presenting a report annually to the national health conference and to parliament. Health insurance funds are the principal promoters of preventing accidents in the home. The Minister of Transport tackles the prevention of road accidents.

The need to strengthen programmes and activities to promote public health in France became apparent in the 1990s. Regional health conferences now define priorities for public health within each region.

On the whole, prevention and health promotion suffer from the multiplicity of financers, the dilution of responsibilities and the fragmentation of actors, which impairs their global efficacy. The Public Health Bill, discussed in parliament in 2003, aims to enforce a more ambitious and more effective public health policy. It set out about one hundred objectives for a five-year period and proposes the implementation of five national public health plans between 2004 and 2008 (on cancer, unhealthy behaviour and addiction, health and environment, rare diseases, quality of life of people suffering from chronic illnesses). The bill also proposes clarifying the roles of different actors and devolving more power to regional levels through the creation of "public associations" gathering together actors involved in public health in each region. It also contains several provisions giving a more important role to systematic prevention. The bill should be passed in Spring 2004.

## **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 working in their own practices, and to a lesser extent, salaried staff in hospitals and health centres. Outpatient care and examinations in hospitals represent about 15% of all outpatient consultations. Around 1000 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.

Almost all self-employed health care professionals practise within the framework of the national agreements signed by the professionals' representatives and the health insurance funds.<sup>16</sup> Signed for four or five years, these agreements include a number of provisions concerning conditions of practice and list (in an appendix) the rates professionals are allowed to charge. Nevertheless, approximately a quarter of doctors within the agreement are authorized to charge prices that are higher than those indicated; these are doctors practising in what is known as the second sector or Sector 2 (24%) (see below) and doctors who still benefit from a permanent right to exceed rates that was granted to certain doctors in the past (1.5%).

In general, patients pay the health care provider and are subsequently reimbursed by their health insurance fund at the rate of reimbursement applied to the charge listed in the agreement (see the section on *Health care finance and expenditure*).

### **Ambulatory care by doctors**

Outpatient care is largely provided by self-employed doctors (both generalists and specialists) in their own practices. Most of these doctors work alone. Only 38% of doctors are involved in group practices, and these are usually general practitioners aiming to achieve a better allocation of time or specialists in fields that require extensive technical capacity.

The national agreement between doctors and health insurance funds allows some of them to charge more than the standard negotiated tariff. 15% of general practitioners and 35% of specialists opt for this practice, which is known as Sector 2. When Sector 2 was introduced (in 1980), all doctors were given the opportunity to join it, but opportunities to join were subsequently restricted. Currently, only doctors with specific qualifications can join Sector 2.

Office-based consultations form the basis of general practitioners' work, but home visits represent about 25% of their work. In one year a general practitioner sees, on average, 1400 different patients and carries out around 4800 consultations and visits. French people have an average of 4.7 contacts with a general practitioner per year (they can visit several general practitioners).

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 for-profit hospitals).

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<sup>16</sup> Doctors can choose not to work within the context of the agreement. In such cases they are free to set their own price for services, but patients will receive almost no reimbursement from the statutory health insurance system. At present, only 0.5% of self-employed doctors have chosen this option.

Patients have a free choice of doctor, regardless of specialty, and do not need a referral from a general practitioner in order to consult a specialist.

### **Geographical access to doctors**

Doctors benefit from total freedom to choose where they wish to practice, and geographical disparities in the distribution of doctors have existed for a long time. At regional level, for example, the density of medical capacity varies in ratio from 1 to 1.5 for general practitioners and from 1 to 2.2 for specialists, without any justification for these disparities in terms of different health needs. The north of France has a lower supply of doctors than the southern regions and Paris, which are more attractive to doctors (although people living in the northern regions are in poorer health and have higher mortality rates). At sub-regional level, inequalities are even more significant between urban and rural areas, as well as between the centre and the periphery in urban areas.

In spite of these geographical variations, 84% of the French people live in a municipality with at least one general practitioner, and for those who do not, the average distance to a general practitioner is 7 km and the journey time is 8 minutes. A recent survey showed that, in general, the French were satisfied with the proximity of the available health services, although 36% of respondents in rural areas considered that specialists were not close enough.

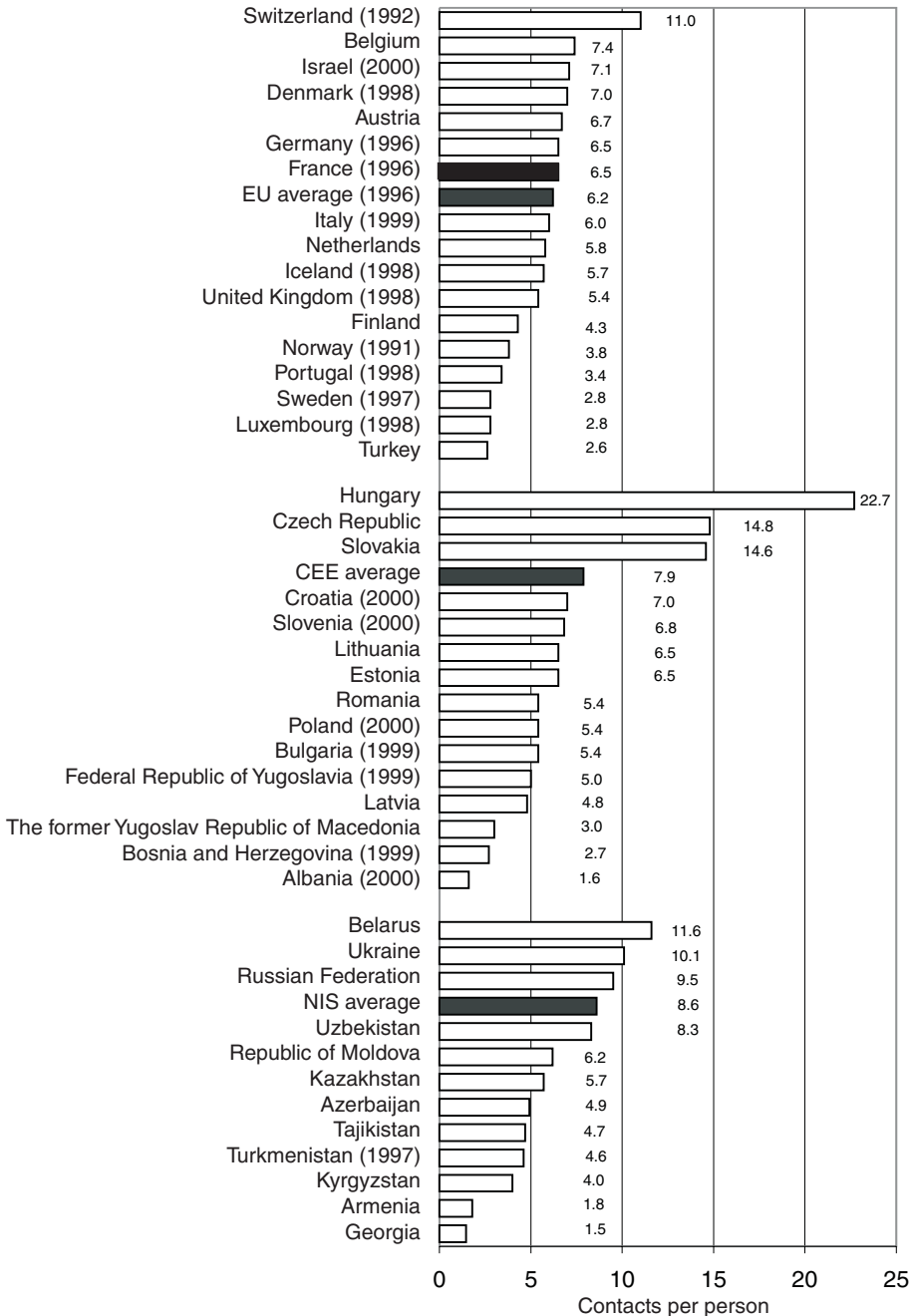
### **Quality of care and evaluation of medical practice**

Promoting the quality of care provided and the evaluation of medical practice only became visible issues in the mid-1990s. In practical terms, these issues were addressed in two ways: by establishing and disseminating a system of practice guidelines and by increasing the emphasis on continuing medical education.

Until the beginning of the 1990s, medical practice was only subject to partial control exercised by the medical advisers of the health insurance funds who were responsible for detecting anomalies and abuses in practice. Since then, the agreements, and later the ordinances of 1996, have emphasized the need to evaluate medical practice. The National Agency for Accreditation and Health Care Evaluation (ANAES) is responsible for issuing and disseminating recommendations and practice guidelines and for assisting doctors in evaluating their practices. It has published approximately 30 recommendations on clinical practice (RPC), relating to the diagnosis, treatment and supervision of certain conditions, and in some cases, to the evaluation of reimbursement arrangements.

ANAES also publishes practice guidelines (RMOs), which are recommendations on good practice that doctors are required to follow according to the

**Fig. 12. Outpatient contacts per person in the WHO European Region, 2001 or latest available year (in parentheses)**



Source: WHO Regional Office for Europe health for all database.

CEE: central and eastern Europe; EU: European Union; NIS: Newly independent states.



terms of the agreements signed between their professional representatives and the health insurance funds in 1994, 1995 and 1997. Up until 1999, failure to comply with these recommendations, if non-compliance was frequent, serious, or particularly expensive for the health insurance system, could have resulted in financial penalties for the doctor concerned. These recommendations (200 for general practitioners and 250 for specialists in 1998) mainly involve drug prescriptions, and to a lesser extent, the prescription or provision of medical examinations. They are generally presented in negative form, indicating ineffective or possibly dangerous practice. For example: "It is not advisable to employ two or more vaso-active substances, in cases of arteriopathy of the lower limbs".

Evaluation of the effects of the first two phases of the practice guidelines showed that the most relevant guidelines had caused doctors to modify their prescribing behaviour significantly. In the first year in which the guidelines appeared, doctors changed their prescriptions in 26% of cases where recommendations applied. Even though the effect was greater in the first year than in subsequent years, some of the guidelines have had a lasting impact. For example, the percentage of prescriptions not complying with the recommendation mentioned above changed from 19% in 1994 to 8% in 1996. The system of penalties was rarely used before it was abolished by a judicial decision at the end of 1999,<sup>17</sup> so the guidelines appear to work through self-regulation.

Continuing medical education (known as FMC) is another mechanism aimed at improving the quality of health care. Further medical training was originally mainly organized by professional associations, but the agreement of 1990 made provision for continuing education, ensuring that finance for education programmes would be provided by the health insurance funds, and that doctors participating in courses would be paid allowances. The ordinances of 1996 reaffirmed the importance of continuing education by making it compulsory, with any failure to comply liable to sanctions by the Council of the Order of Physicians. However, difficulties in implementing this aspect of the reform have meant that the system of continuing education for doctors has not improved.

### **Targeted agreements for good practice, good practice contracts and public health contracts**

The March 2002 law renewing relationships between professionals and health insurance funds enables them to sign different types of agreements: targeted

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<sup>17</sup>The highest administrative jurisdiction (Conseil d'Etat) cancelled the sanctions because they were calculated according to the doctor's income and could therefore be disproportionate to the fault.

agreements for good practice commit all members of one profession (physicians, nurses etc) at the national or the regional level, whereas good practice contracts and public health contracts are individual commitments. The logic behind all these agreements is to obtain professionals' commitment to improve their practice in return for higher fees or lump sum specific payments. These agreements offer the opportunity to improve the quality and the efficiency of professional practices.

### **Ambulatory care by other providers**

Dental care and orthodontic treatment are provided by 40 500 dentists, mostly practising privately. Just over 1500 of them specialize in orthodontics. Almost a third of self-employed dentists work in groups.

Midwives carry out outpatient prenatal and postnatal supervision, mostly in hospitals. 80% of the 14 400 midwives in France work in hospitals. About 1900 midwives have their own practices and carry out check-ups either in their practice or in the patient's home.

Nursing care is mainly provided by 57 000 self-employed nurses. Nursing and home care of patients makes up two thirds of the work of these nurses, who have on average 275 patients. Home nursing services have been developing since 1981, staffed mainly by wage-earning nursing auxiliaries. Today, there are just over 1500 home nursing services, with a total of 56 650 places.

Some types of outpatient care are provided by medical auxiliaries, who are also self-employed. There are 40 000 physiotherapists, 10 000 speech therapists, 1500 orthoptists and 8500 chiropodists.

Outpatient laboratory tests are usually carried out at 4000 laboratories. They may also be carried out in hospitals, particularly when they have been prescribed by a hospital doctor.

Finally, there are some 22 700 pharmacies, which provide drugs, accessories and bandages (see the section on *Pharmaceuticals*).

### **Coordination and organization of care: current experiments**

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 paths and insufficient quality. For example, a national study conducted by the main health insurance fund shows that only 40% of patients with diabetes have an eye examination once a year, as the practice guidelines issued by ANAES recommend. Even if doctors advise their patients correctly, they are not in a position to monitor the whole process of care.

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 experiments have been set up to try and address this situation: the “referring doctor” and provider networks.

Since 1998, every general practitioner can become a referring doctor for any patient that is willing to enter into the referral system. General practitioners that voluntarily adopt this system (and their patients) undertake to respect certain rules: applying the prices listed in the agreement, using the third party payment system (to shelter patients from direct payment), keeping patients’ medical records, providing continuous service, ensuring continuity of care, participating in public preventive programmes, complying with practice guidelines and ensuring that at least 15% of prescribed drugs are cheap drugs and 5% are generic. Patients undertake to consult their general practitioner in the first instance (except in emergencies), to bring their medical record to each consultation and to follow their general practitioner’s recommendations regarding prevention and screening. To date, only about 10% of general practitioners and 1% of patients have accepted this gatekeeping system, in spite of the financial incentives for doctors, who receive an annual payment for each patient registered (in addition to the fees charged for each visit). In 2001, the annual payment was even doubled, from €23 to €46 (which is 2.6 times the charge of a consultation). This sum is relatively large and could become expensive for health insurance funds. The annual expenditure of an average enrollee of the main health insurance fund for general practitioner care is around €69, so if all those enrolled joined the scheme, the expenses of the health insurance fund would increase by 67%.

Another initiative was taken in a 1996 reform, which opened up the possibility of experimenting with different forms of provider networks at the local level. The aim of the experiment 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 AIDS patients, 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 (tariffs, services reimbursed, remuneration of professionals, etc.). This innovation permitted the financing of factors that are not considered in the current system of payment (professionals’ coordination and management time, information systems for

sharing access to medical records, etc.) and the introduction of new benefits, such as joint consultations. The 1996 Act also left the field very open: networks could focus on a specific chronic disease (for example, diabetes or asthma), a specific population (the elderly), a specific type of care (palliative care) or 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, two years ago the regional level was permitted to take part and new funds were made available for this purpose. It is still too early to draw lessons from this experiment, but it may well succeed in encouraging innovation in the health care system.

## Secondary and tertiary inpatient care

### Hospitals

Hospitals in France can be public, private non-profit or private for-profit. They can be specialized or non-specialized.

Public hospitals account for a quarter of all hospitals (1000 out of 4000) and two thirds of the inpatient beds (320 000 out of 490 000). They are legally autonomous and manage their own budget. There are three levels of public hospital:

- 562 general hospitals (*centres hospitaliers*), providing a range of services covering acute care (medicine, surgery, obstetrics), follow-up care and rehabilitation and long-term care. They may also provide psychiatric care;
- 29 regional hospitals (*centres hospitaliers régionaux*), with a higher level of specialization and the technical capacity to treat more complex cases. Most of them are linked to a university and operate as teaching hospitals.
- 349 local hospitals; community level structures that fulfil a health and social care function, offering acute care, follow-up care and rehabilitation and long-term care. They are not equipped to carry out surgery or deal with childbirth. Most doctors working in local hospitals are self-employed private practitioners, although some doctors may be employed to provide follow-up care and rehabilitation and long-term care. Local hospitals tend to be small, with 160 beds on average.

In addition to these hospitals providing a range of services, there are 93 psychiatric hospitals.

Private hospitals fall into two categories: non-profit or for-profit.

Non-profit hospitals are owned by foundations, religious organizations or mutual insurance associations. They account for a third of hospitals (1400) and 15% of inpatient beds (75 000). Some non-profit hospitals are known as “participant in public service” (PSH), which means that they carry out public functions such as emergency care, teaching and social programmes for deprived populations.

The range of services provided by non-profit hospitals varies (see Table 10). In total, they account for a third of follow-up and rehabilitation capacity, but fewer than 10% of acute care beds. 20 non-profit private hospitals specialize in cancer treatment, with a broad remit that includes prevention, screening,

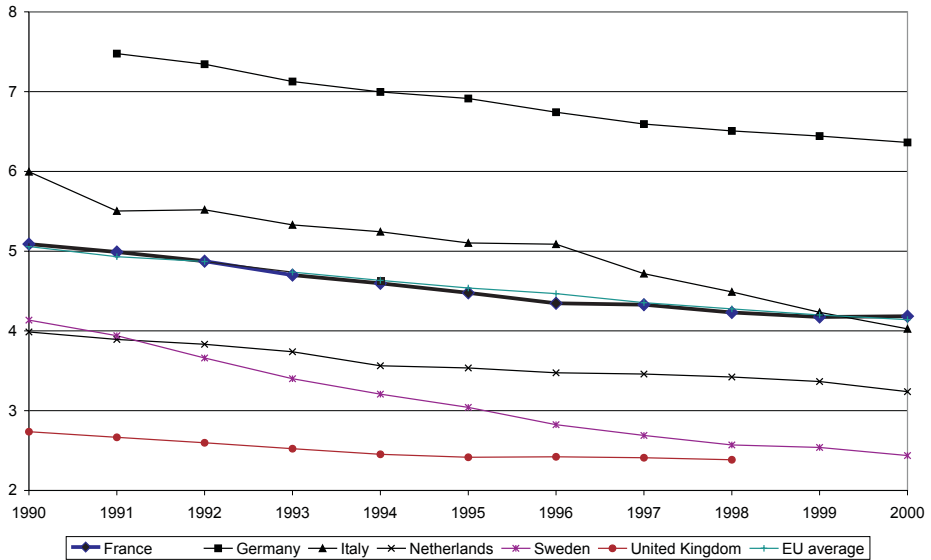
**Table 10. Distribution of hospital capacity between public and private sectors (on 1 January 1998)<sup>a</sup>**

	Public institutions		Private PSPH institutions		Private non PSPH institutions		Total Number
	Number	%	Number	%	Number	%	
Inpatient beds (full)							
Medicine	94 897	79.5	10 159	8.5	14 256	11.9	119 312
Surgery	48 043	45.9	8 398	8.0	48 166	46.0	104 607
Obstetrics	15 083	60.2	1 402	5.6	8 568	34.2	25 053
Total	158 023	63.5	19 959	8.0	70 990	28.5	248 972
Psychiatry	46 030	68.2	10 650	15.8	10 798	16.0	67 478
Drug addiction and alcoholism	1 174	64.8	367	20.3	271	15.0	1 812
Sub-total	205 227	64.5	30 976	9.7	82 059	25.8	318 262
After-care and rehabilitation	38 287	41.9	30 080	32.9	22 971	25.1	91 338
Long term treatment	75 273	91.3	5 040	6.1	2 121	2.6	82 434
Sub-total	318 787	64.8	66 096	13.4	107 151	21.8	492 034
Inpatient beds (partial)							
Psychiatric, day or night	21 287	79.5	5 210	19.5	279	1.0	26 776
Non-psychiatric, day or night	5 830	51.8	3 005	26.7	2 429	21.6	11 264
Anaesthesia and surgery (outpatient)	977	13.8	330	4.7	5 754	81.5	7 061
Sub-total	28 094	62.3	8 545	18.9	8 462	18.8	45 101

Source: Carrasco et al. 2001; IRDES/DREES 2001.

<sup>a</sup> The figures quoted, unless otherwise indicated, concern metropolitan France. The volume of activity and equipment in the overseas departments represented about 2% of hospital activity in France in 1998, and the patterns observed are the same as in metropolitan France.

**Fig. 13. Number of acute hospital beds in France and selected countries (per 1000 population), 1990–2000**



Source: WHO Regional Office for Europe health for all database.

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 in general hospitals.

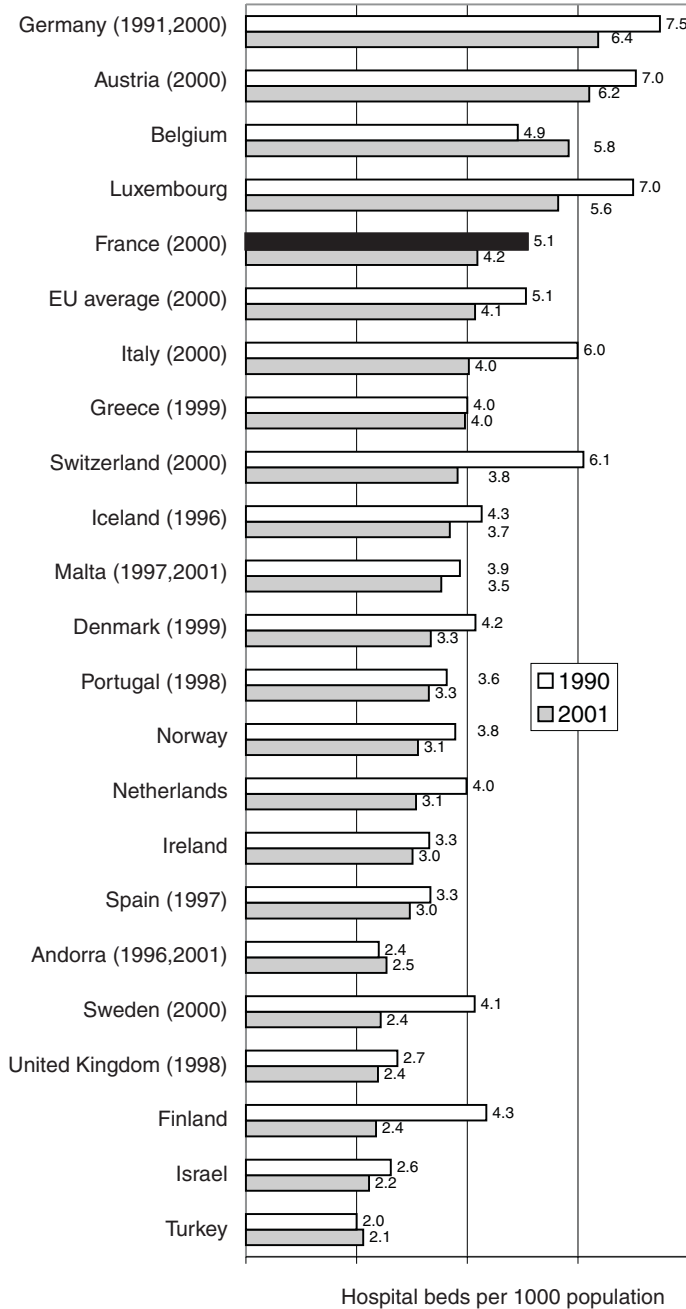
Private for-profit hospitals account for 40% of all hospitals in France (1750) and 20% of all inpatient beds (45% of surgical beds and 33% of obstetric beds) (see Table 10). They tend to specialize in certain areas (see below).

### Production factors in hospitals

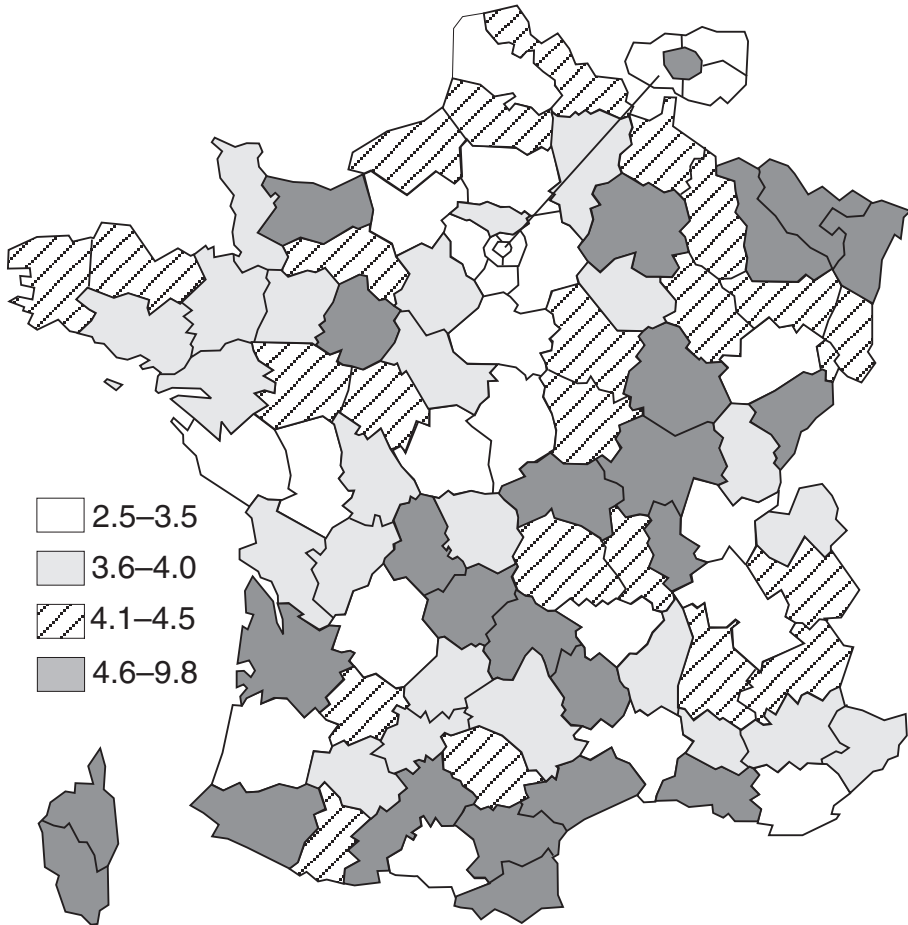
With an average of 8.4 hospital beds per 1000 inhabitants, half of which are acute beds, France is close to the European average (see Fig. 13, Fig. 14 and Fig. 15). Between 1980 and 1998, there was a marked downward trend in the number of hospital beds, linked to a reduction in the average length of stay. During the same period, the number of people admitted to hospitals continued to rise (see Table 11). These trends seem to be reflected in most countries in western Europe (see Table 12).

At the regional and department level, there are considerable discrepancies in bed numbers. The number of acute beds in the departments varies from 2.5 to 6 beds per 1000 inhabitants, excluding Paris, which has 9.8.

**Fig. 14. Hospital beds in acute hospitals per 1000 population in western Europe, 1990 and 2001 or latest available year (in parentheses)**



Source: WHO Regional Office for Europe health for all database.  
 EU: European Union.

**Fig. 15. Number of acute hospital beds per 1000 inhabitants in 1998**

Source: IRDES/DREES 2001.

In 1998, health care institutions employed just over one million people, 80% of whom were on the payrolls of public hospitals. Medical staff (doctors and pharmacists), make up 14% of these employees, with administrative and technical (maintenance) staff accounting for around 10% each. Nursing staff and educational staff are the most numerous (60%; mainly nurses, nurse auxiliaries and hospital liaison workers). Finally, 4% of employees are technical staff (laboratory technicians, X-ray operators, etc.). Part-time work is increasingly frequent in health care institutions, applying to 20% of non-medical staff in public hospitals.



Nowadays, hospitals complain about pressures on staff: the implementation of the EU Working Time Directive for physicians and the enforcement of the French “35 hours law” for other members of staff increased staff pressure already observed in some hospitals. Lack of sufficient personnel has been cited as one of the causes of the high mortality observed in the particularly hot summer of 2003 and unions representing hospital staff fear new pressures with the onset of winter epidemics.

### **Services provided by public and private hospitals**

Public and private hospitals provide different types of services. Private hospitals not participating in public service provide over a third of inpatient stays involving medical, surgical and obstetric procedures and almost 50% of minor surgical or outpatient cases. This sector invests in relatively minor surgical procedures, carrying out three quarters of cataract surgical procedures and with slightly over 60% of admissions for digestive system disorders (appendectomies, treatment of abdominal hernias, cholecystectomies, etc.). It is much less involved in emergency admission or rehabilitation, accounting for just over a quarter of these types of hospital stay. Their involvement with patients needing long-term care or psychiatric treatment is even more marginal.

### **Expansion of outpatient care**

A number of policies exist to encourage methods of providing care that are alternatives to complete hospitalization, such as day care surgery or treating patients in their homes (known as “hospitalization at home” in France). In each case, the extension of capacity must be authorized. Authorization is granted in return for closing down acute beds, with a theoretical exchange rate of one place for two beds, which may be adjusted at the regional level to take account of existing bed numbers.

Hospitalization at home (HH) has existed in France for about forty years, even though the statutes that define its precise functions as an alternative to hospitalization are comparatively recent.<sup>18</sup> HH consists of providing continuous and necessary coordinated medical and paramedical treatment in the patient’s home. It can be organized structurally under a hospital service or a non-profit association and calls on the services of health care professionals who may be employed by hospitals or self-employed practitioners. Within each structure, a

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<sup>18</sup> Following the Hospitals Act of 1970, circulars issued by CNAMTS (1974) and by the Ministry of Health (1986) authorized the creation of HH services and defined their functioning. The decrees of 1992 specified the role of HH as a genuine alternative to admission to hospital.

**Table 11. Inpatient utilization and performance, 1980–1998**

	1980	1985	1990	1995	1996	1997	1998
<b>All inpatient care</b>							
Number of beds per 1000 inhabitants	11.1	10.5	9.7	8.9	8.7	8.5	8.4
Occupancy rate	81.4	81.8	80.4	80.7	80.9	81.6	81.8
Number of hospital stays per 1000 inhabitants	193.0	210.0	232.0	228.0	228	230.0	229.0
Average length of stay (days)	17.1	14.9	12.3	11.5	11.2	11.0	10.9
<b>Acute care</b>							
Number of beds per 1000 inhabitants	6.2	5.7	5.2	4.6	4.5	4.3	4.2
Occupancy rate	79.0	79.1	77.3	76	75.9	76.4	76.1
Number of hospital stays per 1000 inhabitants	175.0	189.0	209.0	203.0	203.0	204.0	203.0
Average length of stay (days)	10.2	8.6	7.0	6.2	6.1	5.9	5.8

Source: IRDES/DREES 2001

coordinator (a doctor) ensures the satisfactory medical functioning of the whole service, but nurse-managers coordinate individual treatment. In 2000, France had around 4000 HH places, organized into 76 structures, two thirds of which are within the public sector (including private hospitals participating in public service) and vary widely in size, from 5 to 1200 places. HH is mainly used for patients suffering from serious acute or chronic illnesses such as cancer, neurological disorders and HIV/AIDS who would otherwise be hospitalized. It can also be used in cases where treatment is needed after childbirth or where there are complications during pregnancy. In 2000, the Ministry of Health enlarged the scope of HH involvement to encompass very dependent patients, in order to alleviate the foreseeable lack of capacity to accommodate elderly dependent patients in long-term care facilities.

Alongside HH, structures for part-time hospitalization and facilities for carrying out outpatient surgery have been set up. A 1992 decree specifies the conditions under which these facilities may function. In 1998, there were 7572 places for outpatient surgery, or 0.11 places per 1000 inhabitants, with wide regional disparities. The private for-profit sector is particularly active in this field, being responsible for more than 75% of places, with nearly 90% of private for-profit hospitals having facilities for outpatient surgery. The number of authorized places has grown by 18% since 1994. Partial hospitalization is growing rapidly, with admissions for periods of less than 24 hours increasing by 11% between 1997 and 1998. Full admissions to hospital decreased by 3%.

In spite of the incentives available, the development of alternatives to complete hospitalization remains limited by international standards. In a study comparing 14 countries in 1996–1997, Lathouwer and Poullier (2000) showed that the rate of ambulatory surgery for 18 current procedures was 30% in France,

**Table 12. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2001 or latest available year**

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
<b>Western Europe</b>				
Andorra	2.5	9.4	6.7 <sup>b</sup>	70.0 <sup>b</sup>
Austria	6.2 <sup>a</sup>	27.2 <sup>a</sup>	6.3 <sup>a</sup>	75.5 <sup>a</sup>
Belgium	5.8	16.9 <sup>b</sup>	8.0 <sup>b</sup>	80.0 <sup>c</sup>
Denmark	3.3 <sup>b</sup>	17.9	5.2 <sup>a</sup>	83.5 <sup>a</sup>
EU average	4.1 <sup>a</sup>	18.9 <sup>b</sup>	7.7 <sup>b</sup>	77.4 <sup>c</sup>
Finland	2.4	19.7	4.4	74.0 <sup>f</sup>
France	4.2 <sup>a</sup>	20.4 <sup>b</sup>	5.5 <sup>b</sup>	77.4 <sup>b</sup>
Germany	6.4 <sup>a</sup>	20.5 <sup>a</sup>	9.6 <sup>b</sup>	81.1 <sup>a</sup>
Greece	4.0 <sup>b</sup>	15.2 <sup>c</sup>	—	—
Iceland	3.7 <sup>e</sup>	18.1 <sup>f</sup>	6.8 <sup>f</sup>	—
Ireland	3.0	14.5	6.4	83.8
Israel	2.2	17.8	4.1	93.0
Italy	4.0 <sup>a</sup>	16.0 <sup>a</sup>	7.0 <sup>a</sup>	75.5 <sup>a</sup>
Luxembourg	5.6	18.4 <sup>g</sup>	7.7 <sup>c</sup>	74.3 <sup>g</sup>
Malta	3.5	11.2 <sup>a</sup>	4.3	75.5 <sup>a</sup>
Netherlands	3.1	8.8	7.4	58.4
Norway	3.1	16.1	5.8	87.2
Portugal	3.3 <sup>c</sup>	11.9 <sup>c</sup>	7.3 <sup>c</sup>	75.5 <sup>c</sup>
Spain	3.0 <sup>d</sup>	11.3 <sup>d</sup>	7.6 <sup>d</sup>	76.2 <sup>d</sup>
Sweden	2.4 <sup>a</sup>	14.9	4.9	77.5 <sup>e</sup>
Switzerland	3.8 <sup>a</sup>	16.3 <sup>c</sup>	10.0 <sup>a</sup>	85.0 <sup>a</sup>
Turkey	2.1	7.6 <sup>a</sup>	5.4	58.8
United Kingdom	2.4 <sup>c</sup>	21.4 <sup>e</sup>	5.0 <sup>e</sup>	80.8 <sup>c</sup>
<b>CEE</b>				
Albania	2.8 <sup>a</sup>	—	—	—
Bosnia and Herzegovina	3.3 <sup>c</sup>	7.2 <sup>c</sup>	9.8 <sup>c</sup>	62.6 <sup>b</sup>
Bulgaria	—	14.8 <sup>e</sup>	10.7 <sup>e</sup>	64.1 <sup>e</sup>
CEE average	5.4	17.8	8.3	72.3
Croatia	4.0	13.9	8.9	85.5
Czech Republic	6.3	18.9	8.6	70.5
Estonia	5.1	17.9	6.9	62.3
Hungary	6.4 <sup>a</sup>	24.2	7.0	76.9
Latvia	5.8	18.6	—	—
Lithuania	6.3	21.7	8.0	76.3
Slovakia	6.7	18.8	9.2	70.9
Slovenia	4.2	15.9	6.8	70.5
The former Yugoslav Republic of Macedonia	3.4	8.2	8.0	53.7
<b>NIS</b>				
Armenia	3.7	4.7	9.6	31.6
Azerbaijan	7.9	4.7	15.5	25.7
Georgia	3.9	4.3	7.4	82.0
Kazakhstan	5.4	14.7	11.3	96.5
Kyrgyzstan	4.8	13.9	10.8	87.6
NIS average	7.9	19.1	12.5	85.0
Republic of Moldova	4.7	11.9	10.3	70.7
Russian Federation	9.1	21.6	13.2	85.8
Tajikistan	5.8 <sup>d</sup>	8.9	13.0	54.5
Turkmenistan	6.0	12.4 <sup>d</sup>	11.1 <sup>d</sup>	72.1 <sup>d</sup>
Ukraine	7.1	18.7	12.5	89.5
Uzbekistan	—	—	—	84.5

Source: WHO Regional Office for Europe health for all database.

Notes: <sup>a</sup> 2000, <sup>b</sup> 1999, <sup>c</sup> 1998, <sup>d</sup> 1997, <sup>e</sup> 1996, <sup>f</sup> 1995, <sup>g</sup> 1994, <sup>h</sup> 1993, <sup>i</sup> 1992, <sup>j</sup> 1991.

**Table 13. Public-private distribution of hospital activity, 1998**

	Public institutions		Private PSPH institutions		Private institutions under OQN		Total for all institutions
	Number (thousands)	% <sup>a</sup>	Number (thousands)	% <sup>a</sup>	Number (thousands)	%	
<b>Total inpatient stays</b>							
Number of stays	6 855	57.8	993	8.4	4 008	34.0	11 856
Number of days	93 729	64.9	18 681	13.0	32 048	22.0	144 458
<b>Medicine, surgery, obstetrics</b>							
Number of stays	6 202	58.7	693	6.6	3 672	35.0	10 567
Number of days	42 361	63.5	4 640	7.0	19 715	30.0	66 716
<b>Mental health care</b>							
Number of stays	365	69.1	59	11.0	104	20.0	528
Number of days in full inpatient care	13 205	64.8	3 296	16.0	3 878	19.0	20 379
<b>After care, rehabilitation</b>							
Number of stays	225	32.8	233	34.0	227	33.0	685
Number of days in full inpatient care	11 373	40.9	8 834	32.0	7 594	27.0	27 800
<b>Long-term treatment</b>							
Number of stays	36	90.0	3	7.5	1	3.5	40
Number of days in full inpatient care	26 490	91.2	1 798	6.2	763	2.6	29 050
<b>Drug addiction, alcoholism</b>							
Number of stays	27	75.0	5	14.0	4	11.0	36
Number of days in full inpatient care	300	58.6	113	22.0	99	19.0	512
<b>Total stays &lt;24 hours</b>	6 211	59.8	1 929	19.0	2 253	22.0	10 392
<b>Medicine, surgery, obstetrics</b>	1 843	46.4	204	5.1	1 928	49.0	3 975
<b>Mental health care</b>	4 113	77.7	1 106	21.0	77	1.5	5 295
<b>After-care, rehabilitation</b>	255	22.7	619	55.0	248	22.0	1 122

Source: Carrasco et al. 2001; DREES.

<sup>a</sup> percentage of total for hospital.

compared to 60% in the United Kingdom, 85% in Quebec (Canada) and 94% in the United States.

More recently, Sourty le Guellec (2002) evaluated the potential for ambulatory surgery for different procedures. While some procedures are already largely performed on an outpatient basis, in other cases the development of ambulatory surgery is far below what it could be (currently 14% for strabismus surgery, whereas it could be 92%).

### **Promoting quality of hospital care**

The 1990s saw a rapid expansion in the promotion and evaluation of health care in hospitals. 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.<sup>19</sup> It was promoted within hospitals and in the organization and restructuring of hospital facilities.

Within hospitals, control of hospital-acquired infections, which still affect 7% of those admitted to hospital, is a key priority. Committees for combating hospital-acquired infections were set up in 1988, first in the public sector, and then in the private sector.

According to the terms of the 1996 Ordinances, all health care institutions must be accredited in order to continue providing treatment. This accreditation procedure, carried out by ANAES, is an external evaluation of the quality and safety of the health care provided within an institution. For the institution concerned it involves the implementation of a certain number of procedures and requires the compilation of a large amount of information, particularly with regard to quality indicators. The procedure lasts 10 months, on average, and includes a period of self-assessment, expert visits and exchanges with ANAES. The hospital is evaluated on several dimensions: quality of care, information given to the patient, medical records, general management (human resources, information systems, logistics), risk prevention strategies etc. By May 2002, about 150 hospitals had completed the process. The accreditation reviews are published on the ANAES website.

For quality purposes, the Ministry of Health has also defined more clearly the role of different hospitals in providing emergency and perinatal care. Two 1998 decrees define hospitals' roles in these areas on the basis of their technical capacity and promote cooperation between them. For example, there are four different levels for hospitals providing obstetric care. Hospitals at the first level

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<sup>19</sup> In 1997, the review *Sciences Avenir* published lists of the "best institutions" for certain surgical procedures, based on the number of procedures carried out annually, the mortality rate adjusted for age and a "popularity" index based on the institution's ability to attract patients not resident within its own area.

only conduct antenatal consultations, while those at the fourth level are capable of providing neonatal intensive care.

## Mental health

Since the 1960s, mental health policy in France has been based on a desire to restore patients' dignity and autonomy, which can often be impaired by internment in specialized institutions. The characteristic feature of this policy is a continuous movement towards de-institutionalization. A key process in this movement has been to divide the country up into geographical zones or areas (*secteurs*) serving a particular population and to establish a multi-disciplinary team in each zone to provide preventive care, treatment, follow-up care and rehabilitation for people living in that area and suffering from psychiatric disorders.<sup>20</sup>

Each psychiatric zone is linked to a hospital (either a public hospital or a private hospital participating in the public hospital service) which is obliged to treat psychiatric patients in that area. The hospital is responsible for providing diagnostic and therapeutic services, while facilities outside the hospital focus on domestic issues, rehabilitation and social support (for example, therapeutic reception centres, therapeutic accommodation etc). In each zone, a Medical and Psychological Centre (CMP) provides consultations and directs patients towards the services they need.

On average, an adult zone covers 67 000 inhabitants and a child-juvenile zone covers 210 000 inhabitants. Three types of areas are defined: one for adults, one for children and adolescents and one for prisons. In 2000, there were 1123 zones across the country, 812 of them for adults and 311 for children and juveniles. In 1999, the sectors had about 1.1 million adults and 400 000 children in their care. Most zones (58%) are linked to hospitals that specialize in psychiatry, 33% to general hospitals and 9% to private hospitals participating in public service.

The establishment of psychiatric zones was first implemented in the 1970s and developed rapidly in the 1980s. However, the curative logic often continues to prevail, and the range of services for the social support of patients varies significantly between geographical zones.

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<sup>20</sup> Psychiatric zones were first defined in a circular from the Ministry of Health dated 15 March 1960. In 1972, ordinances made a distinction between psychiatric zones for adults and children/juveniles. In 1985 and 1986, the health insurance system was given responsibility for the entire management and financing of these psychiatric zones, whereas previously they had co-managed them with the social services offices in the departments that had financed and organized the accommodation element.

Private hospitals accept patients with psychiatric disorders on the same basis as public hospitals. About thirty private PSPH hospitals are allowed, like public hospitals, to admit persons under restraint. Private hospitals that do not participate in the public hospital service are only marginally involved in outpatient treatment, but they account for 20% of cases involving inpatient care. The Ordinance for the simplification of hospital planning might be less restrictive and gives the private sector an opportunity to develop its participation in outpatient psychiatric care.

Finally, it should be noted that a large number of psychological disorders are dealt with on an outpatient basis by private general practitioners (in 1997, 16% of general practitioners' consultations concerned a psychological problem or sleeping disorder), psychiatrists or psychologists, some of them practising psychotherapy and, occasionally, psychoanalysis. In 1999, there were 13 213 practising psychiatrists in France (22.5 per 100 000 inhabitants), of which 6300 practised privately, at least part-time. In spite of this rather high ratio, there is a shortage of psychiatrists in public hospitals. This shortage may be linked to the level of earnings, or to working conditions in the public sector (treating more seriously ill patients, the constraints of public service etc). 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.

## **Social care**

Residential care of elderly people and dependent disabled adults is the responsibility of the social sector and is run by general councils at department level. However, health care for people in residential care is, in principle, the responsibility of the health insurance system. The health insurance system also covers all costs of residential care and treatment in specialized institutions for disabled children.

The social sector in France is involved both in the protection of children and in the provision of residential care for vulnerable people.

### **Residential care and treatment for elderly people**

In 2000, there were just over 12 million people aged over 60 in France. 628 000 of them were categorized as heavily dependent (that is confined to bed or a chair, or requiring assistance in using the lavatory and dressing). 500 000 people (of

whom 217 000 are heavily dependent) are based in long-term care facilities. 18 000 people aged 60 and over are in psychiatric hospitals and institutions for disabled people.

Home care is delivered by self-employed professionals or by specialized home care services, but it is likely that supply is insufficient to meet need. Furthermore, although care in the community is considered a priority, it suffers from poor coordination between health services financed by the health insurance funds and social services managed by local government.

Residential care for elderly people is provided by many types of institutions offering different levels of services. Some are basically collective housing, offering a range of non-medical facilities (such as catering and laundry) and infirmary services.

Institutions financed by the health insurance funds to provide health care to elderly people include:

- so-called “retirement homes”, in which the level of health care provided is classified in two categories according to the severity of cases; health care is financed by the health insurance funds in the form of daily allowances of €3 for routine health care and €23 for more heavily dependent people; the total number of beds in these facilities amounts to 416 000 (153 000 of which are for dependent people);
- long-term care, provided in autonomous nursing homes or in hospital wards, for very sick and dependent people; the per diem rate is €41 and 83 000 beds are available.

In these institutions, medical care and nursing are entirely financed by the health insurance funds; there is no co-payment. However, the costs of residential accommodation, borne by the patient or their family, is high (around €40–45 per day). For people with low incomes, the costs of residential accommodation may be financed by the general councils. There is a recurrent debate about the sharing of costs between the two institutions.

National Health Accounts include all expenditure on long-term care facilities, but only the health care expenditure of the retirement homes. These costs amount to about €46 billion (that is, 3% of total expenditure on health care).

In January 1997, a specific dependency allowance (PSD) was set up. Funded by the general councils, it financed the employment of people working in the homes of or within institutions for heavily dependent people aged 60 and over.<sup>21</sup> 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

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<sup>21</sup> Before the introduction of this benefit, elderly dependent persons might have qualified for a grant to finance care in their home (a grant introduced in 1975 and intended for disabled people).



ceiling, established by decree, of €950 per month for a single person. By the end of 2000, 140 000 people were receiving this allowance, 53% of them living at home. The average PSD allowance was €530 per month for those employing someone in their own home and €290 per month for those in institutions. The average PSD allowance varied widely between departments.

In July 2001, a new act substituted this PSD with a personal independence allowance (APA). Unlike PSD, this is a uniform allowance throughout the country. It is means tested and adjusted in relation to the individual's dependence level and living conditions and needs, as assessed by a joint health and social care team. However, it will no longer depend on the wealth and priorities of the general councils. Currently, demand seems to exceed the initial forecasts of 800 000 persons eligible for this benefit.

### **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 at the department level, for children and for adults, 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.

A large number of institutions offer treatment, special education and vocational training to children affected by motor, cerebral or intellectual deficiencies. The costs of these institutions are financed by the statutory health insurance system. Nearly 130 000 disabled children are catered for in 2500 facilities.

Different types of institution cater 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 out 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 deficiency and the need for care. Institutions for the most heavily dependent persons are financed entirely by the health insurance funds, while in other institutions there is a double source of funding, as with residential care for the elderly: the health care part is paid for by the health insurance fund and the costs of residential care are charged to the patient or to the department.<sup>22</sup> Around 200 000 adults are accommodated in 4400 facilities.

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<sup>22</sup> This expenditure is not included in the National Health Accounts

An incapacity rating of over 80%, or for some conditions over 50%, confers the right to cash allowances that are paid out by the family allowance funds: a special education allowance for children and an allowance for disabled adults. Finally, a compensation allowance, paid out by the general councils, finances the wages of people employed by disabled people or their families.

## Reforms in process

Current policies concerning elderly people and disabled people have two aims: increasing the capacity of admission to institutions to meet growing demand and developing “lighter” forms of care (such as family placements and assistance with care in the home), which promote better integration and autonomy and are also much cheaper to provide.

In 2000, the Government presented proposals for reform of social and health and social care policy. These proposals foresee the creation of 16 500 places for residential care for disabled people in five years, along with a programme of providing health care within institutions taking care of elderly dependent people and developing nursing care in home services. The proposals also define reforms envisaged for institutions in the health and social care sector, some of which take their inspiration from recent reforms in the health sector. Features include: recognizing and promoting patients’ rights, extending institutional functions, establishing more effective health and social care planning through the introduction of social and health and social care plans covering a 5-year period, diversifying the rules for charges, and introducing better decision-making, in particular through establishing long-term contracts with health institutions, setting targets for outcomes and resources, and implementing measures to encourage cooperation between institutions and services.

The bill on social modernization adopted in 2002 also contains provision for improving conditions in the family placements system, which currently involves approximately 6000 elderly people and 6000 disabled adults. By specifying the conditions that host families have to fulfil and by strengthening their social rights (pay, holidays, etc.), the draft law aims to enhance the quality of care in family placements.

## Human resources and training

There are about 1.6 million health care professionals in France, accounting for approximately 6.2% of the working population. Nurses and nursing aides (*aides-soignants*) form the majority of these professionals (383 000 nurses and 377 000 nursing aides).

Those employed in the health care sector also include clerical and technical staff working in hospitals, health insurance funds and the pharmaceutical industry, who account for almost 500 000 persons.

**Table 14. Health care personnel per 100 000 inhabitants, 1975–2000**

Density (per 100 000 inhabitants)	1975	1980	1985	1990	1995	2000
All physicians	146.7	193.7	266.2	306.0	323.3	330.3
– general practitioners	91.7	121.5	151.1	162.2	163.7	161.3
– specialists	54.9	72.2	115.1	143.8	159.6	169.0
Dentists	47.7	56.4	63.0	67.0	68.8	69.0
Nurses	356.5	457.1	518.8	538.2	590.6	651.9
Midwives	16.7	17.5	16.6	18.9	21.2	24.4
Pharmacists	56.0	67.9	79.7	90.8	97.7	99.4
Medical students	195.2	157.9	101.6	82.5	92.2	82.3 <sup>a</sup>
Nurse students	98.9	87.7	72.9	66.0	91.4	86.2 <sup>b</sup>

Source: IRDES/DREES 2001.

<sup>a</sup> 1998 <sup>b</sup> 1999.

## Medical training

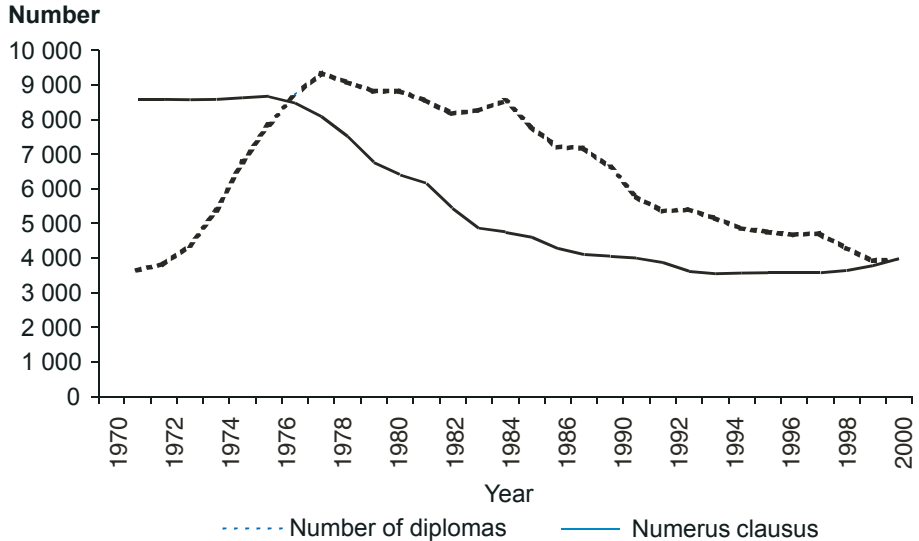
Medical training is divided into three phases. The first phase (PCEM) takes place over two years. Any student with the qualifications to register with a university may enroll for the first year, which is common to students of medicine and dentistry. A competitive examination limits access to the second year. Every year a ministerial decree specifies the number of places available (*numerus clausus*) for each of the 33 education and research units.

A drastic reduction in *the numerus clausus* took place in the 1970s in order to limit the number of doctors, which was increasing rapidly. Since 1960, the number of doctors has more than trebled, reaching an average ratio of 332 doctors per 100 000 inhabitants in 2000.

Today this policy has resulted in a stabilization of doctor numbers and a significant decrease is forecast for the next ten years. Many fear that this will lead to a lack of doctors in some specialties or geographical areas. There are already difficulties in recruiting doctors in specialties such as anesthesiology or gynaecology and obstetrics. As a result, the intake of students has been raised once again (from 3850 in 1998 to 4100, 4700 and 5200 in 2002–2003) and may be raised even further in future.

The second phase of medical training takes four years and includes both theoretical and practical training.

**Fig. 16. Evolution of the *numerus clausus* and the number of medical graduates, 1970–2000**



The third phase has two aspects: residency (*résidanat*), reserved for the training of general practitioners, and internship (*internat*), reserved for the training of specialists. Residency takes two and a half years and includes a compulsory six month training period with a general practitioner.

Internships give medical students the opportunity to specialize. Posts are divided according to 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 entrance exams. In 2000/2001, 1843 posts were available, which means that almost half of medical students become specialists. The specialist diploma is obtained after four or five years of internship.

A recent reform puts general practice on an equal footing with specialties. The initial training period will be lengthened and recruitment will be more selective (in contrast to the "default" recruitment of students who have not attempted or been successful in the internship examination). This is part of a process aimed at upgrading general practice.

**Table 15. Health care personnel entering work force in western Europe per 100 000 population, 1998 or latest available year**

	Physicians	Midwives	Dentists	Nurses	Pharmacists
Austria	13.29 <sup>d</sup>	0.50	–	38.36	2.54 <sup>d</sup>
Belgium	10.91	–	1.96	–	5.17
Denmark	6.96 <sup>d</sup>	1.40 <sup>d</sup>	1.48 <sup>d</sup>	33.08 <sup>d</sup>	2.20 <sup>d</sup>
EU average	12.09 <sup>c</sup>	–	1.85 <sup>c</sup>	27.31 <sup>c</sup>	3.11 <sup>d</sup>
Finland	10.73	4.80	1.82	85.99	6.79
France	–	1.00 <sup>a</sup>	–	25.28 <sup>a</sup>	–
Germany	14.36	0.60 <sup>a</sup>	1.90	18.99 <sup>a</sup>	2.00
Greece	–	–	–	–	–
Iceland	15.5 <sup>d</sup>	2.60 <sup>d</sup>	2.58 <sup>d</sup>	36.17 <sup>d</sup>	4.43 <sup>d</sup>
Ireland	14.34 <sup>c</sup>	5.30	2.10 <sup>d</sup>	36.79	1.39 <sup>d</sup>
Israel	5.21	0.70	1.04	20.28	0.54
Italy				31.21 <sup>c</sup>	4.34
Luxembourg		1.20		27.20	
Netherlands	9.90 <sup>d</sup>	0.60 <sup>d</sup>	1.15 <sup>d</sup>	39.09 <sup>b</sup>	1.32 <sup>d</sup>
Norway					
Portugal	5.23	0.30 <sup>a</sup>	2.94	13.11	3.24
Spain	10.51 <sup>c</sup>		1.24 <sup>c</sup>	20.65 <sup>c</sup>	
Sweden	9.47 <sup>d</sup>	2.10 <sup>d</sup>	2.38 <sup>c</sup>	34.14 <sup>c</sup>	
Switzerland	10.89	1.00	1.49	46.58	2.33
Turkey	6.89	4.60	1.43	12.58	1.40
United Kingdom	–	–	–	–	–

Source: WHO Regional Office for Europe health for all database.

<sup>a</sup> 1994, <sup>b</sup> 1995, <sup>c</sup> 1996, <sup>d</sup> 1997.

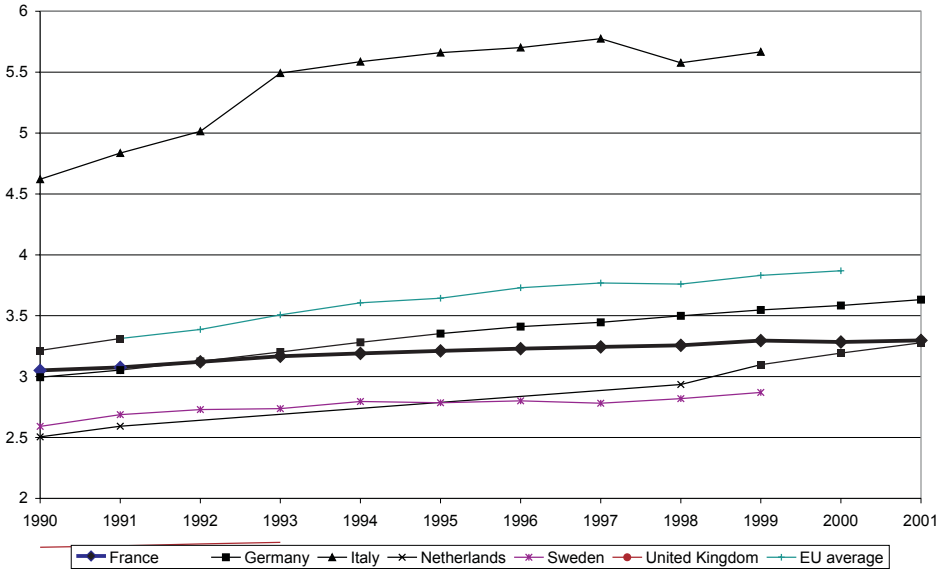
## Health care supply

### The supply of doctors

In 2000, there were a total of 194 000 doctors in France (51% specialists and 49% general practitioners). Recent developments in medical demography have shown an increase in specialists (up from 45% of all doctors in 1985), a relative redistribution of the balance of regional doctor/population ratios and an increase in the number of salaried medical staff.

In 2000, 50% of specialists and 29% of general practitioners were salaried employees. Salaried specialists mainly work in hospitals (83%), preventive services (7%), the pharmaceutical industry and laboratories. Almost half of all salaried general practitioners work in hospitals (45%), 20% in preventive services (occupational medicine, specialized services at the department level for pregnant women and children, etc.) and the remainder are employed in health centres, in social services or in the pharmaceutical industry.

**Fig. 17. Physicians per 1000 population, France and selected western European countries, 1990–2001**



Source: WHO Regional Office for Europe health for all database.

As noted above, the number of doctors has risen rapidly in recent decades, but is now stable and should begin to decrease from 2006 onwards. Depending on the *numerus clausus*, the doctor/population ratio in 2020 should be around 250–275 doctors per 100 000 inhabitants (Niel, 2000).

It is not easy to judge the correct level of health care supply in relation to the needs and expectations of the population, even less so where the future is concerned. It may actually be the case that new methods of health care organization, that redistribute the roles of different health care professionals, will result in a decrease in the need for doctors. For example, the ratio of ophthalmologists (currently 9 per 100 000 inhabitants) is to be halved between now and 2020, assuming no decrease in needs. In this particular case, it is likely that ophthalmologists will share tasks and responsibilities with orthoptists and opticians. However, substitutions of this type presuppose that the necessary lower-qualified human resources are available.

In the meantime, tensions may arise, for example in rural areas, where several general practitioners may want to retire but be unable to find replacements, or in underprivileged areas, where doctors may be reluctant to set up practice due to the burdensome social content of the workload. Furthermore, some

specialties are already registering a decrease in the number of doctors. This is the case for anaesthesiology in intensive care, which is associated with heavy responsibilities and numerous obligations (and for which a specific internship was created in 1999).

The geographical distribution of health care supply is characterized by a wide disparity in regional doctor/population ratios, ranging from 241 doctors per 100 000 inhabitants in Picardy to 425 in Ile-de-France, with even more marked differences for specialists than for general practitioners. Public authorities have tried to remedy this situation through differentiation within the *numerus clausus* system and the number of posts open for internship, giving priority to regions with a low ratio. 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, 69% of doctors practise in the region where they did their training, but many specialists find internships in regions where there are fewer doctors and then return to their region of origin to practise. In future, however, it may be possible to equalize capacity between regions, as the regions that currently have the most generous provision (Ile-de-France, Provence-Alpes-Côte d'Azur, etc.) are also those in which there is a high proportion of older doctors in practice.

### **The supply of nursing and routine care staff**

There were 383 000 nurses in France on 1 January 2000, about 15% of whom specialize in the care of psychiatric patients.<sup>23</sup> Nurses can be self-employed, but almost 83% of them are employed as salaried staff. Public hospitals employ 56% of nurses and private hospitals 13%.

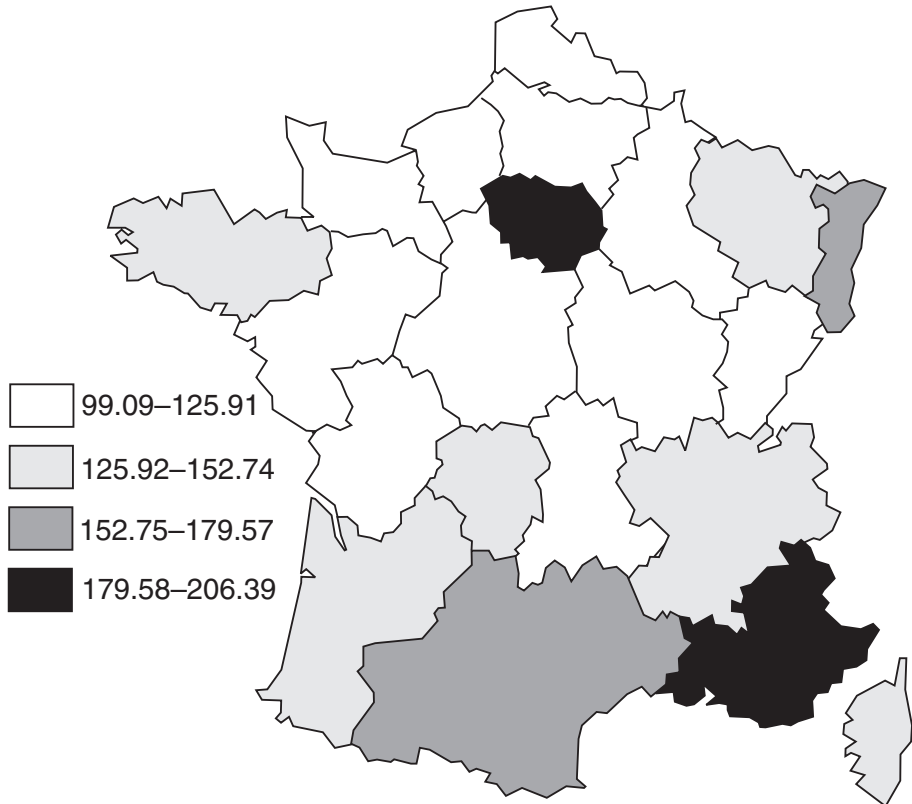
Nurse training is accessible via competition at the *baccalauréat* level (that is, the national exam taken at the end of secondary school). The basic training takes three years, with subsequent optional specializations in theatre nursing, paediatric nursing and anaesthesia, taking 9, 12 and 24 months respectively. It is estimated that for each 100 students admitted for study, 75 will eventually work as nurses.

France is currently facing a shortage of nurses, which might become more severe in the near future, given the ageing of the profession and the existence of recent employment laws restricting the working week to 35 hours (even in hospitals). Although the number of places in nursing schools (existing since 1983) has risen significantly (from 18 270 in 1999 to 26 180 in 2000 and 26 142 in 2001), in 2001 there were not enough candidates. In order to fill vacant

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<sup>23</sup> Until 1992, specific training was provided for psychiatric nurses.

**Fig. 18. Number of specialists per 100 000 inhabitants in each region in 1999**



Source: IRDES/DREES 2001.

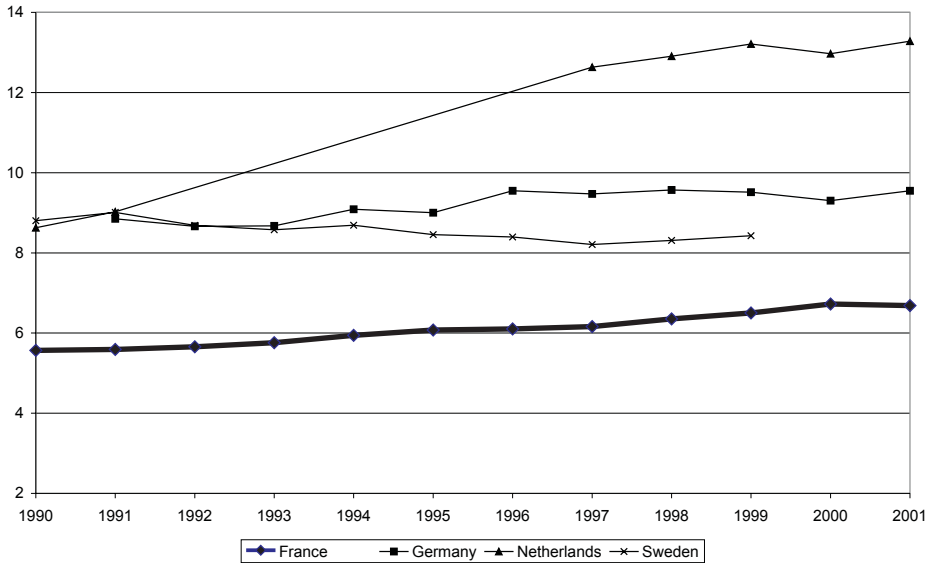
positions, the government and hospitals are attempting to encourage nurses to return to the profession or to recruit nurses from other countries (for example, Spain and Lebanon).

377 000 nursing aides assist 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 services that employ them. A large proportion of care in outpatient settings is provided by nurses working independently.

France



**Fig. 19. Nurses per 1000 population, France and selected western European countries, 1990–2001**



Source: WHO Regional Office for Europe health for all database.

A nursing care project currently under discussion proposes that the responsibilities delegated to self-employed nurses should be broadened by adding the management and coordination of patient treatment. It is also proposed that part of this function could be delegated to less qualified staff.

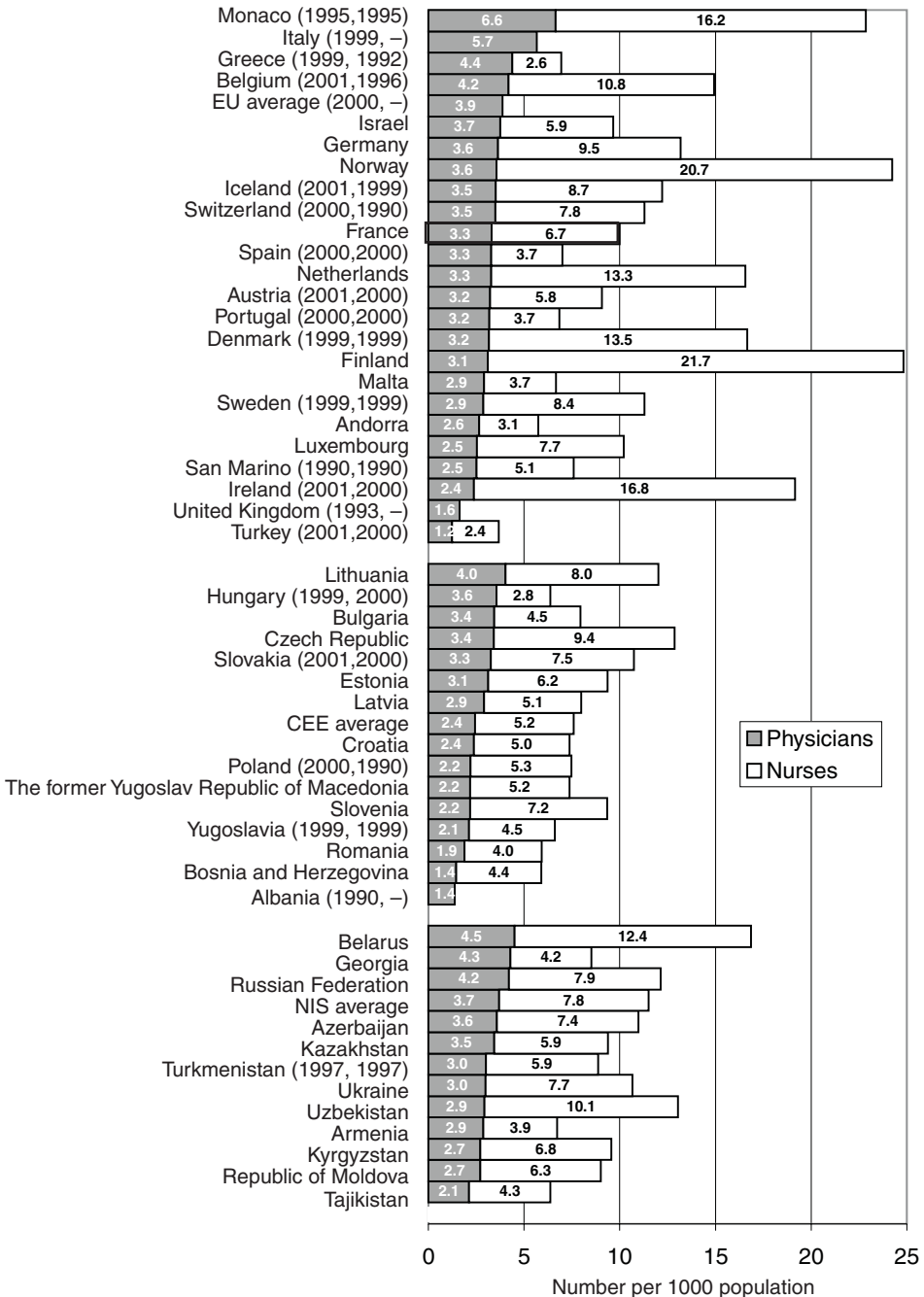
**The supply of paramedical staff**

In addition to nurses and nursing aides, paediatric nurses and paediatric auxiliaries provide care for children.

Physiotherapists, speech therapists, orthoptists, psychometricians and occupational health therapists are involved in rehabilitation. The latter two only practise as salaried employees in hospitals. The same applies to dieticians. Chiropodists may practise privately. Opticians, hearing aid specialists, laboratory technicians, X-ray technicians and ambulance personnel form a group of medical-technical professionals.

Most of these 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).

**Fig. 20. Number of physicians and nurses per 1000 population in the WHO European Region, 2000 or latest available year (in parentheses)**



Source: WHO Regional Office for Europe health for all database.

CEE: central and eastern Europe; EU: European Union; NIS: Newly independent states.

## The supply of other health care professionals

There were 40 500 dentists in 2000. Almost all of them (93%) are self-employed; most of those in salaried posts work in health centres or for social security bodies. Dentists share their first year of study with medical students. After this they are selected by means of a competitive examination subject to the *numerus clausus* system. Between 1985 and 2000, the number of dentists in France rose by 16.6%, which is half the rate of increase in the number of doctors.

Some procedures carried out by dentists – notably orthodontic processes and the fitting of prostheses – are also performed by stomatologists (specialist doctors). Stomatologists' area of expertise is more extensive, however, also covering surgical operations on the mouth and teeth. Most (87%) of the 1400 stomatologists in France are self-employed.

The majority of midwives work in hospitals with childbirth facilities, where a large proportion of antenatal care takes place. This type of work involves 80% of the 14 400 midwives practising in 2000. 13.5% of midwives opt for self-employment, while 5% work for local communities or for maternal and child care services. Since 1988, midwife training has taken four years and a quota is used to limit entrance (723 places in 1999). The number of midwives has risen by 57.4% since 1985.

In 2000, there were about 58 400 practising pharmacists. 72% of them work in retail pharmacies, either as the qualified title-holder or as an assistant. Other pharmacists work in laboratories (12%) or as employees in health care institutions, administrators in the mutual insurance associations or officials responsible for blood products (15%). The number of pharmacists has been increasing at a rate of 2.2% per year since the beginning of the 1990s, which is slower than in the preceding period. This slowing down results from a *numerus clausus*, which has limited access to pharmaceutical studies since 1980, and which decreased continuously until 1989. At present, 2200 degrees in pharmacy are awarded each year.

Biology is a specialization that has a particular status because it can be accessed by two internship pathways, one for medical students and one for students of pharmacy. In 2000, 75% of the 10 000 medical biologists were pharmacists.

## Pharmaceuticals

### Market entry and public reimbursement

About 8250 drug presentations (corresponding to 4570 different drugs) are available on the French market. More than half of these are included in the positive list of reimbursable drugs, which lists 4500 products. Reimbursable drugs account for 91.5% of the turnover of pharmacies.

All drugs must obtain market authorization (AMM) before being put on sale. Authorization may be obtained through three different procedures in EU member states:

- an EU AMM may be obtained through a centralized procedure within the European Agency for the Evaluation of Medicinal Products (EMA);
- 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 the EMA or by the French Agency for the Medical Safety of Health Products (AFSSAPS).

In order to obtain an AMM, a drug has to meet three criteria: pharmaceutical quality, safety and effectiveness. All drugs sold in France since 1976 have been given an AMM, with the exception of the following: homeopathic products (which can sometimes be exempted), magistral preparations made up in pharmacies and drugs for which a temporary authorization for use has been issued.<sup>24</sup>

The AMM specifies the conditions for the prescription and the supply of drugs subject to prescription, 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 hospital and drugs that require particular supervision).

In order to qualify for reimbursement by the statutory health insurance system, a drug must be included in the positive list of reimbursable drugs established by ministerial ordinance on the advice of the Commission on Transparency and the Economic Committee for Medical Products (CEPS).<sup>25</sup>

Inclusion on the positive list of reimbursable drugs depends on two factors: the drug has to contribute either to an improvement in the prescribed treatment,

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<sup>24</sup> This procedure is reserved for drugs that have not yet undergone all trial phases but are used to treat a serious or rare ailment for which there is no pre-existing treatment.

<sup>25</sup> CEPS was created in 1999. It replaces the Economic Committee on Medicines, set up in 1996, and has a wider remit, which includes medical devices.

evaluated in relation to other drugs in the same class, or to a decrease in the cost of treatment. Drugs considered to be ‘not substitutable and particularly expensive’ are reimbursed fully; drugs ‘mainly used for the treatment of disorders not usually of a serious nature’ are reimbursed at the rate of 35%, and other drugs are reimbursed at 65%.<sup>26</sup>

Since October 1999, in order for a drug to be included on the positive list, evidence must be supplied of its medical service rendered (SMR). The Transparency Commission 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 medical service rendered is evaluated in absolute terms, for all different types of use. If the SMR of a product is “major or considerable” (A), “moderate” (B) or “low but nevertheless justifies reimbursement” (C), it can be included in the positive list for a period of five years, after which it has to be re-evaluated. The level of reimbursement is determined by the SMR and the seriousness of the condition, in accordance with Table 16.

**Table 16. Rate of reimbursement resulting from the decree of 27 October 1999**

Medical service rendered	Serious conditions	Conditions “not usually of a serious nature”
Major or considerable	65%	35%
Moderate	35%	35%
Low but reimbursable by insurance	35%	35%
Insufficient	0%	0%

Source: Social Security Agency.

The Commission on Transparency has the mandate for re-evaluating all drugs in accordance with these new criteria. Between 1999 and 2001, it gave an insufficient SMR to 835 special drugs (that is, 18% of those currently on the positive list). According to the 1999 decree, these drugs should no longer figure on the positive list and 84 of them were removed from the list in September 2003. Moreover, about 200 of them saw their reimbursement rate lowered from 65% to 35% in December 2001 and have been subject to price cuts.

<sup>26</sup> Medicines reimbursed at 35% represent 7% of the spending on drugs reimbursed by statutory health insurance.

Drug prices are set by CEPS, in agreement with drug manufacturers. A drug's price is set with regard to the improvement it provides (in comparison with other drugs on the positive list in the same therapeutic class), the price of other drugs with same therapeutic indications and the estimated volume of sales and both the expected and actual conditions of its use.

CEPS consists of representatives from the Directorate of Social Security, the Directorate-General of Health, the Directorate-General for Competition, Consumption and Control of Fraud and the Directorate-General for Industry, Technology, Information and Postal Services, as well as a representative from the statutory health insurance system. CEPS also has a mandate to ensure that the agreements are respected by drug manufacturers (CEPS 2002).

### **Production, distribution, consumption**

Since 1995, France has been the largest European producer of pharmaceutical products. The French pharmaceutical industry includes 300 firms and employs around 90 000 people. It has a turnover of €24 billion from drugs, a third of which are exported. Reimbursable drugs represent 91.5% of the industry's turnover supplied through retail pharmacies (SNIP 2000).

Like production, the distribution of drugs is closely regulated, both for wholesalers and for pharmacies. 79% 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/distributors form a very concentrated sector, involving 16 firms and employing 15 000 people. They obtain their income on the basis of a statutory sliding scale margin. Since April 1999, the margin is 10.74% up to a price of €22.90, and 6% on amounts above this threshold. In addition to the wholesalers/distributors, 138 firms act as depository agents participating in the wholesale distribution of drugs.

Pharmacies have a monopoly on the dispensing of medicines. Only qualified pharmacists can be proprietors of a retail dispensing pharmacy or form a company to run a retail pharmacy. These pharmacists or companies cannot be proprietors of more than one pharmacy. There were about 22 700 retail pharmacies in 2000. Unless special dispensation is granted, the establishment of pharmacies 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.

Since September 1999, 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 on the positive list) and a sliding scale margin (26.1% of the

proportion of the manufacturer's pre-tax price that is below €23 and 10% on any proportion above that threshold). Alongside private pharmacies, there are pharmacies that are owned by mutual insurance associations or by the health insurance scheme for miners.

For a long time, the general system for obtaining drugs involved the patient paying for the drug, being reimbursed by their health insurance fund, and then reimbursed 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 the health insurance fund, so that the patient does not incur any direct cost. This system of payment applies to about two thirds of drug purchases. The average rate of reimbursement for prescribed drugs is about 73%.<sup>27</sup>

In comparison to their European neighbours, the French are considered to be heavy consumers of drugs.<sup>28</sup> Annual per capita expenditure on drugs amounts to €380. Since 1990, expenditure has risen by 5.3% per year (4.8% in volume) and this growth has been accelerating in recent years. 63% of this total expenditure, covering both prescribed drugs and products purchased over the counter, is publicly funded; the remainder is financed, in equal proportion (18.5%), by private households and complementary VHI.

## Drug policies

The regulation of drug prices has often been used as a tool to influence the development of pharmaceutical expenditure. Manufacturers' prices, the profit margins of wholesalers and pharmacists and taxes have regularly been reviewed downwards, particularly during the 1980s.

Also during the 1980s, two mechanisms were used to lower the level of public expenditure on the reimbursement of drugs. First, the reimbursement rate of some drugs or groups of drugs was lowered or reduced to zero. This was the case for cough medicines, expectorants, phlebotonics and certain vitamins, whose reimbursement rate was reduced in 1982, and for anti-diarrhoeal medicines, anti-spasmodic medicines and peripheral vasodilators, which shared the same fate in 1985. Secondly, the reimbursement rates of pharmaceutical products in general (apart from those fully reimbursable) were reduced by 5% in 1992, decreasing from 70% to 65% and from 40% to 35%.

Since the beginning of the 1990s, there has been a change in drugs policies, both to promote the rational use of drugs and to adopt a more contractual

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<sup>27</sup> For the general health insurance scheme.

<sup>28</sup> For example, in 1992 the consumption of psycholeptic medicines was two to three times higher than that of Italians and four times higher than that of Germans or Britons; the consumption of antibiotics or vasodilators was also on a ratio of two to one with the same countries (Lecomte and Paris 1994).

form of regulation with the pharmaceutical sector. Since 1994, the state and the National Union for the Pharmaceutical Industry (SNIP) have periodically signed “framework agreements”. These agreements define objectives common to both parties and establish the general framework for agreements which are then signed by CEPS and by each manufacturer. In the framework agreement signed in June 2003 for the 2003–2006 period, the pharmaceutical industry and the state undertook to exchange information, to operate a periodic follow-up of pharmaceutical expenditure, to foster the rational use of drugs and the development of generic drugs, reference prices and self-medication. The state undertook to accelerate procedures and to grant specific advantages for innovative products (‘free’ price), orphan and paediatric drugs. In compensation, pharmaceutical companies undertook to carry out post-marketing studies to assess the utilization of certain drugs in practice. With these basic elements, the individual agreements define for each company the price of reimbursable drugs, taking account of current market conditions and estimated sales. By the end of 1999, 143 agreements had been signed, covering 97% of turnover. Finally, within the framework of compliance with ONDAM (see the section on *Financial resource allocation*), pharmaceutical companies may have to make repayments for cost over-runs in the pharmaceutical sector.

Regulation aimed at influencing prescribers has followed two different routes. On one hand, in line with the aim of promoting the rational use of medicines, a system of practice guidelines has been set up. On the other hand, the expenditure targets imposed on doctors, envisaged in the ordinances of 1996, included totals for drugs prescribed, making doctors responsible for the amount they prescribe. For legal reasons, however, it has not been possible to define the sanctions applicable in cases where the target is exceeded, and no sanctions have been imposed.

The promotion of generic drugs, largely non-existent until recently due to the relatively low price of drugs in France, first appeared in the 1990s. This was implemented via the publication of a ministerial order in 1997, which defined the concept of a generic drug, and CNAMTS’s publication (in 2000) of a guide to therapeutic equivalents that was distributed to doctors and publicized in campaigns aimed at the general public. Finally, regulatory changes in June 1999 gave pharmacists the right to make substitutions, while guaranteeing them, in cases of substitution, a profit margin equivalent to the margin that would have applied for the original product. A draft agreement between the state and the retail pharmacists’ unions even envisages the introduction of a target rate of substitution, with this target figuring as a factor in the next remuneration review for pharmacists. At the end of 1999, generic drugs represented only



2% of the market for reimbursable drugs. Since January 2002, physicians are allowed to prescribe a drug by its generic and not its brand name (which was not previously the case).

## Health care technology assessment

### Marketing and reimbursement of medical devices

In France, the term ‘medical device’ is used to cover ‘any instrument, apparatus, equipment, materials or products, with the exception of products of human origin ... intended by the manufacturer to be used by humans for medical purposes’. These devices may be used for diagnostic purposes, prevention, monitoring treatment or disease alleviation, injury or disability, for the study, replacement or modification of a person’s anatomy, for physiological purposes or for birth control (see Charvet-Protat and Maisonneuve 2000).<sup>29</sup>

According to professional sources, the medical technology industry employs about 20 000 people and has a total turnover of FRF 30 billion. All medical devices are subject to common regulations for market entry, but not all are reimbursed in the same way. Market entry of a medical device is subject to being awarded the EU mark of approval (CE), which has been compulsory for all medical devices since 1998. Conferral of the CE mark is an EU authorization process, not specific to medical devices, that permits EU member states to place products on the market without further inspection or checks and guarantees conformity with EU production norms. Each member state delegates its responsibilities to the bodies responsible for supplying the CE mark. In France, this body is a partnership based on common economic interest formed by the National Experimentation Laboratory and the Central Laboratory for Electrical Industries (G-MED).

AFFSAPS ensures compliance with laws and regulations concerning imports, trials, wholesale distribution, operational use, market entry, advertising and the introduction of products intended for human health purposes.

The state and the health insurance funds then define the list of products to be reimbursed and set the reimbursement rate. The rules for reimbursement differ according to whether or not the devices can be implanted and whether or not they can be used at home. They have two basic forms.

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<sup>29</sup> Items not considered to be medical devices include: mechanisms associated with in vitro diagnosis, drugs, cosmetic products, human blood and derivative products, organs, tissue or cells of human origin and derivative products, organs, tissue or cells of animal origin and derivative products unless they non-viably enter into the construction of the device, and equipment for individual protection under the terms of the Work Code (articles L 665-3 and R 665-1 of the Public Health Code defining medical devices).

First, the cost of the medical device can be integrated into the reimbursement of a medical or surgical procedure involving the use of the device. This is the case, for instance, for material used in the context of an exploratory operation, whether this consists of minor disposable supplies, endoscopes or apparatus for anaesthesia and intensive care. In such cases, if the procedure is carried out in the public sector, the device is financed from the hospital's global budget. If the procedure is carried out in the private sector or by self-employed professionals, the cost of the device is taken into account either within the charge for the specific procedure listed on the official schedule of professional procedures, or in the charge for the technical environment concerned (such as the fixed price for an operating theatre).

Secondly, the device is reimbursed in its own right. This is the case, for example, for artificial limbs, internal prostheses, implants of human or animal origin and vehicles for disabled people. In such cases the device is included in TIPS (the interministerial scale of charges for medical services) and a "responsibility price" is defined by CEPS, with advice from AFSSAPS. This price sets the amount to which the health insurance funds' reimbursement rate applies. Practitioners may not be allowed to charge more than this price for some medical devices, while the price of other medical devices may be freely set by manufacturers and sellers. In some cases (dental prostheses, for example), the prices usually charged are very high in relation to the official rates set, leaving a considerable proportion of the costs to be paid by patients themselves (often through complementary VHI).

Since 1981, the Consultative Committee on Health Benefits has been responsible for the technical and medical assessment of devices, studying operating instructions and conditions of use, examining costs and proposing both additions to the list of reimbursable products and the 'responsibility rates' that should apply. The committee is composed of representatives from the Ministry of Health, the Ministry of Agriculture, the Ministry of War Veterans and the three main health insurance schemes. Manufacturers and health professionals are consulted in the framework of the committee's work.

Until recently, responsibility rates have been fixed in accordance with the costs of production for a class or category of product, without reference to the brand name. Industry representatives recently criticized the lack of transparency in the committee's procedures, and their failure to take international assessment findings into account, arguing that this resulted in possible delays in accepting devices for reimbursement. They also considered it regrettable that the health benefit of a device was not evaluated. In their view, prices were often set at too low a level, and the obligation (from 1988 onwards) to provide products free of charge for use in trials threatened the sector's viability (Biot and Corbin 1999).

Since March 2001, the procedures for the assessment of medical devices and criteria for reimbursement by the health insurance funds are similar to those applied to drugs. An equivalent Commission on Transparency has been set up.

### Technology assessment and regulation

At present, the assessment of new or existing technologies in France is only partial, and much of the initiative for assessment is left to professionals and institutions. It was expected that the new agency AFFSAPS would lead to more systematic evaluation, although it is still too early to judge whether this has been the case or not. ANAES was originally given a role in technology assessment, but has so far invested little in this area. However, at the request of CNAMTS it has evaluated a number of technical procedures in order to validate their inclusion in the future list of medical procedures. It has also recently produced an evaluation of MRI scanners with low magnetic fields.

**Table 17. Equipment requiring authorization for installation per million inhabitants in France and selected European countries, 1997**

Country	CT scanners	MRI scanners	Radiotherapy equipment	Lithotripters
France	9.7	2.5	7.8	0.8
Germany	17.1	6.2	4.6	1.7
Italy	14.6	4.1	2.4	–
United Kingdom	–	–	3.3	–
United States	13.7	7.6	4.4	2.3
Netherlands	–	–	7.2	–

Source: OECD 2001.

The supervision of technologies, particularly the most expensive ones, such as MRI and CT scanners, generally operates through control of their distribution (see the section on *Historical background*). Doctors sometimes complain that France lags behind its European neighbours in certain areas of technology (see Table 17).



# Financial resource allocation

## Third party budget setting and resource allocation

### The national ceiling for health insurance expenditure (ONDAM)

Every year since 1996, within the context of social security funding legislation, parliament has approved a national ceiling for health insurance expenditure (ONDAM) for the following year. Initially, the ONDAM was fixed by applying a rate of growth to the ONDAM for the previous year. For 1998 and 1999, the rates of growth applied were 2.3% and 2.6% respectively. With the exception of the first year, however, actual expenditure has always exceeded the target, and so it has become even more difficult to meet the target in subsequent years.

The method of setting the ONDAM changed in 2000. The rate of growth no longer applies to estimated expenditure, but to actual expenditure, or at least to the provisional estimate of this expenditure available in September, since voting on the ONDAM takes place before the end of the year. This change 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.<sup>30</sup>

Table 18 shows the ceilings and the expenditure actually incurred during the period 1997–2001. Since it was introduced in 1996, the ONDAM target has only been met once, in the first year, 1997. Actual expenditure for the four subsequent years has been much higher than the ceilings set.

The credibility of this system is questionable: the constraint is soft, there are no effective mechanisms to ensure respect of the ONDAM, 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 doctors' associations.

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<sup>30</sup> Some risk remains, however, if actual expenditure is very different from the forecast figure, which was the case in 2000.

**Table 18. A comparison of the ONDAM and actual expenditure, 1997–2002**

	1997	1998	1999	2000	2001	2002 <sup>b</sup>
ONDAM in billions of €	91.5	93.6	96.0	100.4	105.7	112.8
Actual expenditure <sup>a</sup>	81.4	95.1	97.6	103.0	108.1	–
Actual expenditure – ONDAM	–0.1	1.5	1.6	2.7	2.4	–
Growth rate for ONDAM <sup>a</sup>		2.4%	1.0%	2.8%	2.6%	4.3%
Growth rate for actual expenditure	–	4.0%	2.6%	5.6%	5.0%	–

Source: Social Security Accounts.

<sup>a</sup> provisional result for 2001

<sup>b</sup> from 2002 the accounting system of the health insurance funds has changed; the 2002 ONDAM is thus not strictly comparable to the figures for the previous years; if the calculation rules had not been changed, the rate of growth would have been 3.8% (instead of 4.3%).

### The sub-division of the ONDAM into four sub-targets

Once the overall ceiling has been set, the government splits it into four sub-targets:

- health care in private practice, including:
  - payment for treatment provided in private practice (mainly ambulatory care, but also private for-profit hospitals) by doctors, dentists, medical auxiliaries and biologists (that is, the fees of all self-employed professionals and professionals employed by private institutions); to this are added the fees of doctors practising privately in public hospitals;
  - prescriptions issued in private practice (for drugs, transport etc) and disability allowances paid in case of inability to work;
- health care in public hospitals
- health care in private for-profit hospitals (apart from fees, included in the first part)
- social care (that is, the cost of institutions and services for elderly and disabled people).

For 2001, the overall target of 3.5% growth is split into 3% for health care in private practice, 3.4% for health care in public hospitals, 3.3% for private for-profit hospitals and 5.8% for social care. Since the ONDAM was introduced, priority has regularly been given to the social care sector over the purely health care sector.

### Expenditure on health care in private practice and the allocated expenditure target

Since 2000, within the category of health care in private practice, a separate sub-category has been defined under the heading “allocated expenditure”. Allocated

expenditure includes the costs of self-employed health care professionals' fees and the costs of special transport (prescriptions for drugs, orthopaedic appliances and spectacles are not included). This sub-category is managed by the health insurance funds, who are responsible for ensuring compliance with the growth rates set by the government for these costs, and included in the budget target agreed between the state and CNAMTS.

The health insurance funds then have, in principle, the responsibility of negotiating with self-employed health care professionals to define allocated expenditure targets specific to each profession and measures to enable the targets to be met.<sup>31</sup> They are supposed to report regularly to the government. However, this system was only effective in 2000. In 2001, the government and the health insurance funds did not reach an agreement on the target budget. In 2002 the target was not defined.

The other costs of treatment in private practice include prescriptions for drugs and other products. The pharmaceutical sector is regulated by a specific target. The turnover of companies with reimbursable drugs is subject to a growth rate target 'taux K', defined in the annual act for the funding of social security. The overshooting of this target releases the regulatory devices managed by the CEPS (see the section on *Pharmaceuticals*), which leads to financial penalties for pharmaceutical companies.

## Public hospital expenditure

Once the target for expenditure on public hospitals has been set, it is divided between the regions, with the aim of reducing regional inequalities. The adjustment is made on the basis of a formula that takes into account four 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, measured by their value in terms of an indicator known as the "ISA point" (see below); the regional value of an ISA point is calculated by dividing the total regional budget by the volume of activity (that is, the case mix of the hospitals, using a categorization similar to the diagnostic-related groups (DRG) used in the United States) weighted

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<sup>31</sup> In 2000, the allocated expenditure target (2%) was shared between general practitioners (1.3%), specialists (0.9%), dentists (0%), laboratories (0%), nurses (2.1%), speech therapists and orthoptists (eye therapy) (4%).

by the relative cost of each case according to a national scale; if the unit cost per point is higher than the average, the region is considered to be less productive and this is taken into account when setting its grant, even if the region is otherwise considered to be underprivileged in terms of needs;

- the flow of patients between regions.

In 2001, regional growth rates ranged from 2.5% (Paris) to 5.4% (Poitou-Charentes), with an average increase of 3.5%. The objective is for the three less favoured regions to catch up with the regions immediately above in five years (1999–2004). During the last 3 years, hospital budgets have grown by up to 14% in these three regions, compared to 9% for the national average.

Variations in “productivity” between regions have tended to decrease, even though productivity is not the only criterion used in the allocation formula.

### **Private for-profit hospital expenditure**

Each year, a “national quantified target” (OQN) sets up a target budget for private for-profit hospitals. If actual expenditure exceeds the target, tariffs are lowered; if expenditure is below the target, tariffs are increased. From 1992 to 1999, the OQN and the tariff adjustments were negotiated between the state, the health insurance funds and representatives of private for-profit hospitals. Since 2000, the negotiation takes place between the state and the private for-profit hospitals’ representatives, and adjustments can be made at the regional level. The national agreement defines:

- the average national increase in tariffs
- the average increase in each region (to reduce regional disparities)
- the scope of possible variation within regions (the tariffs of each hospital are then established by the ARH).

Then, at regional level, agreements are made between the ARH and the private for-profit hospitals’ representatives to establish rules for setting tariffs. These rules take into account SROS objectives, regional priorities and hospitals’ productivity.

## **Payment of hospitals**

Payment of hospitals varies according to their status. Until 1983, public hospitals were financed on the basis of a per diem rate, which was calculated to balance the hospital budget. In effect, there was retrospective reimbursement of all costs incurred by public hospitals. However, the growth of hospital budgets could not



exceed a growth rate set annually by the Ministry of Health. In the first years, the constraint was soft, but it was reinforced in the middle of the 1980s, and at the same time the per diem rate was replaced by a system of global budgets. Today, the system for paying public hospitals is essentially prospective.

The remuneration of for-profit hospitals has two components: on one hand, fixed-rate payments covering the costs of accommodation, nursing and routine care, drugs and minor supplies; on the other hand, a payment based on the technical environment that is directly linked to the nature and scale of the diagnostic and therapeutic procedures carried out. Doctors providing treatment in private for-profit hospitals are paid on a fee-for-service basis.

Private non-profit hospitals may or may not participate in the public hospital service. If they are, they are paid as public hospitals; if they are not, they can choose between the two systems of payment (public hospitals or private for-profit hospitals).

**Table 19. Targets for expenditure and actual expenditure by type of treatment, 1997–2001**

	1997		1998		1999		2000		2001		2002
	Target	Actual expenditures	Target	Actual expenditures	Target	Actual expenditures	Target	Actual expenditures	Target	Actual expenditures	Target
Private practice	39.9	39.8	40.8	42.1	41.9	43.6	44.5	47.0	47.6	50.0	–
Public hospitals	37.1	37.1	37.9	37.7	36.7	38.6	39.8	39.9	41.1	41.2	–
Private hospitals	6.2	6.2	6.3	6.4	6.3	6.3	6.4	6.5	6.7	6.8	–
Social care	6.1	6.2	6.3	6.6	6.7	6.7	7.2	7.1	7.7	7.5	–
Other	2.2	2.1	2.3	2.3	2.4	2.3	2.5	2.5	2.6	2.6	–
Total	91.5	91.4	93.6	95.1	96.0	97.6	100.4	103.0	105.7	108.1	112.8

Source: Social Security Agency; Comptes de la Sécurité Sociale, 1998–2002.

### Hospitals with global budgets

The global budgets transferred by the health insurance funds to hospitals participating in the public hospital service (public hospitals and some non-profit private hospitals) are determined according to the following rules:

1. each hospital draws up and transmits to the ARH a provisional budget, which includes operating costs and revenues;
2. the ARH may ask the hospital to modify its budget, on the basis of one or more of the following factors: the size of the total regional grant from the Ministry of Health, the priorities set by the SROS or by health policy, the hospital's proposed level of activity and costs, which are viewed in relation

to those of other hospitals; once the ARH accepts the hospital's proposed budget, it sets the amount of authorized expenditure;

3. the global budget is then calculated as the balance of the authorized expenditure minus the hospital's other sources of revenue, which include: the daily fee charged to hospital patients, payments for external consultations, the sale of drugs that are restricted to hospital distribution and payments for meals made by hospital staff.

Budgets and global budgets were initially fixed on an historical basis, by applying uniform growth rates to all hospitals. In recent years, ARHs have made use of the so-called Programme to Medicalise Information Systems (see below) to allocate budgets. There are no general rules such as a defined mix of historical and target budgets. Each ARH can decide for itself and the way in which hospital budgets are defined therefore varies between regions.

The global budget is paid to the hospital in twelve monthly instalments by the main health insurance scheme, usually the national health insurance office of the sector in which the hospital is situated. In theory, hospitals cannot spend more than the allowed expenditure. They are permitted to run a deficit only if their additional revenue from other sources is lower than expected. In practice, however, a hospital director may postpone payments from one year to another to meet his budget, resulting in significant financial difficulties over time, which may force the ARH to grant the hospital additional funds.

A per diem rate is still used as the basis for patient co-payments.

### **Private for-profit hospitals**

In 2000, private for-profit hospitals were remunerated in the following way:

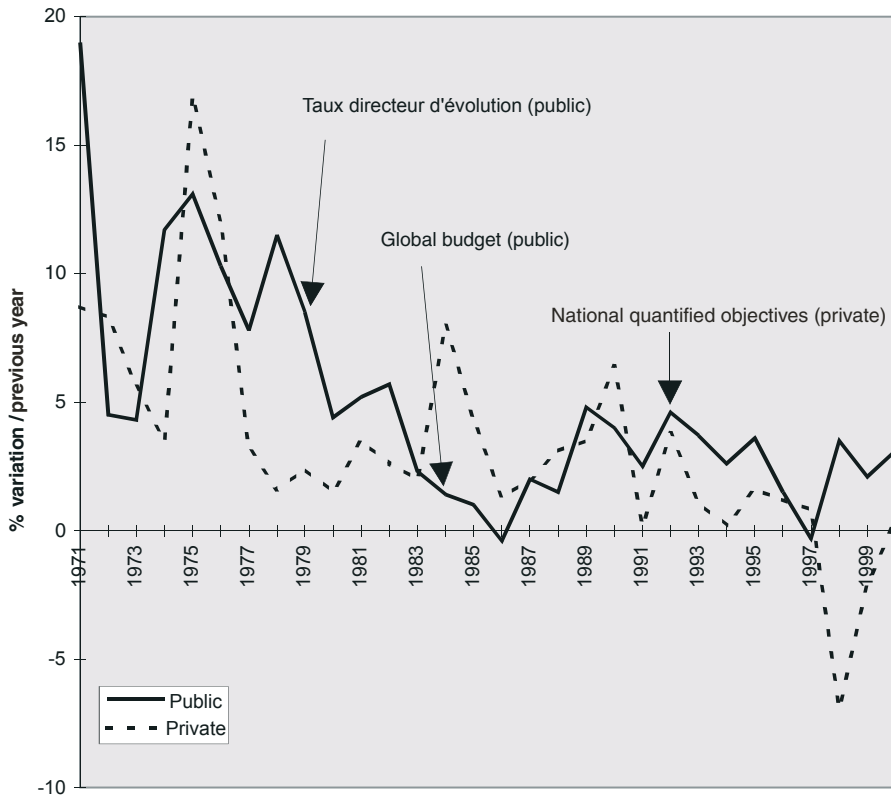
- a per diem rate covering all accommodation expenses, nursing expenses and routine care of patients with overnight stays; the value of this fixed sum is determined by agreement at regional level between the ARHs and the private for-profit hospitals' representatives; the rate is set by discipline (medicine, surgery, obstetrics, etc.);
- a specific (national) tariff for ambulatory surgery or treatment (€46 or €76 depending on the nature and scale of the procedure carried out);
- a fixed sum covering the use of minor supplies in the context of procedures carried out on an outpatient basis; this is fixed at €15 and applies to the whole country;
- a per diem rate covering the consumption of drugs;
- finally, the technical facilities necessary for carrying out a procedure (diagnosis, treatment or childbirth) are paid for on the basis of a schedule

which is strictly proportional to the fee schedule of doctors, and which corresponds to the use of an operating room, an examination room or a labour room.

With the exceptions indicated above, tariffs vary between regions and between hospitals. These variations have decreased during the last ten years.

Fees for medical and surgical procedures, examinations using medical imaging and biological procedures carried out in private for-profit hospitals are paid directly to the self-employed professionals working in these hospitals. In general, they transfer part of their fees to the hospital in which they practise, in exchange for having the hospital's equipment and staff at their disposal.

**Fig. 21. The evolution of public and private hospital expenditure (deflated by the general price index), 1971–2000**



Source: Social Security Agency; Comptes nationaux de la santé IRDES, DREES.

These fees are specified in the contract between the doctor and the hospital, and are extremely variable, not only according to the specialty and the region, but also according to the individual characteristics of the hospital or the doctor (reputation, etc.).

Between 1995 and 2000, the profitability<sup>32</sup> of private for-profit hospitals decreased from 1.9% in 1996 to 0.9% in 1999. It increased again in 2000 to 1.2%.

### **The Programme to Medicalise Information Systems (PMSI) and prospects for diagnosis-related payment**

Diagnosis-related payment is one of the options envisaged for funding hospitals in future. Trials were launched in 2002 to test new methods of financing public and private hospitals. A “mission” was created in 2003 to prepare the implementation of a payment per case for medicine, surgery and obstetric services in 2004–2005. This trial relies on the voluntary participation of hospitals in both the public and private sectors and is based on figures for activities and costs produced by these hospitals in the context of the Programme to Medicalise Information Systems (PMSI). Introduced in France in 1983, and directly resulting from experience with Medicare in the United States, PMSI has developed significantly during the 1990s.

Following an act passed in 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 (known as the 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 one of 512 ‘patient groupings’ (GHM) for classification of hospital stays, adapted from the US DRG classification system.

A national baseline for costs per stay has been constructed from a sample of hospitals producing an evaluation of the total cost of each stay. 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), which is conventionally allocated a weighting of 1000 points in the artificial index of activities (ISA).

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<sup>32</sup> Measured through the ratio net benefit/turnover.

A hospital's (or a service's) activities can therefore be summarized by the total number of ISA points corresponding to the case-mix of its inpatient stays. This tool, which only applies to hospital stays involving medical, surgical and obstetric procedures, allows a relative comparison of hospitals' activities, and should serve as a basis for diagnosis-related payment.

### **Hospital expenditure trends**

In the public sector, hospital expenditure has clearly slowed down since the establishment in 1979 of the 'taux directeur d'évolution' and of the global budget in 1984. Since the beginning of the 1990s, the annual growth rates (of expenditure deflated by GDP price indices) have regularly been higher than 3%. For clinics, the implementation of the 'quantified national objective' in 1992 marked the beginning of a very weak growth period.

### **Payment of health care 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, it is common for professionals to have mixed activities, so their total remuneration is likely to be a composite sum.

#### **Self-employed professionals working within the terms of an agreement**

Self-employed professionals (general practitioners, 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 for patients in private hospitals. These self-employed professionals are all paid directly 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. No clear answer has been found, but provisions have been made to establish a framework for the total cost of payments for these services.

Most of those working on a self-employed basis do so under agreements that govern their relations with insured clients and the health insurance funds. The method of payment and the amount they 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.

Agreements for each profession are signed for four or five years or renewed. Until 1998, a single agreement applied to general practitioners and specialists. Since then, there have been two different documents, one for each group, even though the method of payment remains the same for the both types of doctor. The National Agreement for General Practitioners came into force on 7 December 1998 for a period of four years. At present there are minimum contractual regulations applying to specialists (see the section on *Historical background*).

The agreements with general practitioners, nurses, physiotherapists, ambulance personnel, speech therapists and orthoptists include an annual target for expenditure. Tariff increases are granted providing that the target is met. In addition, nurses must respect an individual annual ceiling; if they do not they must pay back part of the fees to the health insurance funds. Laboratories must also pay back if total expenditure exceeds the ceiling.

A recent law reformed the agreement system between health insurance funds and professionals. The new agreement system will comprise three levels:

- the first will set up common rules for all professionals
- the second will contain specific items for each profession
- if a profession does not sign an agreement, the third will allow health insurance funds to conclude contracts (“public health contracts”) with individual professionals to develop preventive care or participate in networks; in exchange, the professionals would receive additional payments (lump sums).

While the revenue of other self-employed professionals is closely linked to the rates for charges that serve as the basis for reimbursement by statutory health insurance, for dentists it also includes the proceeds from dentures, which can be charged without restriction and are reimbursed at a very low level.

### **Rules for the remuneration of self-employed professionals**

In most cases, self-employed professionals are paid directly by patients at the time of the provision of the service; the statutory health insurance system usually only reimburses the patient at a later stage, and usually only partially (see the section on *Health care benefits and rationing*). Since self-employed professionals are paid per service provided, their gross income is equal to the sum of the amount received for each service. Their income therefore depends on the number, type and price of the services they provide, and their net income before tax is equivalent to their gross income minus their professional costs.

Health professionals are not free to fix the rates they charge for their services and are required to apply the official charges set out in the agreements. However, there are notable exceptions, particularly for doctors holding a permanent right to exceed the official charges and those who have opted for a so-called second sector with variable fees (Sector 2). Doctors who opt for Sector 2 relinquish certain social and fiscal advantages accorded to doctors under the agreements.

The official charge per service provided can be calculated from its value in one of the official schedules combined with its rate of charge. For each professional category, the official schedules assign a value (consisting of a key letter and a coefficient) to the various procedures reimbursed by statutory health insurance (see Table 20). The key letters correspond to groups of procedures of a similar nature. At present, these procedures are grouped as follows for doctors: consultations in the doctor's surgery, visits by the doctor to the patient's home, specialist procedures, surgical procedures, ultrasound scanning, physical examinations, pathological cytology, procedures using ionizing radiation, dental orthopaedic treatment, prophylactic treatment and dental prostheses. Other key letters are used to describe the activities of dentists, midwives and different medical auxiliaries. In principle, the coefficients attached to key letters take account of the relative importance of the procedure within its group.

A commission has been given responsibility for revising the official schedule with a view to modernizing it and improving the descriptions of the professional procedures concerned. Nevertheless, consideration of new techniques and of changes in the economic conditions of production takes up too much time and generates distortions between procedures. A reclassification of the official schedule is currently under way, with a more detailed classification (6000 procedures). Expert medical committees have assessed each of these 6000 procedures (time required, skills involved, level of stress incurred, etc.), and economic studies are being conducted. The implementation of this new classification, delayed partly due to the opposition of certain specialists, is planned for 2004.

Until recently, 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. In the future, the nature of the procedure will be stated in reimbursement claims, which will improve the information collected by the health insurance funds. It is already being done for laboratory tests.

A procedure's official charge is calculated by multiplying the corresponding coefficient by the rate for the key letter. The charges for the different key letters are included in an appendix to the agreements.

**Table 20. Examples of official schedules and charges on 1 January 2001**

Item	Charge
General practitioner consultation	€17.50
Specialist consultation	€22.90
Electrocardiogram	K 6.5/€13.60 (K = €2.10)
X-ray of the lung, front and profile	Z 25/€33.20 (Z = €1.30)
Appendectomy	KC 70/€146 (KC = €2.10)

Source: Social Security Agency.

Agreements with some professions permit tariffs to be revised upwards or downwards, in relation to respect of financial targets. In 2000,<sup>33</sup> several readjustments took place. Among them were the introduction of an extra charge for visits to general practitioners for people aged 75 and above, an upgrading of midwives' consultations and the key letters for certain medical auxiliaries (nurses, speech therapists), and a decrease in charges for ultrasound scanning and laboratory tests. Since 2002, targeted agreements on good practice, signed by professionals and health insurance funds, bind increases in medical fees to commitments of good practice from professionals. For example, the agreement signed in June by general practitioners leads to increases in the fee for visits, in return for commitments by general practitioners to prescribe more generic drugs and to limit health insurance fund expenditure for 'unjustified' home visits".

### **Supplementary revenue for referring (gatekeeping) general practitioners**

Referring (or gatekeeping) general practitioners receive a supplementary fixed sum per registered patient per year of €46 in 2001, which is 2.6 times the charge of a consultation. This sum constitutes a strong financial incentive for doctors to enter the referral scheme. If doctors registered all their patients, the additional costs for the health insurance funds would be substantial. The annual expenditure of an average enrollee of the main health insurance fund for general practitioner care is around €69, so if all those covered entered the scheme, the expenses of the health insurance fund would increase by 67%. In spite of the strong financial incentive given to doctors, only 10% of general practitioners and 1% of patients have joined the gatekeeping system.

<sup>33</sup> It should be recalled that in 2000 the health insurance funds were responsible for meeting an allocated expenditure target covering the fees of self-employed professionals.



## Total income

Table 21 shows the total amounts of gross and net payments received in certain health care professions compared with general economic indicators. In 1997, the gross revenue of general practitioners was 4.3 times higher than the GDP per capita, and their net revenue 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 6.5 times the salary of managerial staff, while the net revenue of paediatricians is below that of general practitioners.

## Doctors 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 due to 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;

**Table 21. Remuneration of self-employed health care professionals in 1997**

	GPs	Surgeons	Ear-nose-throat specialists	Paediatricians	Dentists	Nurses	Masseurs
Average fees by profession (in FRF thousands)	590	1 014	853	575	944	283	328
Index (GDP per capita = 1)	4.3	7.4	6.3	4.2	6.9	2.1	2.4
Gross income (before tax) by profession (in FRF thousands)	333	578	439	315	384	179	166
Index (gross income per capita = 1)	3.8	6.5	5.0	3.6	4.3	1.9	1.9
Index (average wage of managerial staff = 1)	1.4	2.4	1.8	1.3	1.6	0.7	0.7
Index (average wage of workers = 1)	3.5	6.1	4.7	3.3	4.1	1.8	1.8

Source: IRDES/DREES 2001, INSEE 2001.

- *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.

In 1998, the net salary of a full-time hospital doctor was €51 500, very close to the net income of a self-employed general practitioner.

# Health care reforms

## Why embark on reforms?

The defining characteristics of the French health care system demonstrate that a handful of major issues have been on the policy agenda for several decades. But other questions have entered the public debate over time, and priorities have shifted in recent years.

### The defining characteristics of the French health care system

As noted in the previous sections, the French health care system is a mixed system combining elements of various organizational models:

- it lies between the Beveridge and Bismarck models, with health insurance funds 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 for-profit hospitals;
- it is a publicly funded system characterized by freedom of choice and 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 the health insurance funds.

This mixed system of organization reflects a balance between different values, such as equity, freedom and efficiency, but it also generates structural difficulties which provide the impetus for health care reforms.

## Reform objectives

The objectives of health care reforms in France concern the issues listed below. The content of corresponding policy measures and their evaluation is analysed in the following section.

## **Cost containment: a permanent objective**

Following the oil crisis of 1974, economic growth slowed and unemployment spread, making it increasingly difficult to sustain a system of health care funding that relied on wages. It is in this context that cost containment became the main goal of health care reform in France and remains a major objective.

The organizational structure of the French health care system makes this goal difficult to achieve. It is difficult to control expenditure in a system where the freedom of patients and providers is unrestricted, where care is largely publicly funded and retrospectively reimbursed and where health insurance funds have no real financial responsibility.

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 recently occurred in France, in the second half of the 1990s.

Although relatively high levels of expenditure on health care result in patient satisfaction and good health outcomes, cost containment remains a permanent subject of debate, since many of the measures taken to reduce expenditure growth have been ineffective and have always been strongly opposed by professional associations, particularly doctors' associations.

## **Managing the system**

A second major issue is the institutional complexity of the French health care system and the conflicts of power and legitimacy associated with it. This conflict is particularly evident in relations between the state and the health insurance funds, which have deteriorated in the last ten years. The search for institutional equilibrium is a growing concern.

The 1990s saw substantial re-organization, 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 the health insurance funds.

These changes were consistent with the simultaneous reform of public funding for health care, involving the substitution of employee contributions based on wages with a tax based on total income.

Nevertheless, the debate is far from closed, particularly since the main employers' organization resigned from the boards of the health insurance funds in September 2001 and now supports a reform based on competition between insurers.

### **Health care system performance and concern for public safety**

In spite of the complexity of the French health care system, and the inherent difficulty of managing it, until recently its performance was not called into question. In fact, it was ranked as number one in the world by the World Health Organization in 2000 (WHO 2000). This absence of criticism was largely due to the availability of a plentiful supply of providers, a high degree of freedom for physicians and patients, few restrictions on the range of services covered by statutory health insurance, easy access to health care and the absence of waiting lists for treatment, all of which resulted in substantial levels of patient and public satisfaction with the health care system.

This positive perception was somewhat dented by the “contaminated blood scandal”, which drew attention to organizational weaknesses in the system and led to the trial of three government ministers, one of whom was found guilty of dereliction of duty with respect to safety and prudence. Since then, decision-makers and the general public have been increasingly concerned by safety issues. Currently, the precautionary principle is being invoked in the government’s handling of the so-called “mad cow” crisis.

Beyond this question of safety, quality of care and public health concerns have emerged as new priorities, and a number of steps have been taken in these areas in the last few years, without reference to the costs involved. The law to be passed in 2004 sets out an ambitious policy for public health, with a view to meeting about one hundred objectives over a five-year period.

### **Equity**

Equity has emerged as an issue in response to a growing recognition of inequalities in mortality and access to treatment. Statistical data underlining the gap in life expectancy between manual workers and senior managers and lower levels of dental and specialist treatment for underprivileged sections of the population have stimulated debate on the equity of the French health care system.

In this respect, the 1999 Universal Health Coverage Act (CMU) has been a major reform. Again, the equity objective has prevailed over cost containment, as this reform explicitly aims to increase access and, consequently, health care expenditure, for people on low incomes.

Decentralization at the regional level has also raised the issue of regional inequalities and some steps have been taken to reduce them, particularly in the hospital sector.

## **In summary**

The goal of cost containment remains at the heart of recent reforms: it was the impetus for most of the Juppé reform, which was the major reform process of the 1990s, alongside the introduction of expenditure targets. However, it increasingly competes with other objectives concerning the quality and safety of care and equity. Some measures taken to increase the latter have been introduced without reference to controlling costs and, occasionally, in direct contravention of the cost control goal.

## **Contents of the main reforms and related legislation**

This section describes the reforms implemented in the 1990s under the objectives given above, and provides some evaluation. Three preliminary remarks. First, some countries (for example, the United Kingdom) conducted global and structural reforms of their health care systems in the 1990s. Changes in France appear to be less radical, even though the Juppé reform has resulted in major evolutions of institutional and organizational structures.

Secondly, ideas about competition, internal markets and economic decentralization, which inspired reforms in many countries during the 1990s, have never been seriously considered in France. This is linked to French culture and the strong role of the state, but is also partly due to the fact that the impetus for such reforms were less present in France; patients already have free choice, fee-for-service payments tend to raise provider activity levels and waiting lists are rare.

Finally, the trend towards political decentralization has not been as evident in France as in other European countries, because the responsibilities delegated to the regional levels are handled by regional administrations and do not involve elected bodies.

## **Cost containment**

Traditionally, cost containment policies addressed both the demand side (often by raising co-payments) and the supply side (hospital planning, limitation of the number of medical students, price control).

## **Measures to control demand**

Efforts to control demand by reducing the proportion of health care reimbursed by the statutory health insurance system came to an end in 1993, the last

year in which patients' contributions to health care costs (in the form of co-payments) increased. Since then, measures of a different kind have been introduced, with the aim of steering demand and encouraging consumers to adopt more rational behaviour. These measures include keeping medical records to summarize a patient's contact with the health care system and to avoid unnecessary or contradictory prescriptions, and requiring patients to register with a gatekeeping general practitioner. However, patients and doctors have regarded both measures as constraints. As a result, the first measure rapidly fell into disuse. The government has tried to revive the second measure, which was largely unsuccessful, by doubling the payments made to gatekeeping general practitioners (from €23 to €46 per registered patient from 1 January 2000).

The 1999 CMU Act was passed in spite of the likelihood that it would increase demand for health care, illustrating that the objective of equity has taken precedence over cost containment. CMU should stimulate demand for health care because it lowers financial barriers to access, not only by extending basic coverage to all French residents, but also by exempting those with the least resources from direct payment of costs and giving them free access to complementary VHI.<sup>34</sup>

Since the mid-1990s, attempts to contain costs have focused on the supply side. The old instruments have not been abandoned, but they have evolved in recent years, and their validity has been questioned.

### **The *numerus clausus* in medical schools**

The reduction of the number of places available in medical schools (*numerus clausus*) began at the end of the 1970s. The result is now visible, since the number of doctors is stable and will decrease significantly in the next twenty years.

Until recently, everybody (including the medical unions) agreed that France had too many doctors; but it is noticeable that the debate has shifted in recent years and there is now fear of a shortage of doctors in some specialties or geographical areas. The problem facing France now is to cope with demographic change without having many tools with which to adjust the distribution of doctors. In spite of a relatively high ratio of doctors to people (330 doctors per 100 000 inhabitants), there are already difficulties in recruiting doctors in specialties such as anesthesiology or gynaecology and obstetrics.

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<sup>34</sup> However, the financial impact was limited in 2000; it explains 0.3% to 0.5% of expenditure growth for ambulatory care, out of a total of 7.8%.

Consequently, the number of medical students has been raised again (from 3850 in 1998 to 4100, 4700 and 5200 in 2002–2003), and might be increased even further. A *numerus clausus* of 6000 students per year would lead to a ratio of 275 physicians per 100 000 inhabitants in 2020.

### **Hospital planning**

Since the implementation of the medical map (*carte sanitaire*) at the beginning of the 1980s (see the section on *Historical background*), the number of acute care beds has decreased significantly, from 6.2 to 4.2 beds per 1000 inhabitants.

In the last decade, with the introduction of regional strategic health plans (SROSs), hospital planning has moved to a more qualitative approach, looking at geographical distribution and establishing networks of hospitals. A major goal of the 1994–1999 SROSs was to merge facilities and close small hospitals which 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. By the end of 2001, more than 300 operations aimed at merging or closing hospitals or hospital wards or re-orienting them towards new activities (for example, from acute care to rehabilitation) had been conducted nationwide.

### **Price control**

The price of pharmaceuticals is still fixed by the government, but whereas previously prices were low by international standards, this is no longer the case for new products. Price-setting is now part of larger agreements with the drug manufacturers, which include targets for the volume of drugs prescribed and a reduction in advertising expenditure. This change towards global negotiation of price and volumes is a general trend and concerns other sectors (see below).

A recurring debate concerns the way in which providers of health care should be paid. Fee-for-service payment is often questioned, as are the discrepancies between the tariffs of public hospitals and private for-profit hospitals. The latest trend is to replace the current system with DRG-based remuneration, and an experiment is currently under way (see the section on *Payment of hospitals*).

### **New tools**

In addition to the traditional tools already mentioned, new mechanisms have been conceived to control costs by setting expenditure ceilings for sectors or professions. Private for-profit hospitals, medical laboratories and nurses in



private practice agreed to comply with such mechanisms as early as 1992. However, repeated attempts to obtain doctors' compliance have always failed, and the global expenditure targets defined by parliament have usually been exceeded.

Nevertheless, in the long term, the rate of health care expenditure growth has undoubtedly decreased, and the gap between health care expenditure growth and economic growth fell from an average of 3 points in the 1970s and 2 points in the 1970s to 1 point in the 1990s. By the end of the 1990s, the growth rates were equal, although they have started to diverge quite rapidly since then.

### **Reform of institutions and management of the system**

The 1996 Juppé reform changed the balance of responsibilities for the French health care system, leading to an evolution that can be analysed as a double shift of power:

- from the national to the regional level, and
- from the health insurance funds to the state, although this point may be more debatable.

### **Decentralization at the regional level**

Although some steps in this direction had been taken earlier, the Juppé reform introduced major changes, setting up three new institutions:

- the regional hospital agencies (ARHs), which are responsible for hospital planning (for both public and private hospitals) and financial resource allocation to public hospitals and adjustment of tariffs for private for-profit hospitals; they bring together, at the regional level, the health services of the state and the health insurance funds;
- the regional unions of the health insurance funds (URCAMs), bringing together the three main health insurance schemes at the regional level;
- the regional health conferences to assess regional health needs and set regional priorities for public health.

The trend towards decentralization contrasts with the policies of the previous two decades, which were characterized by a centralizing tendency. A criticism of this change of direction is that it has created new actors without dismantling existing administrative and organizational structures, leading to a complex system with several points of conflict.

Construction of the decentralized framework continues. In March 2002 a law was enacted to create a regional council on health by merging several

commissions. The current debate focuses on the possibility of moving towards regional health agencies, broadening the scope of the ARHs.

### **The state and the health insurance funds**

Before 1990, the health insurance funds were mainly responsible for the private sector (ambulatory care provided by self-employed professionals and treatment in private for-profit hospitals), which was regulated through national agreements between the health insurance funds and the professional organizations. Public hospitals and the pharmaceutical industry were regulated by the government, at the national level. The government also took responsibility for hospital planning at the regional level (including private for-profit hospitals).

Since 1996 the state has assumed new responsibilities through:

- the involvement of parliament and the annual Social Security Funding Act; to date the focus of parliamentary debate has mainly been financial, but in future it might encompass 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 for-profit hospitals (and therefore the entire hospital sector).

In spite of attempts to clarify the responsibilities of the state and the responsibilities of the health insurance funds, the division of responsibilities remains unclear, and in recent years relations between state authorities and the health insurance funds have been marked by periods of open conflict. As noted above, this debate is far from closed.

### **Quality and safety of care and public health**

A range of measures has been taken in recent years to address the issue of quality and safety of health care in France. Examples from ambulatory care include:

- the creation and dissemination of practice guidelines
- lengthening the initial training period for general practitioners
- experiments with networks of health care providers to improve coordination and continuity of care
- the development of information systems.

Different technical agencies are now responsible for health and health care related safety issues (see the section on *Historical background*).

National programmes have been designed to improve treatment in specific areas, such as cancer, asthma, mental health, pain control, chronic renal failure, etc. The public health law to be passed in 2004 will set out about one hundred goals for public health to be achieved over a 5-year period.

## Equity

The CMU reform implemented in January 2000 has had a clear impact in terms of extending health insurance coverage. By the end of 2001, it provided statutory health insurance to 900 000 people and complementary VHI coverage to 4.3 million people (only some of whom had been previously covered through social assistance provided by local communities, with variations in levels of coverage across the country).

It is still too early to assess CMU's impact on increasing access to health care. During the first year (2000), those with complementary VHI CMU coverage had higher ambulatory care expenses in comparison to the rest of the population, particularly for care provided by general practitioners, but it is difficult to say whether the current level of health care is equitable, given the fact that they tend, on average, to have higher levels of ill health. Where dental care and spectacles are concerned (two areas that are poorly covered by statutory health insurance), their consumption levels were below average.

The allocation of resources to public hospitals in different regions is based on a formula that takes into account population health needs and hospitals' efficiency, in order to achieve a more equitable allocation in the long term. The pace with which hospitals are able to meet their target budgets is slow, but the poorer regions are making steady progress in this respect.

An attempt to extend this system to ambulatory care expenditure was made in 1997, but it proved difficult to work in practice, since the attempt involved targets rather than actual allocations of resources, as for hospitals. The idea was subsequently abandoned.

For private for-profit hospitals there are regional variations in price according to productivity indicators, although the scope of these variations is more limited. In 2001, the variations in price for medical, surgical and obstetric procedures were between 1% and 1.5%.

## A chronology of health care reforms, 1990–2003

The major health policy developments mentioned above are listed below in chronological order.

**1990–1991**

- EVIN Act (Act 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 a General Social Contribution (CSG) to strengthen social security financing;
- Hospital Act setting up regional strategic health 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 biomedical sector, in nursing care and in private for-profit hospitals, with options for imposing penalties in cases where targets are exceeded.

**1993**

- Loi Teulade (Act 93-8) concerning relations between health care professions and health insurance funds including, in particular, the setting of ceilings for growth in health care expenditure, the introduction of practice guidelines (RMOs), the establishment of a basis for the coding of procedures and 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, monitor the quality of treatment and participate in public health action;
- Agreement of 21 October 1993 bringing the Loi Teulade into force: ceilings for expenditure growth, setting out RMOs and implementation of their negative phrasing;
- Act on the Medical Safety of Blood Transfusions and Medicines (Act 93-5 of 4 January 1993) creating the Blood Agency and the Medicines Agency;
- last increase, to date, in patients' contributions to the costs of health care.

**1994**

- creation of the French Institute for Transplants (Act 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**

- 15 November: announcement of the Juppé Plan.

Important stages in reform developments:

- institutional reforms and, in particular, the new role of parliament, the establishment of regional hospital agencies, modification of the respective responsibilities of the government and the health insurance funds;
- 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, continuing medical education, RMOs, accreditation);
- possibilities for experimentation with new ways of delivering care;
- Act authorizing the government to legislate by ordinance to reform social protection (Act 95-1348 of 30 December 1995).

**1996**

- Constitutional Act (96-138 of 22 February 1996) introducing annual legislation on social security funding, estimating the receipts of social security bodies for the year to come and setting a growth target (ceiling) for total health care expenditure by the health insurance funds; the Act also approved the government's policy directions in health and social security.

Following on from the Juppé Plan, five 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 general practitioners 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 Funding Act (Act 96-1160 of 27 December 1996) introducing for 1997 the first stage of 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 (ANAES).

**1997**

- 1998 Social Security Funding 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 between the government and the health insurance funds, covering three years;
- scheme for early retirement of self-employed doctors.

**1997/1998**

- innovation with regard to agreements: adoption of an agreement for general practitioners and minimum contractual regulations for specialists as a result of failure to reach agreement with specialists' professional representatives; introduction of referring (gatekeeping) general practitioners, targets for regional expenditure, RMOs, promotion of generic drugs, continuing medical education and use of information technology.

**1998**

- Act reinforcing medical safety, with the creation of the Institute for Monitoring Public Health, the French Agency for the Medical Safety of Food Products, and the French Agency for the Medical Safety of Health Products;
- 1999 Social Security Funding 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 General Practitioners' Agreement from 1998 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 CNAMTS of a policy plan for 'quality health care for all' aimed at a substantial reduction of statutory health insurance costs: definition

of a 'basket of care' and adjustment of reimbursement rates in light of medical effectiveness; the government rejects these provisions, which were much disputed, but debate continues on the plan's provisions and, in particular, on the basket of care;

- 2000 Social Security Funding Act: restriction of the areas of expenditure managed by CNAMTS, defining a 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);
- 2001 Social Security Funding 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, 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 dependant elderly people;
- reform of medical training, endowing general practice with specialty status;
- 2002 Social Security Funding Act: allows doctors to prescribe drugs using generic names, introduces specific budget for experiments with provider networks.

## **2002**

- Act on Patients' Rights and Quality of Care (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, compensation of patients for accidents occurring without any fault on the part of the health care professionals involved;

- Act reforming the agreement system between the health insurance funds and the health care professions; the new agreement system will comprise three levels: the first will set up common rules for all professionals; the second will contain specific items for each profession; the third will allow the health insurance funds to conclude contracts with individual professionals willing to engage in projects (networks, health promotion, etc.);
- targeted agreement on good practice signed between general practitioners and health insurance funds binding increases in fees to commitments of good practice (prescription of generic drugs and decrease of health insurance fund expenditure for unjustified home visits);
- presentation of the “Hospital 2007” plan to be implemented over five years and containing the implementation of a payment per case system, an ambitious programme of investment and the simplification of the planning process;
- 2003 Social Security Funding Act announces, among other things, the implementation of payment per case for hospitals, of reference prices for groups of generic drugs, the partial liberalization of prices for innovative drugs, the simplification of the hospital planning process and budgets for investment in hospital facilities.

## 2003

- the Ordinance for the simplification of hospital and other medical facilities planning merges in a single tool (the regional strategic plan) the strategic planning of hospital facilities and activities; previously, this was managed using several tools; the Ordinance also decentralizes almost all types of authorization for hospital activities, facilities and other medical equipment to the regional hospital agency;
- presentation of the Public Health Bill to parliament (to be passed in 2004);
- creation of the High Council for the future of health insurance to propose solutions for the modernization of health insurance;
- 2004 Social Security Funding Act details the implementation of payment per case for hospitals.

## The implementation of reforms

Important reforms have been launched in recent last decades. When it was announced, the Juppé reform was seen as a profound re-organization that



tackled the main problems of the French health care system. The fact that the reform was introduced through ordinances rather than ordinary laws was a clear expression of strong political will to achieve its goals.

After the change of government in 1997, the Juppé reform was not really contested; in fact, there was general consensus about most of the proposed measures. However, the reform has only achieved some of its goals, largely due to opposition from the majority of doctors.

### **The role of professional organizations**

The measures designed to control expenditure, and the increased financial responsibility of doctors on which these measure relied – a core element of the Juppé reform – have not been effective.

While the provisions giving parliament responsibility for passing annual legislation on social security funding were rapidly adopted and put into force, the national expenditure ceiling for health insurance (ONDAM) voted for every year has only been met once, in the first year (1997). Since then, actual expenditure has always exceeded the target, which is now fixed in reference to actual expenditure rather than the previous year's target, as was originally intended.

Doctors' fees have also exceeded their target, without any application of the anticipated financial penalties, even though the original plan (in which doctors had to pay back not only in case of excessive fees, but also in case of excessive prescribing) was watered down.

The medical profession plays an important part in the implementation of policies relating to health care. Since 1996, an important faction within the profession has consistently and vociferously opposed any reform aimed at limiting health care expenditure on economic grounds. In 2001/2002, this conflict was exacerbated by doctors' strikes over emergency care and illegal rises in their fees.

However, the reform had, for the first time, allowed the signing of separate agreements with general practitioners and specialists. The idea was to gain the support of a large union of general practitioners, in return for raising the status of general practice and introducing the concept of referring doctors, but the latter did not meet with much success, and the union supporting the reform was defeated in the regional medical unions' elections.

Tensions within the medical profession have resulted in numerous cases of deadlock, leading to crises over the signing of agreements. Opposition from health care professionals has contributed to the total failure of the medical record policy and to the relative failure of the experiment with referring doctors. It has

also played a part in the difficulties encountered in implementing compulsory continuing education.

In 2001, the government sought to restart dialogue with the professionals in private practice by setting up a consultation process. One of the proposals of the commission in charge of these consultations was to reform the system of agreements between the health insurance funds and the medical professions. It was enacted in March 2002 and the new agreement system will include three levels:

- the first will set up common rules for all professionals
- the second will contain specific items for each profession
- if a profession does not sign an agreement, the third will allow health insurance funds to conclude contracts (“public health contracts”) with individual professionals to develop preventive care or participate in networks; in exchange, the professionals would receive additional payments (lump sums).

It remains to be seen whether this new system, which does not have the support of doctors – provides leverage to improve the delivery of health care. The process of consultation was unable to avoid the long conflict that took place over the winter of 2001/2002 and has only just come to an end, with the acceptance of the new conservative government (in power since June 2002) of a large increase in tariffs (a 20% increase from 2001), in exchange for commitments on good practice.

The tendency of medical representation in France, which has traditionally been fragmented due to the existence of a large number of unions, is to unite to increase its bargaining power. A single organization brings together all unions representing professionals in private practice and the two organizations representing private for-profit hospitals have recently merged. The emergence of organizations outside the official unions was also noticeable during the recent conflict.

### **The institutional actors: the state and the health insurance funds**

The Social Security Funding Acts have not succeeded in improving relations between the government and the health insurance funds. This is reflected in the successive changes introduced by the act. Although theoretically responsible for ensuring compliance with the approved ceilings for

expenditure in private practice, the health insurance funds are not in fact able to take the action they consider to be effective for this purpose. In fact the so-called allocated expenditure target was only in effect for one year.

Experimentation with provider networks also suffered initial setbacks due to the bureaucratic process of approval that discouraged initiatives. The approval process has now been delegated to the regional level to improve efficiency.

### **The increasing role of patients**

The role of users of the health care system is slowly developing in France. In future users will play a larger part in setting priorities and determining quality and safety standards for the delivery of health care, either directly or through representative bodies. The role of patients' associations in the area of HIV/AIDS provides a case study in this respect.

Patients' associations were active in promoting the Act on Patients' Rights and Quality of Care passed in March 2002. The act's first objective is to enhance patients' ability to use "voice" in the health care system; this is reflected in the act's opening section, which is titled "Democracy in the health care system". A key emphasis is on individual rights for the patient; the most publicized and debated measure involves patients' direct access to their medical records. Other measures aim to promote collective representation and consumer expression, by strengthening patients' associations (status, ability to sue in courts, representation in national and regional institutions), setting up commissions with patients representatives in all hospitals and developing consumer information.

The act's second objective is to improve quality of care and to develop continuing education for health care professionals and evaluation of professional practice.

A third objective concerns risks related to diagnostic or therapeutic procedures. Here, the main measure involves the provision of compensation for accidents that are not the fault of the health care professionals involved.

### **An emerging role for complementary VHI?**

Complementary VHI plays a significant role in the French health care system, covering 86% of the population and accounting for 12% of total expenditure on health care. In the past, however, voluntary health insurers have been passive purchasers of health care. The benefits provided by complementary VHI are closely linked to the benefits provided by statutory health insurance, as the former covers the cost of statutory co-payments, so any decline in the reimbursement rate of statutory health insurance was immediately matched by an increase in complementary VHI premiums.

Recently, voluntary health insurers have made attempts to adopt new roles within the health care system. The most radical initiatives they have proposed have been rejected by the government. For example, a major voluntary health insurer proposed the establishment of a “managed care” organization under the framework of the provider network experiments.

Voluntary health insurers have also been involved in implementing CMU. Again, some insurers requested permission to establish a network of providers in order to be able to negotiate their own prices for services such as the provision of dental prostheses and spectacles, which are a major component of complementary VHI. The scheme was not adopted.

These examples illustrate voluntary health insurers’ efforts to change the rules of the game in France. Even if they did not enjoy much success in either of these cases, they have launched other initiatives, within the framework of the current legislative framework, including:

- setting up call centres, to give advice to their subscribers on payment for dental prostheses and spectacles, two areas in which they have gained expertise;
- selective contracting, primarily in those sectors in which there is a market and room for negotiation, such as spectacles; some voluntary health insurers have set up networks of preferred opticians and direct their subscribers to those opticians; attempts to do the same with doctors were rejected by the doctors concerned;
- coverage of new services which are not part of the basic package of the statutory health insurance scheme, such as bone densitometry and surgical correction of myopia.

In October 2002, a High Council for the future of health insurance was created to diagnose the problems of the current situation and to propose a direction for future reform. Its preliminary findings are expected in 2004.

## Conclusions

The French health care system was inspired by the Bismarckian model, with health insurance funds under the supervision of the state. It relies on a combination of public and private supply, even in the hospital sector. Patients benefit from easy access to care (freedom of choice, direct access to the specialists) and an abundant supply, particularly of self-employed doctors. Complementary VHI to cover the cost of statutory co-payments is widespread.

Recent reforms have transformed the original characteristics of the system:

- the 1996 Juppé reform increased the role of parliament; since then, an annual Social Security Funding Act defines a national expenditure ceiling for health insurance (ONDAM) in the following year; parliament also approves a government report on the future direction of national health policy;
- since 1997, employees' contributions based on wages have been replaced by a contribution based on total income, which has the character of a tax.

This move towards adopting some features of the Beveridge model has been reinforced by the introduction of the Universal Health Coverage (CMU) Act, which extends statutory health insurance coverage to all French residents.

In future, the French health care system will face a number of challenges. On the supply side, the number of doctors will decline as a result of past decisions to impose quotas in medical schools. Many fear a shortage of doctors, and this fear also raises the question of the geographical distribution of doctors; it is already difficult to persuade doctors to practise in some rural or suburban areas. Financial incentives are to be created to encourage doctors to work in these areas, but beyond these incentives, doctors' freedom of choice in deciding where to locate their practice and the optimal skill mix required are among the issues currently subject to debate.

These debates take place in a tense climate. Relations with doctors have deteriorated since 1996, when a major reform was implemented that put a

ceiling on doctors' fees. Since then the main doctors' union has refused to sign an agreement with the health insurance schemes. The winter of 2001/2002 was marked by conflict with general practitioners, who have been on strike over out-of-hours care for several months. The conflict recently came to an end, but only after general practitioners were awarded with large increases in their fees. While the arrival of a new government has somewhat eased relationships, tensions persist.

On the demand side, it is likely that patients will play a greater part in setting priorities and determining quality and safety standards for the delivery of health care, either directly or through representative bodies. Their role has been reinforced by the recent law on patients' rights and quality of care.

The ageing of the population and its impact on health care needs and costs is further area of concern, while the regulation of the health care system raises institutional and financial issues.

Juppé's 1996 reform has changed the institutional balance of the French health care system, shifting power from the health insurance funds to the state (government and parliament) and from the national to the regional level. The current form of 'mixed organization' is the source of much debate, as is the continuing process of decentralization at the regional level.

Finally, the financial sustainability of the health care system is a perpetual source of concern, particularly due to the fact that actual expenditure consistently exceeds the targets set. Until now, the high cost of the health care system has been accompanied by high levels of access to health care, but the demographic change expected within the health professions may lead to an increase in explicit rationing in future years.

The government in place since June 2002 has introduced or announced several reforms. The Public Health Law announced by the Minister of Health has been discussed in parliament. It sets out about one hundred goals to be achieved over the next five years and proposes the implementation of five national public health plans between 2004 and 2008 (on cancer, unhealthy behaviour and addiction, health and environment, rare diseases, quality of life of people suffering from chronic illnesses). The bill also proposes clarifying the roles of different actors involved in public health policy.

Reform of hospital financing, announced in November in the "Hospital 2007" plan, is under way. The use of payment per case for medicine, surgery and obstetric activities is currently being tested by private hospitals. The Social Security Funding Act for 2004 details aspects of the implementation of the reform (types of hospitals and activities covered by this payment method, products and

services excluded from the prices that will be set for “groups of homogeneous stays”, etc.). As announced in the same hospital plan, an ordinance passed in September 2003 has simplified the hospital planning process by merging the strategic planning of all hospital facilities and activities into a single tool (the regional strategic plan). Previously, this process had been managed using several tools. The ordinance gives more power to the regional hospital agencies (ARH). These measures are accompanied by an ambitious programme of investment, initiated by a public endowment of €6 billion between 2003 and 2007.

In the pharmaceutical sector, the delisting of products announced in 1999 started in July 2003 and should continue in 2004 and 2005. Reference prices have been set for 23 generic groups representing about 5% of the total market. A new procedure enables the producers of highly innovative drugs to set, under certain conditions, the price of any new products they put on the market.

Lastly, the modernization of health insurance announced by the government is still on the political agenda: a High Council for the future of health insurance was created in October 2003 with the aim of establishing a diagnosis and proposing a direction for reform.





## List of abbreviations

<b>AFSSA</b>	<i>Agence Française de la Sécurité Sanitaire des Produits Alimentaires</i> French Agency for the Medical Safety of Food Products
<b>AFSSAPS</b>	<i>Agence Française de la Sécurité Sanitaire des Produits de Santé</i> French Agency for the Medical Safety of Health Products
<b>AFSSE</b>	<i>Agence Française de Sécurité Sanitaire Environnementale</i> French Agency for Environmental Health and Safety
<b>AMM</b>	<i>Autorisation de mise sur le marché ; market authorization</i>
<b>ANAES</b>	<i>Agence Nationale d'Accréditation et d'Evaluation en Santé</i> National Agency for Accreditation and Evaluation of Health Care
<b>APA</b>	<i>Allocation personnalisée à l'autonomie ;</i> Personal Independence Allowance
<b>ARH</b>	<i>Agence Régionale de l'Hospitalisation</i> Regional Hospital Agency
<b>ATIH</b>	<i>Agence technique de l'information sur l'hospitalisation</i> Agency for Information on Hospital Care
<b>CANAM</b>	<i>Caisse Nationale d'Assurance Maladie des Professions Indépendantes</i> National Insurance Fund for Self-employed Workers
<b>CEPS</b>	<i>Comité Economique des Produits de Santé</i> Economic Committee for Medical Products
<b>CISS</b>	<i>Collectif Inter-Associatif Sur la Santé</i>
<b>CMP</b>	Medical and Psychological Centre
<b>CMU</b>	<i>Couverture Maladie Universelle</i> Universal Health Coverage

<b>CNAMTS</b>	<i>Caisse Nationale d'Assurance Maladie des Travailleurs Salariés</i> National Insurance Fund for Employed Workers
<b>CSG</b>	<i>Contribution Sociale Généralisée</i> General Social Contribution
<b>CSMF</b>	<i>Confédération des syndicats médicaux français</i> Confederation of French Medical Unions
<b>DDASS</b>	<i>Direction Départementale des Affaires sanitaires et sociales</i> Health and social affairs authority at the department level
<b>DRASS</b>	<i>Direction Régionale des Affaires sanitaires et sociales</i> Regional health and social affairs authority
<b>DREES</b>	<i>Direction de la Recherche, des Etudes, de l'Évaluation et des Statistiques</i> Directorate of Research, Analysis, Evaluation and Statistics
<b>EMEA</b>	European Agency for the Evaluation of Medicinal Products
<b>EU</b>	European Union
<b>FMC</b>	<i>Formation médicale continue</i> Continuing medical education
<b>FMF</b>	<i>Fédération des médecins de France</i> Federation of Doctors in France
<b>HAD</b>	<i>Hospitalisation à domicile</i>
<b>HCSP</b>	<i>Haut Comité de la Santé Publique</i> High Level Committee on Public Health
<b>INPES</b>	<i>Institut National de Prévention et d'Éducation pour la Santé</i> National Institute for prevention and health education
<b>INSEE</b>	<i>Institut National de la Statistique et des Études Économiques</i> French National Institute of Statistics and Economic Studies
<b>INVS</b>	<i>Institut National de la Veille Sanitaire</i> National Institute for Monitoring Public Health
<b>IRDES</b>	<i>Centre de Recherche, d'Étude et de Documentation en Économie de la Santé</i> Centre for Research and Documentation in Health Economics
<b>ISA</b>	<i>Indice Synthétique d'Activité</i> Synthetic index of activities
<b>LEEM</b>	<i>Les Entreprises du médicaments (ex SNIP)</i>

<b>MG France</b>	<i>Fédération française des médecins généralistes</i> French Federation of General Practitioners
<b>MRI</b>	Magnetic resource imaging
<b>MSA</b>	<i>Mutualité Sociale Agricole</i> Agricultural Mutual Insurance Fund
<b>ODD</b>	<i>Objectif Annuel d'Evolution des Dépenses</i> Annual (maximum) expenditure target
<b>ONDAM</b>	<i>Objectif National de Dépenses d'Assurance Maladie</i> National ceiling for health insurance expenditure
<b>OQN</b>	<i>Objectif Quantifié National</i> Quantified National Target (on expenditures)
<b>PMSI</b>	<i>Programme de médicalisation des systèmes d'information</i> Programme for the Medicalization of Information Systems
<b>PSD</b>	<i>Prestation spécifique dépendance</i> Specific Dependency Allowance
<b>PSPH</b>	<i>Participation au Service Public Hospitalier</i> Non-profit hospitals linked to the public system
<b>RMO</b>	<i>Références médicales opposables</i> (practice guidelines)
<b>SML</b>	<i>Syndicat des médecins libéraux</i> Union of Self-Employed Doctors
<b>SMR</b>	<i>Service médical rendu</i> (medical value)
<b>SNIP</b>	<i>Syndicat national de l'Industrie pharmaceutique</i> (now LEEM) National Union of the Pharmaceutical Industry
<b>SROS</b>	<i>Schéma Régional d'Organisation des Soins</i> Regional Strategic Health Plan
<b>TIPS</b>	<i>Tarif interministériel des prestations sanitaires</i> Inter-ministerial scale of charges for medical services
<b>UCCSG</b>	<i>Union des chirurgiens et spécialistes français</i> Union of French Surgeons and Specialists
<b>URCAM</b>	<i>Union régionale des caisses d'assurance maladie</i> Regional Union of Insurance Funds
<b>URML</b>	<i>Union régionale des médecins libéraux</i> Regional Union of Self-Employed Doctors
<b>VHI</b>	Voluntary health insurance



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