The French Healthcare System

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Introduction

Before analyzing the French healthcare system, it is interesting to give some general features on European healthcare systems in order to place the French system in its context.

The French healthcare system in the European context

The healthcare systems in Europe have many similar characteristics. The whole population is covered by the State's budget or by social sickness funds. The financing of the sickness funds is based mainly on proportional contribution according to income level. The State represents a reference for guaranteeing healthcare access for all (principle of equity). France had added the principle of freedom for practitioners to practice and for access to any practitioner. The implementation of these principles induces a predominant role of central State government or its decentralised levels in the supervision of the system. The State can intervene in the field of health supply, health financing, and quality of care.

In Europe, we could distinguish four types of healthcare systems. In the Bismark model, the functions of supervision and financing are separate. Decision and regulation are referred to the State. Sickness funds play a central role in financing. The health insurance coverage is mainly based on employment and, in principle, financed by payroll contributions. Germany, France, Belgium, Austria are part of this model.

In the Beveridge model, the State assumes both functions. The healthcare budget is voted on by the Parliament every year. The State has an effective power on the actors, and on the activities. These systems are mainly public and financed by taxes. The United Kingdom and Nordic countries have beveridgian national health services.

The mixed models derive from a Beveridge configuration by inserting some private structures in healthcare financing and supply. Italy, Spain, Portugal and Greece belong to this model.

The liberal model is represented in Europe by the Swiss healthcare system. In this model, private insurance plays the key role to manage the financing and the supply.

France belongs to the Bismarck model but some features lead us to consider that the system of financing the social protection includes beveridgian elements. The social protection is financed by payroll (employer and employee contributions, mainly employers) and by income taxes.

A pluralistic system: a complex management

The French healthcare system is characterized by centralized public institutions managing a dualistic organization. The healthcare supply is assumed by the public sector and the private sector. The health financing is assured by a compulsory public insurance and a complementary insurance. The dualism of this system induces complex regulation and complex governance.

Independent practitioners and public hospital practitioners have specific references. The former have a relationship with health insurance for the determination of their tariffs and the management of the care they provide. The latter are under the administrative supervision of the State. Moreover the French system is also characterized by public governance which had allowed for decades a relative freedom for the healthcare actors. Controls are less strict than in other countries. Until recently, patients were free to choose their doctors. However, the 2004 reform introduced a gate-keeper mechanism accompanied with an increasing of the payment in case of no-respect. Until recently, there was no systematic assessment of the activities, and no systematic accreditation of practitioners or care institutions.

1. Healthcare expenditures in France [1]

The National Healthcare Accounts assess every year some aggregates concerning the healthcare expenditures. These aggregates are the following:

Medical Care Consumption (Hospital care, Ambulatory Care, Drugs, Optical, Prosthetics); and
Global Health Expenditure (without capital expenditures) includes the financing of Medical Consumption, Hospital Care, Research, Training, and Management.

In 2008 medical consumption was evaluated at 170.5 billion Euros. This represents the main part (79.3%) of the global health expenditures which was 215.0 billion Euros. According to the share of the global current health expenditures to GDP,

France ranks 2nd (11.0% in 2007) behind the USA (16.0%), just before Switzerland (10.8%) and Germany (10.4%).

1.1 Trends of healthcare expenditures [2]

In the following developments we will consider two periods: A long term trend from 1950 to 2005 which will give the level of increasing rates before the setting up of the last structural reform in 2004, and the trend of the recent years due to the effects of the recent measures.

Long-term trends (from 1950 until 2005)

Between 1950 and 2005, the proportion of healthcare expenditures to GDP had multiplied by 3.5 (from 2.5 up to 8.8%). The value of healthcare and medical goods consumption increased according an annual average rate of 2.5 points more than that of GDP: 11.2% for healthcare consumption, 8.7% for the GDP. The main factors in this evolution are (a) induction of the healthcare supply on an unsaturated demand, (b) impact of the social financing improvement on the demand solvency, (c) changing patient behaviours, and (d) Demographic mutations.

Throughout the period, the price effect of this evolution had been oriented obviously toward a decreasing trend. The relative prices of the healthcare consumption compared to GDP decreased around 0.2% in annual average rate. The global trend is characterized by a relative increasing process in comparison to the GDP between 1950 and 1970, and by a decreasing between 1970 and 1985 concerning especially the drugs consumption. Then stagnation had been observed. Until 1985, the increasing gap between the healthcare consumption volume and the GDP volume had been important. The annual average rate had increased by around 9% to 10% for the healthcare consumption. This gap had been decreasing after the setting up of two structural reforms (1987 "Seguin Reform" and 1995 "Juppé Reform").

The beginning of the 2000s had been characterized by a return of the increasing trend. The last structured reform of 2000 induced a slowing down. The share by type of activities expenditures had not changed. The share of hospitalisation represents 44.5% in 2005 versus 43.1% in 1950. The setting up of the evolution rates at the end of the seventies and of a global budget has been very influential on the hospitalisation expenditures increase. The DRG's financing was introduced in 2004 in an attempt to get more efficiency, but it may generate an inflationist process by setting up attractive prices for some medical activities. The share of ambulatory healthcare has kept the same level all along the period. Containment measures concerning the health insurance expenditures from the middle of the 1980s, had sustained this share by reducing the volumes. The proportion of drugs expenditures had been reduced until 1996 but remained at the same level since this date.

Recent trends (the "new deal rates" 2005-2008)

At the end of nineties, the trend of the healthcare expenditures had been decreasing. The evolution rate increased to 3.3% annually on average between 1995 and 2000. The first trend for the 2000s is characterized by a very high acceleration from 4.8% in 2000 until 6.4% in 2003 followed by a huge decrease: 4.4% in 2005, just at the beginning of the 2004 reform. This rate continued for two years, and in 2007 a further decrease appears: 3.8%.

The volume impact was important. The rates of increase were 3.8% annually on average between 2000 and 2005, 3.4% in 2007 and a decrease in 2008 of 2.8%. In 2008 **Hospital Care represents** 44.1% of the medical consumption expenditures. Their trend had been increasing until 2005 (+5.3% annually on average in the public sector and 5.6% in the private sector, between 2002 and 2005). After 2005, a deceleration was observed until 2006, followed by a slight revival (from 4.6% to 3.4% in 2008 in the public sector, and from 6.0% to 4.6% in the private sector). The constraints on professional payments constituted the main factor of the decreasing of hospital expenditures.

The share of ambulatory care represents 27.5% of the Medical Consumption in 2008. The evolution had been evaluated around 4.6% by year for the three last years. The slowdown had been important since 2005 (5.6% from 2000 to 2005). The influence of the volume increase was the main effect of this evolution. It was more important than that of prices (Except for the prices of the doctors' and nurses' services between 2005 and 2007 because of the re-evaluation of acts prices)

The trend of drugs expenditures had been influenced by the evolution of the volumes along the last decade. The 2008 increase is high (5.4%) but represents a slowdown, compared to the previous evolution (around 7.0% annually on average). Since the end of the 1990s the impact of generics promotion on the consumption had been very important. The reimbursement constraints concerning some drugs and a more strict regulation of the medical practice led to the slowdown in 2008.

The prices trend had been negative (-1.0% on average between 2000 and 2005; -3.7% in 2007; and -2.3% in 2008). So the expenditures increasing rates had been slowing down from 5.9% on average between 2000 and 2005 to 3.0% in 2008. The

French drug expenditures by inhabitant rank 4th after the US, Canada and Greece.

1.2 Financing of healthcare expenditure

The Social Security's financing covers 75.5% of the global expenditures. The medical assistance for people who don't have insurance against the risk of sickness accounts for 1.3%. It is paid by the Central State. Complementary insurance financing represents 13.7% of the total (10.2% for the non-profit companies, 3.5% for the private) and the part paid by households represents 8.5%.

The part of Social Security has decreased slightly since 2005 according to the disposals of 2004 reform and the recurrent reimbursement of drugs purchases. In fact, the evolution of the social protection during the 2000s is characterized by two trends: the decrease of the part of the less reimbursed medical services and goods, and the increasing number of people who have long term diseases (completely taken in charge by the Public Health Insurance)

1.3 Healthcare and long-term care of the elderly in France

According to the data of INSEE[3] the proportion of elderly people over 60 years must rise from 16% in 2000 to 29% in 2050 (and the proportion of over people over 85 from 2% to 8%). The impact on hospital, ambulatory healthcare and on health products should be moderate according to INSEE. The ageing impact on social benefits has been estimated at 0.7% annually on average between 2000 and 2020. The impact on the GDP share represents a rise of 1.5% in 20 years and 3.0% in 2050. The long term care in institutions or at home should represent a global impact of three points of GDP in 2050 (2 points for healthcare, 1 point for the dependence). The healthcare access increases much faster than that of the rest of the population. The hospitalization rates increase more for people over 65 and much more for those over 75. The putting out of shape of the expenditure profile is observed as well in France as in the USA, Japan, and Canada. The only exhaustive estimation we can recently present concerns essentially long-term care in hospitals and in establishments for elderly and disabled people.

In 2007 all these care represented 5.7 billion Euros (+8.7% / 2006). The expenditures for elderly in hospitals increased faster (+11.1 / 2006). They have doubled since 1995 under the impact of the dependence. The nursing service at home proposes an alternative model to the lodging in hospitals. 90,000 people are working there currently.

Three scenarios concerning the healthcare access have been presented[4].

1. Healthcare supply characteristics are unchanged all along the period. This scenario is based on the mechanic effect of the increase and of the structural modification of the population.
2. Continuation of the 1998 - 2004 evolution.
3. Taking in consideration the new treatments and the new ways of taking in charge.

In all these scenarios the impact of hospitalized ageing people will be important in terms of length of stay. If the access rates by age and pathology are the same as in 2004, a light increasing of the global rate of hospitalization will be observed. The second and third scenarios indicate an important increase of the global hospitalization rate between 65 and 84, more moderate for the later ages due to an eventual improvement of the taking in charge by extra hospital structures or at home.

The length of stay in global hospitalization in the first scenario increases because of the increasing of ageing people. It decreases in the two others. The decrease is induced by a more important availability of the taking in charge structures following the acute care for ageing people of 65 - 74 and especially for those 75 - 84. The decrease would be more important than those observed on the recent evolution (1994 - 2008).

In ambulatory care, if the practice is constant, we should assist to a decrease of around 2 points of the share of ambulatory stays for the whole population. In scenarios 2 and 3 the hypothesis leads to an important increase of the stays proportion. The results indicate that there are abilities which impact strongly on the evolution. The healthcare system reveals in fact its capacity of fast adaptation to change. The availability of supporting structures is obviously essential.

2. Healthcare supply[5]

The French healthcare system is characterized by an ambulatory healthcare sector which is mainly private and a hospital care sector which is mainly public

Ambulatory care

The principles of the independent medicine are the following: freedom to set up independent practice; freedom for patients to choose their physician; freedom of prescription by the physician. Ambulatory care is delivered by independent professionals. Only 40% of doctors are involved in group practices. But health centres and hospitals can also provide ambulatory care. At the beginning of 2008, the global number of doctors was evaluated at 208,249 (34.0 per 10,000 inhabitants). The share of specialists was 51.3%; 48.7 % are general practitioners.

The number of doctors providing ambulatory

care was estimated in 2008 at 122,145, of which 44.07% are specialists. 63,628 doctors worked in hospitals as full time employees including 44,477 specialists and 19,151 general practitioners. There were 473,447 nurses (6.52 per 1,000 of population), of which 66,169 work in the ambulatory sector (private practice) and 407,278 in hospitals. The other professionals are mainly in private practice: Dentists number 41,422, of which 90% are in private practice, physiotherapists 64,327 of which 75.0% are private.

Relations between National Health insurance and private practice healthcare professionals are stipulated by the terms of a national agreement, or written agreement negotiated with the representatives of the professional unions and approved by the government. The Convention sets out the rules regulating the distribution and payment of services rendered in ambulatory surgeries or in private hospitals. According to the fee agreements, doctors must bill their services according to a calculation based upon two elements: first, a relative value scale (nomenclature) of medical procedures which are designated by key letters and which assign coefficients to each service indicating its relative importance vis-à-vis other services within the same group; second, the fee amount is fixed for each key letter. The introduction of new techniques and procedures, and the evolution of the cost of medical services imply a revaluation of the fees level.

According to the 1980 agreement doctors could choose a new status called sector 2 which permits those doctors to freely set their own fees. In exchange, sector 2 doctors must promise to set their fees with "tact and moderation". Since 1990, only the hospital practitioners who decide to go to a private practice can choose this sector. Sector 2 patients must pay the difference between the regular rate of reimbursement and what the sector 2 doctor is charging.

Hospital care

At the beginning of 2007, there were 977 public hospitals (317,000 beds) and 1,836 private hospitals (174,000 beds). 25,000 beds had been suppressed between 2002 and 2007. There are two categories of private hospitals. The first category consists of 660 not-for-profit private hospitals taking part in the public service (PSHP). These hospitals are financed on the basis of a prospective global budget defined by the Regional Hospital Agency in the frame of strategic plan objectives. The second category, the private for-profit hospitals, is comprised of 1,314 regulated clinics and 50 hospitals funded through a day-price system.

Public and private PSPH hospitals represent 75% of the beds. Public hospitals (65% of the beds) must accept all patients and provide emergency care. They also differ in size and activities. 31 Regional Public Hospitals (Centres hospitaliers Régionaux (CHR), including Overseas departments) dedicated to teaching and research because of their affiliation to medical schools, have highly specialised services. The 500 public hospitals specialize in general surgery medicine and obstetrics. The 340 local hospitals represent only 7% of the beds in the public sector. Most of them are dedicated to long-term care and throughout the last decade they have succeeded in redesigning beds from acute care to nursing home care for the elderly. There are also 88 specialised hospitals for psychiatry.

The private sector with 35.5% of all beds (25% of all beds for private for-profit and 10.5% for non-profit) covers different types of care such as acute care, long-term care, psychiatric care and cancer care (20 non-profit specialized hospitals). The more important private establishments, with more than 250 beds, are specialized in surgery and obstetrics with sophisticated equipment.

There are also local health centres where salaried doctors provide primary and preventive care, usually in urban areas. They are managed by local authorities or mutual organizations and have an important role in providing services for precarious populations.

Pharmaceutical care

The Agency of Health Safety for Health Products (AFFSAPS) gives authorizations to sell drugs and guidance on usage. The prices and the sale volumes of drugs are regulated by a negotiation between the Ministry of Health (the Economic Committee of Health Products) and each pharmaceutical firm. Pharmacies only are allowed to sell the drugs. The establishment of a pharmacy is regulated by a quota of population to be served.

People's access to healthcare

According to the 2004 reform, the patient has to choose a referent doctor (gate-keeper doctor) but he has the free choice of his doctor. Patients are less reimbursed if they don't consult a gate-keeper doctor before entering secondary care. In order to be covered by the healthcare insurance diagnostic and therapeutic services must be officially listed (e.g. official classifications of professional services or lists of reimbursable drugs). They must also be prescribed by a doctor.

According to the regulation the patient pays the entire bill for services rendered directly to the healthcare provider and then receives a refund from

the sickness fund. The reimbursement is usually less than 100 percent of the original cost, except for expensive and long diseases (listed by the National Health Insurance). The level of reimbursement to the patient is calculated from the National Health Insurance tariff minus the required co-payments. Coverage is more or less generous according to the type of care.

In practice, however, there are exceptions to direct payment which attenuate these rules, for instance the third party payer and exemptions from co-payments in case of long and expensive treatments. Under certain conditions medical care is free to the patient, for instance when the doctor has an agreement with the health insurance fund.

In France there are three kinds of complementary insurance: non-profit mutual insurance companies (56% of the complementary insurance), provident institutions (26%) and private profit companies (18%). Mutual companies and provident institutions are organized under professional activities; private profit companies propose individual contracts. The complementary insurance can intervene only to finance the co-payment. A private insurance can be purchased to get expensive care. Currently about 97% of the population are covered by a complementary insurance.[6]

The following developments describe and analyze the governance and the management of the French Healthcare System according to the orientations of its regulation. The recent law on "Hospital, Patient, Health, Territories" adopted on 21 July transforms noticeably these orientations and the meaning of the management although the specific principles are maintained. This law will be presented at the end of this text but the appreciations will be theoretical. In fact the application of this law will begin in 2010.

3. Incentives to control the increasing of healthcare expenditures: The fundamental principles of the management

3.1 Two institutional actors for the control and the regulation: State and health insurance

The role of the State

The French healthcare system is characterized by a powerful State role in the administrative supervision of (a) the economic regulation of the whole system, (b) public health policy (prevention, sanitary policy), (c) functioning of the different professionals, (d) medical training and the conditions of practice, (e) social protection (modalities of financing-prices and reimbursement rates), and (f) The determination of pharmaceutical prices for reimbursable drugs.

The role of the National Health Insurance

Financing is organized by sickness funds which are key institutions in the French healthcare system. The general scheme of social security is the largest sickness fund covering employees, industrial workers, pensioners, unemployed and their dependents (80% of the population). Other funds concern particular categories of population (agricultural workers, independent professions, etc.) The resources of sickness funds consist of contributions deducted from wages. Since 1996 a complementary tax contribution (Contribution Sociale Généralisée) on all kinds of earnings has been instituted. Sickness funds are placed under the supervision of the State. Their role consists of financing the benefits. They have only a weak impact on the activities of practitioners and controls are relatively rare.

Health expenditures and ressources financing: the recurent deficit[7]

The current deficit of health care insurance reached at the end of 2003, just before the application of the 2004's reform, 11.6 billions of Euros. The trend to lowering observed after appeared noticeable.

In fact, according to the health insurance accounts, the deficit level was markedly lower in 2005, that is to say 5.9 billion Euros.

The increasing in 2007 (7.2 billion Euros) corresponds doubtless to the revival of medical activities (see above the results of the National Health Accounts).

The year 2008 was characterized by a deterioration of the employement market which induced a huge amount of the deficit (8.0 billion Euros)

The decrease of resources and the increase of expenditures had constituted a more and more important deficit factor for the last two decades. Its impact is increasing.

In its recent conference - June 2009 - the Social Security Accounts Commission assessed the next deficit around 9,9 Billions Euros

3.2 Administrative management of a pluralistic system

Healthcare management is organized according to different functions: Decision, Organization, Expertise, and Assessment.

First of all, the Parliament has to define the main financial and health aims on the basis of expert reports.

After deciding the main objectives the Parliament determines the financing of health insurance expenditures according to the main activities, both public and private. Ambulatory expenditure goals are

managed by the public health insurance in conjunction with professional unions. Ambulatory care is managed at the local level by Regional Unions of Health Insurance (URCAM) according to national norms (defined benefits and conditions of payment)

Public and non profit hospitals financing is broken down between the different regions and managed by regional agencies which represent the State at decentralized levels. These agencies have to allocate the regional financing to the hospitals of their respective competence areas. The way of allocating is based on assessed needs. The regional agencies have authority to restructure or even suppress hospital services. Hospitals services are assessed by a synthetic index of activities (Point ISA).

The expert evaluation is provided by independent institutions

Health agencies focused on specific medical topics. High Authority of Health is in charge of advising and assessing. The High Council of Public Health is composed of medical and economic experts. The National Conference of Health, composed of representatives of professional colleges, presents reports every year analyzing the health situation.

Management and ideological principles

For a long time the system had worked on the basis of a financing regulation. The rationalization of care supply was based on the optimal level defined according the available social resources. Controls, homogeneous managing, healthcare access, healthcare assessing would have been necessary to rationalize a system which does not work as a competitive model based on prices and activities.

Since the beginning of the 1990s the French management had changed, but slowly and without a real new orientation. Some medical regulations had been adopted but very modest ones. Since 2004 hospital activities have been analyzed but this orientation is very recent and the assessment tools are not effective enough. Until the recent reforms (2004, 2009) the French regulation might be considered as a macro regulation, referred to ideological principles. This regulation had been more focused on management of institutional structures than the results. Inputs had been favoured compared to the outputs. This way of doing business derives from cultural and ideological grounds. The pre-eminence of the public intervention was legitimated by the guarantee of offering the best healthcare according the available financial resources. The main objectives were to give healthcare supply the equilibrium between collective resources and expenditures.

Specific system, specific regulation

French healthcare system regulation is characterized by specific features. The system is inflationary: traditionally, before 2004, patients could go to the practitioner whenever they wanted, wherever they wanted, to be cared for, and they can change their practitioner, they were reimbursed in any case by health insurance - public and private. The situation changed in 2004 but practitioners and patients still enjoy relative freedom in comparison to other countries. The physicians are remunerated on the basis of fee-for-service and their care or prescription activities are only weakly controlled. In this system, waste is a congenital weakness. It is an important problem for a system based on collective references. For a long time the French regulation had developed a collective arbitration between financing and health supply capacities offered to the population in favour of a more and more important equity, but the remaining social and geographic inequalities, also situations of exclusion lead us to reject the view that this model had succeeded.

The regulation is largely focused on the resolution of a macroeconomic imbalance. It consists of controlling the increase of global expenditures and of analyzing the causes of the imbalance between resources and the growth of expenditures. The orientation towards a microanalysis which is able to assess the results of the health supply is very recent.

The causes of the high costs and of the unfavourable relation of costs to benefits are multiple. The freedom characterizing patients' behaviours and practitioners' activity is excessive. The administrative determination of prices and the fee-for-service remuneration encourage practitioners to increase the supply. This kind of price determination corresponds only to the remuneration of practitioners. It doesn't take into consideration the quality and the technical nature of treatment.

Prices are determined by the administration or implicitly in the case of activities financed by global budgets (and therefore constitute ex post prices). So these prices don't have any meaning for the health economic policy. There is no price competition. A supply competition, based on suppliers' strategies, substitute for price competition. For example, in the case of global budgets, *a priori* determined, suppliers can reduce their activities, and the prices are de facto increasing. On the other hand, private practitioners paid by a priori determined tariffs can increase the number of services (the increase of medical activities makes up for the low price level).

Health insurance is a passive payer. It doesn't know very well the medical services it has to finance. All activities are legitimized by the decisions taken at national level by the State concerning

supply and its remuneration (tariffs, prices, reimbursement of the medical services and goods paid by the administration). *Therefore it has a weak influence on medical activity. It can't assess the level of excess capacity to reduce budgets when activity declines. Health insurance and State constitute a de facto understanding with producers, to the detriment of the public good (regulatory capture of regulation)*[8]

4. Healthcare reforms from the point of view of health economics

4.1 The traditional regulation of the system: an orientation towards the rationalization of the supply and demand financing

For some decades French regulation has been anchored mainly to financial measures. Constraining the increase of health expenditures was the main aim. It consisted of increasing the patient's financial participation, rationalizing the hospital financing, and controlling the increase of prices and remunerations.

Increasing of the financial participation of the patient

Since the middle of the 1970s, measures concerning user charges have been developed constantly. Copayment, organizing the patient's financial participation, is a principle of French social protection. Its purpose is to reduce the moral hazard associated with insurance coverage. In fact, it has become a tool of health regulation policy. But its effects are not lasting because of the financial support offered by complementary insurance.

Rationalizing the hospital financing

The most important reforms had concerned the regulation of hospitalization. After the rationalization of medical services at the beginning of the 1980s, the government set up a global budget for the remuneration of public and non-profit private hospitals. This system replaced the former method of remuneration which was based on per diem financing. This kind of arrangement was to be adopted at the end of 1980s for other activities (tests, medical auxiliaries).

This arrangement was effective in reducing the rate of increase of hospital expenditures, but when such financing is set up, healthcare managers need very well performing information systems. The French healthcare management failed in this respect. A Program of Medical Information System (PMSI) for hospitals was introduced in 1984, but only became operational and universal later (1993).

Remunerations control

Professional remunerations are fixed in the framework of agreements negotiated by professional unions and health insurance funds.

The regulation of drug expenditures

The regulation of drug expenditures consists of different measures: increasing user charges, reducing reimbursement and deleting drugs from the list of reimbursement after assessing their medical inadequacy (which is the most recent form of regulation). Pharmaceutical prices are fixed administratively. Agreements about prices and volumes are negotiated between the State and each pharmaceutical laboratory.

The translation between the traditional regulation and the answer to new deals (evaluation, global management)

The development of medical innovations and the reactions of medical professionals against the financial reforms led the public authorities to introduce a "medical regulation". Some official reports insisted on the necessity to get better medical information to justify the doctors' activities. In 1993, the Ministry of Health set up medical guidelines (RMO: référen ces médicales opposables) which define the best way to prescribe appropriate drugs for specific diseases. At the same time the National Agency for the Development of Medical Evaluation (ANDEM) had been created. In 1994 a White Paper on Health and Sickness Insurance (Livre Blanc sur la santé et l'assurance maladie)[9] ordered by the Prime Minister Edouard Balladur called for a better visibility of governance, involvement of national representation, and a link between the national and regional level. This regional level was considered as the best managing area.

It was the first step towards a progressive (but very little) changing of the regulation.

4.2. The first global reform: "The Juppé reform", towards new methods of governance

The orientations taken at the in the mid 1990s reported a willingness to introduce a new state of mind in the healthcare management. The first structural reform, presented in 1996, tried to limit the expenditures increase by administrative procedures: determination of global budgets (for the public hospitals) and annual evolution rates for the private activities. Moreover this reform introduced a new governance, and referred to the necessity of orienting the management towards the patients demand (at the regional level) and of reducing social and geographic inequities. The governance of the whole system is shared between the national level for the

decision and regulation on the one hand and the regional level for the management on the other hand. Moreover the procedures of assessment and the institutions to promote them are now integrated in the new governance.

National level: decision role

In 1996 the Parliament acquired great power in determining the main aims. Henceforth it fixed the global aim concerning the health insurance expenditures (ONDAM). Three kinds of aims are decided:

- Annual budget allocations for public and non profit private Hospitals,
- Increase rates of expenditures for private hospitals and ambulatory services.
- For pharmaceutical expenditures, agreements about consumption volumes and prices have to be negotiated between the ministries in charge of health and of national economy on the one hand and laboratories producers on the other hand. These agreements provide for repayment by laboratories' producers in case of eventual overtaking.

Regional level: management role

Regional Health Authorities for hospitals (civil servants managing the Hospital Regional Agencies) represent the State at regional level. They have to adapt the regional hospital budget according the needs of each hospital and the local inequalities in healthcare supply. Regional Unions of Health Insurance funds (URCAM) regulate and control the private healthcare supply in ambulatory and private clinics. This regulation is based on norms defined at national level by national health insurance funds (under the supervision of state) on copayment levels and professional tariffs.

Otherwise this reform sets up a new device in the French healthcare structures, the Healthcare Network. This structure is integrated now in the annual financing procedures (ONDAM). However, its development has not been significant so far. Probably the device will perform better in the context of the Health Regional Agencies in 2010. The orientation towards activities assessment implies the setting up of a new Agency for improving the medical regulation: the National Agency for Accreditation and Assessment in Healthcare (ANAES) which replaces the National Agency for the development of medical evaluation (ANDEM) created in 1993.

So, the predominant role of the national representation, the recognizing of the necessary improvement by creating agencies, the institutionalization of Healthcare Networks for Healthcare Coordination, the assertion of the regional level as the optimal focus for managing the health affairs, have been the fundamental principles of the reform.

However, this first global reform for the whole system remained fundamentally an institutional reform with a rigidity induced by an administrative governance of each category of care. The different categories were managed according to financial specific aims without the possibility of transfers from one to the other.[10]

4.3 The 2004 reform of healthcare insurance

New approaches, a responsibilization of all the actors

The main orientations proposed by the 2004 reform changed noticeably the mind and the frame of the French governance. The huge deficit of public healthcare insurance remaining on an increasing trend constituted certainly an important factor for setting up a new reform. At the end of 2003 the health insurance deficit, around 11 billion Euros, revealed as structural shortcomings the lack of coordination, the lack of actors' responsibility, and a strong institutional rigidity. The new orientations tend to find a solution to these "not-workings" and set up a new model of governance.

The main options of the 2004 reform are based on the coordination between the different actors, the State, the sickness funds, the practitioners, and the patients. New governance concepts had been introduced.

4.3.1 A regulation model which introduced new concepts of governance[11]

Strategic sharing between the State and Healthcare Insurance

The National Union of public Sickness Funds (UNCAM) gathering the most important sickness funds constitutes a new instance responsible of the health insurance policy. Its aims consist on coordinating the management of the system between healthcare insurance funds on the one hand, and healthcare professionals and patients on the other hand. The UNCAM decides about norms of the health management: tariffs, copayment rates, aims of healthcare regulation. So, healthcare insurance was getting a strategic role in the purpose of expenditures orientation. In fact it negotiates with the professionals agreements about healthcare management, their permanence, and about the evolution of medical demography. In 2006 an agreement was signed by the State and the healthcare insurance stipulating that UNCAM has to guarantee, on a scientific and clear basis, the improvement of the less efficient benefits and to favour a price consistent management.

The State keeps its traditional missions, that is to say, the determination of aims and the guarantee of health insurance principles for anybody. The

State keeps the possibility to intervene in any difficult case. It intervenes also to reduce or to remove the patient's copayment. It can also intervene against UNCAM decisions for public health purposes.

Otherwise, the new regulation has been oriented since 2004 towards a more important responsibility for the actors. The control procedures have become stricter. The orientations aim to create a more important integration of the actors. The new orientations need new management tools: result indicators, quality indicators, and healthcare access indicators.

4.3.2 A new model for new actors[12]

New actors in UNCAM's policy

From now on, two organisms are associated to UNCAM's policy but only for advice: the National Union of Complementary Healthcare Insurance (UNOCAM) and the National Union of Healthcare Professions (UNPS).

These new organisms are therefore integrated in the new governance arrangements. The National Union of Healthcare Professions participates with UNCAM in the meetings about the coordination of healthcare, the patient aftercare and also about the geographical healthcare sharing. They have to participate in the public health policy aims. They have to give their positions concerning the aid for the professional establishment. UNOCAM has to give advice about reforms of the copayment.

The expertise actors

The creation of the High Healthcare Authority (HAS) by the 2004 reform institutes the expertise function and corresponds to the continuation of the trend initiated at the beginning of the 1990s. This function must be independent from the decision function, from the political considerations. The High Health Authority is an independent public agency. Its Chairman is appointed by the President of the Republic. Its missions are very wide: certification of the hospitals, improvement of the medical information quality and of its diffusion, assessment of medical acts, technologies and health strategies. The High Health Authority inputs and completes the expertise policy initiated by the creation of agencies focused on specialized themes: French Agency Safety of Health Products (AFFSAPS), National Institute of Health Surveillance (INVS) and National Institute of Cancer (INCA).

4.3.3 New mechanisms for inserting the actors in the system

The innovation of the 2004 reform consists of the insertion of the actors in the governance of the system. So it is distanced qualitatively from the previous reforms. It introduces and promotes actors responsibility and relations between actors. The French healthcare system had been characterized for a long time by atomized relations between doctors and patients. The behaviour freedom of these two actors for choosing and consulting a doctor in private care and for prescribing, and the lack of control from the health insurance, had led to an inadequate and ineffective management. For these reasons the French healthcare system had been considered as the most liberal, but also the most expensive, and the most generous in terms of waste.

Henceforth specific disposals concerning the relationship between patients, healthcare professionals and health insurance will allow optimal communication, real healthcare coordination, and optimal rationalization of the patient itinerary. A mechanism of gate-keeper has been created. Every insured person has to choose a referent doctor who has to organize the guidance of his patients through the healthcare system. Prior to any consultation of a specialist the patient has to go to his referent doctor. The copayment is increased in case of non respect of this disposal. The preliminary consultation is not compulsory for gynaecologist, ophthalmologist and psychiatrist consultations.

The patient has to pay a set price for each consultation (1 Euro) and for each surgical intervention (18 Euros) whose price is over 91 Euros. The adhesion to a complementary insurance is compulsory. Precarious people may get a tax reduction when they take this insurance. This arrangement allows the complementary insurance companies to insert themselves in the institutional financial healthcare system.

Generally, it must be considered that it is difficult to set up all these measures suited to the French context. In fact this system has never been characterized so far by a responsible relationship between the actors.

4.4 The reform of hospital financing

The hospital reform, implemented in 2004, had begun by setting up a new financing of the hospitals and a new management. Two kinds of problems had been reformed: the disconnection between the global budget and the activities and the coexistence of different methods of financing (between the public sector and the private sector). As a matter of fact the public hospitals and the non profit private hospitals which participate in the public services were financed by global budgets and the for profit private hospitals by fees for services and packages. The result of all this was a complex management and a difficult regulation. The annual allocation of the

global budgets tended to generate individual incomes for the less performing hospitals and underinvestment in the best ones. In private hospitals the levels of the care packages were very different for the same service.

The reform had been generalized in 2007. From now on all the hospitals in France are financed by DRG for the medicine, surgery and obstetric services and also for dialysis and home hospitalisation. Local hospitals, post cure services and psychiatry are still financed by global budget and care packages. Some services like intensive care, palliative care, very expensive drugs, emergency services and organ removals are associated with the DRG tarification.[13]

DRG tarification consist of a prospective payment. It is inspired by the US system adopted by Germany, the United Kingdom, Sweden, Italy, Spain and Australia. According to this system, the price is fixed without reference to the production costs. The producer has to adjust his production costs to the prices. The hospital management is based on productivity research. This way of proceeding can lead to a specialisation according the hospitals specificities and to a global rationalisation of the healthcare supply. Hospitals get the warranty of a financing suited to their activities.

However the system may generate perverse consequences: over-assessed care, restrained care for getting a better productivity, and adverse selection of patients according their healthcare needs. On the other hand, this system involves an inflationary risk. It is necessary to assess the healthcare activities according their quality and their pertinence.

4.5 The new trend of the 2009 reform: integration of all the actors in an operational regional instance: Health Regional Agency

The recent reform, adopted in July 2009, will be set up in 2010. Its main objectives are modernizing, simplifying and clarifying the healthcare supply, the relationship between actors and its governance. The reform law consists more of a reorganization of the healthcare supply than a financing arrangement.

Modernizing, simplifying

The hospitals enjoy the benefit of a wide freedom for their internal management. Hospital communities and collaboration between hospitals will be encouraged. The governance of public hospitals will be provided by the Surveillance Council under the responsibility of the Director. Controls and vigilance regarding the financial situation are assured by the Regional Health Agency. A Medical Committee has to establish the quality improvement policy. Results will be at people's disposal. The National Agency for hospitals performance (ANAP) will have to propose support to improve the quality of healthcare. It will be able to organize management audits. The regional plans for the healthcare organizations (SROS) will include ambulatory care and will encourage the coordination with hospitals.

Henceforth the general practitioner is considered as the central professional. His mission of public service is reinforced by the obligation of care permanence and health watch. Delegation of services is expected between medical and paramedical professionals. Assessment of practices and financial rationality is, henceforth, compulsory.

Public health missions are reinforced and inserted in all interventions: healthcare access equality and emergency permanence. The reform puts the accent on chronic disease and cancer prevention (on the risk factors) and on patient therapeutic education, which is now considered as a national priority.

Regional governance

The reform institutes a new instance which will bring a huge change in the French healthcare system: the Regional Health Agency. The change has to have an important impact on the relationship between regional actors and on the regional governance, but also on national governance. The main aims are favouring healthcare proximity and improving a global and non-compartmentalized approach. The Regional Health Agency will create, finance (by financial delegation), organize, and manage the regional supply (ambulatory and hospital care, and also prevention programmes). A single representative at regional level for the national instances (Ministry of Health, Ministry of Social Affairs, and Ministry of Economic Affairs) will be created.

The regional authorities will be responsible for driving the regional healthcare policy. All services (ambulatory, hospital, healthcare, prevention programmes) are concerned. They have to provide the answer to the regional healthcare needs. They will have also to determine the orientation of the health supply. They will authorize the creation of hospitals and health services. They coordinate the hospital supply by reorganizing the medical services or medical equipments. They control the functioning of the services and the quality of care furnished by all the medical professionals.

New management tools will be created to fulfil these missions: regional organization schemes for ambulatory care (close to the regional organization schemes for hospital care already in operation), multiannual target contracts. So, the Regional Health Agency substitutes for the Regional Hospital Agency (ARH), the Regional Directorate for Health

and Social Affairs (DRASS), the Departmental Directorate for Health and Social Affairs (DDASS), the Regional Union of Healthcare Insurance (URCAM), and the Regional Office of Healthcare (CRAM). The Regional Health Agency gets financial autonomy (although within the scope of the budget attributed at the national level). Interregional agencies may be created. A national steering committee, chaired by the Ministry in charge of health affairs, ageing, disabled and social security affairs has to organize the coordination between the regional health agencies at the national level.

5. Discussion

The conception of regulation induced by Juppe's reform was an institutional regulation. The distinction between the decision level and the management level is not entirely clear. In fact, the regional management is very tied to the central administrative level which determines national aims. The regional funds come from the global financial envelope determined by the Parliament. Regional authorities can allocate their hospitalization budget among their establishments according to the situations and performance, but they are very constrained. They don't have real decision power.

The reform adopted in 1996 aimed to make the institutions aware of their responsibilities. The Hospital Regional Authorities have to organize the hospital supply by developing regional organization schemes (SROS), restructuring hospital supply, setting up care delivery maps, and defining objectives and resources agreements. They define also cooperation formulas between different kinds of establishments even between public and private establishments. The aims consist of developing a better transparency, creating "proximity management" which would be able to assess needs and the adequacy of supply and to improve the quality of the medical services. However, most hospitals still have no care delivery plan!

The Regional Authorities of National Health Insurance (URCAM) operate only on the supply of private medical care and its adequacy to meet the needs. Practitioners develop their activities on the basis of fee schedules decided at national level between the main public insurers and the medical trade unions representatives. There is no financial incentive to improve their activities.

The management model implemented by the 2004 reform is in some ways radically different from Juppe's reform. However, it may generate some competency overlaps between the State and health insurance. For example, the health insurance gets a competency transfer to determine the copayment rate for the drug purchase. This decision can be taken only after the determination of the medical service by the High Health Authority and after the determination of price by the Economic Committee of Health Products. These two last decisions are taken in the framework of the health public policy managed by State organisms. At last the minister in charge of health policy keeps a specific competency to delete any copayment if the drug is considered as especially expensive and irreplaceable.

The 2009 reform could be considered as a continuation of the reform implemented in 2004. In 1996, the government already thought of increasing the role of the region in the management of healthcare. But until 2009 the model was functioning according the dichotomic management characterized by hospital care in majority supervised by the State and ambulatory care managed by health insurance. The new frame of governance appears more rational. Also the institutional tools have been lightened. Nevertheless, the French Healthcare system maintains its inherent anchoring to the national level and to an institutional management. The regionalization is less operational than in other European countries.

What the relationship between regional actors and national supervision will be is still to be determined. How will the regional agency be able to negotiate its financial envelope with the ministries in charge of health and social affairs? How will the inequalities in healthcare access be resolved, and on what basis?

What general assessment can we express concerning the French healthcare system? And now what can we say about its performance?

Is "the most" also "the best"? As is noted by many experts, the French healthcare system is a good one but it is expensive. About 11% of GDP is allocated to health. But does this financial effort correspond to medical benefits? At the macro-economic level, the French healthcare system is one of the most expensive compared with other EU countries, and our performance is not always the best. According to international surveys from the OECD roughly 66% of the population report being fairly satisfied with the system, compared with 40% in the United Kingdom and just 20% in Italy.[14]

75% of total health spending is publicly funded, 10% is financed by complementary insurance (mostly mutual insurers), and the remaining portion is paid directly by patients. In 2000, the government introduced universal health insurance (CMU), paid by public health insurance, providing basic coverage to all residents, regardless of their employment status. In addition, it offers free

supplementary coverage to people who earn less than 570 Euros per month. On the other hand, the State pays for people who are ineligible for CMU or poorly insured, including persons in unstable employment situations or foreigners waiting for official residency papers.

Some medical results are good. For example: female life expectancy at birth is the second highest in the world (after Japan), treatment for cardiovascular diseases, and a reduction of infant mortality (just above the very low levels in Scandinavian countries). Some public health programs have worked very well, such as prevention programs for breast cancer and colorectal cancer. However, male life expectancy is ranked 11th in the world. In addition to that, the level of premature death (before 65) is high. This high level reflects the effects of risky behaviours and a lack of public health education programs. The French health system is more focused on curative care than on prevention programs.

In other respects the social and geographic inequalities continue. During the past decade, the decrease in mortality rates, for most causes, has been more pronounced for the upper than the lower social categories.

The Eurohealth Consumer Index 2009 checks six topics to assess the performance of some European health systems: (a) patient rights and information, (b) e-health, (c) waiting times for treatment, (d) outcomes, (e) range and reach of services provided, and (f) pharmaceuticals. Each topic presents many indicators[15]. In its 2009 version the assessments for France are the following:

The appreciation is good for the references to patients' rights, to the right to second opinion and to the register of legitimate doctors, although the difficulty to get access to information is noted. The appreciation is restrained concerning the involvement of patient organisations in decision making, access to personal medical records, and no-fault malpractice insurance. The worst results concern web-based information and the ability to access cross border care financed from home. Waiting time for treatment is moderately evaluated for family doctor day access, for direct access to specialists, and for major non acute operations (under 90 days) but good for cancer therapy (under 21 days) and bad for CT scans (under 7 days).

Concerning the outcomes assessment, the results are good for myocardial infarction, case fatality, infant deaths, cancer five-year survival and the decline of suicide cases, moderate for the decline of years of life lost, hospital discharges for respiratory system diseases, and rate of patients with high HbA1c levels (above 7), and bad for MRSA infections. Among the provided services (range and reach of services provided), moderate results are registered for equity of healthcare system evaluated by the percentage of public expenditures, the cataract operations per 100,000 persons aged over 65, the four-year old infant disease vaccination, the rate of mammography, and the informal payments to doctors ("would patients be expected to make unofficial payments?"). The rate of kidney transfers per million persons is estimated as good. On the contrary the dental care, included in the public healthcare offering, is very bad.

Concerning pharmaceutical supply and access, the percentage of total sales paid by public subsidy is estimated as good. The layman-adopted pharmacopeia and the new cancer drugs deployment speed are estimated as poor. The access time to new drugs is very long.

The French health system has to face some important health problems (ageing population and increased longevity, reducing premature death, reducing inequality in health).

6. To conclude

The French health system is relatively effective when comparing its medical result to other systems of developed countries, but its costs are very high and its managerial performance is doubtful.

The permanence of its deficit and its increase during the 2000s asks questions of the sustainability of its model of regulation. For many years, this regulation was developed based on very conventional standards within the traditional public policy: pressure on wages and prices of goods and services supported, policies of global funding of certain activities without evaluations, withdrawal of public funding from the social coverage.

The result was an inadequate balance between health policy and the means used - an inadequate balance exacerbated by ups and downs of economic growth over the past forty years, and also pronounced by medical advances that have occurred since the 1980s.

France has probably stayed with a centralized model of governance not conducive to the inclusion of these two conflicting realities: limited available resources and propensity of healthcare demand to grow.

Countries having opted for a Bismarckian model structured around sickness funds have increasingly felt these effects of a "machine to make the public deficit".

It soon became clear to some observers that the economic dimension of the healthcare system implies the insertion health policy in an evaluative perspective. France has slowly integrated this guidance from the 2000s but all the elements for a

satisfactory assessment are not yet in place.

While the instruments of expertise and evaluation exist, the High Authority of Health is, at present, the centre of gravity of healthcare assessment but the links with the imperatives of financial regulation are yet to be created.

The health systems have to face great challenges: aging, growing precariousness, chronic diseases, inequalities in healthcare access, and quality of care. The French healthcare system spends a large proportion of wealth on health but to what extent does this funding respond to the request from these challenges? Choices have to be made to identify priorities and use resources efficiently. Recent French reforms have attempted to streamline the management system to prevent the development of the public deficit: rationalization of medical practice, the therapeutic itinerary of the patient, development of the information systems, simplifying of the governance, and development of evaluation. These guidelines are important but they come later in France and the results are even more difficult to reach. It seems that to meet the challenges mentioned above the problem of repartition should be raised.

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