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The French Healthcare and Hospital System

Social Protection System

The social protection system created in 1945 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.

Today, three main health insurance schemes are dominant: the general scheme for employees and their families (84% of the population) and for CMU beneficiaries (1.6% of the population); the agricultural scheme for farmers and agricultural employees and their families (7.2% of the population); the scheme for non-agricultural self-employed people (5% of the population).

Although run by employers and employees, the social protection system always faced a strong influence of the State in the financial and operational management of health insurance.

This was reinforced by two aspects of the 1996 reform: a new income tax to fund the system instead of full financing by wage contributions; a more active role for parliament in determining policy directions and expenditure targets.

Health Policy Management

The responsibility to define the health policy and to regulate the healthcare system is divided between the State, the statutory health insurance funds and the local communities.

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 health - care 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 (numerus clausus), the planning of equipment and priority areas for national health programmes.

The Ministry of Health has services at local level: directorates of health and social affairs in the regions and departments. A pro - cess of deconcentration of the organisation and management of the French healthcare system began in the early 1990s. Regional hospital agencies are responsible since 1996 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). The directors of those agencies are appointed by the Council of Ministers and are directly responsible to the Minister of Health.

Until 2003, hospital planning involved a combination of two tools: the healthcare mapping as a quantitative tool and the regional strategic health plan as a more qualitative tool. The healthcare mapping divided each region into healthcare sectors and psychiatric sectors. In 2003, the government decided to integrate all planning tools into the regional strategic health plan. It sets out the goals for the development of regional provision over a five-year period in areas corresponding to national or regional boundaries.

Trends and Reforms

The health system faces numerous challenges, many of which are common to other European coun - tries. Health expenditures continue to increase more than re sour ces, leading to budget deficits. The number of doctors will signifi - cantly decrease in the near future, coupled with the persistent unequal distribution in existing medical professionals across the country. The excessively high rates of mortality in the population under 65 show an urgent need to develop preventive actions within a coherent public health framework.

To tackle these challenges and to improve health system organisation and management, several major reforms have been introduced since 2004. They aim to change the behaviour of the stakeholders, focusing on the renewal of the organisation and management of the health system and on financial measures and incentives. The 2004 Public Health Policy and Health In surance Reform Acts insist on the role of the state and parliament

in priority setting in the health sector. They give more power to local and/or dedicated structures for implementation.

The ‘new hospital governance’ gives more flexibility and relative internal organisational freedom to public hospitals, despite relatively strict controls on hospital management. At a higher level, a strategic plan for health workforce development promotes group practice and also experiments with the transfer of tasks away from doctors to paramedical staff. The reforms also focussed on health information systems with the creation of a comprehensive electronic patient record, coupled with the referring doctor system in primary care.The implementationof a French-type non mandatory gatekeeping system is also built on a system of financial in - centives mainly directed towards patients. Healthcare “franchises”, a new out-of-pocket payment, have been put in place in 2007 and 2008 on medical consultation, medicines, non-medical care and transports Pharmaceutical regulations also include financial incentives for pharmacists to substitute generic products for original medications when these are prescribed by doctors, as well as charging levies on the pharmaceutical industry related to advertising, sales promotion expenditures and turnover.

A new process of reform should start following the publication in the first semester 2008 of several reports on various aspects of the healthcare system (see na tional news p. 10).

The French Hospital System

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

Public hospitals account for a third of the 2,890 hospitals (1,599 of which acute care hospitals) but for two thirds of inpatient beds. They are legally autonomous and manage their own budget. There are four levels of public hospitals: local, general, regional and specialised. Local hospitals are providing health and social care at community level. Most of their doctors are self-employed private practitioners. General hospitals provide a range of acute care services (medicine, surgery, and obstetrics), rehabilitation, longterm care and in some cases psychiatric care. 32 regional hospitals, with a higher level of specia lisation and technical capacity are in charge of more complex cases. 29 of them are linked to a university and operate as teaching and research hospitals. In addition, there are 93 psychiatric hospitals. Non-profit hospitals are owned by religious organisations, foundations or mutual insurance associations.

They represent one third of hospitals and 15% of inpatient beds. Most non-profit hospitals are “collaborating to public service” (PSH), since they carry out public activities such as emergen cy care, teaching and social program mes for deprived populations.

The range of services provided by non-profit hospitals varies. In to tal, they account for one third of rehabilitation capacities, but less than 10% of acute care beds. 20 specific non-profit private hospitals are specialised in cancer treatment.

Private for-profit hospitals account for 40% of all hospitals in France but 20% of all inpatient beds. They tend to specialise in cer tain areas such as elective surge ry, where they cover 2/3 of the acti vi ty. This sector invested in relatively minor surgical procedu res, carrying out three quarters of cataract surgical procedures for example, but more than 60% of admissions for digestive system disorders.

Resources and Activities

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

With an average of 8.4 hospital beds (including long-term care) per 1,000 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. The number of acute beds in the departments varies from 2.5 to 6 beds per 1,000 in - habitants, excluding Paris, which has more than 9.

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 mandatory procedure, carried out by a specific agen cy, 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 on buildings and equipments. Total investment in hospitals has doubled between 2003 and 2006. In parallel, the organisational structure and planning of healthcare facilities have been simplified, and the health mapping, that controlled the number of beds and medical equipment authorised for each hospital was stop ped. Regulatory powers have be en shifted from the central level to the regio nal hospital agencies.

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 hospital had budgets allocated by the regional hospital agencies based on historical costs, with limited incentive for efficiency. 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 fee-for service basis unlike those working in public and non-profit hospitals, who are salaried.

A new activity-based payment system has been implemented step by step for public and private non-profit hospitals from January 2004. A payment is made for each patient treated in acute care based on the Groupes Homogènes de Séjour (an equivalent of diagnosis-related groups) prices for the public sector. The activitybased element of the payment was supposed to increase gradually each year: 10% in 2004, 25% in 2005 and 35% in 2006.

Private for-profit hospitals have been paid entirely using the new case-mix based system since 1 March 2005. However, a transition period was allowed where 'national prices' have been adjusted, first taking into account the prices for the private sector, and second using a transition coefficient for each provider based on its own historical costs. The objective was to harmonise the prices for all pro viders (public and private) by 2012.

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.

Although public hospitals have obtained some freedom over their internal organisation, their autonomy is still strictly limited in other ways. The boards and executives of hospitals are still under the control of the Ministry of Health and the ARHs (Agences régio - nales de l'Hospitalisation). Resource allocation and most of the management rules concerning recruitment, investment strategy and the use of new interventions are still constrained.

More recently, several committees and working groups have been involved in designing a new set of reforms on the healthcare system organisation, on the creation of Health (instead of Hospital) Regional Agencies, on health inequalities and on hospitals. The issues range from geographic repartition of doctors, the demography of specialist practitioners to out-of-hours coverage.

More precisely, the main items for hospitals are: the planning of operating theatres and maternities; the new management mechanisms for public hospitals and the extension of the implementation of DRGs that already started with a case mix-based financing representing 100 % of medicine, surgery and obstetrics activities from 1 January 2008.

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