



Healthcare Systems: France

Based on the 2001 Civitas Report by David Green and Benedict Irvine

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Overview

Health care in France is characterised by a national programme of social health insurance (NHI), managed almost entirely by the state and publicly financed through employee and employer payroll contributions and earmarked taxes. For the majority of patients, medical goods and services are not free at the point of use. However, universal access is guaranteed by schemes for those on low incomes and/or chronic conditions. Although NHI covers a reasonable proportion of a patient's health care costs, it does not cover them all. For this reason, the compulsory government scheme is accompanied by a prominent voluntary private health insurance (VHI) sector, which covers most out-of-pocket payments and areas that are under-insured by NHI.¹ Approximately 90 per cent of the population are enrolled in a private plan² – a number that has grown steadily over the years – and for this reason the VHI sector is increasingly making up for shortages in NHI funding through taxes on its growing income. This is in exchange for greater involvement in the management of health care provision.³ Although the management and financing of health care comes from predominantly public sources, the provision of health care is more mixed: providers of outpatient care are largely private, whilst the majority (approximately three-quarters) of hospital beds are provided by public or not-for-profit hospitals.⁴

Faced with increasing health care costs, the government has introduced a number of reforms in the past two decades that have tried to control NHI expense and improve efficiency and quality, whilst also decreasing health disparities between regions and socio-economic groups. Although there are many areas still in need of improvement, it is worth exploring the French health care system for the innovations they have made in using the private health insurance market to supplement public funding of health care and the principles of cost-consciousness that they encourage through user-fees.

Jurisdiction:

Since the 1996 Juppé reforms, the French parliament has had ultimate responsibility for setting the objectives and the annual budget for the social security scheme.⁵ This means that the French government takes prime responsibility for the health and social protection of all its citizens and regulates the healthcare system closely. Specifically, the state underwrites the training of health personnel; defines working conditions; regulates the quality of health service organisations; monitors safety; regulates the volume of health services' supplies and oversees social protection. It manages and intervenes in the methods of financing by setting tariffs and taxes and by regulating relations with health service providers.⁶

Specific roles:

- The *Ministry of Health* is the principal government department responsible for health policy. It oversees the management of resources and regulates health care expenditure, based on the framework set down by parliament and with the input of the Ministry of the Budget. The Ministry of Health is ultimately responsible for setting the prices of specific medical procedures and drugs on the basis of proposals from ad hoc committees.⁷

- In 2007 the *High Council of Public Health* (HCSP) was formally established, having been entered into law under the 2004 Public Health Act.⁸ This body replaced the High Committee of Public Health and the work it did within the Ministry of Health. It is composed of independent experts in the field of public health and produces a number of reports based on the population's health status. These are then used to analyse major public health problems and issues relating to the organisation of health care, from which public health objectives can be defined.
- The *High Council for the Future of Health Insurance* (HCAAM) was influential in creating the 2004 reforms and continues to work on suggesting improvements in health care, particularly in the areas of equity and finance. Its members are chosen by the Ministry of Health from high-profile professionals.⁹
- The *National Health Conference* was created as a permanent body by the 2004 Public Health Act and brings together representatives of health professions, health care facilities, regional health conferences and a number of additional experts to discuss and define health care priorities at the national level.¹⁰ Strategy is mainly implemented through regional strategic health plans (PRS).
- The *National Health Authority* (HAS) was set up in 2004 in order to bring together under one roof a number of activities designed to improve the quality of patient care and to guarantee equity within the health care system. It is not a government body but is mandated by law to undertake work that ranges from the assessment of drugs, medical devices and procedures to publication of guidelines and accreditation of health care organizations and certification of doctors. It liaises closely with government health agencies, NHI, research organizations, unions of health care professionals and patients' representatives.¹¹
- The inter-ministerial *Economic Committee for Medical Products* (CEPS) sets prices for drugs and medical appliances and monitors trends in drug-spending. It also concludes long-term agreements with pharmaceutical firms designed to control growth in expenditure.¹²

Although the central government is prominent in the management of health care, there have been attempts to increase regional devolution through the creation of regional institutions designed to represent main stakeholders such as the NHI schemes, health professionals and public health actors.¹³ Under the *2009 Hospital, Patients, Health and Territories Act* (HPST Act) a number of these regional institutions were merged in the name of efficiency, into Regional Health Agencies (ARS), of which there are several in the country.¹⁴ These bodies are tasked with improving the coordination of ambulatory and hospital sectors, respecting national health expenditure objectives and meeting the needs of the population with regards to health care provision. They are provided with information on the regional health needs of the population by the Regional Conference on Health and Autonomy which replaces the *Conférences Régionales de Santé* (CRS).¹⁵

National Health Insurance: Sécurité Sociale

Anyone resident in France for more than three months must register at their local CPAM (see below) for national health insurance coverage. Having done this, an individual is issued with a 'carte vitale,' similar to a credit card that indicates national insurance rights in electronic form. The carte vitale is not a means of payment, but it does enable the government to credit patients with the correct level of reimbursement immediately (see below) and removes the need for the large amounts of form filling required under the old

carte d'assurance sociale system.¹⁶ The *carte vitale* also enables a rapid exchange of information between health professionals and the CPAM. The French like their privacy and were concerned about the confidentiality of the personal information stored on the card. However, security is ensured by the need for a second doctors' card—the *Carte Professionnel de Santé* (CPS), which identifies the doctor and must be entered into a machine along with the patient's *carte vitale* in order to access patient records.¹⁷ The information subsequently transmitted can only be read by the CPAM and all personal details are guarded by the *Commission Nationale de l'Information et des Libertés*.

Organisation

The NHI system is administered in schemes according to occupation. The general scheme, dominated by the *Caisse Nationale d'Assurance Maladie des Travailleurs Salariés* (CNAMTS: the public fund for salaried employees), covers approximately 87 per cent of the population, including CMU beneficiaries (see below).¹⁸ The CNAMTS operates through a system of 16 regional and 105 local funds, each with a management board composed of an equal number of representatives of employers and trade unions.¹⁹

Other basic funds cover specific occupational groups: for example, the agricultural scheme (Mutualité sociale agricole, MSA) covers around 6 per cent of the population, comprising farmers, agricultural employees and their families.²⁰ There is also a large and recently improved scheme for the self-employed (Régime social des indépendents, RSI) which now provides the same benefits as the CNAMTS.²¹ The three main schemes (CNAMTS, MSA and RSI) were federated by the 2004 reform act into a National Union of Health Insurance Funds that also has structures at regional level. This new federation has become the sole representative of the insured in negotiations with health care providers.²²

CPAMs, also known as the *sécu* of the CNAMTS, are responsible for the reimbursement of claims and benefits. They also manage preventive services and general sanitary and social care in their area.²³ The *Caisse Régionale d'Assurance Maladie* (CRAM), which now fall under their respective ARS, assume responsibility for the CPAMs in their area.²⁴

NHI Coverage

Although the French health care system is predominantly publicly financed, treatment is not free at the point of use; instead, patients will usually pay an up-front cost which is partially reimbursed by the government. The *carte vitale* system means that this reimbursement is usually immediate: a laudable innovation as it prevents patients from being greatly out-of-pocket until reimbursement is received.

The rate of NHI coverage (reimbursement) varies across goods and services but there are several reasons for which patients are exempt from coinsurance. For example, those with chronic conditions such as diabetes and AIDS are exempt from co-payments, as are pregnant women after the fifth month, handicapped children and war pensioners too.²⁵

Below are some examples of NHI reimbursement rates:²⁶

- Hospital treatment: typically 80 per cent of the cost will be reimbursed to the patient, although there is a daily charge of €18 for stays over 24 hours.
- GP visit: 50-75 per cent depending on compliance with recently introduced gatekeeping system (see below).
- Vaccinations: 65-100 per cent
- Prescriptions: 35-100 per cent depending on their medical necessity and effectiveness.
- Dentist treatment: 70 per cent
- Other expenses, including transport costs: 30 per cent.

The remaining costs not covered by NHI, known as the 'ticket modérateur', can be reimbursed if the patient is a member of a voluntary private health insurance plan. However, some recently introduced co-payments are not reimbursable by either NHI or VHI and are intended to improve patient cost-consciousness without causing great financial strain. These co-payments are limited to an annual ceiling of €50 and include: €1 per doctor visit, €0.50 per prescription drug and €18 for hospital treatment above €120. In a further attempt to control costs, NHI will reimburse a greater proportion of health care costs if a patient registers with one doctor (their 'médecin traitant'). This doctor is considered to be the first step in a coordinated care pathway and therefore the system follows a form of gatekeeping. If a patient does not declare which doctor they are registered with, they cannot follow a coordinated care pathway and are therefore liable to pay higher co-payments that cannot be covered by VHI.²⁷ This provides a strong incentive for French citizens to register with a doctor, who becomes their first port of call for health care needs that cannot be solved by the pharmacy.

Medical goods and services covered

Medical goods and services qualifying for coverage by NHI include:²⁸

- Hospital care and treatment in public or private institutions providing health care, rehabilitation or physiotherapy;
- Outpatient care provided by GPs, specialists, dentists and midwives;
- Diagnostic services and care prescribed by doctors and carried out by laboratories and paramedical professionals (nurses, physiotherapists, speech therapists, etc.);
- Pharmaceutical products, medical appliances and prostheses prescribed and included in the positive lists of products eligible for reimbursement;
- Prescribed health care-related transport.

In order to be eligible for coverage, diagnostic services, treatment, drugs and prostheses should have been provided or prescribed by a doctor, a dentist or a midwife and distributed by health care professionals or institutions registered by NHI.

Initially, NHI was supposed to focus on the coverage of curative care in the case of illness or accident. In practice, however, more and more preventive care is covered, particularly for preventive treatment provided in a doctor's practice, such as mammography, cervical smear tests and recommended immunisations. Since 2007, a fixed budget of €50 per year has also been allocated to smokers for covering smoking cessation goods.²⁹ NHI does not cover cosmetic surgery and neither does it cover treatment or drugs considered to be 'ineffective.'

Finance

NHI resources come primarily from income-based contributions from employers and employees. However, since 1998 there have been a series of attempts to widen the social security system's financial base and make it less vulnerable to wage and employment fluctuations. This has meant that employee's payroll contributions have fallen from 6.8 per cent to a mere 0.85 per cent of gross earnings, having been almost fully substituted by an earmarked tax called general social contribution (CSG).¹ The CSG rate is based on total income rather than earned income and the rate varies depending on the source of income: revenue gained from gambling, for example, will face a higher CSG rate than income earned from an individual's place of work. Together, employer contributions, employee contributions and CSG revenue accounted for 87.1 per cent of total health insurance revenue in 2010.³⁰ The rest is made up of state budget allocation and a number of 'sin taxes' on tobacco consumption and particularly polluting commercial activities, for example. The turnover of pharmaceutical companies is also taxed. In total, 85 per cent of SHI expenditure goes towards the coverage of health care costs. The remaining 15 per cent goes towards cash benefits in the form of daily allowances for maternity, sickness or occupational accident leave and disability pensions.

In 2004 a new fund was created called the National Solidarity Fund for Autonomy (CNSA)³¹ which brings together:

- NHI funds allocated to social and health services for the elderly and disabled.
- Revenue generated by the unpaid working day "solidarity day" undertaken by the French working population.

The CNSA was set up in the wake of the heat-wave crisis which hit the elderly population particularly hard. It is hoped that this dedicated fund will help to improve community care services, nursing homes and other long-term care and support services for the disabled. Local authorities, the general councils and households also participate in financing these categories of care.

Until 2000, very poor French citizens could be exempted from co-payments through 'medical assistance' programmes (*Aide Médicale Départementale*), which were managed by local authorities unless the person was homeless. This meant that coverage levels and the conditions under which the programmes applied varied according to local resources and policies. Local schemes were therefore replaced in January 2000 by the CMU Act (*Couverture Maladie Universelle*), which introduced a uniform means-tested public supplementary insurance programme.³² CMU insurance covers the co-payments for all medical goods and services (including hospital services) and will provide dental prostheses and glasses for free. Furthermore, CMU beneficiaries do not have to advance cash at the point-of-service because professionals are directly paid by the state.³³ In 2010 approximately 7 per cent of the population was eligible for CMU benefits.³⁴

¹ CSG is based on total income rather than earned income, as was previously the case.

Voluntary Health Insurance

Private voluntary health insurance financed 13.4 per cent of total expenditure on health in 2010.³⁵ Unlike in Britain, private health insurance is not used in order to benefit from shorter waiting lists, or 'elite' specialists. Instead, it is simply used by people wishing to cover the difference between NHI coverage and the overall cost of health care, or for medical goods and services that are poorly covered, or not covered at all by NHI. This ranges from dental and optical care, to private hospital rooms. VHI usually fully covers a patient's co-payments for medical tests, procedures and pharmaceuticals (unless considered to be "of low medical benefit").³⁶ However, competition between VHI companies means that premiums and coverage levels will obviously vary.

There are 3 categories of operator in the VHI market: mutual insurance companies, commercial insurance companies and provident institutions:³⁷

- **Mutual:** these form the majority of VHI firms and are non-profit. They are regulated by the mutual insurance code, which is articulated around a social doctrine: they aim to achieve solidarity and mutual aid. This implies that they avoid, as much as permitted by competition, differentiation in premiums for a given level of coverage. For this reason, they make limited use of risk rating. Some mutual companies adjust their premium according to income.
- **Commercial:** for-profit companies with no social goals.
- **Provident:** non-profit companies that specialise in group contracts for companies that have a policy of mandatory enrolment in VHI for their employees; (firms are encouraged to have such a policy by the government which offers certain fiscal rebates in exchange). In 2006, a population survey showed that 40 per cent of people privately insured are covered by a company group contract,³⁸ 85 per cent of which are sponsored by an employer who pays, on average, 60 per cent of the premium (Buchmueller, Couffinhall 2004).³⁹ The premium is usually not risk rated according to age, but about 30 per cent of contracts are priced proportionately to wages.

The population covered by a VHI contract increased from 50 per cent in 1970, to 83 per cent in 1990 and 88 per cent in 2006.⁴⁰ There are a number of possible explanations for this:

- Increasing population wealth, meaning that more and more are able to afford supplementary insurance.
- Among others, Redwood in "*Why Ration Health Care?*" observes that the public has shown a clear preference for paying supplementary insurance premiums, rather than unrecoverable fees at the point of use.⁴¹ Therefore, rather than accepting growing out-of-pocket expenditure as NHI coverage is cut, more and more Frenchmen are taking out VHI to cover the costs.

A large number of schemes recently introduced by VHI companies have been trying to attract younger, healthier enrolees, which has helped to increase VHI revenue.⁴² As a result of growing VHI revenues, the government introduced an additional tax on the revenue of VHI firms in 2008, totalling €1 billion, in order to cover shortages in NHI funding.⁴³ In

compensation, the government introduced strengthened coordination between NHI and VHI companies for management of health care coverage and financing.

VHI Reforms

Access

Many criticised the VHI market because those on lower incomes or with chronic conditions seemed to struggle to find a private insurance company that would take them on. Reforms were therefore implemented to meet these equity concerns.

- Alongside the CMU scheme, detailed above, people at the margin of CMU income ceilings are offered assistance through a voucher scheme (CMU-C) that will enable them to buy VHI. This scheme, called “aide pour une complémentaire santé” (ACS), is also financed by the CMU fund. These reforms come under the 2004 Health Insurance Reform Act⁴⁴ and were extended under the 2011 Finance Act, which raised the income ceiling, meaning that many more households became eligible for the scheme.⁴⁵
- In 2002 a solidarity-based contract category was introduced into the VHI market.⁴⁶ Contracts covered under this heading will not require a health questionnaire and thus must offer premiums that are independent of pre-existing conditions.

Although the reforms have done much to improve access to voluntary health insurance, there are still many who cannot afford it. Among the population with no complementary coverage, 53 per cent reported that they did not access VHI because of financial barriers and among the 4 per cent of people that had recently lost their complementary coverage, 30 per cent reported that it was due to financial problems.⁴⁷

Voluntary health insurance coverage is also low amongst those aged 20-29 and those over 80. Although the former probably choose not to take out complementary health insurance in the expectation that their health care needs will be low, the over 80s probably struggle to gain VHI coverage due to lower incomes, the removal of employer group coverage and higher premiums as a result of age-rating.

Cost

In an attempt to bring the gatekeeping system evident in NHI reimbursement rates into the VHI sector as well, ‘responsible contracts’ were introduced.⁴⁸ These contracts define a ‘care network’ made up of registered GPs and specialists, with GPs usually working in a gatekeeping capacity. If a patient opts out of this network then their co-payments will not be covered. However if they do follow the recommended care pathway then their VHI contract will cover 100 per cent of their GP and specialist fees (with the exception of the aforementioned non-reimbursable co-payments). The responsible contracts must also cover at least two types of important preventative service from a list defined by the HAS. As with the solidarity based contracts, responsible contract premiums are exempted from a 7 per cent government tax in order to encourage private health insurance firms to offer them. The reforms were very successful and by 2006 almost all VHI contracts were responsible contracts.⁴⁹

Health Care Provision

Self-employed professionals (mostly outpatient care) are paid on a fee-for-service basis and tariffs are negotiated in pluri-annual agreements between NHI managers and representatives of health professionals.⁵⁰ These are then sent for approval to the Ministry of Health. Financial incentives to improve the quality and efficiency of doctors' practices were recently implemented through individual contracts to general practitioners for practice improvement.⁵¹

Until 2004, public and not-for-profit private hospitals were paid on the basis of global budgets, whilst profit-making, private hospitals were funded on a per diem rate.⁵² However, the payment mechanism used to fund public hospitals, which was based on historical budgets, was not considered to be reflective of health needs and equity. Since 2004 therefore, payment for hospital acute care has operated on a type of Diagnosis Related Group (DRG) model (T2A).² The introduction of T2A in both the public *and* private sector for acute care was intended to improve efficiency and fairness. It was also intended to enhance competition between public and private by harmonising the source and method of their funding. The scheme started in March 2005 and has been gradually implemented from 10 per cent of public hospital budgets in 2004 to 50 per cent in 2005 and 100 per cent in 2008.⁵³ Currently, the funding models for public and private hospitals still have some differences and the tariffs are calculated differently. For example, doctors' fees are billed in addition to the DRG in private clinics, whilst physicians' salaries are covered entirely by DRG tariffs in public and not-for-profit hospitals. Furthermore, public and not-for-profit hospitals benefit from additional non-activity-based grants that compensate research and teaching (up to an additional 13 per cent of the budget)⁵⁴. However, from 2018, the objective is to entirely harmonize the payment method and tariffs of both sectors.

Difficulties facing French Health Care

Cost

Health expenditure per capita in France generally stands above the OECD average, but below the health expenditure of Germany and Switzerland. More importantly from the government's point of view, the vast majority of health spending (79 per cent of total expenditure on health in 2007, amounting to €208 billion) is publicly funded.⁵⁵

Furthermore, although the French parliament has set a budget 'ceiling' for health since 1996, with only a few exceptions this ceiling has been exceeded every year.⁵⁶ There have therefore been several attempts to contain NHI expenditure and reduce the cost borne by

² This means that, 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 (*groups homogènes de séjours*; GHS). The Programme of Medicalization of Information Systems is used as a basis to calculate hospital reimbursement. Every patient stay is classified in one of over 2000 homogeneous patient groups, which are equivalent to DRGs.

the government, particularly at a time of economic downturn. These reforms fell broadly into two categories:

- **Strict accounting cost containment policy:** primarily focused on decreasing the size of the benefit basket and levels of coverage. Alongside the aforementioned coordinated care pathways, stricter control of statutory tariffs was introduced. Furthermore, in 2008 economic considerations were introduced in health technology assessments and pharmacies were obliged to prescribe a certain percentage of generic drugs.⁵⁷
- Linked to these reforms was the creation in 2004 of an Alert Committee which, if the projected health budget is exceeded, can ask the head of the Directorate of Social Security (the watchdog for all social security branches) to present a financial rescue plan.⁵⁸
- **Medically based cost containment policy:** this focused on reducing the loss of money and quality due to medical practice variations and aimed to improve medical practice as a whole. The main tools used were the implementation of 'lifelong learning', the development of practice guidelines by national agencies and the introduction of good practice commitments, enshrined in the agreements between national health insurance providers and health professionals. At first, coercive measures such as fines were used to enforce the policies, but these seemed to make little difference and therefore a system of incentives was developed instead. Most recently, this included the introduction of 'pay for performance' for individual doctors based on achieving good practice targets.⁵⁹

Health Equality across Regions & Coordinating Care

In the 1990s the French government identified the problem of regional and economic disparities in health care availability and quality.⁶⁰ Over a decade later this remains an issue, identified by the World Health Organisation in its 2010 report⁶¹ and shown, for example, by the seven-year gap in male life expectancy between the highest and lowest social categories.⁶² Therefore, alongside the attempts to help those on lower incomes to access private health insurance, the distribution of doctors is also being addressed without impairing freedom of settlement. This involves increasing the attractiveness of under-represented specialities and medically under-served areas, usually by offering higher wages in those areas.⁶³ Further solutions may also be needed to make working in long-term care more attractive.

In the last two decades France was plagued by a lack of coordination between hospital and ambulatory services, between private and public provision of care and between health care and public health. The HPST Act, besides paving the way for ARSs, also created the regional strategic health plans. This should improve coordination and lead to a common approach in planning for hospital ambulatory and health and social care sectors, because it made formal legal provisions for the transfer of tasks between professionals.⁶⁴ The harmonisation of funding methods between for-profit and not for-profit hospitals should also lead to an improvement in the uniformity of care and the ability to compare institutions. However, as with many countries, better data collection and coordination is still needed in order to ensure that there is as little waste and overlap as possible, whilst also avoiding gaps in care. This also ties into the problem of geographic disparities.

Patient Choice

The French traditionally pride themselves on the freedom of choice available in health care provision. The French are completely free to use any doctor or hospital they wish. They may go directly to a specialist either outside or within a hospital. They can choose public or private care and they can opt for a standard 'office-based' generalist, a family' doctor (simply a generalist to whom they have some loyalty) or a 'referring' doctor. Patients take into account a variety of factors when choosing a doctor or hospital, including courtesy, length of appointment, waiting times, cleanliness, catering, and privacy. Interpersonal relations between doctors and patients are very good and highly professional.⁶⁵ However, there is still a lingering problem of nepotism amongst specialisms and the choice that is evident in theory is not always evident in practice. For example, there has been concern over the actual ability of patients either in remote rural areas, or with limited financial capacity, to choose their providers. The 2006 report of HCAAM commented on the difficulty of getting an appointment with a physician who does not practice 'extra billing' (charging above the official tariff set by the government) in regions with a low density of professionals.⁶⁶ It also reported that physicians who usually bill extra refused approximately 40 per cent of patients who were eligible for CMU and therefore couldn't be charged extra. The introduction of the coordinated health care pathway with the 'preferred doctor scheme' is also considered to diminish patient choice. However, despite these difficulties, the French population appear to be satisfied with their health care system: indeed, in a 2006 survey it was found that 80 per cent of French patients were satisfied with the current organisation and funding basis of the health care system.⁶⁷

Conclusions

The concept of 'médecine libérale' underpins the French system and refers to the direct payment made by the patient to the doctor at the point of use, according to the services provided. It is seen as protecting the patient's freedom to choose a doctor and the doctor's freedom of prescription or practice.⁶⁸ These three principles—personal payment, choice of doctor and freedom of practice—remain fundamental to the French healthcare system. The sense of responsibility created by direct payment is regarded as important, even though a proportion of the payment is reimbursed and despite the fact that the majority of people pay for additional insurance to cover any co-payments. Supporting the view that co-payment acts as a brake on consumption, many of the French citizens interviewed by Civitas were conscious that 'free' care may encourage wasteful and frivolous use of health services.⁶⁹ They typically disapprove because 'the many' end up paying for 'the few'. This cost-consciousness is perhaps the most laudable aspect of the French system, alongside their expectation and generally their receipt of medical care that is good value for their money. The other excellent aspect of the French system is the fact that all hospitals, whether public or private are expected to provide the same level of care and, thanks to new regulation, will even be funded in the same ways. This means that private health insurance and private providers are not used in order to gain better service, but instead simply add to the quality of health care as a whole and are available to all. It is true that some on CMU may struggle to gain access to doctors who generally bill 'extra' but this is still better than the NHS system where the majority of patients, rather than the minority, cannot afford to pay to

see a private specialist. French waiting times are short and patient involvement in the process is good according to those surveyed by Civitas. Therefore, although the reshuffling of French health care management may look chaotic in the short term, in reality it would appear that the French system has achieved a pragmatic blend of consumer choice, professional autonomy, central regulation and a government-backed guarantee for the poor, which exceeds the NHS standard on many counts. Furthermore, the French model holds important lessons for the NHS in particular, because competition is limited to the VHI sector. The NHI sector, based on occupation, is not complicated by high levels of competition and this may therefore be a model that is more acceptable to those who support the NHS, than a system closer to full privatisation of health insurance.

The French have introduced the benefits of a competitive market without undermining Beveridgean principles and seem to be dealing with the problems of geographical disparities and gaps in long-term care with no less success than any other developed country. The NHS, by comparison, has universalised the drawbacks of public sector monopoly and seems to be suffering from a number of extremely critical reports on its quality of care, particularly for those in society who are most vulnerable: hardly an accolade for a 'welfare state'.

Statfile: (2009 figures unless otherwise stated)

Funding

Total Health expenditure:	11.8 % of GDP
Public expenditure:	77.9 % of total health expenditure
Out of pocket expenditure:	7.3 % of total health expenditure

Resources

Practising physicians (per 1000 population):	3.3
Practising nurses (per 1000 population):	8.2
MRI scanners (per million population):	7 (2010)
CT scanners (per million population):	11.8 (2010)

Outcomes

Life expectancy (at birth):	85 (female) 2010* 78 (male) 2010*
Infant mortality (per 1000 live births):	3.3 (2010)
Maternal mortality ratio:	10 (2005-2009) ⁺

* CIA World Factbook and WHO statistics

Cited on <http://www.kaiseredu.org/Issue-Modules/International-Health-Systems/France.aspx>

+ UNICEF data

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- ² Commonwealth Fund: *International Profiles of Health Care Systems 2011* (France)
http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2011/Nov/1562_Squires_Intl_Profiles_2011_11_10.pdf
- ³ See section on Voluntary Health Insurance
- ⁴ Commonwealth Fund, *International Profiles 2011*. This report states that two-thirds of hospital beds are provided by government owned or not-for profit hospitals. This figure may be higher given that the World Health Organisation in its 2010 *Health Systems In Transition (HiT): France* report stated that the number of hospital beds in public or not for profit hospitals was closer to 80%.
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