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Overview of the French Healthcare System

Social Protection System

The social protection system created in 1945 was aimed primarily at workers and their families. The expansion of health insurance coverage was implemented in stages during the 1960s. The Universal Health Coverage Act (CMU) concluded this process in 1999 by establishing universal health coverage. Although run by employers and employees, the social protection system is increasingly under the control of the state in the financial and operational management of health insurance. This was reinforced by several reforms and in particular a new income tax to fund the system instead of full financing by wage contributions and a more active role given to the parliament in determining policy directions and expenditure targets.

Governance of Health Policy

The responsibility to define health policy and to regulate the healthcare system is divided between the state, the statutory health insurance funds and the sub-regional and local authorities.

Since 1996, the parliament adopts every year an act that defines a projected ceiling for health insurance spending for the following year, known as the ONDAM. The Ministry of Health then controls a large part of the regulation of healthcare expenditure. It divides the budgeted expenditure between the different sectors and for hospital care between the different regions. It approves the agreements signed between the health insurance funds and the unions representing self-employed healthcare professionals and sets the prices of specific medical procedures and drugs. The state also defines the number of medical students to be admitted to medical school each year, the planning of equipment and priority areas for national health programmes.

The Ministry of Health has services at regional, sub-regional and local levels. A process of deconcentration of the organisation and management of the French healthcare system began in the early 1990s. Regional hospital agencies were responsible from 1996 until 2010 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).

A new process of reform started following the publication of several reports on various aspects of the healthcare system during first semester of 2008. With the aim of achieving better governance of the system at the regional level and better response to needs and higher efficiency, the Regional Health Agency was formed to merge seven regional institutions from 1 April 2010. Each Regional Health Agency has the responsibility of ensuring that healthcare provision meets the needs of the population; in improving articulation between ambulatory and hospital sectors and health and social care sector services, while respecting national health expenditure objectives. In particular it gives authorisations for the creation of new health services and social and health services for the elderly and disabled. The Regional Health Agencies are subsidiaries of the state under the supervision of the ministers in charge of health, social security, the elderly and disabled. Its director, appointed by the Ministry of Health, has extended autonomy.

French Hospital System

Public/Private mix

Hospitals in France can be public, private non-profit or for-profit. But in any case patients are free to choose their hospital. They then get more or less the same social insurance coverage.

Public hospitals account for three quarters of hospital care capacity. They are legally autonomous and manage their own budget. There are 32 regional hospitals, which are in charge of more complex cases as they have a higher level of specialisation and the technical capacity. 29 of them are linked to a university and operate as teaching and research hospitals.

Non-profit hospitals are owned by religious organisations, foundations or mutual insurance associations. They represent one third of hospitals and 15 percent of inpatient beds. Most non-profit hospitals are collaborating with public service, since they carry out public. In total, they account for one third of rehabilitation capacity, but less than 10 percent of acute care beds. 20 specific non-profit private hospitals are specialised in cancer treatment.

Private for-profit hospitals account for 10 percent of full-time beds, but 20 percent of day-care beds. They tend to specialise in certain areas such as elective surgery, where they cover half of the activity. This sector invests in relatively minor surgical procedures.

Resources and Activities

Hospitals, public and private, employ more than one million people: 80 percent of them in public hospitals. 14 percent of these employees are medical staff. Part-time work is increasing and concerns for example 20 percent of non-medical staff in public hospitals.

With an average of over eight hospital beds per 1000 inhabitants, less than half of which are acute beds, France faced a rapid downward trend in the number of hospital beds between 1980 and 2000, linked to a reduction in the average length of stay. However, there are important inequalities in bed numbers between areas.

During the same period, the number of people admitted to hospitals continued to increase. A number of policies have been implemented to encourage methods of providing care that are alternatives to in-patient care, such as day care surgery or home care. The private for-profit sector is particularly active in this field.

Since the 1960s, mental health policy in France has been based on a continuous movement towards de-institutionalisation. A key process in this movement has been to divide the country into geographical zones or areas 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. Each psychiatric zone is linked to a hospital (either a public hospital or a private hospital participating in the public hospital service).

Quality of care has become a significant concern since the 1990s. Since 1996, all hospitals have been following a certification process, originally called accreditation. This procedure, carried out by a specific agency, the Haute Autorité de Santé, is an external evaluation of procedures. The hospital is evaluated on several dimensions: Quality of care, information given to the patient, medical records, general management (human resources, information systems, and logistics), risk prevention strategies, etc.

Reforms

A reform plan, known as 'Hôpital 2007', had set major changes in the late 1990s with the objective of improving overall efficiency and management within the hospital sector. The first element was the modernisation of healthcare facilities by boosting investment in buildings and equipment. Total investment in hospitals doubled between 2003 and 2006. It was followed by a similar programme called 'Hôpital 2012' with targets on security, working conditions, information system and mergers.

The second measure was the introduction of an activity-based payment system both for public and private hospitals. Previously, resources were allocated to public and private hospitals by two different methods. The public and most private non-profit hospitals had budgets allocated by the regional hospital agencies based on historical costs. Private for-profit hospitals had a billing system with different components: Daily tariffs and a separate payment based on diagnostic and treatment procedures. In addition, doctors working in for-profit private hospitals were (and still are) paid on a feefor service basis unlike those working in public and non- profit hospitals, who are salaried.

Now, with the exception of long-term care and psychiatry, all hospitals are funded on the basis of "rates per activity", or homogeneous hospital stay groups. The Programme of Medicalisation of Information Systems is used as a basis to calculate hospital reimbursement. Every patient stay is classified in one of the 2,200 homogeneous patient groups and an associated homogeneous hospital stay groups. Currently, the funding models for public and private hospitals remain different and the tariffs are calculated differently. However, from 2018, the objective is to harmonise the payment method and tariffs of both sectors.

The third element has been to give public hospitals flexibility to deal with this new financial environment. The goal was to simplify the management of public hospitals and to integrate medical staff in managerial decisions. Hospitals now have the opportunity to create large clinical departments in order to organise their medical activities in a more efficient way. Resource allocation and most of the management rules concerning recruitment, investment strategy and the use of new interventions are still constrained.

In 2009, a new law 'Hôpital, Patient, Santé et Territoire' was adopted. Its aim was to reorganise the healthcare supply with the creation of the already mentioned Regional Health Agency but also with new mechanisms of cooperation between providers. It also changed the internal governance of public hospitals giving more power to the Chief Executive. At the same time it enlarged the capacity of the private for profit sector to deliver public service missions.

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