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The French Healthcare System

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Many significant aspects of the French healthcare system have changed over the last few years, and will continue to impact the future of healthcare provision in France, as it adapts to the complexity of modern medicine

Access to Care is Changing

Since its inception in 1945, the public health insurance programme (social security system) has provided cover to all legal residents of France, but even now, a small part of the population has no access.

Originally this programme was based on professional activity ('Bismarck' model). Despite groups such as the selfemployed and agricultural workers who have their own funds, the main fund covers 80% of the population. Funds are financed partly by employer and employee contributions but in another ever-increasing part by personal income taxes ('Beveridge' model). On the basis of this funding, uniform rates of reimbursement are available for all citizens.

Most health insurance entities are private, jointly managed by both employer and employee federations, under the State's supervision. This joint management is subject to discord as the total amount of public money is annually decided by the Parliament, the rate of reimbursement and contributions for the funds being decided by the Cabinet, and tariffs to ensure operating systems are negotiated between funds and healthcare professions.

75% of total health expenditure is covered by the public health insurance system, and the remaining amount is covered both by patients themselves and supplementary private health insurance companies. As a wide range of goods and services are covered by these funds, co-payments were increasingly implemented to limit consumption and expenditures, and are now relatively high for many out-patient services. For example, 30% of the cost for a physician's visits are charged to patients, and 40% of specialists are allowed to charge more than the going rate.

In January 2000, a public supplementary insurance programme ("CMU") was implemented to ensure poor citizens (meaning 10% of the population) have access to healthcare since few have supplementary insurance. Theoretically access to care is free of charge for them as all public co-payments are covered by this insurance, and as health professionals are not allowed to charge more than the going rate.

However, discussions are underway on how to have a more efficient and equitable healthcare service by defining a set of goods and services available for all and 100% publicly financed. The remaining goods and services would be available for those who opt to pay for them, whether or not they rely on private insurance.

Until January 2006, access to care was unlimited in France and patients could see as many physicians as they wished. This may explain France's high rank in WHO's rating, without taking in account its efficiency. This year a kind of gate-keeping system has been initiated in France as patients had to designate their own individual GP, and must now be referred by this GP in order to be fully reimbursed by specialists.

The State's Role is Evolving

Since 1991, healthcare planning has been discussed at regional level, and policy-making continues to be discussed through the SROS plans (regional plans of healthcare organisations). In February 2006, the third level of this plan

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("SROS 3") was delivered for the next 5 years. One of the changes it brings affects radiology equipment, specifying that, for example, in the Greater Paris area (Ile de France) the number of CT machines will increase from 171 to 201 and MRI machines from 114 to 146.

Changes in Care Supply

Hospitals

In France, the core of the healthcare system are hospitals, and care is directed more to very specialised and technical curative aspects, and less to preventive and community services. There are two main categories of hospitals: pubic and private for-profit; as well as some private not-for-profit hospitals. 65% of the total number of beds are in the public part, and most of these hospitals are obliged to ensure continuity of care, teaching and training. University medical centres are more concerned by these obligations and in delivering more complex forms of care. Private for-profit hospitals are funded on fee-for-service remuneration and are more involved in technical procedures such as surgery, which are financially easier to manage.

A general tendency to a decrease in the number of beds has been observed during the last years (8.4 / 1000 inhabitants) and all public and private establishments are progressively monitored on the same payment systems ("T2A"). This is a sort of activity-based cost system introduced in 2005, in order to progressively replace the two different modes of funding that existed before (a public one and a private one).

Health professionals

Physicians play a key role in the healthcare system, and in France approximately 200,000 of them are licensed to practice. But as the number of medical students is limited by the Ministry of Health, retirement of currently active doctors will result in a decrease in the number of physicians in the coming years. Half of these are general practitioners and half are specialists, of which 7,000 are radiologists. Physicians and other professionals work in public establishments (2/3 in hospitals and 1/3 in others) or in private practice. Approximately 40% of them are public employees and paid by the government, while the other 60% work in private practice and are paid on a fee-for-service basis, with prices negotiated by physician's unions and public health insurance funds.

Since 1971, every five years a contract ("convention") is supposed to be signed by physicians' unions to set regulatory frameworks and remuneration. In 1980 and 1990 changes in the ability to charge other than the regular rates were recognised and in 1993, official medical practice guidelines ("RMO") were implemented. Since 1998 negotiations between doctors' unions and the funds failed and mean that only the union of GPs and not specialists sign the convention. Private practitioners are strongly opposed to any control on outpatient expenditures, as it effects how they practice and prescribe, despite that the main part of their income is paid by public funds.

Many problems remain regarding areas such as the following:

'inequality remains among the regions, as there are twice as many specialists in the south of France or in the greater Paris area, than in the north of France

'a great lack of coordination and cooperation exists between the various healthcare actors due to competition between private and public sectors, between out-patient facilities and hospitals, and also between some healthcare professionals themselves.

Recently, incentives have been created to spur the development of managed-care networks ("DNDR"), to build these "missing links", but economical equilibrium has to be found in order to facilitate the process. An Electronic Health Record ("DMP") system is planned to start in 2007, to network and integrate information technology, and would greatly aid modernisation.

Financial Management

As deficits in the healthcare system have been accumulating for the last 30 years, many measures have been progressively introduced to limit health expenditure by regulating the quantity of available care: limiting the number of physicians and number of hospital beds, negotiating prices for ambulatory procedures and regulating prescription drug prices, etc. Since 1990, yearly expenditure caps have been set for some sectors, and prices vary depending on whether or not objectives have been met.

Since 1996, Parliament has determined the national health insurance system's annual budget, and then the amount is distributed to the various sectors (e.g., public, private, ambulatory). Public hospital funds are allocated to the regions to better distribute available care to the needs of the population. Once caps are set, the health insurance funds (private sector) or the government (public sector) are responsible to enforce them, but ineffective financial regulation is worsening the relationship between healthcare providers and authorities.

Future Challenges

Progressively the Bismarckian model of funding is tending to be replaced by a Beveridgian one, and social funding is moving to become less an arbitration between contribution and tax, and more a combination of different taxes (e.g., income tax, corporation tax, VAT, social contributions, etc.). Arbitration in the repartition of these taxes would then become likely and probably animate future political debates in France as in other EU countries.

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