

### Overview

The French health care system was ranked number one by the World Health Organization in 2000 due in large part to its high level of population health, degree of freedom for physicians and patients, easy access to health care for most people, absence of waiting lists for treatment and universal coverage. It changed considerably with the Juppé reform of 1996, which shifted power from the health insurance funds to the state and decentralized at the regional level. Additional reforms in the 1990s dealt with containing costs, improving management and increasing equity of access to health care. While the system has been successful in maintaining a high level of population health, many challenges are emerging, including the ageing population, increasing health care expenditure, the need for rationing and a decreasing supply of doctors.

### Health expenditure and GDP

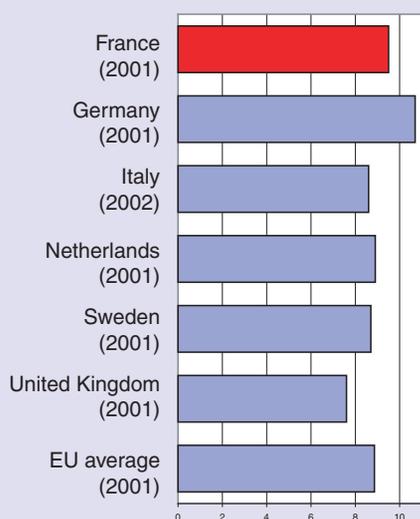
Total expenditure on health care in France was estimated at 9.5% of GDP in 2001. Public expenditure constituted 76% of total health expenditure in the same year.

### Introduction

#### Government and recent political history

France is an independent republic with an elected president and a bicameral parliament (the National Assembly). Administratively the country is divided into three levels (municipal, local and regional), each with its own elected assembly and some autonomy from the centre.

**Fig. 1. Total health care expenditure as % of GDP, comparing France, selected countries and EU average**



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

### Population

In 2001 the population was 59 million inhabitants of mainland France and 1.7 million overseas. In 1999 76% of the population was living in urban areas. Today, one in six people is over 64 years old. From 2020 onwards the over-sixty population will outnumber the under-twenty population.

### Average life expectancy

French women have the longest average life expectancy in Europe at 82.7 years, while men

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are expected to live 75.2 years (2000). Life expectancy continues to increase by three months per year for men and two months for women.

### **Leading causes of death**

The main causes of death are cardiovascular disease (31.3%), cancer (27.7%), accidents (8.3%) and respiratory diseases (8.1%). Infant mortality is low, at 4.4 deaths per 1000 live births.

### **Recent history of the health care system**

The present social security system evolved from mutual benefit associations that proliferated during the 19th and 20th centuries. A compulsory insurance system was established for low-earning employees in industry and business in 1930, covering two thirds of the French population by 1939. National health insurance was introduced after the Second World War. By 1974 coverage was expanded to cover the whole population, but it was not until 1999 that universal coverage was established on the basis of residence in France.

Other recent changes include the substitution of a tax on income for wage contributions to fund the system and an increased role for the parliament in setting expenditure targets and policy directions.

Cost containment has been a major policy goal in the last 25 years, leading to various attempts to influence patients' and doctors' behaviour and to limit the number of doctors.

### **Organizational structure of the health care system**

The health care system is regulated by two main players: the state – the National Assembly, the government and ministries – and the statutory health insurance funds. To a lesser extent, local communities play a role in regulating the system. The Juppé reform of 1996 clarified the roles of

the state and insurance funds and reinforced the role of the regions.

At the national level, the National Assembly has sought to improve the system with annual Acts on Social Security Funding since 1996, which set the national ceiling for health insurance spending, approve a report on health and social security trends and amend benefits and regulations. Recent changes have included improving insurance benefits for self-employed people, setting up funds for the modernization of hospitals and developing pharmaceutical information.

The Ministry of Health has recently been reorganized, with directorates responsible for health policy, hospital and health care, social security and financial matters and social policy. The Ministry also has directorates of health and social affairs at the local regional levels, most importantly the regional hospital agencies, the regional unions of the health insurance funds and the regional unions of self-employed doctors.

Authorities attached to the ministry include the Committee on Public Health, the Agency for the Medical Safety of Food Products, the Agency for the Medical Safety of Health Products, an Institute for Monitoring Public Health, the National Agency for Accreditation and Evaluation of Health Care (ANAES), the Economic Committee for Medical Products and the Agency for Information on Hospital Care.

The statutory health insurance system is composed of three main insurance schemes supervised by the Ministry of Social Security: the general scheme, the agricultural scheme and the scheme for non-agricultural self-employed people.

### **Planning, regulation and management**

#### **Human and material resources**

Regions apply national policies regulating the number of doctors and, to some extent, their specializations. This has led to a stable number of doctors and a decrease in regional disparities.

Hospitals are planned using a medical map (a quantitative tool) and the Regional Strategic Health Plan (a more qualitative approach). The medical map divides each region into health care sectors and psychiatric sectors. The Ministry is required to authorize expensive equipment and specialized care.

## **Financial regulation and management**

Recently financial regulation shifted from an emphasis on price controls to inclusion of budget setting in order to limit expenditure. Prices and budgets are determined through negotiations between professionals and health insurance funds. Budgets are subject to the national ceiling for health insurance expenditure which, since 1996, is decided annually by the National Assembly. The state also regulates outpatient expenditure.

## **Regulation of professional practice**

Doctors, dental surgeons and pharmacists are self-regulating through professional organizations at the national and regional levels. The Ministry of Health sets norms for hospital care, while compliance is monitored by doctors at the local and regional levels. Institutions and professionals are within the work of ANAES, which accredits hospitals, audits professionals and prepares practice guidelines. Malpractice is dealt with via professional organizations and the courts.

## **Decentralization of the health care system**

The French health care system is gradually becoming more decentralized to the regional level. At the same time, there has been a shift in power from the health insurance funds to the state.

# **Health care financing and expenditure**

## **Financing and coverage**

The health care system provides comprehensive coverage to all residents and is mainly financed through statutory health insurance. The general scheme covers about 84% of the population (employees in commerce and industry and their families). The agricultural scheme covers farmers and their families (7.2% of the population). The scheme for self-employed people covers 5% of the population.

The financing of the statutory health insurance system varies from scheme to scheme and is adjusted on the basis of demographic profiles. Employers' and employees' contributions plus "general social contributions" (CSG: taxes on total income rather than salary) account for 87.8% of total health insurance revenue, with state subsidies and earmarked taxes making up the remainder. Since the CSG was introduced in 1998, employees' contributions have fallen from 6.8 to 0.75% of gross earnings. The CSG is proportional to income, but a lower rate applied to those receiving benefits makes it progressive. The CSG now accounts for a third of the health insurance funds' revenue.

## **Benefits and rationing**

The health insurance system specifies medical goods and services that qualify for reimbursement. While benefits initially focused on curative care, more recently preventive care has been eligible for reimbursement. Certain services are not covered, such as cosmetic surgery, thermal cure and services with unknown effectiveness.

For most services, patients make a direct payment and are reimbursed afterwards, with the exception of laboratories, pharmacies, hospitals and outpatient clinics. There is a statutory co-payment, which varies according to the type of treatment and is higher for outpatient care and drugs than for hospital treatment. Exemption is

granted in some circumstances (such as chronic illness).

### Complementary sources of finance

Due to increases in patient cost-sharing, the rate of coverage by health insurance has gone down, leaving a larger role for complementary sources of finance.

### Voluntary health insurance (VHI)

Over the last few years VHI coverage has grown rapidly due to demand for better coverage and the continual reduction in the proportion of costs reimbursed by the statutory health insurance system. In 2000, complementary VHI covering statutory co-payments accounted for 12.4% of total health expenditure and covered about 85% of the population. VHI is provided by three types of organizations: mutual associations, provident associations and private for-profit commercial insurance companies. Since the introduction of CMU (Couverture Maladie

Universelle; Universal Health Coverage in 2000, complementary VHI coverage is available free to those with low incomes and now covers a further 10% of the population.

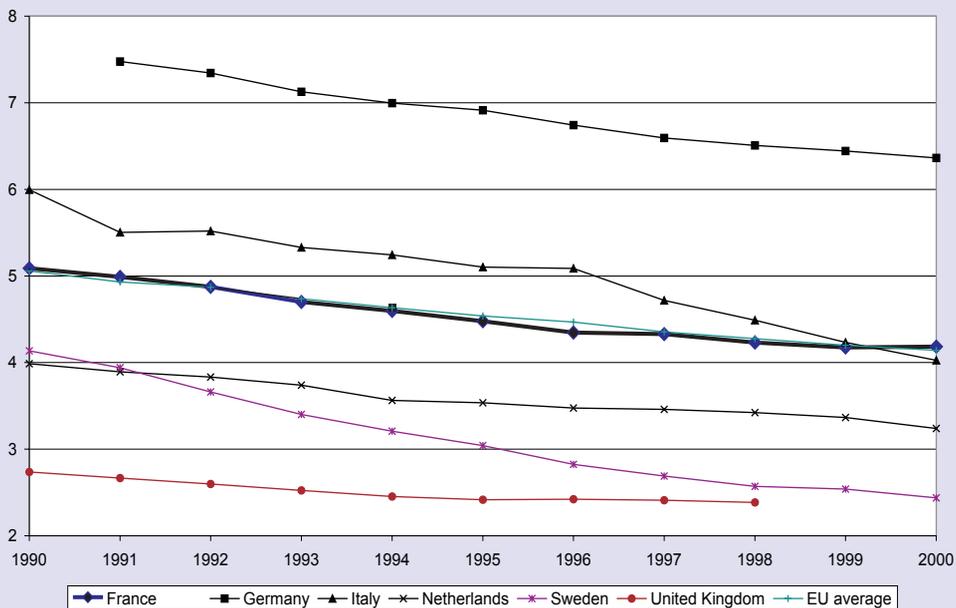
### Out-of-pocket payments

Due to services not covered by the statutory health insurance system, and the discrepancy between the amount of patients' payments and their reimbursements, out-of-pocket payments are prevalent. In 2000, direct payments constituted 11.1% of total health care expenditures, mostly for corrective lenses or orthopaedic appliances (25.7%), dental care (28.75) and drugs (17.9%). However, the amount spent by private households is uncertain and may be underestimated.

### Expenditure

Total health care expenditure as a percentage of GDP has been relatively stable at around 10% since 1995 (See Table 1). However, the relative value of health care spending in France

**Fig. 2. Hospital beds in acute hospitals per 1000 population, France, selected countries and EU average, 1990–2000**



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

has slowed down in the last 25 years. Currently, 46.5% of the total is spent on inpatient care, 26.1% on outpatient care and 20.5% on drugs.

## Health delivery system

### Public health services

In 1998 three public bodies were set up to manage health risks: the French Agency for the Medical Safety of Food Products; The French Agency for the Medical Safety of Health Products; and the National Institute for Monitoring Public Health.

Immunization policy is determined by the Ministry of Health. The majority of vaccinations are carried out by self-employed doctors, as opposed to being offered systematically within the health care system; thus vaccination rates are relatively low. Compulsory and recommended

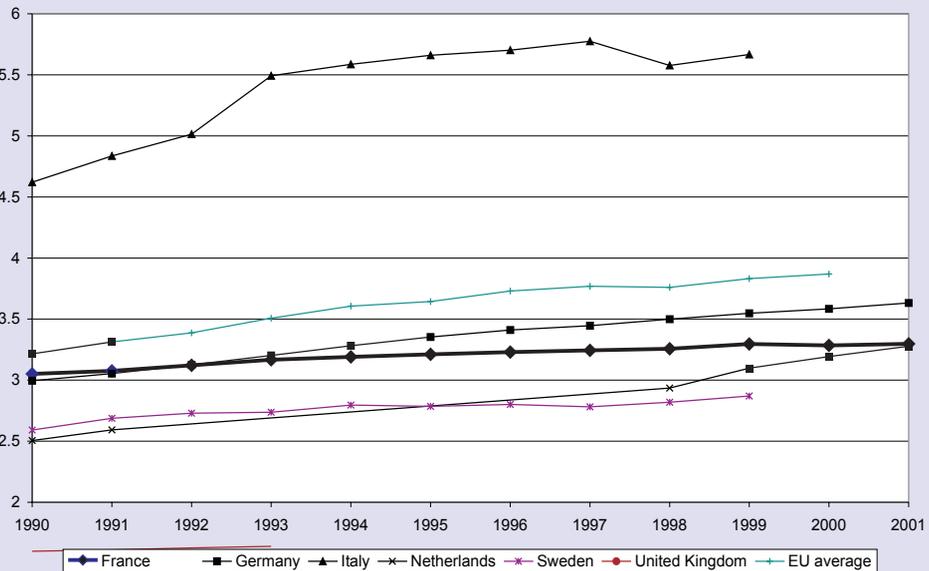
vaccinations are reimbursed by the statutory health insurance system, as are antenatal and postnatal care for mothers and infants.

The local authorities are responsible for preventive care services such as cancer screening and control of alcohol and drug abuse. Health promotion and education involve many actors, including the Ministries of Health and Education and local authorities. The efficacy of public health initiatives is compromised by this multiplicity of financiers, a lack of cohesion among the actors and diffuse responsibilities.

### Primary and secondary ambulatory care

Self-employed doctors, dentists, medical auxiliaries and, to a lesser extent, salaried staff in hospitals deliver primary and secondary care. In general, patients pay the provider and are subsequently reimbursed by their health insurance fund. The national agreement between doctors and the funds specifies a negotiated

Fig. 3. Physicians per 1000 population, France, selected countries and EU average, 1990–2001



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

tariff. Alternatively, doctors can join “Sector 2” which allows them to charge higher tariffs. Patients do not need a referral from their general practitioner to consult a specialist, and have free choice of doctor. Recent attempts to introduce a gatekeeping system have not been particularly successful, despite financial incentives aimed at doctors and patients.

Geographical disparities in the distribution of doctors have existed for a long time. For instance, the north has fewer doctors than Paris and the south. There are also significant inequalities between urban and rural areas.

Since the mid 1990s and the Juppé reform, quality of care and evaluation of medical practices (and hospital care) have become important concerns. A system of practice guidelines is in place and continuing medical education is emphasized. The dissemination of practice guidelines led to some alteration in doctors’ prescribing patterns, at least initially, but the financial penalties originally incurred for non-compliance with the guidelines have been ruled illegal by the courts.

Considerable difficulty remains in coordinating care among professionals and that between hospitals and health and social care institutions, particularly for the disabled and elderly.

## **Secondary and tertiary inpatient care**

Hospitals in France are either public (25%), private non-profit (33%) or private for-profit (40%). Within the public hospital system there are four levels: general, providing acute, follow-up, rehabilitation and long-term care; regional, providing more highly specialized care and teaching facilities; local, providing health and social care functions; and psychiatric.

France has an average of 8.4 hospital beds per 1000 inhabitants. Between 1980 and 1998 there was a decrease in the number of hospital beds and a reduction in average length of stay, along with an increase in admissions.

Public and private hospitals provide different types of services. While the private sector relies mostly on minor surgical procedures, the public sector focuses more on emergency admissions, rehabilitation, long-term care and psychiatric treatment. There is a recent trend towards alternatives to hospitalization including day surgery and “hospitalization at home”.

French mental health policy is characterized by de-institutionalization. Regional multi-disciplinary teams provide preventive care, treatment, follow-up care and rehabilitation. General practitioners and private psychiatrists deal with many psychological disorders, and there are 36 000 psychologists.

## **Social care**

Social services mainly consist of residential care of elderly people and dependent disabled adults. Social care is the responsibility of the general councils at the local level. Home care is provided by self-employed professionals or specialized home care services. Residential care is provided by many different institutions, such as retirement homes and hospitals, for long-term care.

Future challenges to the social sector include the ageing of the population and the possibility of demand for social services exceeding supply. Reforms were introduced in 2000 with the aim of increasing the available level of residential care for the disabled by 16 500 places and developing home services for nursing care.

## **Human resources and training**

There are approximately 1.6 million health care professionals in France, accounting for 6.2% of the working population. Currently the number of doctors has stabilized, due to a policy reducing the number of students entering medicine. However, a significant decrease in doctors is forecast for the next ten years. France is also facing a current shortage of nurses, expected to worsen in the near future. Recent trends include an increase in specialists over the last decade and an increase in

salaried medical staff. At present there is a wide disparity in regional doctor/population ratios, although they have been reduced over the last 30 years.

## **Pharmaceuticals and health care technology assessment**

Pharmaceutical products obtain market authorization from the European Agency for the Evaluation of Medical Products by meeting the criteria of quality, safety and effectiveness. The degree to which a drug is reimbursed by the statutory health insurance fund depends on its medical value, as measured by five criteria, including effectiveness and side effects, and the seriousness of the condition it treats. Reimbursable drugs account for 91% of pharmacy turnover.

France is the largest European producer of pharmaceutical products. Recently the payment has changed from direct payment by patients to pharmacists to direct payment from the insurance fund, so patients no longer incur any costs. Consumption of drugs is relatively high in France compared to other European countries. During the 1980s and 1990s, mechanisms were put in place to lower public expenditure on pharmaceuticals. For example, the reimbursement rates of drugs were lowered and generic drugs were promoted. However, by 2000 generic drugs only represented 2% of the market for reimbursable drugs and only since 2002 have doctors been allowed to prescribe by generic name.

At present there is only partial assessment of new or existing technologies in France. It is expected that more systematic evaluation will take place in the near future as a result of the new French Agency for the Medical Safety of Health Products (AFSAPS).

## **Financial resource allocation**

Since 1996, the National Assembly approves an annual national ceiling for health insurance

expenditure (ONDAM). Once the overall ceiling is set, the budget is divided into four sub-groups: private practice, public hospitals (divided among the regions), private for-profit hospitals and social care. Since the ONDAM was introduced, priority has been given to the social care sector over the health care sector.

## **Payment of hospitals**

After 1983, payment of public hospitals changed from a retrospective reimbursement based on a per diem rate to a prospective payment system of global budgets, paid in monthly instalments by the main health insurance scheme. Hospital directors may postpone payments from one year to another in order to meet their budgets, so financial difficulties may arise eventually.

For-profit hospitals are paid a fixed rate covering all costs other than doctors, who are paid on a fee-for-service basis. Fees are specified in a contract between the doctor and the hospital, with the result that there is much variability in fees across doctors, specialties and hospitals.

Private non-profit hospitals can choose between the two systems of payment.

## **Payment of physicians**

Health care professionals may be self-employed in private practice, employed by institutions or have mixed activities. Self-employed physicians provide the majority of outpatient and private hospital services. They are paid fee-for-service and the potential conflicts of interest in this system are an issue of contention.

Patients pay self-employed physicians directly and are partially reimbursed by the statutory health insurance system. The fees are determined in agreements between the health insurance funds and the physicians, unless the doctors opt for Sector 2. General practitioners who act as gatekeepers receive a supplementary fixed sum per registered patient per year, which acts as an incentive for doctors to enter the scheme.

Doctors who work in public hospitals are state employees with benefits similar to civil servants.

They are mainly paid on a salary basis. Recently, to encourage doctors to stay in the public hospitals, they have been permitted to work in private practice part time within the hospital. Thus the net incomes of public and private physicians are quite similar.

## Health care reforms

The structural difficulties of the complex French system provide an impetus for reform. The main goals of current reform efforts include cost containment, improving management, public safety and equity.

High levels of expenditure result from the combination of unrestricted freedom of patients and providers, retrospective payments and slight financial risk to the insurance funds. Recent efforts to curb spending include reducing reimbursement rates – thereby increasing cost sharing – introducing gatekeeping, limiting the number of doctors, improving hospital planning and controlling drug prices.

Due to conflicts between the state and the health insurance funds there has been a trend towards decentralization at the regional level. However, this is criticized for dismantling existing administrative and organizational structures. There has also been an increased role for the National Assembly, although the responsibilities of the various actors remain unclear.

Decision-makers and the public have been increasingly concerned with safety issues in the light of the “contaminated blood scandal” and fears about “mad cow disease”. Reforms have taken the form of disseminating practice guidelines, lengthening general practice training periods, developing information systems and designing national programmes to improve treatment in areas such as cancer, asthma and mental health.

The growing awareness of inequalities in mortality and access to care led to the extension of health insurance coverage to all residents of France in 2000. The impact of this change on

equity is currently being evaluated. In addition, resources are being allocated to public hospitals based on a formula that accounts for population health needs and hospitals’ efficiency.

Professional organizations play an important role in the implementation of reform. However, increasing doctors’ responsibility for containing costs has been largely ineffective. Also, the national expenditure ceiling for health insurance has only been respected once, in 1997. Tensions within the medical profession have also prevented effective implementation of reforms such as the experiment with gatekeeping.

Persistently poor relations between the state and the insurance funds impede reforms. The growing role of health care users in France also affects the success of various reforms, notably enhancing “democracy” within the health care system and improving the quality of care.

Overall, the remaining challenges include the need to develop new strategies to reform physician payments, and clarifying the responsibilities of professionals and the state, on one hand, and the insurance funds and the state on the other.

## Conclusions

The French health care system was ranked number one by the World Health Organization in 2000 due in large part to its high level of population health, degree of freedom for physicians and patients, easy access to health care for most people, absence of waiting lists for treatment and universal coverage. Recent reforms, notably the Juppé Reform of 1996, have meant a larger role for the National Assembly, decentralizing of the regional level, a shift from a social insurance model based on wage to a more tax-financed model based on total income, and universal coverage. However, due to the challenges posed by an ageing population, shortages of health care professionals and growing costs, the system’s sustainability remains a source of concern.

**Table 1. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2002 or latest available year**

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
France	4.0 <sup>a</sup>	20.4 <sup>c</sup>	5.5 <sup>c</sup>	77.4 <sup>c</sup>
Germany	6.2 <sup>a</sup>	20.5 <sup>a</sup>	9.3 <sup>a</sup>	80.1 <sup>a</sup>
Italy	3.9 <sup>a</sup>	15.6 <sup>a</sup>	6.9 <sup>a</sup>	76.0 <sup>a</sup>
Netherlands	3.1 <sup>a</sup>	8.8 <sup>a</sup>	7.4 <sup>a</sup>	58.4 <sup>a</sup>
Sweden	2.3	15.1	6.4	77.5 <sup>f</sup>
United Kingdom	2.4 <sup>d</sup>	21.4 <sup>f</sup>	5.0 <sup>f</sup>	80.8 <sup>d</sup>
EU average	4.1 <sup>a</sup>	18.1 <sup>c</sup>	7.1 <sup>c</sup>	77.9 <sup>d</sup>

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

Notes: <sup>a</sup> 2001, <sup>b</sup> 2000, <sup>c</sup> 1999, <sup>d</sup> 1998, <sup>e</sup> 1997, <sup>f</sup> 1996.

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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 Couffinhall, 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 editors for their helpful comments, and the Ministry of Health for its support.

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