

Health Systems in Transition

Vol. 25 No. 3 2023

France

Health system review

Zeynep Or
Coralie Gandré
Anna-Veera Seppänen
Cristina Hernández-Quevedo
Erin Webb
Morgane Michel
Karine Chevreul

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Zeynep Or

IRDES

Coralie Gandré

IRDES

Anna-Veera Seppänen

IRDES

Cristina Hernández-Quevedo

European Observatory on Health
Systems and Policies, LSE Health

Erin Webb

Technical University of Berlin and
European Observatory on Health
Systems and Policies

Morgane Michel

Inserm

Karine Chevreul

Inserm



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KEYWORDS:

DELIVERY OF HEALTHCARE

EVALUATION STUDIES

FINANCING, HEALTH

HEALTHCARE REFORM

HEALTH SYSTEM PLANS – organization and administration

FRANCE

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Printed and bound in the United Kingdom.

Suggested citation:

Or Z, Gandré C, Seppänen AV, Hernández-Quevedo C, Webb E, Michel M, Chevreur K. France: Health system review. *Health Systems in Transition*, 2023; 25(3): i–241.

Print ISSN 1817-6119 Vol. 25 No. 3
Web ISSN 1817-6127 Vol. 25 No. 3

ISBN 978 92 890 5944 2 (PDF)
ISBN 978 92 890 5949 7 (Print)

CONTENTS

Preface	v
Acknowledgements	vii
List of abbreviations	ix
List of tables, figures and boxes	xvii
Abstract	xxi
Executive summary	xxiii
1 Introduction	1
1.1 <i>Geography and sociodemography</i>	2
1.2 <i>Economic context</i>	5
1.3 <i>Political Context</i>	6
1.4 <i>Health status</i>	8
2 Organization and governance	12
2.1 <i>Historical background</i>	13
2.2 <i>Organization</i>	14
2.3 <i>Decentralization and centralization</i>	21
2.4 <i>Planning</i>	24
2.5 <i>Intersectorality</i>	26
2.6 <i>Health information systems</i>	27
2.7 <i>Regulation</i>	28
2.8 <i>Person-centred care</i>	35
3 Financing	42
3.1 <i>Health expenditure</i>	43
3.2 <i>Sources of revenue and financial flows</i>	49
3.3 <i>Overview of the statutory financing system</i>	52
3.4 <i>Out-of-pocket payments</i>	64
3.5 <i>Complementary health insurance</i>	68
3.6 <i>Other financing</i>	70
3.7 <i>Payment mechanisms</i>	71

4	Physical and human resources	85
4.1	<i>Physical resources</i>	<u>86</u>
4.2	<i>Human resources</i>	<u>96</u>
5	Provision of services	115
5.1	<i>Public health</i>	<u>116</u>
5.2	<i>Patient pathways</i>	<u>125</u>
5.3	<i>Primary care</i>	<u>127</u>
5.4	<i>Specialized care</i>	<u>131</u>
5.5	<i>Urgent and emergency care</i>	<u>134</u>
5.6	<i>Pharmaceutical care</i>	<u>137</u>
5.7	<i>Rehabilitation/intermediate care</i>	<u>139</u>
5.8	<i>Long-term care</i>	<u>140</u>
5.9	<i>Services for informal carers</i>	<u>147</u>
5.10	<i>Palliative care</i>	<u>148</u>
5.11	<i>Mental health care</i>	<u>149</u>
5.12	<i>Dental care</i>	<u>151</u>
6	Principal health reforms	153
6.1	<i>Analysis of recent reforms</i>	<u>154</u>
6.2	<i>Future developments</i>	<u>161</u>
7	Assessment of the health system	164
7.1	<i>Health system governance</i>	<u>165</u>
7.2	<i>Accessibility</i>	<u>169</u>
7.3	<i>Financial protection</i>	<u>173</u>
7.4	<i>Healthcare quality</i>	<u>175</u>
7.5	<i>Health system outcomes</i>	<u>181</u>
7.6	<i>Health system efficiency</i>	<u>186</u>
8	Conclusions	193
9	Appendices	196
9.1	<i>References</i>	<u>196</u>
9.2	<i>Principal legislation</i>	<u>230</u>
9.3	<i>Useful websites</i>	<u>236</u>
9.4	<i>HiT methodology and production process</i>	<u>236</u>
9.5	<i>About the authors</i>	<u>239</u>

PREFACE

The Health Systems in Transition (HiT) series consists of country-based reviews that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each review is produced by country experts in collaboration with the Observatory's staff. In order to facilitate comparisons between countries, reviews are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a report.

HiTs seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe. They are building blocks that can be used to:

- learn in detail about different approaches to the organization, financing and delivery of health services, and the role of the main actors in health systems;
- describe the institutional framework, process, content and implementation of healthcare reform programmes;
- highlight challenges and areas that require more in-depth analysis;
- provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries; and
- assist other researchers in more in-depth comparative health policy analysis.

Compiling the reviews poses a number of methodological problems. In many countries there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including the World Health Organization (WHO) Regional Office for Europe's European Health for All database, data from national

statistical offices, Eurostat, the Organisation for Economic Co-operation and Development (OECD) Health Data, data from the International Monetary Fund (IMF), the World Bank's World Development Indicators and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate review.

A standardized review has certain disadvantages because the financing and delivery of healthcare differ across countries. However, it also offers advantages because it raises similar issues and questions. HiTs can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situations. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative and material is updated at regular intervals.

Comments and suggestions for the further development and improvement of the HiT series are most welcome and can be sent to contact@obs.who.int.

HiTs and HiT summaries are available on the Observatory's website (www.healthobservatory.eu).

ACKNOWLEDGEMENTS

The HiT on France was produced by the European Observatory on Health Systems and Policies. This edition was written by Zeynep Or (IRDES), Coralie Gandré (IRDES), Anna-Veera Seppänen (IRDES), Morgane Michel (Inserm), and Karine Chevreur (Inserm). It was edited by Cristina Hernández-Quevedo and Erin Webb, working with the support of Anna Maresso and Ewout van Ginneken of the European Observatory on Health Systems and Policies.

This report benefited from the comments and inputs of several researchers at the Institute for Research and Information in Health Economics (IRDES). The authors would like to thank in particular Renaud Legal for his comments on Chapter 2, Damien Bricard, Marc Perronnin and Aurélie Pierre for their careful revisions of Chapter 3, Guillaume Chevillard, Cécile Fournier, Louise Luan and Véronique Lucas-Gabrielli for their inputs on Chapter 4, Maude Espagnacq on Chapter 5, and Anne Penneau, Sylvain Pichetti and Julien Mousquès for their helpful comments on Chapters 4 and 5. They are grateful to Pascale Lengagne who provided valuable input on occupational health in Chapters 3 and 5, and Denis Raynaud who supported this work all along and provided comments on Chapter 7 and indebted to Marie Bonal and Franck Clérembault who produced various maps for this HiT. The authors are also grateful to Marie-Camille Lenormand (High Council for the Future of Health Insurance, HCAAM) and Pierre Bergman (National Health Insurance Fund, CNAM) for their comments on a previous version of the report. Thanks are also due to the Ministry of Health for providing comments on an earlier version of the report, in particular, to Virginie Delattre-Escudie and Mickaël Portela (Ministry of Health) for their detailed review of the report and for facilitating the latest data. Thanks are also extended to the WHO Regional Office for Europe for their European Health for All database from which data on health services were extracted; to the OECD for the data on health services in Western Europe; and to the World Bank for the data on health expenditure in Central and

Eastern European countries, and the European Commission for the Eurostat database. The HiT uses data available at the end of December 2022, unless otherwise indicated. The HiT reflects the organization of the health system and the data availability, unless otherwise indicated, as it was at the end of December 2022.

The Observatory is a partnership that includes the Governments of Austria, Belgium, Finland, Ireland, the Kingdom of the Netherlands, Norway, Slovenia, Sweden, Switzerland and the United Kingdom; the Veneto Region of Italy; the French National Union of Health Insurance Funds (UNCAM); the World Health Organization; the European Commission; the World Bank; the London School of Economics and Political Science (LSE); and the London School of Hygiene & Tropical Medicine (LSHTM). The partnership is hosted by the WHO Regional Office for Europe. The Observatory is composed of a Steering Committee, core management team, research policy group and staff. Its Secretariat is based in Brussels and it has offices in London at LSE, LSHTM and the Technical University of Berlin. The Observatory team working on HiTs is led by Josep Figueras, Director; Elias Mossialos, Martin McKee, Reinhard Busse (Co-directors); Ewout van Ginneken and Suszy Lessof. The Country Monitoring Programme of the Observatory and the HiT series are coordinated by Anna Maresso. The production and copy-editing process of this HiT was coordinated by Jonathan North, with the support of Lucie Jackson, Sarah Cook (copy-editing) and Prepress Projects (design and layout).

LIST OF ABBREVIATIONS

Abbreviation	English	French
ABP	Activity-based payment	<i>Tarification à l'activité (T2A)</i>
ACS	Voucher plan for the purchase of complementary health insurance	<i>Aide à l'acquisition d'une complémentaire santé</i>
ADALIS	Drug and alcohol addiction prevention service	<i>Addictions drogues alcool info service</i>
ADELI	Automated directory of health professionals	<i>Automatisation des listes</i>
ADL	Activities of daily living	<i>Activités de la vie quotidienne</i>
ALD	Long-term illness scheme	<i>Affection de longue durée</i>
AME	State medical aid	<i>Aide médicale de l'Etat</i>
AMM	Marketing authorization	<i>Autorisation de mise sur le marché</i>
ANAP	National agency to support the performance of health and social care institutions	<i>Agence nationale d'appui à la performance des établissements de santé et médico-sociaux</i>
ANI	National interprofessional agreement	<i>Accord national interprofessionnel</i>
ANS	Digital health agency	<i>Agence du numérique en santé</i>
ANSES	French agency for food, environmental and occupational health and safety	<i>Agence nationale de sécurité sanitaire de l'alimentation, de l'environnement et du travail</i>
ANSM	National agency for medicines and health products safety	<i>Agence nationale de sécurité du médicament et des produits de santé</i>
APA	Personal autonomy allowance (a cash-for-care scheme for social care)	<i>Allocation personnalisée d'autonomie</i>
ARS	Regional health agency	<i>Agence régionale de santé</i>

Abbreviation	English	French
ASALEE	Pilot projects on task shifting from GPs to nurses	<i>Action de santé libérale en équipe</i>
ASMR	Improvement of medical benefit	<i>Amélioration du service médical rendu</i>
ATIH	Technical agency for information on hospital care	<i>Agence technique de l'information sur l'hospitalisation</i>
CADA	Commission on Access to Administrative Documents	<i>Commission d'accès aux documents administratifs</i>
CAPI	P4Q contract to improve clinical quality of care and encourage generic prescription and prevention	<i>Contrat d'amélioration des pratiques individuelles</i>
CEPS	Economic committee for health products	<i>Comité économique des produits de santé</i>
CES	Health examination centre	<i>Centre d'examen de santé</i>
CHI	Complementary private health insurance	<i>Assurance privée complémentaire</i>
CICE	Tax credit for competitiveness and employment	<i>Crédit d'impôt pour la compétitivité et l'emploi</i>
Cire	Regional branches of French public health agency	<i>Cellules d'intervention en région</i>
CLCC	Centre specialized in cancer treatment	<i>Centre de lutte contre le cancer</i>
CMP	Medico-psychological centre	<i>Centre médico-psychologique</i>
CMU	Universal health insurance	<i>Couverture maladie universelle</i>
CMU-C	Publicly subsidized complementary health insurance	<i>Couverture maladie universelle complémentaire</i>
CNAM	National health insurance fund (statutory scheme)	<i>Caisse nationale d'assurance maladie</i>
CNSA	National solidarity fund for autonomy	<i>Caisse nationale de solidarité pour l'autonomie</i>
CPAM	Local health insurance fund	<i>Caisse primaire d'assurance maladie</i>
CPTS	Local healthcare networks	<i>Communauté professionnelle territoriale de santé</i>
CRPV	Regional centre for pharmaceutical vigilance	<i>Centre régional de pharmacovigilance</i>

Abbreviation	English	French
CRSA	Regional Conference on Health and Autonomy	<i>Conférence régionale de la santé et de l'autonomie</i>
CSG	General social contribution (income tax dedicated to health)	<i>Contribution sociale généralisée</i>
CTS	Regional health council	<i>Conseil territorial de santé</i>
CTV	Technical Commission on Vaccinations	<i>Commission technique des vaccinations</i>
C2S	Publicly subsidized complementary insurance scheme which integrated CMU-C and ACS in 2019	<i>Complémentaire santé solidaire</i>
DGCS	General Directorate for Social Policy	<i>Direction générale de la cohésion sociale</i>
DGS	General Directorate of Health	<i>Direction générale de la santé</i>
DGOS	General Directorate of Healthcare Supply	<i>Direction générale de l'offre de soins</i>
DSS	Directorate of Social Security	<i>Direction de la sécurité sociale</i>
DMP	Shared medical record	<i>Dossier médical partagé</i>
DNS	Ministerial delegation for digital health	<i>Délégation ministérielle du numérique en santé</i>
DPC	Continuous learning activities	<i>Développement professionnel continu</i>
DREES	Directorate for research, studies, evaluations and statistics of the Ministry of Health	<i>Direction de la recherche, des études, de l'évaluation et des statistiques</i>
DRG	Diagnosis-related group	<i>Groupe homogène de malades</i>
EAM	Medical reception centres for persons with disability	<i>Etablissement d'accueil médicalisé</i>
ECN	National exam at the end of the second cycle of medical school	<i>Epreuves classantes nationales</i>
ED	Emergency department	<i>Service d'urgence</i>
EDS	Episode-based funding	<i>Financement à l'épisode de soins</i>
EEA	European Economic Area	<i>Espace économique européen</i>

Abbreviation	English	French
ECHR	European Convention on Human Rights	<i>Convention européenne des droits de l'homme</i>
EHPAD	Medical residential nursing home	<i>Établissement d'hébergement pour personnes âgées dépendantes</i>
EMA	European medicines agency	
EMSP	Mobile palliative care team	<i>Équipe mobile de soins palliatifs</i>
ENCC	National cost study	<i>Étude nationale de coûts à méthodologie commune</i>
ENMR	Pilots of new payment models	<i>Expérimentations des nouveaux modes de rémunération</i>
EPRUS	Agency for Health Emergency Response and Preparedness	<i>Etablissement de Préparation et de Réponse aux Urgences Sanitaires</i>
ESPIC	Private non-profit hospital under contract with the SHI	<i>Établissement de santé privé d'intérêt collectif</i>
EU	European Union	<i>Union européenne</i>
FFS	Fee-for-service	<i>Rémunération à l'acte</i>
GATT	General Agreement on Tariffs and Trade	<i>Accord général sur les tarifs douaniers et le commerce</i>
GDP	Gross domestic product	<i>Produit intérieur brut</i>
GHM	Homogeneous patient groups	<i>Groupes Homogènes de Malades</i>
GHT	Local hospital group	<i>Groupement hospitalier de territoire</i>
GIR	Iso-weighted resource groups defining the dependency score	<i>Groupes iso-ressources</i>
GP	General practitioner	<i>Médecin généraliste</i>
HAD	Hospitalization at home	<i>Hospitalisation à domicile</i>
HAS	French National Authority for Health	<i>Haute Autorité de santé</i>
HCAAM	High council for the future of health insurance	<i>Haut conseil pour l'avenir de l'assurance maladie</i>
HCSP	High council for public health	<i>Haut conseil de la santé publique</i>

Abbreviation	English	French
HDH	Health data hub	<i>Plateforme des données de santé</i>
HSPA	Health system performance assessment	<i>Évaluation de la performance du système de santé</i>
HTA	Health technology assessment	<i>Évaluation des technologies de la santé</i>
ICU	Intensive care unit	<i>Unité de soins intensifs</i>
IGAS	General Inspectorate of Social Affairs	<i>Inspection générale des affaires sociales</i>
INCa	National cancer institute	<i>Institut national du cancer</i>
INPES	National institute for prevention and health education	<i>Institut national de prévention et d'éducation pour la santé</i>
IPA	Advance practice nurse	<i>Infirmier en pratique avancée</i>
IPEP	Incentive for shared care – P4Q-type payment to be shared between volunteering care providers across settings	<i>Incitation à une prise en charge partagée</i>
IRSN	Radioprotection and Nuclear Safety Institute	<i>Institut de radioprotection et de sécurité nucléaire</i>
LAS	Bachelor's degree programme with a health option	<i>Licence accès santé</i>
LFSS	Social Security Financing Act	<i>Loi de financement de la sécurité sociale</i>
LISP	Bed dedicated to palliative care	<i>Lit identifié en soins palliatifs</i>
LOS	Length of stay	<i>Durée de séjour</i>
LTC	Long-term care	<i>Soins de longue durée</i>
MAS	Specialized reception centres for persons with disability	<i>Maison d'accueil spécialisé</i>
MDPH	Departmental home for persons with disabilities	<i>Maison départementale pour les personnes handicapées</i>
MIGAC	Additional payments for hospitals for performing activities with public interest	<i>Missions d'intérêt général et d'aide à la contractualisation</i>
MoH	Ministry of Health	<i>Ministère de la santé et de la prévention</i>

Abbreviation	English	French
MSA	Agricultural health insurance scheme	<i>Mutualité sociale agricole</i>
MSP	Multidisciplinary group practice	<i>Maison de santé pluriprofessionnelle</i>
OECD	Organisation for Economic Co-operation and Development	<i>Organisation de coopération et de développement économiques (OCDE)</i>
OFDT	French Monitoring Center for Drugs and Drug Addictions	<i>Observatoire français des drogues et des conduites addictives</i>
ONDAM	National objective for SHI spending	<i>Objectif national des dépenses d'assurance maladie</i>
ONDPS	National observatory on demography of health professions	<i>Observatoire national de la démographie des professions de santé</i>
OOP	Out-of-pocket payment	<i>Reste à charge</i>
OPTAM	Optional tariff contract regulating prices charged by physicians in sector 2	<i>Option de pratique tarifaire maîtrisée</i>
OPTAM-CO	Optional tariff contract regulating prices charged by specialists performing surgical or obstetrical procedures in private practice or in hospitals	<i>Option de pratique tarifaire maîtrisée pour la chirurgie et l'obstétrique</i>
OTC	Over-the-counter	<i>Médicaments non soumis à prescription obligatoire</i>
OTSS	Law relating to the organization and transformation of the health system	<i>Loi relative à l'organisation et à la transformation du système de santé</i>
PACES	First year of studies in the medical field	<i>Première année commune aux études de santé</i>
PASS	Health-specific university track	<i>Parcours spécifique accès santé</i>
PCH	Disability compensation allowance	<i>Prestation de compensation du handicap</i>
PEPS	Lump sum payments for teams of health professionals	<i>Paiement forfaitaire en équipe de professionnels de santé</i>
PMI	Maternal and child protection services	<i>Protection maternelle et infantile</i>

Abbreviation	English	French
PMSI	Hospital discharge database	<i>Programme de médicalisation des systèmes d'information</i>
PNNS	National Health Nutrition Programme	<i>Programme national nutrition santé</i>
PPP	Purchasing power parity	<i>Parité de pouvoir d'achat</i>
PREM	Patient-reported experience measure	<i>Mesure de l'expérience de soins perçue par le patient</i>
PROM	Patient-reported outcome measure	<i>Mesure de résultats de soins perçus par le patient</i>
PRS	Regional health projects	<i>Projets régionaux de santé</i>
PSRS	Strategic regional plan for health	<i>Plan stratégique régional de santé</i>
PTSM	Territorial network for mental health	<i>Projet territorial de santé mentale</i>
PUMA	Universal medical coverage	<i>Protection universelle maladie</i>
P4P	Pay-for-performance	<i>Rémunération à la performance</i>
P4Q	Pay-for-quality	<i>Rémunération à la qualité</i>
ROSP	Pay-for-quality scheme for ambulatory physicians	<i>Rémunération sur objectifs de santé publique</i>
RPPS	National directory of healthcare professionals	<i>Répertoire partagé des professionnels de santé</i>
RSI	Health insurance fund of self-employed workers	<i>Régime social des indépendants</i>
SAAD	Home-care and support services	<i>Service d'aide et d'accompagnement à domicile</i>
SAMSAH	LTC at home – services for older populations with disability	<i>Service d'accompagnement médico-social pour adultes handicapés</i>
SAMU	Emergency call centre	<i>Service d'aide médicale urgente</i>
SHI	Statutory health insurance	<i>Assurance maladie</i>
SMUR	Hospital ambulance service	<i>Structure mobile d'urgence et de réanimation</i>
SNDS	National health data system	<i>Système national des données de santé</i>
SPASAD	Multipurpose services for home-care	<i>Services polyvalents d'aide et de soins à domicile</i>

Abbreviation	English	French
SPF	French public health agency	<i>Santé publique France</i>
SROS	Regional health organization plan	<i>Schéma régional d'organisation des soins</i>
SROSMS	Regional scheme of health and social care sector organization	<i>Schéma régional de l'organisation médico-sociale</i>
SRS	Regional health plan	<i>Schéma régional de santé</i>
SSFA	Social Security Financing Act	<i>Loi de financement de la sécurité sociale (LFSS)</i>
SSIAD	Home-nursing care service	<i>Service de soins infirmiers à domicile</i>
SSR	Post-acute and rehabilitation service	<i>Soins de suite et de réadaptation</i>
TSA	Solidarity tax	<i>Taxe de solidarité additionnelle</i>
T2A	Activity (Diagnosis-Related Group) based payment	<i>Tarification à l'activité</i>
UNCAM	National Union of Health Insurance Funds	<i>Union nationale des caisses d'assurance maladie</i>
UNOCAM	National Union of Complementary Health Insurance Funds	<i>Union nationale des organismes complémentaires d'assurance maladie</i>
UNPS	National Union of Health Professions	<i>Union nationale des professions de santé</i>
URPS	Regional unions of health professionals	<i>Unions régionales des professionnels de santé</i>
USLD	Long-term care unit in hospital	<i>Unité de soins de longue durée</i>
USP	Palliative care unit	<i>Unité de soins palliatifs</i>
WHO	World Health Organization	<i>Organisation mondiale de la santé (OMS)</i>

LIST OF TABLES, FIGURES AND BOXES

■ Tables

TABLE 1.1	Trends in population/demographic indicators for mainland France, selected years	<u>4</u>
TABLE 1.2	Macroeconomic indicators, selected years	<u>5</u>
TABLE 1.3	Mortality and health indicators, selected years	<u>9</u>
TABLE 2.1	Overview of the regulation of providers	<u>32</u>
TABLE 2.2	Patient information	<u>36</u>
TABLE 2.3	Patient choice	<u>38</u>
TABLE 2.4	Patient rights	<u>39</u>
TABLE 3.1	Trends in health expenditure in France, 2000–2021	<u>46</u>
TABLE 3.2	Expenditure on health (as % of current health expenditure) according to function and type of financing in 2019	<u>50</u>
TABLE 3.3	Targeted and actual SHI expenditures by care sector (billion €), selected years	<u>62</u>
TABLE 3.4	List of flat deductibles by types of goods/services, 2021 prices	<u>65</u>
TABLE 3.5	User charges for health services	<u>66</u>
TABLE 3.6	Provider payment mechanisms	<u>71</u>
TABLE 4.1	Number of inpatient beds in acute, psychiatric and long-term care hospitals in France, per 1000 inhabitants, 2000–2019, selected years	<u>92</u>
TABLE 4.2	Diagnostic imaging technologies per 1 000 000 inhabitants in France and selected countries, 2019	<u>94</u>
TABLE 4.3	Density of the health workforce in France, 2012–2021, selected years	<u>100</u>

TABLE 5.1	Description of major LTC providers and their users, 2019 or latest available year	<u>144</u>
TABLE 6.1	Major health reforms	<u>155</u>

■ Figures

FIG. 1.1	Map of France	<u>3</u>
FIG. 1.2	Risk factors affecting health status, latest available year	<u>10</u>
FIG. 2.1	Overview of the health system in France, 2021	<u>15</u>
FIG. 3.1	Current health expenditure as a share (%) of GDP in the WHO European Region, 2020	<u>44</u>
FIG. 3.2	Trends in current health expenditure as a share (%) of GDP in France and selected countries, 2000–2021 or latest available year	<u>45</u>
FIG. 3.3	Current health expenditure in US\$ PPP per capita in the WHO European Region, 2020	<u>47</u>
FIG. 3.4	Public expenditure on health as a share (%) of general government expenditure in the WHO European Region, 2020	<u>48</u>
FIG. 3.5	Financial flows in the French health system	<u>51</u>
FIG. 3.6	Evolution of total hospital consumption expenditure in price and volume in France, 2011–2020	<u>77</u>
FIG. 4.1	Density of hospital inpatient and ambulatory beds in French local authorities (<i>départements</i>), 2019	<u>90</u>
FIG. 4.2	Beds in acute hospitals per 100 000 inhabitants in France and selected countries, 2000–2019	<u>91</u>
FIG. 4.3	Practising nurses and physicians per 100 000 inhabitants, 2020	<u>101</u>
FIG. 4.4	Number of physicians per 100 000 population in France and selected countries, 2000–2020	<u>102</u>
FIG. 4.5	Density of physicians (generalists vs. specialists) across French local authorities (<i>départements</i>), 2021	<u>104</u>
FIG. 4.6	Number of nurses per 100 000 population in France and selected countries, 2000–2020	<u>105</u>
FIG. 4.7	Density of nurses in the community and in hospitals across local authorities (<i>départements</i>), 2021	<u>107</u>
FIG. 5.1	Patient pathways	<u>127</u>
FIG. 5.2	Number of visits to emergency services in France	<u>135</u>

FIG. 7.1	Percentage of adults aged 65 years or older reporting difficulties getting after-hours care and waiting six days or more for an appointment when sick	<u>171</u>
FIG. 7.2	Unmet needs for a medical examination (due to cost, waiting time or travel distance), by income quintile, EU/EEA countries, 2021 or latest available year	<u>172</u>
FIG. 7.3	Share of households that experienced catastrophic health expenditure, latest year for all countries with data available	<u>175</u>
FIG. 7.4	Avoidable hospital admission rates for asthma, chronic obstructive pulmonary disease, congestive heart failure, hypertension and diabetes-related complications, France and selected countries	<u>176</u>
FIG. 7.5	In-hospital mortality rates (deaths within 30 days of admission) for admissions following acute myocardial infarction, haemorrhagic stroke and ischaemic stroke, France and selected countries in 2019 or latest available year	<u>178</u>
FIG. 7.6	Five-year survival rates for colon, breast (among women) and prostate (among men) cancer diagnosed in 2010–2014	<u>179</u>
FIG. 7.7	Mortality from preventable and treatable causes in France and selected countries, 2011 and 2019 (or latest year available), all persons, age-standardized death rates per 100 000 population	<u>182</u>
FIG. 7.8	Daily smoking and alcohol consumption rates in the population aged 15 and older in 2019 or latest available year in France and selected countries	<u>184</u>
FIG. 7.9	Treatable mortality per 100 000 population vs. health expenditure per capita, 2019	<u>187</u>

■ Boxes

BOX 3.1	What are the key gaps in coverage?	<u>58</u>
BOX 3.2	Is health financing fair?	<u>60</u>
BOX 3.3	Are resources put where they are most effective?	<u>63</u>
BOX 4.1	Are health facilities appropriately distributed?	<u>89</u>
BOX 4.2	Are health workers appropriately distributed?	<u>103</u>
BOX 5.1	Are public health interventions making a difference?	<u>124</u>
BOX 5.2	Typical pathway of patients at risk of Type 2 diabetes	<u>126</u>

BOX 5.3	What are the key strengths and weaknesses of primary care?	<u>130</u>
BOX 5.4	Are efforts to improve integration of care working?	<u>132</u>
BOX 5.5	What do patients think of the care they receive?	<u>133</u>
BOX 5.6	Patient pathways in an emergency care episode	<u>136</u>
BOX 5.7	Is there waste in pharmaceutical spending?	<u>138</u>

ABSTRACT

This review of the French health system analyses recent developments in health organisation and governance, financing, healthcare provision, recent reforms and health system performance.

Overall health status continues to improve in France, although geographic and socioeconomic inequalities in life expectancy persist. The health system combines a social health insurance (SHI) model with an important role for tax-based revenues to finance healthcare. The health system provides universal coverage, with a broad benefits basket, but cost-sharing is required for all essential services. Private complementary insurance to cover these costs results in very low average out-of-pocket (OOP) payments, although there are concerns regarding solidarity, financial redistribution and efficiency in the health system. The macroeconomic context in the last couple of years in the country has been affected by the Covid-19 pandemic, which resulted in subsequent increases of total health expenditure in France in 2020 (3.7%) and 2021 (9.8%).

Healthcare provision continues to be highly fragmented in France, with a segmented approach to care organization and funding across primary, secondary and long-term care. Recent reforms aim to strengthen primary care by encouraging multidisciplinary group practices, while public health efforts over the last decade have focused on boosting prevention strategies and tackling lifestyle risk factors, such as smoking and obesity with limited success. Continued challenges include ensuring the sustainability of the health workforce, particularly to secure adequate numbers of health professionals in medically underserved areas, such as rural and less affluent communities, and improving working conditions, remuneration and career prospects, especially for nurses, to support retention. The Covid-19 pandemic has brought to light some structural weaknesses within the French health system, but it has also provided opportunities for improving its sustainability. There has been a notable shift in the will to give more room to decision-making at the local level, involving healthcare professionals, and to find new ways of funding healthcare providers to encourage care coordination and integration.

EXECUTIVE SUMMARY

The Republic of France is comprised of mainland France located in western Europe and a collection of overseas islands and territories on other continents. The French population totalled 67.1 million inhabitants as of 1 January 2020, with 64.9 million inhabitants in mainland France and 2.2 million inhabitants in the five overseas departments and regions, being the second most populous country in the EU after Germany. Large areas remain sparsely populated, with close to half of the population living in just over 15% of this territory.

Life expectancy at birth has increased by almost five years since 1995 and reached 82.5 years in 2021, although the Covid-19 pandemic has also impacted life expectancy, reducing it temporarily. As a result, life expectancy has yet to reach its pre-pandemic value. The gender gap in life expectancy (79.3 for men and 85.4 for women) is one of the highest in the world, and geographic and socioeconomic variations persist in the country.

The all-cause standardized mortality rate was 829.6 per 100 000 in 2017. The leading causes of death were cancer (28.4%) and circulatory diseases (23.8%), unlike most EU countries, where circulatory diseases are the highest cause of death. The prevalence of daily smoking and excessive alcohol consumption is higher in France than the EU average, despite some reduction in smoking through public health interventions.

- **The organization of the health system reflects a traditionally strong role for the State, with regional and local responsibilities**

The French health system is of a mixed type; while it is structurally based on a social health insurance approach, it shares National Health System goals reflected in the single public payer model, the importance of tax-based revenue for financing healthcare, strong state intervention and residency-based benefits. There is statutory health insurance (SHI), which, under various schemes, currently covers almost 100% of the resident population. The

delivery of care is shared among private, fee-for-service (FFS) physicians and other health professionals, private for-profit hospitals, private non-profit hospitals, and public hospitals.

The leadership of health policy and regulation of the healthcare system is divided among the State (parliament, government and the Ministry of Health), SHI and, to a lesser extent, local authorities (*départements*). Reforms in the past decade have attempted to devolve a greater remit in governance and health policy decision-making, around planning, to the regional level. Cutting across the traditional boundaries of healthcare, public health and social care sectors, regional health agencies (*Agence régionale de santé*, ARS) have responsibility for ensuring that healthcare provision meets the needs of the population.

Responsibility for planning health system resources and capacity is shared by the Ministry of Health and the ARS. The goal of this partial devolution of the planning function is to enable regional authorities to meet population health needs more appropriately. In the context of increasing healthcare expenditure, the increasing deficit of the SHI and the overall social security system, the role of the State in steering the system through regulation has increased since the early 1990s. Regulation involves negotiations among provider representatives (hospitals and health professionals), the State (represented by both the Ministry of Health and the Ministry of the Budget and Public Accounts), and the SHI.

Most providers are either paid by the SHI or directly by patients who are later reimbursed. The statutory tariffs are set through negotiations between providers and the SHI and are approved by the Ministry of Health. Quality of care is regulated at the national level.

■ Spending targets play an increasing role in managing health expenditure

The SHI system in France is universal and provides a broad benefits basket, although cost-sharing is required for all essential services. The reliance of the population on private complementary insurance to cover these out-of-pocket costs leads to very low average OOP payments, but raises concerns about solidarity, financial redistribution and efficiency in the health system.

To ensure financial sustainability, sources of health funding have been extended beyond payroll contributions in the past decades to include a broader range of sources of tax-based revenue, including financial assets, investments, earmarked and value-added taxes. The national government has introduced spending targets and monitoring mechanisms for health insurance since 2010, playing an increasingly important role in managing health expenditure by reducing the initial independence of the SHI in controlling health expenditure. While the implementation of spending targets has been successful in containing overall health expenditure in the past decade, the division of budgets (spending targets) between different care sectors (ambulatory, hospital and social care) reinforces the segmented approach to healthcare, and hinders integration, effective preventive services and allocative efficiency.

In the ambulatory sector the prices of health services are set through national formal negotiations between the unions of statutory and complementary health insurance funds and health professionals' unions, but there is no regulation of service volumes. Dominant fee-for-service (FFS) payment for self-employed health professionals is increasingly supplemented with pay-for-quality (P4Q) to encourage better care coordination, prevention and efficiency.

A prospective activity-based funding model has been used since 2005 in the acute hospital sector. While this has initially improved the productivity of hospitals, it also created new problems related to quality and appropriateness of care. In recent years new payment models have been implemented and piloted to encourage better quality, coordination and efficiency of care.

■ **The health workforce and capital resources have remained stable over the last decade, but they are unequally distributed**

In the last decade the number of inpatient beds has decreased by 5%, while ambulatory and home hospital beds have increased in parallel. During the Covid-19 pandemic the hospital system demonstrated flexibility with a rapid increase of intensive care capacity and public-private partnerships in order to meet demand.

Several digital innovations are still under development, including e-prescriptions and shared medical files, but major investments have recently

been made to improve the eHealth systems. The Covid-19 pandemic has accelerated health reforms further in this area, which is reflected in a significant increase in teleconsultations.

While the number of health workers has increased over the past 10 years in most professions (including specialist physicians), the number of general practitioners (GPs) per capita has reduced and is predicted to continue this trend at least until 2028. The number of nurses per capita is relatively high compared to the EU average; however, their role and responsibility in primary care remain limited.

The distribution of GPs and specialists across the country is very unequal. Physicians are free to choose their place of practice and therefore are concentrated in well-off urban areas and not necessarily geared to meet population needs. Financial incentives to attract physicians to underserved areas have been implemented, with limited success so far, but other interventions, such as multidisciplinary group practices, have shown potential to attract especially younger GPs to these areas, which include rural communities and deprived inner-city neighbourhoods.

The Covid-19 pandemic highlighted the underinvestment in public hospitals over the past 10 years, as well as the difficult working conditions of nurses and allied health professionals who were largely underpaid compared to other European countries. Wages were significantly increased in 2021 for 1.5 million health professionals through a health reform package; however, there are remaining issues that impact on the ability to secure recruitment, such as difficult working conditions and lack of autonomy and recognition, especially in the long-term care sector. An advanced nurse position was created in 2019 in France to broaden nurses' responsibilities and facilitate task shifting; nevertheless, teamwork and task shifting between healthcare professionals is still developing slowly. The dominant fee-for-service remuneration of healthcare professionals continue to be the main obstacle for task shifting since the delegation of tasks to nurses may result in loss of income for physicians.

■ Care provision remains hospital-centered despite recent reforms aiming to strengthen primary care

Healthcare provision is highly fragmented in France with a segmented approach to care organization and funding across primary, secondary and

long-term care. The system is hospital centred, with many public and private providers competing for patients who have freedom of choice. A voluntary gatekeeping system has been in place since 2004; however, primary care providers have little connection with care providers in other sectors and are not very active in health promotion and disease prevention.

Recent reforms aim to strengthen primary care by encouraging multi-disciplinary group practices, introducing financial incentives for better care coordination and prevention, and expanding the roles and responsibilities of allied health professionals. In addition, cooperation between healthcare providers in different settings is supported by the creation of local care networks.

■ Pharmaceutical spending and utilisation are high

France is Europe's fourth largest pharmaceutical manufacturer, accounting for 3% of the global pharmaceutical market. Accessibility of pharmaceuticals is high due to an extensive public benefits basket and a well distributed network of pharmacies. The SHI covers around 80% of pharmaceutical expenditures, which pays for prescription medicines based on their effectiveness. However, France has high volumes of pharmaceutical consumption, with an overuse of certain medicines such as antibiotics, and low generics utilization rates despite multiple policies aimed at encouraging it.

■ The long-term care and mental health sectors face growing challenges

Long-term care (LTC) is funded and managed by different levels of government. While the SHI system allows a unified and relatively good coverage of medical LTC needs, the type and funding of personal and social LTC services vary depending on the local authority (*département*). Almost 10% of people over 75 years old, and one in three individuals over 90 years old, live in a residential nursing home. Home care nursing and home support services are developing slowly but are not always well articulated with secondary care. Although the number of home-based LTC services has increased, the LTC sector's low level of attractiveness as an employment setting is detrimental

to securing sufficient staff, with a growing number of patients needing such services.

Mental health care has historically been organized around hospitals which have the main responsibility for providing public mental health care (including outpatient care) to the population in their catchment areas. Therefore, mental health care provision remains very hospital-centred, with a lack of both gradual care planning and an adequate supply of alternative structures in ambulatory settings. The negative impact of the Covid-19 pandemic on the mental health of the general population has shed light on the limitations of the current system of mental health care provision. Recent reforms aim to change funding models to improve the coordination of services across all sectors and to increase access to psychologists.

■ Recent reforms have focused on enhancing access to health care

Recent reforms in France have focused on four main areas: improving financial access to care to avoid forgone care; improving physical access, particularly in underserved areas; strengthening prevention; and reforming payment methods for care providers.

Improving financial access to care has included better coverage – via the “100% Santé” reform in 2020 – of OOP payments for optical devices, dental care and hearing aids – as well as better coverage of mental health care by reimbursing psychologist visits under certain conditions. Improving physical access meant increasing the number of training places for medical students, improving the territorial organization of health services, supporting task sharing, and forming new health professions to address workforce shortages.

Measures for reinforcing prevention in the system included a change in medical education requiring all healthcare students to practice health promotion and prevention activities as part of their training, and free prevention consultations for key age groups (teenagers for sexual issues, older people at retirement, etc.) as well as extended mandatory vaccination for children. However, these measures have not been linked to a major increase in primary prevention funding.

Future reforms focus mainly on promoting better coverage and equity in access to care and prevention, and continuing the reforms of primary care and provider payment.

■ Future challenges for the health system include improving data availability for quality monitoring and regular evaluation of health system performance

The accountability and transparency of the French health system have improved over the past decade, following major adverse events which exposed deficiencies in healthcare governance. Patients' rights have been strengthened, but there is little information to guide patients through the health system and patients have low participation in treatment decisions.

Financial accessibility to healthcare is generally high in France. All residents are covered by universal health insurance, and they have access to a broad benefits package. OOP payments and catastrophic health spending are among the lowest in the EU; however, there are significant geographic inequalities in access to care because of the unequal distribution of the health workforce across the country.

France performs well in terms of all-cause mortality, life expectancy and mortality from treatable causes. However, there is a limited focus on health promotion, disease prevention and behavioural risk factors, which is reflected in relatively higher preventable mortality rates. Further, large inequalities in health outcomes between regions, socioeconomic classes and gender persist in the country.

There has been progress in routine reporting of quality of care, especially in acute hospitals, but available data are not used for benchmarking the quality by disease categories and across settings. There is a lack of systematic monitoring of major international quality indicators across providers, including readmission and complication rates, patient experience and safety, and inappropriate prescriptions. Available data are mostly outdated, and provide a mixed picture on quality of care, with good results for cardiovascular diseases but low performance for assuring care continuity for chronic disorders (such as respiratory diseases). Data on care quality are lacking in the primary and long-term care settings.

The implementation of macro-level spending targets by sectors in France has successfully contained overall expenditure. However, this strict budgetary process with a segmented approach to healthcare has also become a barrier for improving allocative efficiency. The absence of a national health system performance assessment framework to monitor and evaluate health system performance in France reduces the capacity to identify problem areas as well as good practices to promote policies aiming to improve care quality and efficiency.

Introduction

■ Summary

- France is comprised of mainland France located in Western Europe and a collection of overseas islands and territories on other continents.
- It has a population of 67.1 million inhabitants and is the second most populous country in the EU after Germany. Close to half of the population live in just over 15% of this territory. Although its population is ageing, this is due to increased life expectancy, as the fertility rate remains high.
- France has the second largest economy in Europe. Its gross domestic product per capita was US\$51 184 PPP in 2021. After an increase in unemployment following the 2008 economic crisis, the unemployment rate has been decreasing since 2015 to reach 8.0% in 2020. However, it is more than twice that in young people.
- France is a semi-presidential republic led by a President elected by direct universal suffrage for a five-year term. The government, led by a Prime Minister appointed by the President, develops and guides policy implementation. The Prime Minister is accountable to the parliament, which exercises legislative power and is made up of the National Assembly and the Senate.

- Life expectancy at birth has increased by almost five years since 1995 and reached 82.5 years in 2021 (79.3 for men and 85.4 for women, one of the highest in the world). In addition to this gender gap, there are marked geographic and socioeconomic variations in life expectancy in France. The Covid-19 pandemic has also impacted life expectancy, which has yet to reach its pre-pandemic value.
- The all-cause standardized mortality rate was 829.6 per 100 000 in 2017. The leading causes of death were cancer (28.4%) and circulatory diseases (23.8%), unlike the majority of EU countries, where circulatory diseases are the highest cause of death.
- Healthy behaviours are not always optimal, with a prevalence for daily smoking and excessive alcohol consumption which is higher in France than the EU average.

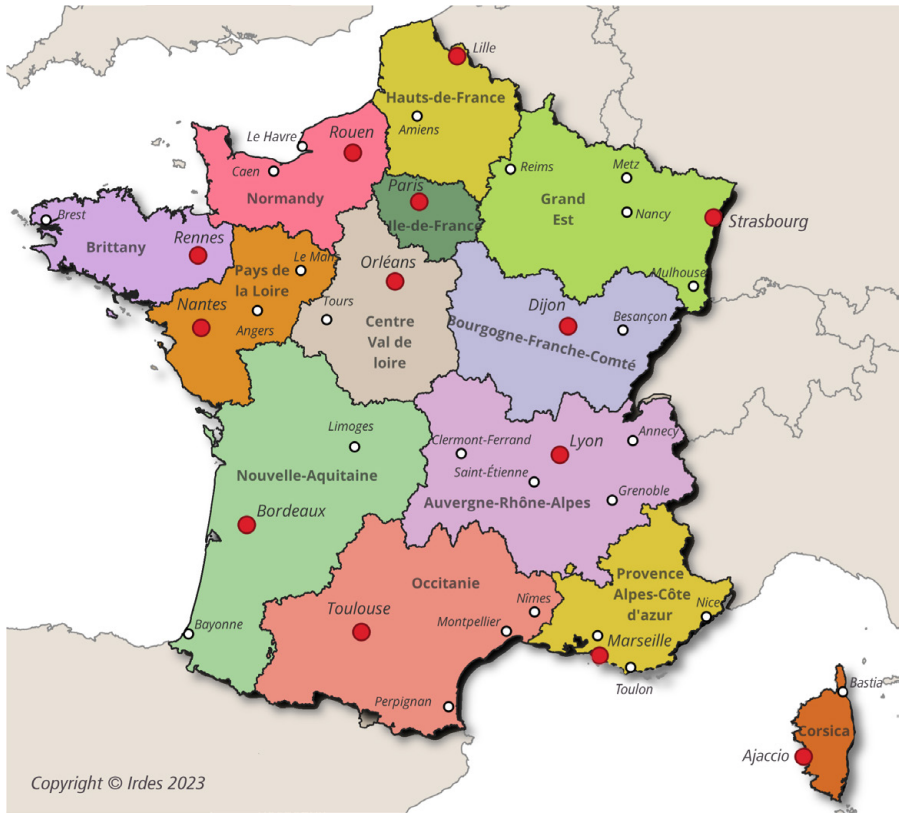
■ 1.1 Geography and sociodemography

The French Republic is comprised of mainland France¹ located in Western Europe and a collection of overseas islands and territories on other continents. There are three sub-levels of governance in France: the regions (*régions*), the departments (*départements*) and the municipalities (*communes*). The five overseas departments and regions (French Guiana, Guadeloupe, Martinique, Mayotte and Réunion) are an integral part of the French Republic and subject to the same laws and regulations, although local adjustments are possible. The other overseas collectivities and territories (French Polynesia, Saint Barthélemy, Saint Martin, Saint Pierre and Miquelon, Wallis and Futuna, New Caledonia, Clipperton Island and the French Southern and Antarctic Lands) are also part of France but have differing legal status.

Mainland France is bordered by Germany, Switzerland, Italy, Monaco, Belgium, Luxembourg, Andorra and Spain (Fig. 1.1). Its geography is varied, from coastal plains in the north and west to mountain ranges in the south-west (the Pyrenees) and the southeast (the Alps), including Mont Blanc, the highest point in Western Europe at 4810 m (15 781 ft). The climate is temperate.

¹ Mainland France in this text refers to the French territory on mainland Europe and the island of Corsica. In French this is commonly known as 'France métropolitaine'.

FIG. 1.1 Map of France



On 1 January 2020 the French population totalled 67.1 million inhabitants, including 64.9 million inhabitants in mainland France and 2.2 million inhabitants in the five overseas departments and regions (Insee, 2020b). It is the second most populous country in the EU after Germany. Table 1.1 shows the most recent demographic indicators.

Mainland France covers an area of about 552 000 km², and, with an average population density of 118/km², it ranks 10th in the EU. However, this average density conceals considerable variations; close to half of the population live in just over 15% of this territory, while large areas remain sparsely populated. In 2020, 81% of the population lived in urban areas, but a new definition of rural areas introduced in 2020 by Insee would see this percentage fall to 67% (Insee, 2021c). Between 2007 and 2017 the population grew faster in rural areas than in urban areas (0.66% vs. 0.38% annually).

TABLE 1.1 Trends in population/demographic indicators for mainland France, selected years

	1995	2000	2005	2010	2015	2020
Total population (million)	57.8	58.9	61.0	62.8	64.3	64.9
Population aged 0–14 (% of total)	19.6	18.9	18.4	18.4	18.4	17.6
Population aged 65 and above (% of total)	15.0	16.0	16.5	16.8	18.6	20.7
Population density (people per km²)	104.7	106.7	110.5	113.8	116.6	117.6
Population growth (average annual growth rate)	0.4	0.7	0.8	0.5	0.4	0.2
Fertility rate, total (births per woman)	1.7	1.9	1.9	2.0	2.0	1.9 ^a
Percentage of urban population^c	75	76	77	78	80	81 ^b

Notes: ^a 2019 data; ^b 2018 data; ^c This has been calculated under the current definition of rural population.

Sources: Insee, 2020b, 2021b, 2021c, 2021d; World Bank, 2022

In 2020 an estimated 6.7 million immigrants (people born in a foreign country) resided in France (excluding Mayotte), representing 10.1% of the population (Insee, 2021b). Individuals born in Algeria, Morocco and Tunisia accounted for 29.7% of France's immigrant population.

The government does not gather data on ethnicity, and available data usually concern the country of birth of the parents or the language spoken at home. It tells us that in addition to the 6.7 million people who immigrated to France, an additional 7.6 million (11.4% of the population) have one or two parents born in a foreign country (Insee, 2021b).

Regarding religion, a 2019 survey for the *Observatoire de la laïcité* found that close to half of the population described themselves as Catholic (47%), while 34% declared themselves agnostic or atheist. In addition, 3% were Muslim, 3% Protestant, 2% Buddhist, 1% Orthodox, 1% Jewish, and 1% other (Observatoire de la laïcité, 2020).

France has the highest fertility rate in Europe (1.87 births per woman), which has remained stable since 1995 (Table 1.1). The French population is ageing and the post-Second World War baby boom effect will exacerbate this trend in the medium term: people aged over 75 years are expected to constitute 16.3% of the population by 2050, compared to 9.6% today (Insee,

2021d). This is a result of increasing life expectancy, not declining fertility rates, unlike other European countries.

Just over 80% of the French population have attained an upper secondary education (Insee, 2020b). In 2019 nearly 70% of the population aged between 18 and 23 years old were enrolled in higher education.

1.2 Economic context

France is the seventh largest economy in the world and the second largest in Europe. Thanks to its overseas departments and territories, France has the largest exclusive economic zone in the world in terms of area.

In 2021 the gross domestic product (GDP) of France exceeded US\$3 trillion PPP (Table 1.2), with a per capita GDP of US\$51 184 PPP, ranking

TABLE 1.2 Macroeconomic indicators, selected years

	1995	2000	2005	2010	2015	2021
GDP per capita, PPP (current international US\$)	20 771	26 095	30 504	35 912	40 830	51 184
GDP, PPP (current international US\$, million)	1 236 489	1 589 246	1 926 880	2 334 677	2 718 495	3 480 643
GDP average annual growth rate (%)	2.1	3.9	1.7	1.9	1.1	7.0
Public expenditure (% of GDP)	54.8	51.7	53.3	56.9	56.8	59.2
Government deficit/surplus (% of GDP)	-5.1	-1.3	-3.4	-6.9	-3.6	-6.5
General government gross debt (% of GDP)	56.1	58.9	67.4	85.3	95.6	112.9
Unemployment, total (% of labour force)	11.8	10.2	8.5	8.9	10.4	8.0 ^a
Poverty rate^b (%)	14.5 ^c	13.6	13.2	14.0	13.6	13.6 ^d
Income inequality (Gini coefficient of disposable income)	–	–	0.286	0.306	0.295	0.292 ^e

Notes: ^a 2020 data; ^b Percentage of people who have an equalized disposable income below the risk-of-poverty threshold, which is set at 60% of the national median equalized disposable income (after social transfers); ^c 1996 data; ^d 2018 data; ^e 2019 data.

Sources: Insee, 2021a; OECD, 2019c; World Bank, 2022

10th among EU countries. The GDP increased by 7.0% between 2020 and 2021, putting it 1.6 percentage points below the 2019 GDP, following a sharp 7.9 percentage points decrease in 2020 due to the Covid-19 pandemic. The budget deficit was 6.5% of GDP in 2021 (vs. 9.2% in 2020 and 3.1% in 2019).

In 2020, 28.9 million people (43.3% of the French population, excluding Mayotte) were active in the labour market (Insee, 2021a). Women represented 48.8% of the country's workforce. The unemployment rate was 8.0%, similar in men and women but much higher in young people (20.2% in the 15–24 age group). When accounting for the halo of unemployment², the unemployment rate rose to 10.3%. After a continuous increase following the 2008 economic crisis, the unemployment rate has been decreasing since 2015.

Around 14% of the population are below the poverty level, defined as 60% of the country's median income. This is lower than the EU average (17%). Income differs across the population: the income ratio of the richest 10% and the poorest 10% was 3.5 in 2019, and the Gini index was 0.292 (Table 1.2). In comparison with other European countries, income is more equally distributed than in the Kingdom of the Netherlands, Spain, the United Kingdom or Italy, but less so than in Germany, Belgium and Scandinavian countries (OECD, 2019c).

■ 1.3 Political Context

The institutions of the French Republic are governed by the 1958 Constitution, which ushered in the Fifth Republic and strengthened the role of the executive branch (the President of the Republic and the Prime Minister) relative to the parliament.

The President is elected by direct universal suffrage for a five-year term. The government, led by a Prime Minister nominated by the President, develops and guides policy implementation. The Prime Minister is accountable to parliament, which exercises legislative power and is made up of the National Assembly and the Senate.

² According to Insee's definition, the "halo of unemployment" is made up of inactive people who are not counted as unemployed as defined by the International Labour Office but whose situation is very similar (for example, unemployed people not seeking work but wanting to work and available for work).

The National Assembly has 577 deputies elected by direct universal suffrage. Voting takes place on the basis of a single majority vote (that is, voting for one deputy only) in two rounds, within the framework of constituencies of variable size (one deputy for approximately 100 000 inhabitants). The National Assembly's session is five years but can be shortened if the President decides to dissolve the National Assembly, which has happened five times since the inauguration of the Fifth Republic.

The Senate consists of 348 senators who are elected for six years by indirect universal suffrage, through an electoral college consisting of elected officials in each department. Roughly half of its members are renewed every three years.

The French civil service has become more decentralized over the past 30 years, a substantial change from its long tradition of centralizing policies. There are three levels of administration: the municipality, the department and the region. These three levels are both administrative constituencies of the State and decentralized local communities run by locally elected assemblies. They have their own separate areas of responsibility in which they are autonomous. However, the State defines the competencies of each level of administration. Municipalities oversee local activities, and their responsibilities are extensive in the economic and social sectors. Departments (96 in mainland France and 5 overseas) are run by elected departmental councils (*conseil départemental*), which vote on the department's budget and have authority in the areas of health and social care and the financing and provision of lower secondary education (*collèges*). Regions' jurisdiction mainly concerns planning, development, economic development, vocational training and upper secondary educational institutions (*lycées*).

The current President of the Republic, Emmanuel Macron, was elected in May 2022, and he appointed Elisabeth Borne as Prime Minister the same month. The June 2022 election of deputies resulted in a National Assembly with no majority (the President's party and its allies (*Ensemble!*), who characterise themselves as centrist parties, won 245 seats, 42%). The opposition is comprised of left-wing and green parties (mainly from *Nupes*, 131 seats, and other left-wing parties 22 seats), far right-wing parties (*Rassemblement National*, RN, 89 seats) and right-wing parties (mostly from *Les Républicains*, LR, with 61 seats, and other right-wing parties 10 seats) (Ministère de l'Intérieur et des Outre-Mer, 2022).

France is a founding Member State of the EU. France also belongs to numerous international organizations, including the United Nations, the World Health Organization (WHO), the European Economic Agreement (EEA), the Organisation for Economic Co-operation and Development (OECD), the World Trade Organization (WTO), the North Atlantic Treaty Organization (NATO) and the Council of Europe.

France has signed several treaties with direct or indirect impact on health, including the General Agreement on Tariffs and Trade (GATT), the European Convention on Human Rights (ECHR), the WHO Framework Convention on Tobacco Control, and the United Nations Convention on the Rights of Persons with Disabilities.

■ 1.4 Health status

Life expectancy at birth has increased by almost five years since 1995 (Table 1.3), although it decreased by 0.5 years in women and 0.6 years in men in 2020 due to the Covid-19 pandemic. While it went up again in 2021, it did not reach its 2019 value (85.6 years for women and 79.7 for men). The French average life expectancy for women is the fifth highest in the world. Health-adjusted life expectancy was 64.6 for women and 63.7 for men in 2019 (Insee, 2021b), which is slightly higher than the EU mean (respectively 63.8 years and 63.4 years in 2018).

Looking at causes of death, the leading causes in 2017 were cancer (28.4%), circulatory diseases (23.8%), symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (9.8%), respiratory diseases (7.4%) and external causes (6.5%). This makes France one of the few countries in the EU where cancer kills more people than circulatory diseases. Suicide rates are also high in France compared to the EU average (13.2 vs. 10.5 per 100 000 population) (OECD, 2020a).

The gender gap in life expectancy in France was 6.1 years in 2020, which is higher than the EU average of 5.6 years that same year. There are also geographic and socioeconomic variations: life expectancy is lower in the five overseas departments and regions, reaching its lowest in Mayotte (72.5 years for men and 73.9 for women). There are also differences associated with income, level of education and socioeconomic status. For example, during the 2012–2016 period there was a 13-year and 8-year difference in

TABLE 1.3 Mortality and health indicators, selected years

	1995	2000	2005	2010	2015	2021
Life expectancy (years)						
Life expectancy at birth, total	77.8	79.1	80.2	81.7	82.3	82.5
Life expectancy at birth, male	73.9	75.3	76.8	78.0	79.1	79.3
Life expectancy at birth, female	81.9	82.8	83.9	84.7	85.1	85.4
Life expectancy at 65 years, male	16.1	16.7	17.7	18.6	19.1	19.2
Life expectancy at 65 years, female	20.6	21.2	22.0	22.7	23.0	23.2
Mortality						
Mortality, SDR per 100 000 population^a						
Circulatory diseases	339.7	285.3	257.4	203.1	169.6 ^b	-
Malignant neoplasms	281.8	266.2	256.9	236.5	222.0 ^b	-
Communicable diseases	22.1	18.2	17.0	15.9	13.3 ^b	-
External causes of death	81.9	70.6	64.5	56.1	50.8 ^b	-
All causes	–	1 072.7 ^c	1 004.2	886.0	858.2	829.6 ^d
Infant mortality rate, per 1 000 live births	5.0	4.5	3.8	3.6	3.7	3.6
Maternal mortality rate, per 100 000 live births	9.6	6.5	5.8	8.5	4.5	–

Notes: ^a Mean annual mortality rate over a three-year period for mainland France; ^b The latest data available concern the 2015–2017 period; ^c 2001 data; ^d 2017 data.

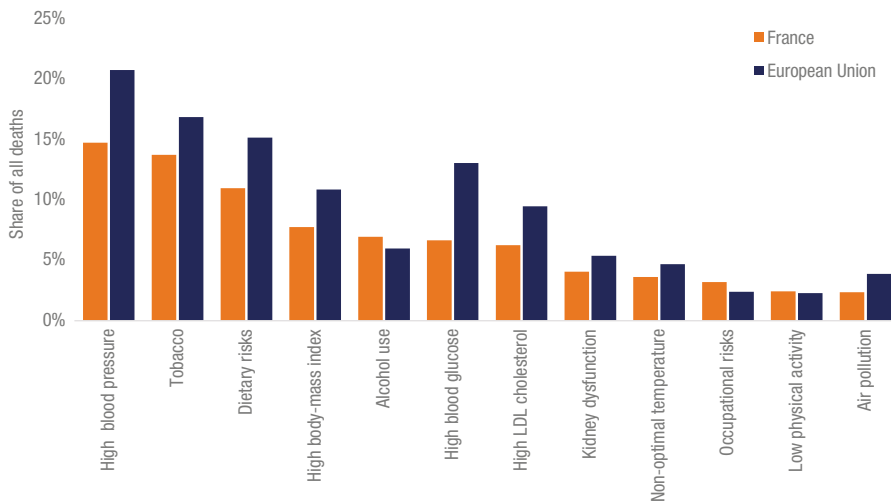
Sources: Insee, 2018; CepiDc, 2022; Eurostat, 2022

life expectancy between the 5% richest and the 5% poorest men and women, respectively (Insee, 2018).

The premature mortality rate was almost twice as high in men compared to women in 2021 (239 per 100 000 inhabitants vs. 122). It is higher in the overseas departments and regions. Roughly 30% of premature deaths were deemed avoidable, and avoidable mortality was 3.3 times higher in men and 5.1 times higher in the overseas departments and regions in 2013 (DREES and Santé publique France, 2017). However, it has been decreasingly steadily in the past decades, at a faster rate in men.

Alcohol consumption, tobacco, a sedentary lifestyle and poor nutrition are the main risk factors for morbidity and mortality in France, as in many other countries (Fig. 1.2).

FIG. 1.2 Risk factors affecting health status, latest available year



Source: IHME, 2021b

Overall, smoking prevalence has decreased in France in the past few years, following the implementation of national tobacco control plans. However, it remains higher than the EU mean and social inequalities are notable. In 2020, 31.8% of French people reported that they consumed tobacco (36.2% of men and 27.7% of women), and 25.5% that they were daily smokers (vs.18.4% in the EU) (Pasquereau et al., 2021). There was a 15-percentage point difference between the lowest and highest income groups, a 17-percentage point difference between unemployed and employed

groups, and an 18.5-percentage point difference between lowest and highest education levels. While tobacco-related standardized mortality rates have been decreasing, it increased in women under 65 between 2000 and 2013 (DREES and Santé publique France, 2017). There are regional variations, and an increased mortality in people living in the most socially disadvantaged areas.

Regarding alcohol consumption, in 2020, 23.7% of the population aged 18 to 75 had high alcohol consumption, a little over the EU average (20%). It was more common in men (33.5% vs. 14.9% in women). All other things being equal, women with a high academic degree, unemployed men and those (both men and women) with high incomes were more likely to exceed guideline amounts (Andler et al., 2021). In 2017 alcohol-related illnesses corresponded to 17 400 deaths, but related standardized mortality rates have been improving since 2000. Regional variations and higher mortality in disadvantaged groups were also observed.

Obesity rates in France are among the lowest in the OECD, but have been increasing steadily. About 1 in 10 people are obese in France, and almost 40% are overweight (including obese). Significant socioeconomic disparities in obesity exist in both men and women (OECD, 2020b). Only 5% of adults exercise enough for it to protect their health, and 38% were sedentary (up to 60% for those with the lowest levels of education) (ANSES, 2022).

In 2019, 73% of the French population declared they were in good or very good health. This positive perception decreased with age (54% in the age group over 65 vs. 92% among 18–24 years old). Women were less likely to consider themselves in good health, as were those in the lowest income group, with a decrease along the social gradient (DREES, 2021f).

Finally, 34.2% of individuals declared a limitation in their usual activities since at least 6 months (36.3% of women and 31.7% of men). Unsurprisingly, this increased with age and was three times higher in people aged 85 and over compared to the 45–54 age group. In the former, 34.1% of women and 32.1% of men reported a severe limitation (Insee, 2021b).

2

Organization and governance

■ Summary

- The French health system is of a mixed type, structurally based on a Bismarckian (Social Health Insurance) approach with Beveridge (National Health System/NHS) goals reflected in the single public payer model, the importance of tax-based revenue for financing healthcare, strong state intervention and residency-based benefits.
- There is Statutory Health Insurance (SHI), which, under various schemes, currently covers almost 100% of the resident population.
- The delivery of care is shared among private, fee-for-service (FFS) physicians and other health professionals, private for-profit hospitals, private non-profit hospitals and public hospitals. There is a medico-social care sector, known as the third sector, which provides social care and services to older and disabled people.
- Jurisdiction in terms of health policy and regulation of the health-care system is divided among the State (parliament, government and the MoH), SHI and, to a lesser extent, local authorities (*départements*). Trends in reforms have attempted to devolve a greater remit in governance and health policy decision-making, in particular in the area of planning, to the regional level. Cutting across

the traditional boundaries of healthcare, public health and social care sectors, regional health agencies (ARS) have responsibility for ensuring that healthcare provision meets the needs of the population.

- Planning and regulation of healthcare involve negotiations among provider representatives (health professionals); the State, mainly represented by the ministries of health; and the SHI. In the context of increasing healthcare expenditure in the 2000s, the role of the State in planning and regulation has increased over the past decade.
- Most providers are paid by the SHI (or directly by patients who are later reimbursed). The statutory tariffs are set through negotiations between providers and the SHI and are approved by the Ministry of Health. Quality of care is regulated at the national level. Hospitals must undergo a certification process but, until 2023, there was no formal recertification or relicensing process for health professionals. Responsibility for capacity planning is shared by the central and regional levels.

■ 2.1 Historical background

The present system of social security, including SHI, was established after the Second World War. Prior to this, healthcare and social care were largely provided through mutual benefit associations. The statutory insurance system first emerged with the 1930 Act on Social Insurance, which created a system of compulsory protection paid for by employers for employees whose earnings fell below a certain level. Coverage encompassed five areas: illness, maternity, disability, old age and death. By 1939 two thirds of the French population was covered for illness by mutual benefit associations, with free choice of the organization providing coverage. The creation of SHI in 1945 within the social security system changed the role of these associations, which either disappeared or became providers of complementary private health insurance (CHI), which is a type of co-insurance in France (see Section 3.5).

Social security consists of compulsory protection, with four branches covering health (disease, maternity, incapacity and death), work-related illness and injuries. SHI is the branch of social security covering health, initially funded by contributions from both employers and employees, with benefits

provided in cash and in-kind. While the founders of the social security system, largely inspired by the Beveridge report in the United Kingdom, aimed to ensure uniform rights for all, this was opposed by certain social-professional groups that already benefited from insurance coverage with more favourable terms. Several of them succeeded in maintaining their particular systems, which were transformed into small SHI schemes. However, today, the main SHI schemes cover over 90% of the population (see Section 3.3.1).

Initially, the SHI covered workers and their families only. However, the principle of expanding coverage to the whole population had been raised as early as 1945 but was only put into practice in stages (for more details, see Section 2.2 in Chevreur et al., 2010). The shift from an employment-based system towards universal health coverage was nearly achieved with the 1999 Universal Health Coverage Act (*couverture maladie universelle*, CMU), which instituted a residency-based right to SHI coverage (see Section 3.2 in Chevreur et al., 2015), while in parallel, funding methods on the beneficiary side have shifted from an employee earned income-based contribution to an earmarked tax on every type of revenue (*Contribution sociale généralisée*, CSG) (see Section 3.3.2).

■ 2.2 Organization

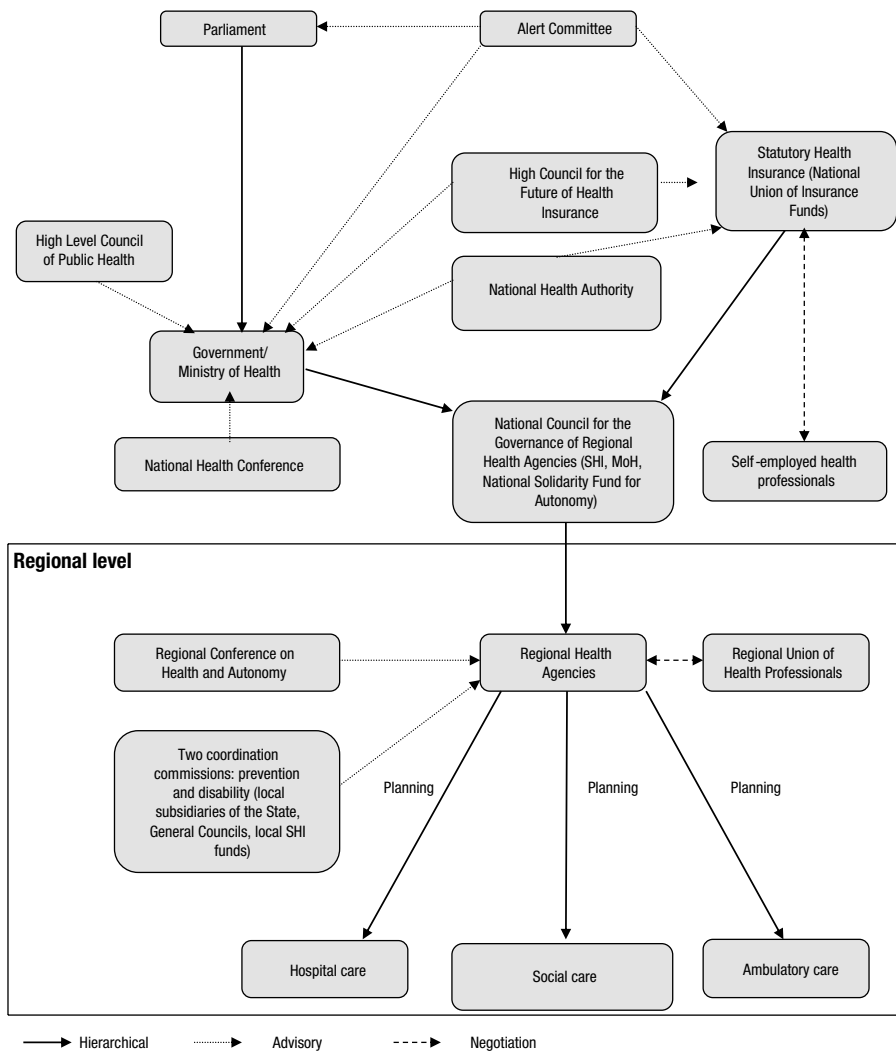
The French healthcare system is structurally based on a Bismarckian (SHI) approach, with goals of universality and solidarity that have led to an increasingly Beveridgian-type (NHS) system. The SHI currently covers 100% of the resident population (including undocumented migrants under certain conditions). Jurisdiction over health policy and regulation of the healthcare system (Fig. 2.1) is divided among:

- the State: parliament and the government, specifically the Ministry of Health³
- the SHI; and
- to a lesser extent, local authorities (*départements*).

³ In this HiT, the Ministry of Health will refer to the administration of both health and social affairs (see Section 2.2.2).

Delivery of care is shared among private, fee-for-service (FFS) physicians and other health professionals, private for-profit hospitals, private non-profit hospitals and public hospitals. The current institutional organization of the health system is the result of the will of the founders of the social security system to create a single block system, guaranteeing uniform rights for all. Health insurance in France has, therefore, always been more concentrated and uniform than in other Bismarckian systems.

FIG. 2.1 Overview of the health system in France, 2021



Notes: SHI: Statutory health insurance; MoH: Ministry of Health

■ 2.2.1 *The parliament*

The parliament has control over the healthcare system via an annual Social Security Financing Act which sets a spending target for the health sector. It also influences health policy priorities by passing public health acts. The Social Security Financing Act is proposed by the government after a six-month preparation period in which all the directorates of the Ministry of Health are consulted as well as the Ministry of Finance; it is mostly based on proposals from the SHI Fund published in their yearly activity report (*Rapport Charges et Produits*). Several reports serve as a basis for discussion, including reports of: the National Court of Auditors (*Cour des comptes*), which is an independent public body responsible for monitoring state and social security bodies, to ensure adequate control over and proper use of public funds; the SHI; the High Council for the Future of Health Insurance (*Haut conseil pour l'avenir de l'assurance maladie*, HCAAM); and to a lesser extent the High Council of Public Health (*Haut conseil de la santé publique*, HCSP); and the National Health Conference (*Conférence nationale de santé*). The Social Security Financing Act:

- sets a projected target (ceiling) for health insurance spending for the following year, known as the national objective for SHI spending (*Objectif national des dépenses d'assurance maladie*, ONDAM);
- approves a report on trends in policy for health and social security; and
- contains new provisions concerning benefits and regulation.

The parliament also approves the revenue side of the budget based on the contribution rates for employers, beneficiaries and employees, and specific earmarked taxation proposed by the government.

The government, however, retains the leading role in proposing both public health and social security financing acts to the parliament and in writing the by-laws and decrees that result from the acts passed.

■ 2.2.2 *Ministry of Health*

The Ministry of Health (MoH) is the central level of the Administration of Health and Social Affairs (*Administration sanitaire et sociale*). It comprises four directorates, which have the following responsibilities:

- General Directorate of Health (*Direction générale de la santé*, DGS), which oversees health policy;
- General Directorate of Healthcare Supply (*Direction générale de l'offre de soins*, DGOS), which manages the human and capital resources of the entire healthcare system;
- Directorate of Social Security (*Direction de la sécurité sociale*, DSS), which is responsible for the policies, governance and financing of the social security system, including preparation of the annual social security financing acts passed by the parliament; and
- General Directorate for Social Policy (*Direction générale de la cohésion sociale*, DGCS), which is responsible for health and social care for elderly, disabled and vulnerable people.

There is also a support directorate, shared between several ministries, that belongs to the public service of statistics and that is in charge of providing information and statistics on the system (*Direction de la recherche, des études, de l'évaluation et des statistiques*, DREES).

Depending on the government in place, the MoH has different names; it may include all four directorates or fewer – and each of the directorates will be under the responsibility of one or more ministers. This depends on the political power of the Minister who oversees health. For instance, after the election in 2017 the MoH had only one ministry grouping the four directorates and named the Ministry for Solidarity and Health (*Ministère des solidarités et de la santé*), while after the last election in May 2022 two ministries were created instead: the Ministry for Health and Prevention (*Ministère de la Santé et de la Prévention*) and the Ministry for solidarity, autonomy and disabled people (*Ministère des Solidarités, de l'Autonomie et des Personnes handicapées*).

The MoH is responsible for preparing and implementing government policy in the areas of public health, organization and financing of the healthcare system within the framework of the Public Health Act. It controls a large part of the regulation of healthcare expenditures on the basis of the overall framework established by the parliament. Its specific responsibilities include the following:

- allocating the budgeted expenditure among the different sectors (hospitals, ambulatory care, mental health care, etc.) and, among the different regions;

- deciding on a pluri-annual number of health students to be trained in medical, pharmaceutical, dental and midwifery school each year, the number of hospital beds and the amount of equipment, including expensive medical technologies;
- setting the tariffs for public and private hospitals under the medical activity-based payment (ABP) system;
- approving the agreements signed between SHI and unions representing self-employed healthcare professionals (see Section 3.7);
- setting the prices of medicines and devices on the basis of proposals from the French National Authority for Health (*Haute autorité de santé*, HAS) ad hoc committees;
- establishing safety standards in hospitals; and
- defining priority areas for national health programmes.

At the regional level the Administration of Health and Social Affairs is represented by the Regional Health Agencies (*Agences régionale de santé*, ARS) (see Section 2.2.4), which are not directly under the supervision of the MoH but fall under the administrative supervision of the National steering council (*Conseil national de pilotage*, CNP), which is composed of delegates of the ministries in charge of health and in charge of public accounts and social security, the SHI and the National Solidarity Fund for Autonomy (*Caisse nationale de solidarité pour l'autonomie*, CNSA).

■ 2.2.3 Other public agencies

The MoH relies upon a number of health agencies, which are under its supervision, and other public bodies in the development and implementation of policies for which it is responsible. Most of them are subordinate agencies with missions in a specific health area. These are:

- the French biomedicine agency (*Agence de la biomédecine*, ABM);
- the National agency for medical and health products safety (*Agence nationale de sécurité du médicament et des produits de santé*, ANSM);

- the French agency for food, environmental and occupational health and safety (*Agence nationale de sécurité sanitaire de l'alimentation, de l'environnement et du travail*, ANSES);
- the National agency to support the performance of health and health and social care institutions (*Agence nationale d'appui à la performance des établissements de santé et médico-sociaux*, ANAP);
- the Technical agency for information on hospital care (*Agence technique de l'information sur l'hospitalisation*, ATIH);
- the French Blood Agency (*Etablissement français du sang*, EFS);
- the Radioprotection and Nuclear Safety Institute (*Institut de radioprotection et de sécurité nucléaire*, IRSN);
- the National Cancer Institute (*Institut national du cancer*, INCa); and
- the French public health agency (*Santé publique France*, SPF).

For more information on their missions see Section 5.1.

Moreover, the HAS, an independent public body with financial autonomy, undertakes a number of activities designed to improve the quality of patient care. The HAS remit is diverse, ranging from assessment of drugs, medical devices and procedures to publication of guidelines, accreditation of healthcare organizations and protocols for recertification of doctors. It is mandated by law to carry out specific missions on which it reports to the government and the parliament.

■ 2.2.4 *Statutory health insurance*

The SHI is composed of three categories of schemes, which cover the entire population. Individuals and their families are affiliated with a scheme based on employment status. Working people have no choice regarding the scheme in which they are enrolled and may not opt out of coverage except in certain cases (for example, expatriates and employees of international corporations or institutions). Thus, there is no competition among the schemes. Persons who are not working are automatically enrolled in the general scheme, which is the major scheme.

The three categories of schemes and their beneficiaries in 2020 are approximately as follows:

1. the general scheme (*Caisse nationale d'assurance maladie*, CNAM) covers everybody (around 88% of the population) except those eligible for other schemes (CNAM, 2021k);
2. the agricultural scheme (*Mutualité sociale agricole*, MSA) covers farmers and agricultural employees and their families (around 5% of the population); and
3. the numerous “special schemes”, over 20 in number, built upon pre-SHI prepayment systems for defined categories of workers: local and national civil servants, miners, military personnel, employees of the national railway company, the clergy, sailors, the national bank, the gas and electricity company (they cover 7% of the population but technically manage claims and benefits for hardly 3%) (UNRS, 2022) (see Section 3.3.1).

These schemes are federated into a National Union of Health Insurance Funds (*Union nationale des caisses d'assurance maladie*, UNCAM) for the purpose of representing the funds in negotiations with healthcare providers.

Each of the two major health insurance schemes is made up of a national health insurance fund and local structures corresponding to the degree of geographical distribution involved.

■ 2.2.5 Professional organizations

There are two types of professional organization: professional associations or councils (*Conseil de l'ordre*) and trade unions. For most medical specialties both an association and a union exist. Professional councils for doctors, pharmacists, dentists, midwives, physiotherapists and nurses are concerned with medical ethics and the supervision of professional practice. The council is responsible for all matters pertaining to the scientific activities of a speciality, including developing guidelines and ensuring compliance with annual continuing professional development (*Développement professionnel continu*, DPC) requirements, and from 2023 onwards recertification of some health professionals, while the union is in charge of the negotiations between the professionals and the SHI (see Section 4.2.1) over fees and other matters affecting practice.

At the national level an umbrella organization represents all healthcare professionals in private practice: the National Union of Health Professions (*Union nationale des professions de santé*, UNPS). It sets the agenda for negotiations between health professionals and the SHI and CHI. Similarly, at regional level regional unions of health professionals (*Unions régionales des professionnels de santé*, URPS) negotiate with the ARS (see Section 2.7.2).

In addition to their professional organizations and councils, health professionals may also join any of the trade unions that exist to represent workers in all fields of industry and services. In 2008 less than 20% of the health workforce were union members (Borgetto, 2008) – a rate which may have decreased since. Trade union representation is fragmented, not only because of the existence of different professions, but also through differences in status, for example, between salaried and self-employed professionals, or working in the hospital sector or not, or in the public or private sector. In addition to “vertical” unions, which represent interests at the national level, “horizontal” unions have developed at the local authority (*département*) level. As a result of this diversity, the unions’ positions on government measures may differ and decrease their power in negotiating. In 2021, as an attempt to partly solve this issue, a union of trade-unions of self-employed health professionals, “*Les Libéraux de Santé*” (“The self-employed”), was set up.

■ 2.3 Decentralization and centralization

■ 2.3.1 National level

The MoH has substantial control over the health system, although reforms both at the regional and the national levels have challenged its traditional role. For example, at the regional level the regional health authorities (see below) have public health and healthcare planning and financing responsibilities within their remit; at the national level the HAS independently monitors technologies, hospitals, health professionals and the basic benefits package (see Section 2.2.3).

The policy agenda is set by the MoH through acts approved by the parliament that define health targets pursuant to the objectives of the Public Health Act. However, this is done jointly with the Ministry of Finance and

Public Accounts with respect to the annual Social Security Financing Act, which deals with the collection of revenues and delivery of health services.

Policy formulation is undertaken with the help of several advisory committees such as the High council for the future of health insurance (*Haut conseil pour l'avenir de l'assurance maladie*, HCAAM), the National health conference (*Conférence nationale de santé*, CNS) and the High council on public health (*Haute conseil de la santé publique*, HCSP).

HCAAM is an independent committee that publishes reports on the situation of the healthcare system. Members are high-profile professionals selected by the MoH to provide detailed figures and policy forecasts as well as policy proposals to ensure the sustainability and fairness of the system.

The CNS brings together representatives of the health professions, healthcare facilities, the Regional Conferences on Health and Autonomy (*Conférence régionale de la santé et de l'autonomie*, CRSA) and other experts to discuss and define healthcare priorities at the national level. The strategy is mainly implemented through the regional health projects (*Projets régionaux de santé*, PRS), through which the strategic regional plan for health (*Plan stratégique régional de santé*, PSRS) is developed by the ARS in consultation with the stakeholders who participate in the CRSAs on health and autonomy (see Section 2.4).

The HCSP is composed of independent public health experts; it provides guidance regarding public health problems and issues related to the organization of healthcare. It undertakes regular overviews of the population's health status, contributes to the definition of public health objectives, and makes proposals for strengthening preventive measures. It also monitors the health target objectives of the Public Health Act and suggests new objectives.

■ 2.3.2 Regional level

The general philosophy underlying decentralization in France reflects a marked reluctance to reduce central control over policy and finance, and as a result it has mainly come in the form of deconcentration. The creation of the ARS in 2010 changed the regional landscape by merging seven regional institutions into a single regional entity traversing the traditional boundaries of healthcare, public health, and health and social care for elderly and disabled people.

The 18 ARS (13 for mainland France and 5 for overseas departments) are responsible for ensuring that the provision of healthcare services meets the needs of the population by improving the coordination between the ambulatory and hospital sectors and health and social care sector services, while respecting national objectives for SHI spending (ONDAM). It is also responsible for implementing regional health policy in relation to occupational health services, maternal and child protection services (*Protection maternelle et infantile*, PMI), and university and school health services.

The ARS monitor the regional health status of the population, ensure that hygiene rules are respected, participate in prevention and patient health education, and assess health professionals' education. They authorize the creation of new health services and social care services for the elderly and disabled. In the environmental health sector they oversee water and air quality.

The CRSAs inform the ARS' directors about regional issues, including healthcare and social services' needs. Moreover, the ARS are advised by two commissions for coordination of public policies that group representatives of the State and local authorities (*départements*), as well as local SHI fund representatives. One is dedicated to prevention, school health, occupational health and mother and child health. The other is dedicated to health and social care for elderly and disabled persons.

The ARS are subsidiaries of the State under the umbrella of the ministers in charge of health, social security, the elderly and the disabled. However, they are autonomous bodies, and their directors, appointed by the MoH, have extended autonomy with respect to SHI and CNSA budget management and capacity planning in the region. The Surveillance Council (*Conseil de surveillance*), headed by the regional prefect, is in charge of approving the budgets and expenses of the ARS and providing opinions on the PRS, the main regional capacity planning tool. In order to implement national policies at the regional level, services of the State do not communicate directly with the ARS but rather are approved first by the National steering council (*CNP*), which passes orders on to the ARS. The National steering council groups representatives of SHI, CNSA and the ministries in charge of health, social security and the elderly and disabled.

These organizational arrangements, by increasing delegation to the ARS, have sometimes led to differences between regional policies and national health policies in addressing cost-containment constraints, improving health services delivery and meeting the objectives of the triennial contract

(*Convention d'objectifs et de gestion*, COG) between SHI and the State (see Section 2.8.1).

■ 2.3.3 Institutions at the department level

Each ARS covers several local authorities (*départements*). The ARS is represented in each local authority (*département*) by a local delegation (*Délégation territoriale de l'agence régionale de santé*) that is responsible for implementing the ARS' regional policies and supporting local actors.

Several healthcare and health and social care services are under the jurisdiction of the Departmental Council (see Section 1.3). These include:

- health and social care institutions and services for elderly and disabled people (nonmedical facilities come under the authority of the departmental councils, which supervise and finance them through social assistance budgets, while facilities combining social and medical services come under the joint supervision of the State and the departmental councils);
- protection of children, particularly through the management of maternal and child protection services, which offer consultations and free healthcare;
- prevention of certain diseases, such as tuberculosis, sexually transmitted diseases and cancer; and
- public health and hygiene (environmental health, sanitation, etc.), in conjunction with municipalities.

■ 2.4 Planning

As stated above, the MoH has substantial control over the health system. Responsibility for planning health system resources and capacity is shared by the MoH and the ARS. The goal of this partial devolution of the planning function is to enable regional authorities to meet the health needs of the population more appropriately.

The MoH has established a national strategy (*Stratégie nationale de santé*) that moulds the regional planning strategy for a five-year period. This strategy

aims at improving population health while decreasing health inequalities, by improving preventive practices and access to care for equal needs for all, whatever the geographical location.

For particular issues identified as being underinvested or requiring special investment and attention because of their public health burden, national plans are set up by the MoH in collaboration with relevant stakeholders. There are, for instance, national plans for disease prevention, Alzheimer's disease, cancer, mental health, rare diseases, autism, each of which gives general guidance on how planning should be done in these areas.

The responsibility for providing health services is shared between self-employed health professionals (physicians, nurses, allied health professionals, etc.) and healthcare facilities, of which ownership is shared between the government, non-profit organizations, which include charities and mutual benefit societies, and for-profit organizations. The latter are predominant in the social care sector for the frail elderly.

Planning of these services largely takes place at the regional level and involves the ARS, which design a strategic regional health project (*Projet régional de santé*, PRS) in collaboration with the Regional Conference on Health and Autonomy (CRSA), the regional council, the local authority (*département*) councils, the representative of the State at the regional level, and municipal councils. It has three components: the Strategic orientation frame (*Cadre d'orientation stratégique*, COS) that sets general goals on a 10 year-horizon, the Strategic regional health plan (*Schéma régional de santé*, SRS) and the Regional programme for access to care and prevention for the less well-off (*Programme régional relatif à l'accès aux soins et à la prévention des personnes les plus démunies*, PRAPS).

The PRS encompasses prevention services, ambulatory and inpatient healthcare services and the health and social care sector services. It is developed for a five-year period and aims to tailor healthcare and health and social care services delivery to local needs by setting strategic goals and defining priorities in line with the national strategy. For the healthcare sector this mainly concerns hospitals, major medical equipment and lab test services, while planning of self-employed professionals is not really a concern as there are no formal restrictions on setting up a practice. Strategic planning requires the ARS to assess population health needs based on regional data regarding healthcare utilization, mortality and morbidity. Data are analysed by region and compared across regions to identify demand and

over/under capacity. As a result, access to hospital care is good without major territorial inequalities when compared to access to general practitioners and specialists, which remains highly unequal across areas of France (see Box 4.2).

■ 2.5 Intersectorality

The Public health national committee (*Comité national de santé publique*, CNSP) is the steering committee for broad intersectoral health plans. It is designed to improve coordination and information exchange among the ministries whose policies may have a health impact, particularly in the areas of health security and prevention. The CNSP is composed of directors or representatives from the ministries in charge of health, social security, social affairs, labour, education, security, defence, justice, finance, agriculture and the environment, as well as the UNCAM, DREES and the inter-ministerial missions regarding drugs and addictions, cities and road safety. Although an intersectoral approach is in place, to date the CNSP has undertaken few operational activities.

Nonetheless, there are specific areas in which intersectoral cooperation is better defined and developed, as is the case, for example, with health emergency preparedness and with the policy against drug addiction, which is the oldest and most developed intersectoral action based on a Health in All Policies approach. Ten ministries are part of the *Mission interministérielle de lutte contre les drogues et les conduites addictives* (MILDECA) (<http://www.drogues.gouv.fr>). This interministerial mission against drugs and addiction aims to coordinate public policies on this matter but also to provide funding and help in designing appropriate policies. It works with the help of the French observatory on drugs and addictions (*Observatoire français des drogues et des conduites addictives*, OFDT) and the Interministerial centre on anti-drug training (*Le centre interministériel de formation anti-drogue*, CiFAD) that focus on the fight against cocaine.

Moreover, the National council to combat poverty and social exclusion (*Conseil national de la lutte contre la pauvreté et l'exclusion sociale*, CNLE), which comprises representatives of all public decision-makers in this area, currently takes actions that aim to reduce health inequalities by improving access to SHI coverage and care to the most deprived.

With regards to promoting a healthier diet, the MoH first launched in 2005 the National Health Nutrition Programme (*Programme national nutrition santé*, PNNS), which is regularly renewed (fourth edition in course for 2019–2023) (see Section 5.1.4).

This enlisted support from other ministries, most notably the Ministry of Agriculture, which has developed a food policy “to incentivize the agricultural and agrifood industries to launch varied, high-quality foods that meet consumer expectations and public health objectives”.

Similarly, the national Health and Environment Programme (fourth edition in course for 2021–2025) is led by the MoH and the Ministry of Ecology and developed with all relevant stakeholders.

■ 2.6 Health information systems

There are several coexisting information systems in France. The main ones collect exhaustive information on the consumption of SHI-covered care by SHI beneficiaries for reimbursement claims both in the hospital and the ambulatory care sectors. From 2016, together with the national database on medical causes of death, they were merged into a single database, the National health claims database (*Système National des données de santé*, SNDS) that will also include, when fully available, the database on health and social care consumption. As such, the SNDS is said to be one of the largest health databases with information on 3000 variables and a yearly flow of 1.2 billion claims, 11 million hospital stays, 500 million medical acts and 450 Terabytes of data. However, there has been much criticism of the difficulties experienced in accessing this database.

Partly in response to this criticism, the Health Data Hub (*Plateforme des données de santé*) was set up in 2019 (see Section 4.1.3). Its objective is to enable researchers to easily access anonymized data hosted on a secure platform, in compliance with regulations and citizens’ rights. It covers and allows linking data from the National health claims database (SNDS) with other sources such as research cohorts, epidemiological and practice registers, etc. Moreover, it has the major advantage of adding medical information to data that are collected for reimbursement purposes and therefore do not capture all information on clinical and socioeconomic characteristics, risk factors, test results, etc.

On the supply side a national Automated directory of health professionals (*Automatisation des listes*, ADELI) provides information on gender, geographical distribution, specialty, type of practice (employed, self-employed, both, starting practice date, etc.) of all practising health professionals. This should disappear in 2023, as it is progressively replaced by a larger directory (*Répertoire partagé des professionnels intervenant dans le système de santé*, RPPS). The *Fichier National des Établissements Sanitaires et Sociaux* (FINESS) provides information on healthcare, health and social care and social facilities. It is completed by the *Répertoire Opérationnel des Ressources* (ROR) and describes the services provided by healthcare producers and the availability of certain types of services (such as intensive care beds, maternity beds, etc.).

■ 2.7 Regulation

In the context of increasing healthcare expenditure, the increasing deficit of the SHI and the overall social security system, the role of the State in steering the system through regulation has increased since the early 1990s. Regulation, therefore, involves negotiations among provider representatives (hospitals and health professionals), the State represented by both the MoH and the Ministry of the Budget and Public Accounts, and the SHI.

The Directorate of Social Security of the Administration of Health and Social Affairs (see Section 2.2.2), which is also under the authority of the Ministry of Finance and the Ministry of Labour, proposes an annual Social Security Financing Act, which is debated and approved by the parliament. This Act establishes the provisional healthcare budget, or rather the expected national ceiling for SHI expenditure (ONDAM) (see Section 3.3.3). Because in France providers are mostly paid on through FFS and retrospective per-case payments, ensuring that SHI health expenditure will match the (approved) national ceiling for SHI expenditure is difficult (see Section 3.3.3). Indeed, the MoH approves statutory tariffs but does not control volume as there is still freedom of choice and no limitation of utilization of services. However, regulatory mechanisms such as gatekeeping with financial incentives and non-refundable deductibles on physician visits, drugs and ambulance transportation (see Section 3.4.1) can be seen as attempts to regulate volume by using price sensitivity of consumers.

■ 2.7.1 Regulation and governance of third-party payers

STATUTORY HEALTH INSURANCE

SHI schemes are under the supervision of the Directorate of Social Security. In order to ensure that SHI measures will meet the objectives of the government health policy, SHI schemes sign a triennial contract (COG) with the MoH defining the objectives, the management and the governance of the SHI. The objectives of the COG are to improve efficiency in the management of the SHI, reduce inequities in access to healthcare services and develop risk management.

The National Union of Health Insurance Funds (UNCAM) (see Section 2.2.4) is the sole representative of the insured in negotiations with the State and healthcare providers. The director-general of UNCAM is also the director of the CNAM general scheme. The director-general is appointed by the government, and the executive power of this position has been strongly reinforced at the expense of the board, whose role is now limited to strategic matters. Collective agreements with doctors and other organizations of professionals in private practice are negotiated and signed by the director-general alone, illustrating the withdrawal of employee and employer unions from the management of the SHI. The SHI is therefore fully responsible for the economic consequences of the agreements that they negotiate and sign, for example with health professionals in private practice. The SHI can also set the level of user charges, although this power is limited to a certain extent by the political acceptability of the proposals.

COMPLEMENTARY HEALTH INSURANCE

There are three types of CHI companies (see Section 3.5) that operate under three different sets of regulations. The mutual insurance companies are regulated by the mutual insurance code, the commercial insurance companies are regulated by the commercial insurance code, and the provident institutions are regulated by the social security code. All three types of CHI companies fall under the supervision of the Prudential Control and Resolution Authority (*Autorité de contrôle prudentiel et de résolution*, ACPR).

CHI providers participate in the governance of the healthcare system through the national union of CHI companies (*Union nationale des organismes d'assurance maladie complémentaire*, UNOCAM), which is consulted prior to the annual Social Security Financing Act and other healthcare reforms, in particular when it is related to healthcare system financing. It is also consulted prior to changes on the SHI coverage rate and prior to the introduction of new products in the SHI benefits basket. It can participate in the negotiation of national agreements with healthcare professionals. As a member of the Economic committee for health products (*Comité économique des produits de santé*, CEPS), it participates in the negotiation of drug and medical devices prices, along with representatives of several ministries and the SHI.

■ 2.7.2 Regulation and governance of provision

PROFESSIONALS

Professionals practise under the regulations of the Public Health Code, which includes all regulations related to patient and professional rights with respect to medical goods and health services, planning the provision of out-of-hospital services and ensuring coordination between hospital and ambulatory care. In France roughly two thirds of practising health professionals are independent self-employed providers. Despite recent regulations aiming to plan doctors' geographical distribution, doctors retain the freedom to establish their practices where they wish (see Section 6.1; Box 4.2; Box 5.3).

The National Union of Health Professions (*Union nationale des professions de santé*, UNPS) is the single organization that can legitimately negotiate with the payers at the national level on behalf of all types of self-employed independent health professionals. It is consulted annually by SHI and CHI representatives on matters related to the organization of the healthcare system and health professions, such as the relationship between community-based and hospital physicians, demography of medical professions, access to care, continuing medical training and regulation of healthcare expenditures. At the regional level regional unions of health professionals (URPS) negotiate with the ARS (see Section 2.2.5).

Until 2023 there was no formal obligation for a recertification or relicensing process for health professionals. However, in order to maintain quality

of practice, doctors, midwives, dentists, pharmacists, biologists, nurses, physiotherapists and podiatrists must undergo Continuous Professional Education activities (*Développement professionnel continu*, DPC) (see Section 4.2.1 *Planning and registration of human resources*). Within the DPC process, accreditation exists for a limited number of high-risk medical specialties (that is, specialties with a high medical risk for the patients). It is optional and concerns physicians or medical teams practising in hospitals. Medical specialties involved include obstetrics and gynaecology (including ultrasound imaging), surgery, interventional radiology, anaesthesiology and other interventional specialties such as cardiology. Accreditation permits physicians to claim a deduction on the premium they pay for their professional insurance. From 2023, these activities of accreditation and continuous professional education will be considered in the periodic re-licencing process that will be conducted every six years via the various professional associations (see Section 4.2.1).

Hospitals

Both human and physical resources of hospitals are controlled by the government through different mechanisms. The MoH, through the French National Authority for Health (HAS), ensures that public and private hospitals and hospital physicians meet standards of competence through a certification process every four years.

Certification is a two-step process. First, a self-appraisal is conducted by hospitals based on HAS guidelines. Second, a team of experts assigned by HAS visits the hospital and undertakes the certification review.

Purchase of major medical equipment in both outpatient and inpatient settings in the private and public sectors is subject to authorization by the ARS, which is granted for five years, according to needs defined in the SRS.

■ 2.7.3 Regulation of services and goods

BASIC BENEFITS BASKET

Outpatient goods and services covered by the SHI are included in positive lists established by ministerial decree. The process of inclusion in the positive list varies with the type of good and service. However, in order to be listed on one of the positive lists and covered by the SHI, all new drugs, devices and

TABLE 2.1 Overview of the regulation of providers

	LEGISLATION	PLANNING	LICENSING/ ACCREDITATION	PRICING/ TARIFF SETTING	QUALITY ASSURANCE	PURCHASING/ FINANCING
Public health services	Public Health Code (<i>Code de la santé publique</i>)	ARS		MoH		ARS
Ambulatory care (primary and secondary care)	Public Health Code (<i>Code de la santé publique</i>)		University (region)	SHI/MoH	SHI	SHI
Inpatient care	Public Health Code (<i>Code de la santé publique</i>)	ARS	ARS	SHI/MoH	HAS	SHI
Dental care	Public Health Code (<i>Code de la santé publique</i>)	None	None	SHI	SHI	SHI
Pharmaceuticals (ambulatory)	Public Health Code (<i>Code de la santé publique</i>)	ARS		CEPS	HAS	
Long-term care	Public Health Code (<i>Code de la santé publique</i>) and social action and families code (<i>Code de l'action sociale et des familles</i>)	ARS & local authorities (<i>départements</i>)	Local authorities (<i>départements</i>) & ARS	Local authorities (<i>départements</i>)	HAS	SHI Local authorities (<i>départements</i>)
University education of personnel	Public Health Code (<i>Code de la santé publique</i>)	MoH ARS	National Universities Councils	N/A		N/A

Source: Authors

procedures must undergo an assessment. This assessment is prior to market launch and is used directly to determine the coverage rate and less directly the price (statutory tariff) (see Section 2.7.4).

HEALTH TECHNOLOGY ASSESSMENT

Governance and organization of health technology assessment (*Évaluation des technologies de la santé*, HTA) are defined by the government and the SHI. The major HTA body in France is the French National Authority for Health (HAS), which has in-house expertise as well as the authority to

commission assessments from external groups such as academic centres or professional societies.

All medical procedures and technologies (drugs, devices, equipment, reagents and tests) are assessed at the request of manufacturers or professional societies in the case of procedures. For technologies, the first assessment concerns safety and may be supranational, for example undertaken by the European Medicines Agency (*Agence européenne des médicaments*, EMA). The second assessment concerns coverage and is specific to the French healthcare system.

Assessments are performed by ad hoc committees. Drugs are assessed by the Transparency Commission (CT), while devices and procedures are assessed by the National Commission for the Evaluation of Medical Devices (CNEDIMTS).

■ 2.7.4 Regulation and governance of pharmaceuticals

Before being put on the market, all drugs must obtain market authorization (*Autorisation de mise sur le marché*, AMM) either at the European or national level. This specifies the conditions for the prescription and supply of drugs for which a medical prescription is mandatory and identifies drugs that are subject to special prescription rules (see Section 5.6).

In order to qualify for SHI coverage, a drug must be included in the so-called positive list of reimbursable drugs established by ministerial decree on the advice of the Transparency Commission (CT; from the HAS) and the Economic committee for health products (*Comité économique des produits de santé*, CEPS).

The level of coverage is determined by decree by the drug's medical benefit or therapeutic value (*Service médical rendu*, SMR) and the seriousness of the condition evaluated by the CT that also evaluates the relative medical benefit of the drug (*Amélioration du service médical rendu*, ASMR) in comparison with similar available treatments or drugs already available for the same pathologies. The drug price, which is equivalent to the statutory tariff, is then set either as a result of a bargaining process between the CEPS, composed of representatives of the MoH, the ministries of economy and of research, the SHI and UNOCAM and the manufacturer, or through an international benchmarking procedure. According to the social security code,

the price must be set according to the ASMR, the price of other drugs with similar therapeutic indications and the estimated volume of sales.

Drugs that fall into the category that do not require a prescription can currently only be sold in pharmacies. The distribution of drugs is closely regulated, both for wholesalers and for pharmacies. Wholesalers have a public service mission and fall under the regulatory control of the ANSM. They are regulated in terms of the range of drugs supplied, level of stock, territory, delivery time and profit margins.

Pharmacies have a monopoly on the dispensing of medicines. As a general rule, retail pharmacies must be owned by a qualified pharmacist or by a group of pharmacists associated in a company; these pharmacists or companies cannot be owners of more than one pharmacy. As an exception to this rule, mutual insurance associations and the SHI scheme for miners may also own retail pharmacies. The number of pharmacies is regulated by a *numerus clausus* that takes into account both the size of the population to be served and the distance to the nearest pharmacy.

Public advertisement for drugs is subject to prior authorization and is restricted to specialties that meet three criteria: they can be delivered without physician prescriptions, they are not covered by the SHI, and no restriction on advertisement has been included in the AMM of the product. Since 2012 advertisement directed at health professionals is also subject to prior authorization and is prohibited for health products that are undergoing a risk-benefit re-evaluation.

Internet sales of non-prescription drugs have been authorized since 2013, but uptake has been very limited owing to the significant regulatory burden in establishing an online sales presence. Only pharmacists are eligible to engage in this activity, which must be directly linked to a physical pharmacy and authorized by the ARS.

All drug-related adverse events must be reported by physicians to the regional centre for pharmaceutical vigilance (*Centre régional de pharmacovigilance*, CRPV), which is responsible for making the necessary inquiries and notifying the manufacturer. The ANSM oversees and coordinates the national system for pharmaceutical vigilance. Since 2011 patients and patient associations may directly declare adverse events. Validated reports of adverse events must be reported to the European Medicines Agency (EMA) within 15 days. Moreover, ANSM inspectors have a key role in the fight against

counterfeit pharmaceuticals, in collaboration with customs inspectors, the Ministry of Justice, and the police force. In the event of suspected fraud, drugs may be subject to recall or quarantine.

■ 2.7.5 Regulation of medical devices and aids

The market for medical devices is more loosely regulated than the markets for drugs or major medical equipment, particularly in terms of quality and safety standards. Compliance with quality and safety standards is assessed by the provider for devices that present a very low risk for the patient (medical beds, stethoscopes, etc.). Other devices must be assessed by an independent body selected by the manufacturer. Monitoring of the market is the responsibility of the ANSM.

The National Commission for the Evaluation of Medical Devices (CNEDIMTS) advises the Ministry of Health, which decides whether to include a device in the positive list based on the medical benefit value (*Service attendu*, SA). It also advises CEPS regarding pricing that will depend on the improvement in expected benefit (*Amélioration du service attendu*, ASA) (see Section 2.7.2). In this sector, the market price generally is not fixed; rather, the SHI statutory tariff is negotiated with the manufacturer and then is used as the basis for reimbursement. As a result, there is a high level of extra billing for medical devices. Medical devices and prostheses are subject to various rates of coverage depending on the medical device. In certain cases (for example, glasses, dentures, hearing aids), the levels of reimbursement are particularly low.

■ 2.8 Person-centred care

The principles of health democracy (*Démocratie sanitaire*) were instituted by the 2002 Patients' Rights and Quality of Care Act, which included improved representation of health system users, the right of patients to directly access their full medical records, and principles of professional liability and compensation for victims of medical malpractice. However, since then, public debate has focused on how to better account for the expectations of healthcare users (see Section 7.1.2).

■ 2.8.1 Patient information

Several government and public websites provide information to the general public on their rights, access to coverage and access to care, but also on quality of care and on environmental health risk factors (see Table 2.2). However, there is very little information for patients on the quality of providers and services. Moreover, there is also little information on PREMs and PROMs (see Section 7.4.2).

For instance, the public service website reports on health matters such as SHI access and patient rights (<https://www.service-public.fr/particuliers/vosdroits/F748>). The SHI website is also highly valuable to guide patients through the healthcare system and to provide advice on good practice for patients (<https://www.ameli.fr/assure>). Moreover, two databases provide healthcare consumers with searchable data: one includes all drugs available on the French market (*Base de données publique des médicaments*; <http://base-donnees-publique.medicaments.gouv.fr/>), while the HAS website (https://www.has-sante.fr/jcms/c_1725555/fr/qualite-des-soins-dans-les-hopitaux-et-les-cliniques) provides data on quality and safety indicators for all public and private hospitals.

Some websites provide information on the determinants of health such as air pollution (Recosanté, <https://recosante.beta.gouv.fr>) and the quality

TABLE 2.2 Patient information

TYPE OF INFORMATION	IS IT EASILY AVAILABLE?	COMMENTS
Information about statutory benefits	Y	Government and SHI websites
Information on hospital clinical outcomes	Y	HAS website
Information on hospital waiting times	N	
Comparative information about the quality of other providers (for example, GPs)	N	
Patient access to own medical record	Y	
Interactive web or 24/7 telephone information	Y	SHI website
Information on patient satisfaction collected (systematically or occasionally)	Y	Occasionally
Information on medical errors	N	

of water in swimming areas (<https://baignades.sante.gouv.fr/baignades/homeMap.do>).

In terms of freedom of information, access to public documents, including medical records, is provided through the Commission on Access to Administrative Documents (*Commission d'accès aux documents administratifs*, CADA), an independent administrative authority that provides opinions on requests for information when not satisfied first by the administration involved.

■ 2.8.2 Patient choice

France is generally perceived as a country with extensive patient choice in terms of providers. Indeed, the Public Health Code states that a patient's right to freely choose a health professional and hospital is a fundamental principle of France's health law. Implementation of a gatekeeping function (see Section 5.2) has not significantly limited that right, as patients may designate the referring physician of their choice and, once a specialist referral is made, may visit any professional in that specialty even if it is not the specialist identified by the gatekeeper. Nonetheless, real choice may be undermined by geographical disparities and financial disincentives such as lower coverage rate and, particularly with respect to specialists, extra billing (see Section 3.7.1.2).

With regards to coverage, there is no choice in SHI regimes and funds but full choice in private insurers.

■ 2.8.3 Patient rights

Patient information on the process of care is mandated by law and must be provided in understandable terms. A number of tools exist to facilitate awareness of patient rights (see Table 2.4), including:

- the charter of rights and freedom (*Charte des droits et des libertés*), which states the principles that apply to all hospitalized people, including non-discrimination, respect of dignity and privacy, right to information, protection, informed consent and autonomy;

TABLE 2.3 Patient choice

TYPE OF CHOICE	DO PEOPLE EXERCISE CHOICE? ARE THERE ANY CONSTRAINTS (E.G. CHOICE IN THE REGION BUT NOT COUNTRY-WIDE)? OTHER COMMENTS?
Choices around coverage	
Choice of being covered or not	All residents have the right for SHI coverage, which is compulsory.
Choice between public or private coverage	No. CHI is complementary; there is no CHI of a substitute type
Choice of purchasing organization	N/A
Choices of provider	
Choice of primary care practitioner	Yes
Direct access to specialists	Yes, but financial disincentives apply (rare exceptions)
Choice of hospital	Yes
Choice to have treatment abroad	Yes
Choices of treatment	
Participation in treatment decisions	Yes
Right to informed consent	Yes
Right to request a second opinion	Yes
Right to information about alternative treatment options	Yes

- an information booklet provided to every person admitted to hospital;
- a specific “admission contract” that must be given to individuals who are admitted to an institution for an extended period of time (over two months), signed by the patient or their representative; and
- provision of assistance from a “qualified person” to help to enforce patient rights.

Courts have repeatedly ruled that a signed document is neither necessary nor sufficient to meet the obligation of informed consent because physicians could simply ask a patient to sign the form without providing sufficient information. The recommended form of information and consent is by writing in the patient’s medical chart, which the patient may access, the

TABLE 2.4 Patient rights

	Y/N	COMMENTS
Protection of patient rights		
Does a formal definition of patient rights exist at national level?	Y	
Are patient rights included in legislation?	Y	The 2002 Patients' Rights and Quality of Care Act « <i>Loi relative aux droits des malades et à la qualité du système de santé</i> » The 2005 Act for equal rights, access, participation and citizenship for disabled persons « <i>loi pour l'égalité des droits et des chances, la participation et la citoyenneté des personnes handicapées</i> »
Does the legislation conform with WHO's patient rights framework?	Y	
Patient complaints avenues		
Are hospitals required to have a designated desk responsible for collecting and resolving patient complaints?	Y	
Is a health-specific Ombudsman responsible for investigating and resolving patient complaints about health services?	Y	
Are there other complaint avenues?	Y	
Liability/compensation		
Is liability insurance required for physicians and/or other medical professionals?	Y	
Can legal redress be sought through the courts in the case of medical error?	Y	
Is there a basis for no-fault compensation?	Y	
If a tort system exists, can patients obtain damage awards for economic and non-economic losses?	Y	
Can class action suits be taken against healthcare providers, pharmaceutical companies, etc.?	Y	

exact information process that took place before the procedure. Nonetheless, many professional organizations continue to use information leaflets that patients must sign before undergoing an invasive procedure.

The 2002 Patients' Rights and Quality of Care Act enumerated the general rules for patient complaint and compensation procedures, which differ depending on the setting in which care is delivered. It also established the possibility for patients to obtain compensation without demonstrating that there was an error either by a health professional or by an institution, and simplified the procedure for patients pursuing claims in court (for more details see Chevreur et al., 2010, Section 2.5.6).

In public hospitals the first step of a patient's complaint (before a formal case is brought against the hospital) is addressed through a conciliatory procedure involving the hospital mediator (usually a senior physician) and the patient or the patient's family.

Patients with complaints against self-employed doctors (working in solo or group practices or working in private for-profit hospitals) may bring a case against doctors in the courts and may also bring a case to the physician's professional association. The physicians' associations are qualified to take disciplinary sanctions against their members.

■ 2.8.4 *Patients and cross-border healthcare*

Unanticipated emergency care for French SHI beneficiaries travelling outside France, including outside the European Economic Area (EEA), may be reimbursed at the usual SHI tariffs upon presentation of the bills and justification of the urgency of the medical need. Within the EEA and Switzerland, medically necessary care arising in the context of short stays (holidays, professional travel, language study, etc.) is facilitated by a European health insurance card (*Carte européenne d'assurance maladie*, CEAM), which ensures that care is provided under the same conditions as for beneficiaries in that country.

For planned ambulatory care in a foreign country covered by regulation or agreement, the patient is not required to seek pre-authorization from the SHI fund and normally would pay for the services and then submit the bills for reimbursement based on the usual SHI tariffs. For scheduled hospitalizations and treatments involving heavy equipment (MRI, PET scan,

etc.), the patient must seek authorization from the SHI fund, explaining the nature and reasons for seeking treatment outside France. Hospitalizations are usually authorized unless it involves a treatment not covered by the SHI.

In 2020 France reimbursed €587 million for cross-border healthcare, which constitutes a 30% decrease over 2019, reflecting a slowdown (CLEISS, 2020), probably attributable to the COVID-19 pandemic. Care provided for French SHI beneficiaries in Belgium, Spain, Germany, Switzerland and Italy accounted for 95% of the cross-border reimbursements.

3

Financing

■ Summary

- France has a universal social health insurance (SHI), which provides a broad benefits basket, but cost-sharing is required for all essential services. Reliance on private complementary insurance for covering these costs leads to very low average OOP payments, but raises concerns for solidarity, financial redistribution and efficiency in the health system.
- To ensure financial sustainability, sources of health funding have been extended beyond payroll contributions in the past decades to include a broader range of sources of income, including financial assets, investments, and earmarked and value-added taxes.
- The national government has been playing an increasingly important role in managing health expenditure since 2010 through the introduction of spending targets and monitoring mechanisms for health insurance, reducing the initial independence of the SHI in controlling health expenditure. While the implementation of spending targets has been successful in containing overall health expenditure in the past decade, the division of budgets (spending targets) between different care sectors (ambulatory, hospital and social care) reinforces the segmented approach to healthcare, and

hinders integration, effective preventive services and allocative efficiency.

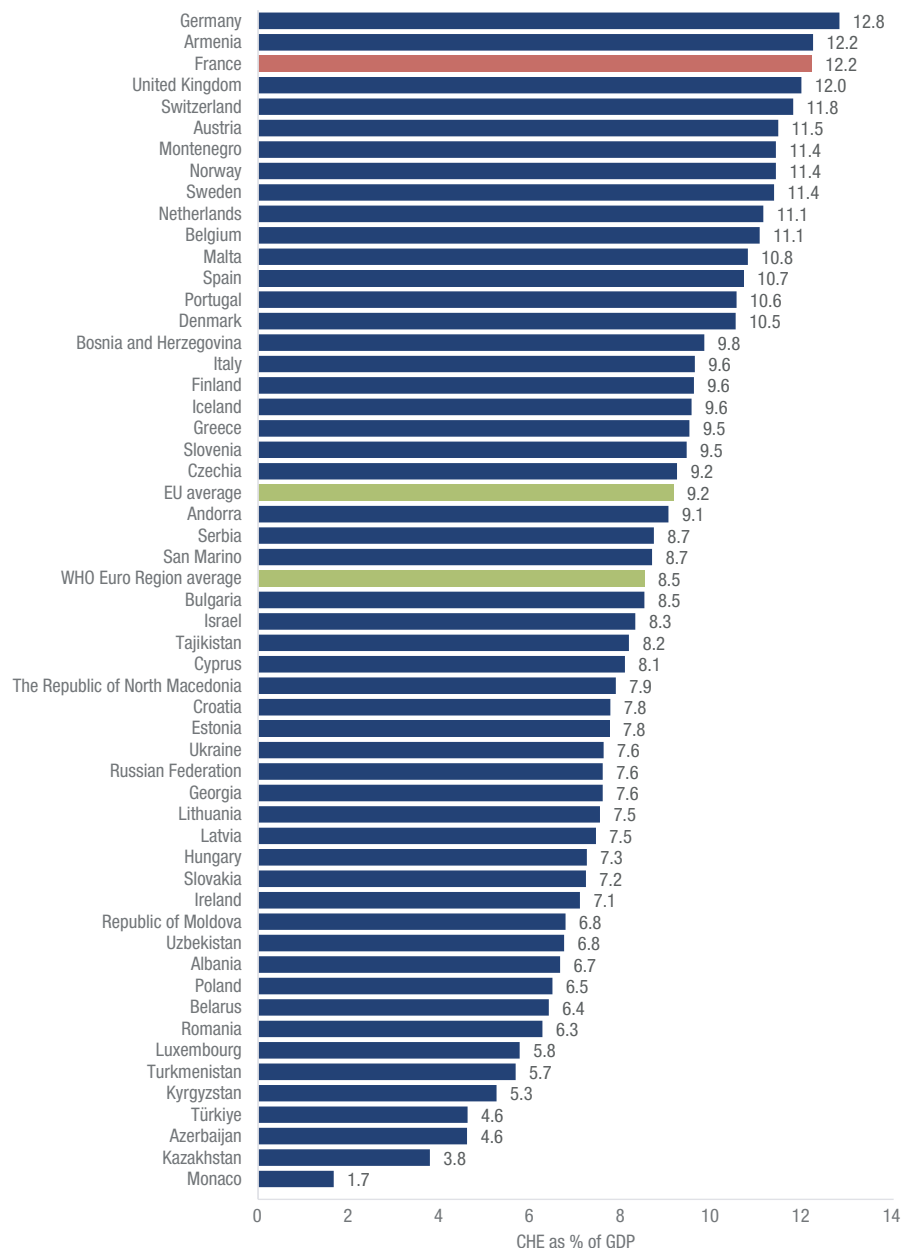
- In the ambulatory sector the prices of health services are set through national formal negotiations between the unions of statutory and complementary health insurance funds and health professionals' unions, but there is no regulation of service volumes. Dominant fee-for-service payment for self-employed health professionals is increasingly supplemented with pay-for-quality to encourage better care coordination, prevention and efficiency.
- In the acute hospital sector a prospective activity-based funding model has been used since 2005. While this has boosted productivity of hospitals, it has also created new problems related to quality and appropriateness of care.
- To improve care coordination, quality and efficiency, and support multidisciplinary care, new payment models are being tested, including capitation and episode-based fundings. Waivers to regulatory barriers for implementing innovations in care organization and payment have been introduced to encourage bottom-up proposals from healthcare providers.

■ 3.1 Health expenditure

France spends a high proportion of its national income on healthcare: in 2020, 12.2% of GDP was spent on healthcare, which was the third highest in Europe, after Germany (12.8%) and Armenia (12.2%) (Figs 3.1 and 3.2). Measured in terms of health spending per capita, France's position has fallen to ninth in the European region. However, with a spending of US\$5740 per capita (PPP) in 2020, it is well above the EU average of US\$4224 (Fig. 3.3).

Spending on health as a share of GDP has been persistently higher in France than the EU average in the past 20 years. Nevertheless, the growth rate, in real terms, has slowed down significantly since 2010, to under 1% on average between 2010 and 2019, against 2.2% per year between 2000 and 2009 (Fig. 3.2; Table 3.1). While the average per capita health spending increased by 2.7% per year in the OECD countries between 2015 and 2019, it only grew by 0.7% in France (OECD, 2021a). This is largely due to a macro-level budgeting strategy specifying an overall expenditure target

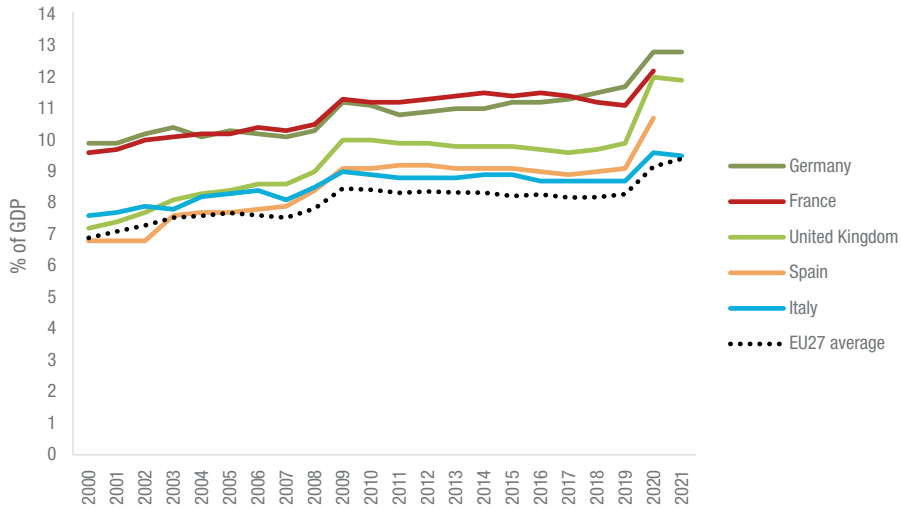
FIG. 3.1 Current health expenditure as a share (%) of GDP in the WHO European Region, 2020



Note: Current health expenditure corresponds to the final consumption of healthcare goods and services consumed during each year, including curative, rehabilitative and long-term care, ancillary services and medical goods, prevention and public health services as well as health administration, but excluding spending on investment. Data for Albania are from 2018.

Source: WHO, 2022a

FIG. 3.2 Trends in current health expenditure as a share (%) of GDP in France and selected countries, 2000–2021 or latest available year



Note: *Data for 2020 and 2021 from OECD Health Statistics (OECD, 2022b).

Source: WHO, 2022a

for health insurance, known as the National objective for health insurance spending (ONDAM). Setting a prospective global budget for healthcare each year marked a significant shift in the management of health spending, giving more power to the government to control healthcare spending (see Section 3.3.3).

However, the Covid-19 pandemic had a visible impact on health spending in France. The total health expenditure increased by 3.7% in 2020 and by a further 9.8% in 2021 owing to the Covid-19 pandemic (DREES, 2022b). The share of healthcare spending as a percentage of GDP rose by 1.1 percentage points (from 11.1% in 2019 to 12.2% in 2020) and reached 12.3% in 2021 (DREES, 2022b). Nevertheless, the estimated growth in per capita spending in France was much lower (2.9%) than the average growth in the OECD area (4.7%) in 2020 (OECD, 2021a).

In 2020 the additional cost of expenditure linked to the Covid-19 pandemic was estimated at €14.8 billion (DREES, 2022b). This includes both direct Covid-19 expenditures such as the cost of masks, personal protective equipment and tests, additional costs of recruiting staff in hospitals and nursing homes, exceptional bonuses, and indirect expenditures such as derogatory sickness allowances, which included payments to people who were unable

to work owing to lockdown measures and support to self-employed health professionals who lost income owing to reduced activity, etc. In 2021 additional health insurance expenditure, with continuing deployment of measures against Covid-19 (including vaccination), is estimated at €17.4 billion (a further 17% compared to 2020 (DREES, 2022b)).

TABLE 3.1 Trends in health expenditure in France, 2000–2021

	2000	2005	2010	2015	2019	2020	2021
Current expenditure on health, per capita (US\$, PPP)	2 686	3 265	4 047	4 670	5 168	5 468	6 115
Current expenditure on health as % of GDP	9.6	10.2	11.2	11.4	11.1	12.2	12.4
Government and compulsory health insurance schemes, % of current expenditure on health	78.9	78.7	76.3	82.3	83.3	83.6	84.7
Government expenditure on health as % of general government expenditure	14.6	15.1	15.0	15.4	16.7	–	–
OOP payments as % of total expenditure on health	7.3	7.4	10.2	9.8	9.5	8.9	–
Average annual real growth rate of current expenditure in health	–	–	0.9	0.8	0.9	1.0	8.5

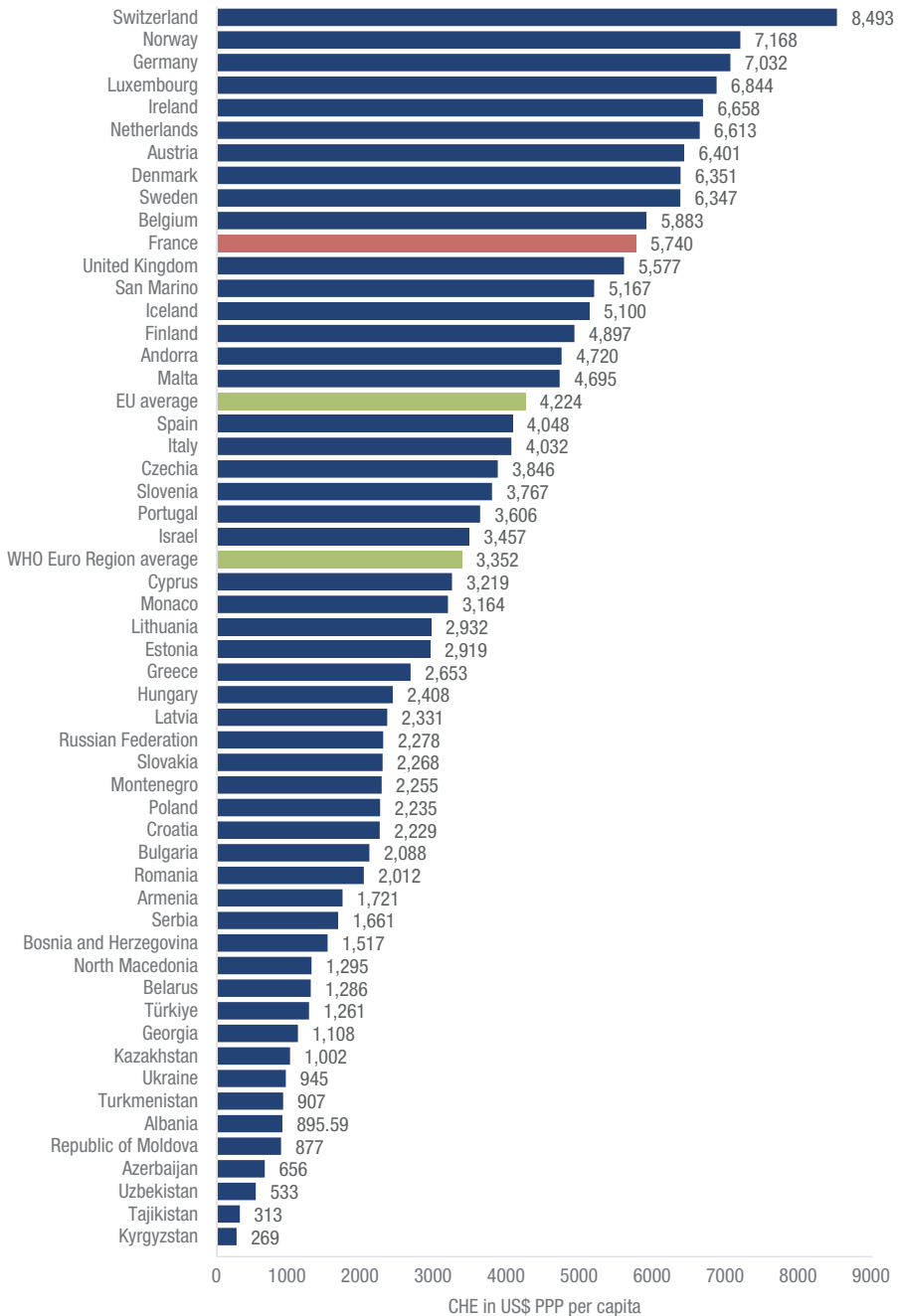
Notes: The data presented in this Table vary slightly from those presented in Figs 3.1–3.4 and from some national sources quoted in the text due to the different database used. PPP = purchasing power parity; GDP = Gross domestic product; OOP = out-of-pocket payment.

Source: OECD Health Data (<https://www.oecd.org/health/health-data.htm>)

Unlike most European countries, France spends more on the inpatient sector than on ambulatory care. In 2019 about 3.5% of GDP or 32% of all health spending was devoted to acute and post-acute inpatient services, which is 4 percentage points higher than the OECD average (OECD, 2021a). By contrast, outpatient care, covering generalist and specialist outpatient services and dental care, but also home care and ancillary services, accounted for 28% of all health spending, compared to 33% on average in the OECD area (OECD, 2021a).

In 2021 current health expenditure in France amounted to €308 billion or about €4600 per capita (DREES, 2022b). Hospital care represented about 30% of the expenditure, while primary care accounted for 18% and long-term care (LTC) for about 17% of the total health expenditure. The spending on the governance of the health system amounted to €15 billion (+1.7%

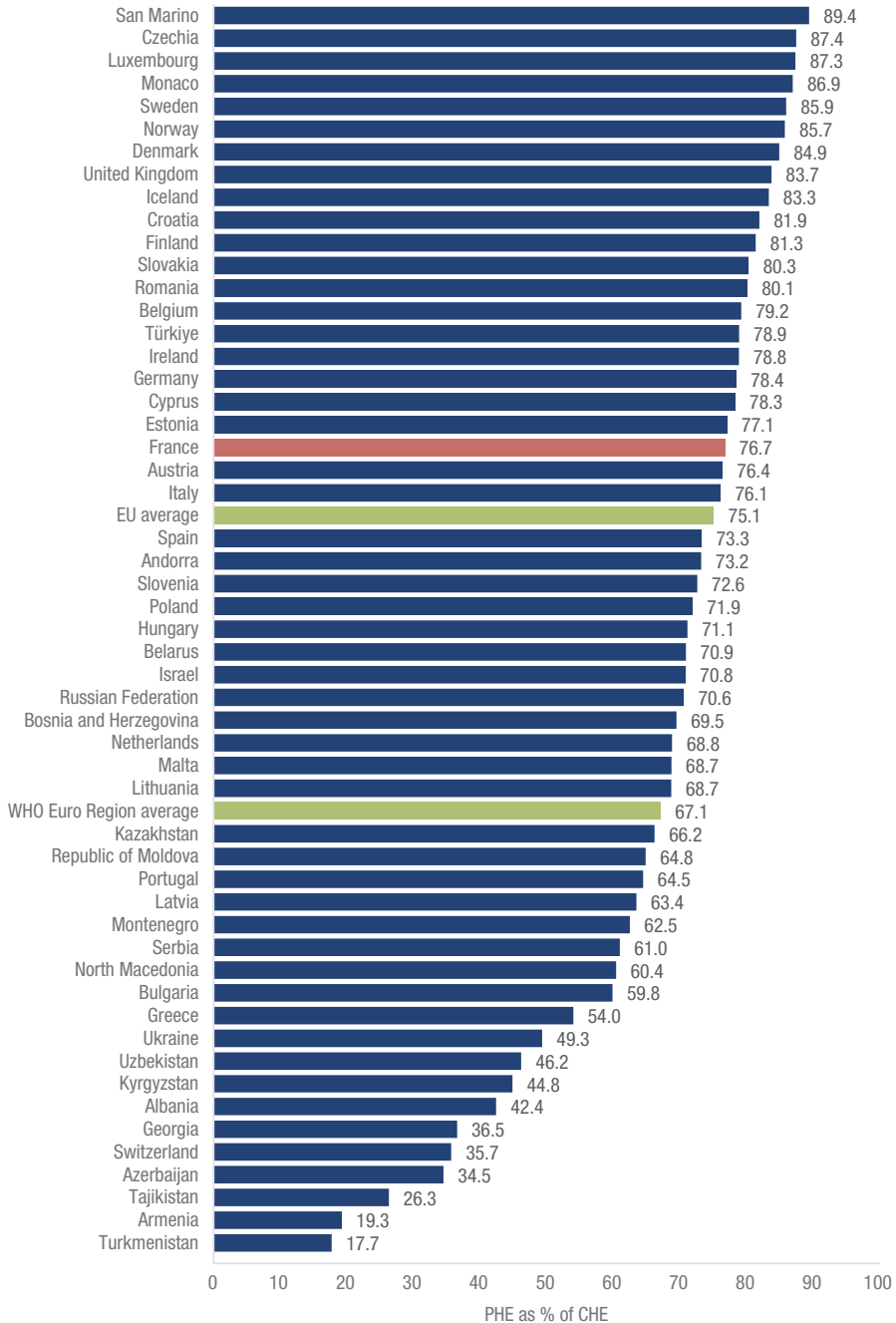
FIG. 3.3 Current health expenditure in US\$ PPP per capita in the WHO European Region, 2020



Note: Current health expenditure corresponds to the final consumption of healthcare goods and services consumed during each year, including curative, rehabilitative and long-term care, ancillary services and medical goods, prevention and public health services as well as health administration, but excluding spending on investment. Data for Albania are from 2018.

Source: WHO, 2022a

FIG. 3.4 Public expenditure on health as a share (%) of general government expenditure in the WHO European Region, 2020



Note: Data for Albania are from 2018.

Source: WHO, 2022a

compared to 2020) representing 7% of the current expenditure, of which about 50% was administrative costs of complementary health insurances. The spending on institutional prevention, which corresponds to preventive actions financed by national and departmental funds or programmes for promoting vaccination, screening, etc., tripled between 2019 and 2021 owing to the Covid-19 pandemic, passing from €5.5 billion in 2019 to €16.7 billion in 2021. However, excluding the spending linked to measures to fight the pandemic (cost of contact tracing, vaccination, etc.), the growth in prevention expenditure is only slightly higher than that before the crisis: 3.0% in 2021 and +2.5% in 2020, against +1.1% on average per year between 2013 and 2019 (DREES, 2022b).

■ 3.2 Sources of revenue and financial flows

Healthcare funding in France relies on a universal public health insurance system which is complemented by private complementary health insurance (CHI) for 96% of the population (Pierre & Rochereau, 2022) (see Section 3.5). Revenues for healthcare come from social security contributions, earmarked income taxes, other taxes including on tobacco and alcohol, value-added taxes, and a small contribution from the national government. The share of social security contributions has significantly dropped since 2016, while the share of tax revenues has more than doubled (see Section 3.3.2).

In 2019, overall, about 77% of the current health expenditure was funded by public resources, mainly the SHI (71%) and the State (6%) (Table 3.2; Fig. 3.4). CHI funded about 14% of the expenditure while OOP payments represented only about 9% of the current health expenditure (2019 data) (OECD, 2021a). The employer-supported mandatory private CHI (see Section 3.5) contributed to 6.7% of the expenditure while individual CHI accounted for 7% of the total expenditure (2019 data) (Table 3.2).

The SHI, together with mandatory CHI and the State, financed about 84% of the current health expenditure in 2019. However, this share varied according to services, ranging from 90% for standard care in the community or in hospital to less than 70% for institutional prevention (Table 3.2). While the CHI schemes play almost no role in funding long-term care services, they can offer and cover preventive services more generously. Therefore, even though France has a universal public health insurance system, the

TABLE 3.2 Expenditure on health (as % of current health expenditure) according to function and type of financing in 2019

FINANCING AGENT	ALL SECTORS	STANDARD CARE (IN THE COMMUNITY OR IN HOSPITAL SETTINGS)	LONG-TERM CARE (NURSING HOMES, NURSING CARE AT HOME...)	ANCILLARY SERVICES (LABORATORY DIAGNOSIS SERVICES, TRANSPORT...)	MEDICAL GOODS (PHARMACEUTICALS)	INSTITUTIONAL PREVENTION	GOVERNANCE
SHI, mandatory CHI and State	83.7	90.1	75.0	87.1	76.2	66.7	72.1
Individual CHI	7.0	5.1	0.0	6.2	10.1	33.3	27.9
OOP payments	9.3	4.7	25.0	6.7	13.7	0.0	0.0

Notes: SHI = Statutory health insurance; CHI = complementary health insurance; OOP = out-of-pocket payment.

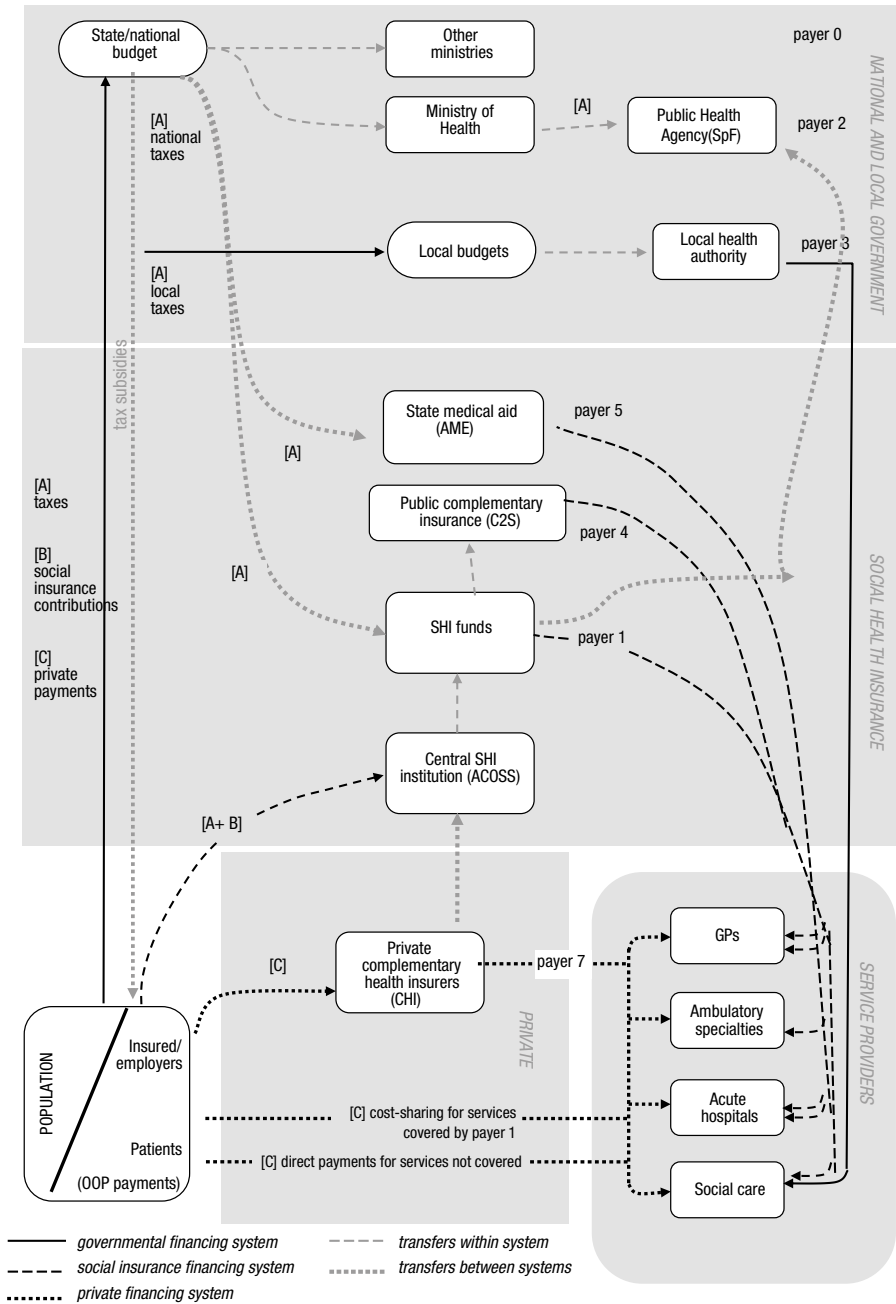
Source: DREES, 2021b

public coverage of services varies. The generosity of CHI varies between contracts, and an estimated 4% of the French population do not have CHI (see Section 3.5).

In 2018 the government financed 5.4% of total expenditure on health (DREES, 2020a). The national government mainly funds State medical aid (*Aide médicale de l'Etat*, AME) for undocumented migrants and supports the complementary health insurance scheme for individuals with low income (*Complémentaire santé solidaire*, C2S) (see Section 3.3.1). In addition, the State contributes to funding prevention (a third of the government expenditure on health) through the national public health agency, which can organize national and local health promotion and prevention activities (see Section 5.1.1). Funding for medical research and training of medical professionals represent almost half of the State budget. In 2019 the State and local authorities (*départements*) financed half (51%) of public prevention activities (such as vaccinations, family planning, occupational health services, screening, and public health campaigns, as well as surveillance and monitoring) (DREES, 2020a) (see Section 3.7.1.1).

Fig. 3.5 summarizes the financial flows in the French health system, which are described in detail in the following sections.

FIG. 3.5 Financial flows in the French health system



■ 3.3 Overview of the statutory financing system

All persons residing or working in France are covered under statutory health insurance (SHI), which provides a comprehensive basket of care and funds about 80% of health consumption expenditure (DREES, 2021b), but requires cost-sharing for all services. In 2019 about 96% of the French population held private complementary health insurance (CHI) to cover mainly these co-payments (Pierre & Rochereau, 2022) (Section 3.5). Therefore, France has one of the lowest average OOP expenditures amongst OECD countries (Section 3.4).

■ 3.3.1 Coverage

BREADTH OF COVERAGE: WHO IS COVERED?

Enrolment in an SHI scheme is mandatory and determined by the employment status (salaried, self-employed, farmer or agricultural employee, student, etc.). Individuals cannot choose their scheme or insurer, nor can they opt out. Thus, there are no competing health insurance markets for SHI. Three main SHI schemes cover almost the entire French population:

- the general scheme (*Régime général*) is managed by the CNAM and its local representatives (*Caisses primaires d'assurance maladie*, CPAM) (Section 2.2.4) and covers all salaried workers and their dependents, as well as all persons who have lived legally in France for more than three months.
- Since 2018 self-employed professionals who used to have a specific health insurance fund (*Régime social des indépendants*, RSI) have been managed by the general scheme (Decree no. 2018-174 of 9 March 2018) but with some pre-existing differences in terms of coverage, namely lower allowances for sick leave. In total, in 2021 the general scheme covered about 88% of the French population (CNAM, 2021k).
- the agricultural scheme (*Régime agricole*) covers all farmers and agricultural employees (about 5% of the population) and is managed by a dedicated fund (*Mutualité sociale agricole*); and

- special schemes (*Régimes spéciaux*). These include a variety of small schemes that cover specific professions such as the national railway company (SNCF), civil servants (including the military) or notaries. They cover 7% of the population but technically manage claims and benefits for hardly 3% (some special schemes are operated by the general scheme for management costs reasons) (UNRS, 2022).

All schemes remain uninterrupted and unchanged even if the beneficiary becomes unemployed. In 2000 universal medical coverage (known since 2016 as *Protection universelle maladie*, PUMA) was implemented in order to provide public health insurance to the 2% of individuals who were not covered under any scheme given their employment status (for example, those who have never worked). This universal coverage, established under the 1999 Universal Health Coverage Act (Law no. 99-641 of 27 July 1999), offers basic health insurance coverage to all those legally residing in France. Contributions to PUMA are based on all means of income, including capital and assets. Pensioners, students and people with a taxable income of less than €8200 per year (unless they have capital and assets over a certain value) are exempt from paying contributions (Code of Social Security on 22 December 2018). Undocumented migrants and foreigners who do not regularly reside in France are covered by a separate, fully state-funded medical aid scheme (AME), which provides access to a more limited benefits basket. This scheme is means-tested, and applicants must be residents for more than three months on French territory (Social welfare and family code of 28 December 2019) (Wittwer et al., 2019). People who are not eligible for the AME (those in France for less than three months) always have a right to emergency hospital care in France. In 2018 AME had approximately 318 000 beneficiaries – a relatively stable number since 2015 – and represented less than 0.5% of the health consumption expenditure (Latournerie et al., 2019).

SCOPE OF COVERAGE: WHAT IS COVERED?

All SHI schemes provide access to the same benefits basket, which offers a wide range of medical services and goods. The benefits basket is defined through explicit positive lists/catalogues of covered services, drugs and devices/equipment. Catalogues also list excluded medical procedures (such

as chiropractic care and cosmetic surgery). There are different drug catalogues for hospital and ambulatory care.

Overall, the following services, procedures and products are included in the benefits basket and reimbursed at various rates (see the section below on the depth of coverage):

- outpatient consultations provided by physicians, dentists and midwives;
- care provided by allied health professionals (nurses, physiotherapists, speech therapists, podiatrists and orthoptists) if they are prescribed by a physician;
- diagnostic services (such as biological tests) carried out by physicians, dentists, midwives and laboratory staff;
- prescribed pharmaceutical products, depending on their medical efficiency (see Section 2.7.4);
- hospitalizations in public or private hospitals, including in post-acute care, psychiatric hospitals and hospitalization at home;
- basic dental care (including annual check-ups and cleaning, fillings, extractions, root canal work and orthodontal treatments for children aged under 16 years);
- prescribed medical devices and prostheses included in the positive lists of products eligible for reimbursement, such as glasses, hearing aids, orthopedic appliances, prostheses and wheelchairs;
- healthcare-related transport including ambulance transportation and medical taxi;
- screening (colon, breast and cervical cancer) according to national programmes (see Section 5.1);
- all pregnancy and birth-related care for women (including infertility treatments) and infants, contraception for women (free of charge for women aged under 25 years), and terminations of pregnancy;
- therapeutic thermal treatments; and
- compulsory and recommended immunizations (see Section 5.1).

Prevention services have historically been neglected in the benefits basket as the healthcare system has focused on treating diseases. However, in the past decade the SHI has introduced several preventive programmes for immunization and cancer screening for which it covers 100% of the costs.

There are also public health programmes funded directly by local authorities (*départements*) or by the government budget (see Section 3.7.1.1). The SHI also covers costs for medicines, medical equipment and medical care in nursing homes and in other LTC facilities, for which the residents do not have co-payments (see Section 5.8).

Volumes of care reimbursed are generally not controlled for common services and products. However, volumes can be capped for expensive drugs, devices or innovative expensive treatments (for example, a maximum of four in vitro fertilizations). While outpatient visits in public psychiatric hospitals are covered by the SHI, consultations with self-employed psychologists were not reimbursed until 2022. Starting in spring 2022, patients with mild to moderate mental disorders can be reimbursed for a maximum of eight consultations per year with a psychologist upon prescription by a regular physician (CNAM, 2022b).

Finally, the SHI also provides cash benefits to compensate for specific periods where workers are temporarily or permanently unable to work and do not receive their usual income. This is the case for sick leave (with a maximum of 360 days over three years for most illnesses, but this maximum duration is topped up to three years for patients with a long-term illness recognized in a list established by the MoH), maternity leave (between 16 and 46 weeks depending on whether it is a multiple pregnancy and there are other children in the family) and paternity leave (between 25 and 32 days) (CNAM, 2021a, 2021d, 2021e, 2021h). The SHI also provides a disability pension for individuals presenting substantial and long-lasting difficulties for working (loss of at least two thirds of working capacity) as assessed by an SHI physician. The amount of disability pension paid to eligible claimants represents between 30% and 50% of the mean annual income earned in the best past 10 years and is variable depending on the degree of disability (CNAM, 2021h). In 2020 cash benefits provided by the SHI to compensate for periods not worked (not including civil servants) amounted to €19 billion (DREES, 2021b). Since the beginning of the Covid-19 crisis, exceptional measures extending eligibility to SHI sick leave payments have been implemented, with the objective of limiting the propagation of the virus via workplaces and securing income for those who cannot work due to the sanitary restrictions. During the first waves of the pandemic (2020–2021), eligibility to receive leave payments was extended to workers with Covid-19 symptoms, but also to those who had to stop working for childcare (due to school closures), to

Covid-19 contact cases and to self-employed health professionals. These exceptional measures cost about €3 billion over 2020–2021 and represented a strong increase in cash benefits provided for sick leave (+33% compared to the previous year) (DREES, 2021b).

DEPTH OF THE COVERAGE: HOW MUCH OF THE BENEFIT COST IS COVERED?

The SHI does not cover all healthcare expenses. There are considerable co-payments for almost all health services and the possibility to extra-bill for some practitioners (see Section 3.7). In general, beneficiaries are expected to pay upfront for ambulatory care and to claim reimbursement from insurance funds (both SHI and CHI), based on predefined rates. While providers increasingly accept a third-party payment system (*Tiers payant*), which exempts patients from paying the full cost of care at the point of use, direct payment is still common in the ambulatory sector.

Co-payments are fixed rates defined by the SHI (*Ticket modérateur*) based on the regulated prices. The same rates apply regardless of the scheme and the patient's income level. The share of costs covered by the SHI varies by type of service and type of medication: 70% of ambulatory visit costs, about 80% of hospital care costs, and between 15% and 100% of the cost of approved drugs (CNAM, 2022c). Since the 2004 “gatekeeping” reform, consultations with specialists without a referral are reimbursed to a reduced rate of 30% (see Section 5.2) (CNAM, 2021j). However, certain services, such as gynaecology, ophthalmology, and psychiatry for patients under 26 years old, and all pregnancy-related care are accessible without referral to be reimbursed at the maximum rate (70%) (CNAM, 2021j). Since 2018 teleconsultations have been reimbursed as normal consultations under certain conditions (for example, only with physicians, either with the patient's regular GP or with referral, in proximity of the patient's residence, etc.). During the Covid-19 pandemic these conditions were lifted and all health professionals, including nurses, psychiatrists and physiotherapists, were allowed to provide teleconsultations. Moreover, teleconsultations were 100% reimbursed by the SHI, initially during 2020, but this period was prolonged gradually until mid-2022 (National Assembly, 2021). The level of reimbursement for prescription drugs is determined according to the effectiveness of the drug and the seriousness of the disease treated: 100% for rare diseases, highly effective and expensive

drugs, and 65%, 35% or 15% for other drugs depending on their therapeutic value (rates decreasing with lower therapeutic value) with no reimbursement for drugs considered ineffective (CNAM, 2022c) (see Section 2.7.4). Reimbursement rates are lower when patients opt for non-generic drugs when generic options are available (see Section 5.6). Homoeopathic products are no longer reimbursed by the SHI, since January 2021 (CNAM, 2021p).

Given the importance of co-payments, from the very inception of the French health system protective mechanisms were introduced to reduce the financial burden for patients suffering from chronic illnesses and those with very low income. Persons with chronic illnesses can be included, upon medical criteria, in a long-term illness scheme (*Affection de longue durée*, ALD). Irrespective of their income, these patients are exempt from co-payments for treatments associated with their chronic disease. Initially introduced to cover four groups of diseases (cancer, tuberculosis, poliomyelitis and mental illness), the scheme was extended over time and now covers 32 groups of diseases (CNAM, 2021o). In 2019, 12.5 million individuals were covered by the ALD scheme, representing less than 20% of SHI beneficiaries, and about 60% of their health expenditures was reimbursed by the SHI (both for their conditions covered in the ALD and other care consumption) (Adjerad & Courtejoie, 2021a).

To reduce the burden of co-payments for the lowest income groups (individuals living 20% under the poverty limit), a state-funded complementary health insurance scheme (*Couverture maladie universelle complémentaire*, CMU-C) was introduced in 2000. In addition, CHI vouchers (*Aide à l'acquisition d'une complémentaire santé*, ACS) were introduced in 2004 to subsidize the purchasing of private CHI for individuals who are not eligible for the CMU-C but whose income is under the poverty line. These schemes were replaced by a new one (*Complémentaire santé solidaire*, C2S) in 2019 to cover all persons living under the poverty limit (see Section 3.5). This public complementary insurance allows 100% coverage of the costs of services and drugs included in the benefits basket (with no cost-sharing). It has also better coverage of dental care and optics, which are poorly reimbursed by the basic SHI package. Moreover, patients are exempt from upfront payments, and professionals are not allowed to extra-bill patients under this scheme. The income threshold to benefit from this scheme depends on the household income and varies by its composition (about €9000/year for a single person or €13560/year for a couple) (CNAM, 2021m). In 2021 approximately

7.2 million persons benefited from this complementary scheme, although it is estimated that almost 10 million are eligible (Blanchon et al., 2021).

Historically, eyeglasses, contact lenses, dental crowns, bridges, dentures and orthodontic treatments for adults have been poorly reimbursed by the SHI. In 2020 the reform “100% Health” (*100% Santé*) introduced a new benefits basket for these services, regulating the prices of basic dental care,

BOX 3.1 What are the key gaps in coverage?

France has a SHI system which provides universal coverage for a broad basket of services. The benefits are almost the same for all insured, regardless of their scheme. However, the high level of cost-sharing imposed by the SHI for essential services means that most of the population buys CHI to reduce OOP payments. Despite the existence of protective schemes for people with chronic conditions and those with very low income, persons with the highest care needs (in particular, older individuals and those with multiple chronic conditions) have higher OOP payments (Franc, Perronnin & Pierre, 2016). While most of the population has CHI, the generosity of CHI contracts varies widely. The poorest and sickest populations are likely to have less advantageous contracts, and have a higher share of their income spent on healthcare (Jusot et al., 2017; Perronnin & Louvel, 2018). Moreover, populations with very low revenue are less likely to have CHI: in 2019, 14% of the unemployed and 11% of individuals in the lowest income decile did not have CHI (vs. 4% of the general population) (Pierre & Rochereau, 2022).

To improve equitable access to care, the solution proposed by successive governments has been to increase private CHI coverage for a wider share of the population, such as through public subsidies for people with low income. However, the multiplication of schemes and support mechanisms makes the system complex and results in difficulties in navigating it. A simplified scheme (*Complémentaire santé solidaire, C2S*) was set up in 2019 with the objective of reducing the administrative burden for patients and to facilitate access (Fonds de la C2S, 2019). In 2020 the reform “100% Health” was introduced to reduce OOP payments for dental care, optical and auditive equipment. A selection of basic dental care, dentures, eyeglasses and hearing aids are now fully reimbursed by the SHI and all CHI, based on regulated prices (MoH, 2021a). However, persisting – and even increasing – unequal CHI coverage (with costs increasing with age, unrelated to income) led the government to launch, in 2021, a high-level consultation on the role of CHI in health funding. Proposals being debated include abolishing cost-sharing for essential services (100% reimbursement by the SHI), but currently there is no agreement on the definition of this new benefits package (i.e. essential services) (HCAAM, 2022b).

including basic crowns, bridges and dentures, as well as eyeglasses and hearing aids to improve equity in access (see Section 6.1).

■ 3.3.2 Collection

Historically, the SHI system was almost entirely funded from wage-based contributions from employers (two thirds of the contributions) and employees (one third). Considering the high rate of unemployment in France and the rapid ageing of the population (see Sections 1.1 and 1.2), sources of health funding have been broadened in the past two decades to include a broader range of income beyond payroll contributions. The most profound change was the introduction of a revenue-based tax contribution, the general social contribution (*Contribution sociale généralisée*, CSG), in the 1990s (Barroy et al., 2014). The CSG introduced a basket of taxes applied to a broader range of income than just wages (for example, income from financial assets and investments, pensions, unemployment and disability benefits, gambling, etc.). It is calculated not on all household income by applying a common scale, such as for income taxes, but on the income of each person by applying, from the first euro, a rate that depends on the nature of this income. Since 2019 active workers have paid 9.2% of their revenue to finance social security, of which 6% is used specifically to finance the sickness branch (SHI). Pensioners (including those with disability pensions) pay 8.3% of the pensions, of which 4.8% is used to finance the SHI (Commission des comptes, 2021). Those on unemployment allowance also pay the CSG at the rate of 6.2%. Moreover, revenues from gambling/gaming were taxed at 8.6% in 2019 (of which 7.4% goes to SHI). Those with a yearly income below €11 306 are exempted, and those with low income have reduced CSG rates (3.4% or 6.6% depending on income bracket) (Commission des comptes, 2015b, 2020a).

Gradually, the share of employee payroll contributions to health funding was reduced while CSG rates across various sources of income increased. Since 1998 salaried employees have paid about 0.75% of their income for SHI, against 6.8% previously, while employer contributions remained at around 13% until recently (Commission des comptes, 2015b). In 2018 employee contributions were totally suppressed, and since 2019 employers' payroll contributions have been significantly reduced, compensated by tax revenues (*Crédit d'impôt pour la compétitivité et l'emploi*, CICE). A part of

the value-added taxes is now allocated to health since a portion of the CSG has been assigned to the fifth branch (autonomy) for long-term care since 2020 (see Section 5.8.2). Over the years several earmarked taxes, such as alcohol and tobacco taxes, and taxes on sales for commercial pharmaceutical companies, have also contributed to health financing needs. A specific solidarity tax (*Taxe de solidarité additionnelle*, TSA) is applied to complementary health insurance providers to help finance solidarity insurance for the lower income groups (Commission des comptes, 2020a). In 2021 only about 33% of revenues for the SHI came from payroll contributions (against 39% in

BOX 3.2 Is health financing fair?

The public health insurance in France has been based on the principle of equal access to healthcare depending on health needs, not income. The funding system promotes redistribution between high- and low-income groups since SHI contributions are proportional to income. The contributions of the top 10% were about 14 times higher than those of the poorest 10% in 2017. Over time, financing sources were diversified to cover other income than wages, but keeping the progressive nature of contributions. Moreover, there are various solidarity taxes for employers, companies and CHI providers that allow the raising of resources to finance healthcare costs for the most vulnerable populations. A recent study estimated that the public health insurance, as a compulsory system of taxes and benefits, contributed 20% to the reduction of income inequalities in France in 2017 (Fouquet & Pollak, 2022).

However, notwithstanding the significant share of public funding of health expenditure, high reliance on private CHI to cover OOP costs raises concerns for solidarity, equity in access to care and efficiency of the health system (Franc & Pierre, 2015a; Jusot et al., 2017). This is mostly due to the basic functioning of the private insurance market, where premiums are often adjusted based on the age of the insured and without considering ability to pay, and services covered vary as a function of the bargaining power of consumers. The share of OOP health expenditure in household budgets is higher for low-income households and the weight of OOP expenditure in the budget increases sharply with age, rising from 2.7% between 30 and 39 years old to 8.2% after 80 years old (Fouquet & Pollak, 2022). While the CHI market is closely controlled using a mixture of regulatory measures and financial incentives to reduce the difficulties that the sickest and the poorest would otherwise face in a competitive health insurance market, the cost-efficiency of some measures such as tax reductions for CHI providers and payments to help low income people to buy private CHI are questioned (Or & Pierre, 2020).

2017), while 24% came from the CSG (35% in 2017) and 33% from other taxes, of which 20% came from VAT (HCFi-PS, 2021).

■ 3.3.3 Pooling and allocation of funds

The French parliament ultimately sets the fiscal parameters within which the SHI funds are asked to maintain spending, which is unusual for a social insurance-based system (Barroy et al., 2014). A specific Social Security Financing Act (*Loi de financement de la sécurité sociale*, LFSS), which subjects the expenditure and financing sources of all aspects of French social security (including health, pensions and family benefits) to annual ratification, has been in place since the late 1990s. This process has been enshrined in the Constitution since 1996, making the parliament a major player in health sector management, reasserting the state's influence on the level of social insurance spending.

The annual process behind the LFSS requires the Ministry of Economy and the MoH to work together to control health expenditure. Every year the Ministry of Economy produces a draft of an LFSS, in collaboration with the MoH, the Ministry of Labour and other social security entities. This draft is prepared between June and October by the Social Security Direction (*Direction de la sécurité sociale*), an administrative body under the joint supervision of the Ministry of Budget and the MoH. Following the publication of the LFSS draft, the document is debated in the parliament in accordance with a legislative calendar. In the LFSS the parliament specifies a macro-level health expenditure target for the SHI called ONDAM (*Objectif national de dépenses d'assurance maladie*). ONDAM is an annual financial objective, with separate targets for different healthcare sectors (ambulatory, inpatient and long-term care), and separate targets for private and public sectors for inpatient care (Barroy et al., 2014). A committee assigned to monitor SHI spending (*Comité d'alerte sur l'évolution des dépenses d'assurance maladie*) alerts the parliament if the ONDAM target is at risk of being exceeded by a certain amount. Table 3.3 shows the targeted and actual SHI expenditures by care sector. The monetary ONDAM target is used to signal the percentage of health spending growth that the government is willing to accept in any given year. For example, the 2019 objective was €200 billion, or a 0.5% growth compared to 2018.

TABLE 3.3 Targeted and actual SHI expenditures by care sector (billion €), selected years

	2015		2019		2020		2021	2022
	TARGET	ACTUAL	TARGET	ACTUAL	TARGET	ACTUAL	TARGET	TARGET
Private ambulatory care	83.0	83.1	91.5	91.4	93.6	94.7	98.9	102.5
Hospitals	76.8	76.4	82.6	82.4	84.4	89.7	92.9	95.3
Health and social care	17.9	17.7	20.8	20.9	21.6	24.0	26.0	27.6
<i>Services for persons with disabilities</i>	9.2	9.1	11.4	11.4	11.7	12.0	12.4	13.3
<i>Services for older persons</i>	8.7	8.7	9.5	9.6	10.0	12.0	13.6	14.3
Regional investment funds	3.1	3.0	3.5	3.5	3.6	3.9	3.8	5.9
Other	1.6	1.6	1.9	1.9	2.4	7.0	3.8	5.5
TOTAL	182.3	181.8	200.3	200.2	205.6	219.4	225.4	236.8

Sources: Commission des comptes, 2015a, 2016, 2019, 2020b, 2021

When setting the ONDAM, the government also draws up a precise list of savings necessary to meet budget targets. It has taken over a decade for this expenditure monitoring policy to begin demonstrating consistent results. In the first 10 years after its introduction (between 1998 and 2009) ONDAM targets were consistently overrun (Barroy et al., 2014). As its nonbinding nature meant that no stakeholder was obligated to uphold it, the policy did not suffice to constrain SHI spending within budgetary targets. Therefore, additional measures were put in place and ONDAM targets have evolved progressively from vague objectives to binding targets. Since 2010 the Alert Committee has gained additional powers and can undertake an ex-ante evaluation of the ONDAM, before the draft of the LFSS is submitted to parliament. If the ONDAM targets for the hospital sector are expected to be overrun, hospital tariffs can be decreased (see Section 3.7).

■ 3.3.4 Purchasing and purchaser-provider relations

In France there is no selective contracting between purchasers and individual providers. However, unions of self-employed health professionals and unions

BOX 3.3 Are resources put where they are most effective?

Since 2010, the budgetary processes ushered in by the macro-level cost-management system based on expenditure targets (ONDAM) have been effective in reducing the growth rate of health expenditures.

However, this strict budgetary process represents a segmented approach to healthcare and is a barrier for improving allocative efficiency in the health system. This management of health spending ignores the fact that decisions concerning expenditure in one sector have consequences on the others: the health and social care provision in the community determines the need for hospital care, funding for home care services impacts the need for long-term care facilities, etc. (Deroche & Savary, 2019; HCAAM, 2020b). This reinforces the division of healthcare supply at the local level and reduces the capacity to improve the coordination and efficiency of services across sectors (see Section 7.6).

Moreover, while France had visible success in controlling prices of healthcare services and pharmaceuticals through formal negotiations with healthcare providers and value-based pricing of drugs (see Section 3.7), low prices seem to have a limited impact on health expenditure growth. Healthcare providers tend to compensate for reduced revenues by increasing the volume of services they provide (Or & Gandré, 2021). While healthcare prices in France are well below the OECD average (–23%), it has the third highest healthcare volume per capita in the OECD area, 50% above the average (OECD, 2021a).

Finally, the health insurance system, including the SHI and numerous CHI providers, has a high administrative cost, amounting to €15.7 billion annually in 2020 (5.5% of total health expenditure). Nearly half of this cost (48%) is linked to the management of CHI, followed by the SHI (46%), the MoH (5%) and other public operators (1%) (DREES, 2021b).

of statutory and complementary health insurances sign a national agreement every five years, equivalent to a contract aiming to regulate the expenditure and activity of the ambulatory care sector. Health professionals can choose to opt out, but this means that their consultation fees are not reimbursed, and in practice very few professionals choose to do so. The social contributions of health professionals who agree to charge patients based on the nationally negotiated fees are fully paid by the SHI. However, some physicians, especially specialists, are allowed by the SHI to charge higher fees, which raises issues for access to care (see Section 3.7). Moreover, there is no contractual arrangement with care providers for controlling the volume of their services, either in the ambulatory or hospital sectors.

■ 3.4 Out-of-pocket payments

Given the importance of co-payments left to patients by the SHI, 96% of the French population held CHI in 2019 (Pierre & Rochereau, 2022). Therefore, in 2019 France had the second lowest share of OOP spending in total health expenditure (around 9%) amongst OECD countries (after South Africa at 8%) (OECD, 2021b). On average, OOP costs accounted for 2% of final household expenses in 2019, compared to 3% among all OECD countries (OECD, 2021a). This OOP spending corresponds to the cost of care directly paid by households without counting the premiums paid for private CHI. It is estimated that in 2017 private payments including these premiums accounted for 4% of household budgets but could reach 8% for the lowest income groups (Fouquet & Pollak, 2022).

Overall, the share of direct OOP costs in current health expenditure has been stable and decreased slightly over the past decade, from 10% in 2010 to 9% in 2019 (OECD, 2021b). The reduction in OOP costs related to hospital care appears to be partly driven by the ageing of the population, leading to an increase in patients covered by the ALD scheme for chronic diseases reducing cost-sharing. In the ambulatory sector the caps applied to extra-billing in recent years (see Section 3.7.2) and higher reimbursement rates applied to certain drugs, including hepatitis C treatments and nicotine substitutes, have also contributed to reducing OOP payments (DREES, 2020a). In 2020 the Covid-19 pandemic and related restrictive measures led to a significant reduction in the use of all types of care, and, in particular, a lower use of hospital services for non-urgent conditions, which resulted in a drop in OOP payments as a proportion of all health consumption by 6 percentage points between 2019 and 2020 (DREES, 2020a).

In 2020 the majority of OOP spending was on long-term care (43%), followed by pharmaceuticals and therapeutic devices (26%), outpatient care (26%) and inpatient care (5%) (OECD, 2021a).

■ 3.4.1 User charges

User charges are asked for most healthcare goods and services in France. Primarily, patients are asked to pay a proportion of the tariffs (*Ticket modérateur*) or the full price to be reimbursed later by the SHI (Table 3.4).

Cost-sharing arrangements, initially intended to reduce inappropriate demand for care, are also used increasingly to encourage patients to follow standard care pathways (see Section 5.2). However, given the high proportion of the population with CHI, which sometimes reimburses OOP payments as a third-party payer, the impact of cost-sharing on patients' behaviour appears to be limited. Therefore, over time different types of flat deductibles have been introduced to encourage patients to consider the costs of treatments and to contain demand for targeted services (Table 3.4).

Flat rates, or deductibles (*Participation forfaitaire*), apply to outpatient consultations, pharmaceutical products, medical transportation, and consultations and care from allied health professionals. Overnight hospitalizations are subject to a daily catering fee (*Forfait journalier*); this does not apply to hospitalizations at home nor to day hospitalizations. In 2020 this fee amounted to €20 per day for acute and post-acute rehabilitation care and €15 per day for psychiatric hospitalizations (Adjerad & Courtejoie, 2021b). The hospital fees are regularly reimbursed by CHI, but the deductibles for outpatient consultations and prescriptions are, in principle, not reimbursable by the CHI.

TABLE 3.4 List of flat deductibles by types of goods/services, 2021 prices

TYPES OF SERVICES/GOODS	FLAT RATES
Physician visits	€1/visit; with max. €4/day; €50/year/person
Laboratory tests and radiography	€1 per service
Hospitalizations for acute and post-acute care with overnight stay	€20/day
Hospitalizations in psychiatric facilities with overnight stay	€15/day
Outpatient services/interventions costs above €120	€24/service
Prescriptions	€0.5/drug package; with max €50/year/person
Ancillary service	€0.5/visit; max. €2/day
Medical transportation (except emergencies)	€2/transport; max. €4/day

Sources: CNAM, 2021m; French Administration, 2020

A complex capping system has been introduced concurrently to flat deductibles. Per service, per day, and annual caps have been introduced to limit financial consequences for consumers. Nevertheless, by their nature,

these deductibles (which are not adjusted by income) pose the risk of inducing inequity in access to care. While they have limited effects on the behaviour of higher-income groups, they can be an important barrier for those with low income. Direct cost-sharing expenses could be particularly significant

TABLE 3.5 User charges for health services

TYPE OF HEALTH SERVICE	TYPE OF USER CHARGES BEFORE CHI	TYPE OF USER CHARGES AFTER CHI	EXEMPTIONS
Ambulatory primary and specialist care	30% of conventional tariffs within standard care pathways or 70% outside of standard care pathways + potential extra-billing + €1 per consultation	0% within standard care pathways; 70% of conventional tariffs outside of standard care pathways; possible extra-billing depending on CHI contract; + €1 (flat rate)	Patients in the ALD*, C2S or AME schemes
Outpatient prescription drugs	Between 0% and 85% based on the assessed drug's medical efficiency (reference pricing) + €0.5 per box	0% of base price + €0.5 per box (depending on the contract)	Patients in the ALD*, C2S and AME schemes
Inpatient care	20% of conventional tariffs + potential extra-billing + daily catering fees of €15 to €20/day + potential comfort costs (single room, etc.)	0% of conventional tariffs + potential coverage of other fees by the CHI depending on contracts	Patients in the ALD*, C2S and AME schemes. 100% of conventional tariffs are covered by the SHI for hospitalization after 30 days
Dental care	30% of conventional tariffs for basic dental care; 0% for basic crowns, bridges and dentures (part of the "100% Health" reform)	0% of conventional tariffs for basic dental care; depends on the CHI contract for other care not included in the "100% Health" reform	Patients in the C2S and AME schemes (except for a fixed fee)
Psychologists	40% of conventional tariffs when prescribed by a physician since 2022 (for a maximum of eight visits per year), no extra-billing allowed	0% user charges for conventional tariffs within standard care pathways	Patients in the C2S or AME schemes
Transportation	25% of flat rates in medical situations requiring specific transport + €2 per transport	0% user charges + €2 per transport	Patients in the ALD, C2S and AME schemes, with work-related injuries or at the end of pregnancy

Note: * Only exempt from co-payments for consultations related to the illness which allowed inclusion in the ALD scheme. They must pay co-payments for other services and any extra billing fees.

Sources: CNAM, 2021i, 2021c; MoH, 2021i

for older patients, as they are more likely to need longer hospitalizations, and patients without a CHI contract, especially in post-acute rehabilitation and in psychiatric hospitals, where the average length of stay is longer (Adjerad & Courtejoie, 2021b).

Given the level of cost-sharing, specific measures exist to limit the OOP costs of populations with very low revenue and certain patient groups with high healthcare needs (Table 3.5). Populations exempt from cost-sharing include pregnant women in their third trimester, persons with a disability pension, persons with complementary solidarity insurance due to their low revenue (C2S), as well as persons covered by the long-term illness scheme (ALD) (see Section 3.3.1). There is also a cap for user fees for hospitalizations, limited to 30 consecutive days, which applies to all patient groups. This cap does not include daily catering fees for hospitalizations, which can lead to significant OOP payments for people without CHI (Adjerad & Courtejoie, 2021b). However, there are a number of situations for which the SHI also covers the catering fees, for instance, pregnant women during the last four months of pregnancy, persons covered by the complementary solidarity insurance (C2S), veterans and persons covered by the AME.

Despite these measures, the top 1% of patients with the highest OOP payments for acute hospitalizations paid on average €5540 per year in 2016 (Adjerad & Courtejoie, 2021b). A part of this amount was paid by the CHI, but there are no data on the final OOP payments for patients and their distribution by income categories. Patients with high hospital OOP expenditures (before CHI payment) are on average older, accumulate several short-term hospitalizations, and approximately half (54%) have a chronic illness, suggesting that the long-term illness scheme (ALD) is not sufficient for reducing extreme OOP costs related to hospitalizations (Adjerad & Courtejoie, 2021b).

■ 3.4.2 *Direct payments*

Healthcare in the ambulatory sector has traditionally been paid upfront by patients before being reimbursed by the SHI. This system has been gradually transformed, and third-party payment is now common for pharmaceuticals and medical devices (including eyewear and audio prosthesis), as well as for laboratory tests. It is also systematically applied for specific patient groups,

including those in the long-term illness scheme (ALD), benefiting from the complementary solidarity insurance (C2S) or the state-funded medical aid (AME) scheme, as well as for patients who had a work-related accident. It is also systematically applied in specific types of care, including maternity care, contraception for women aged up to 25 years, as well as in national screening programmes. OOP payments covered by CHI are subject to direct payment to different extents. Increasingly, healthcare providers choose to collaborate with CHI providers and bill them directly to avoid direct payments for patients. However, this practice varies depending on the patient's CHI contract provider and the healthcare provider.

The costs of inpatient hospital services are directly paid by the SHI, and CHI if the patient has it. Outpatient hospital visits are paid similarly to consultations in the ambulatory sector.

■ 3.4.3 *Informal payments*

Informal payments are rare in France, and healthcare providers engaging in these practices are subject to disciplinary sanctions. According to the Eurobarometer survey on corruption, 5% of French patients had to give a gift, favour, extra money or a donation to a public healthcare practitioner (doctor, nurse or hospital) for receiving services in 2019, which is around the EU average (5%) (European Commission, 2020b).

■ 3.5 **Complementary health insurance**

In 2019 around 96% of the French population had CHI (Pierre & Rochereau, 2022), which financed approximately 14% of the total health expenditure (see Section 3.1). In 2019 the premiums collected for CHI amounted to €37.5 billion (DREES, 2020d). The private CHI market is highly regulated in France in terms of premium rates, with conditions limiting patient selection and dumping, and guarantees offered.

Historically, CHI providers reimburse mostly the same benefits basket as the SHI, and cover the co-payments left to patients (Or & Pierre, 2020). However, most plans offer added coverage for medical goods and services above the prices set by the public scheme for dental and optical devices. Some

CHI plans also cover a part (or the totality) of extra-billing charges asked by some professionals (see Section 3.7) and some may also offer extended benefits coverage for goods and services not included in the SHI benefits basket (such as surgery for myopia) and/or provide access to extra amenities (such as individual hospital rooms).

CHI contracts can be purchased either through an employer (collective contracts), for private-sector employees and their dependents, or individually (individual contracts) for public-sector employees, self-employed individuals and those unemployed (Pierre, 2018). CHI contracts obtained through the employer have been subsidized via tax and social contribution exemptions since 1979. CHI premiums vary depending on the age of the policy holder (for individual contracts) or on the average age of the pool of those insured for collective contracts (where the premiums are uniform for all insured persons under the same contract). CHI providers must give a lifetime guarantee for anyone insured so that their premium cannot increase upon renewal of a contract above the premium offered to others in the same pool of insured for that contract. Moreover, to reduce issues with patient selection, since 2002 a tax reduction has been applied to contracts in which the health status of the insured is not used as a variable of risk adjustment (selection) in defining the price. These contracts (*Contrats solidaires et responsables*) prohibit the execution of health questionnaires at the time the insurance is acquired.

The generalization of access to CHI has been a key strategy for improving access to care by successive governments. Since January 2016, within the frame of a national interprofessional agreement (*Accord national interprofessionnel*, ANI), the 2013 law (*Loi relative à la sécurisation de l'emploi*) has required all employers to offer CHI contracts to their employees and pay at least 50% of their premiums (Franc & Pierre, 2015b). Collective contracts are usually more advantageous than individual ones in terms of guarantees and premiums because of the bargaining power of the employers and a concentration of individuals with low risk (working age groups). The 2016 agreement also stipulates that people who lose their job can keep their CHI from previous employment for up to 12 months. In 2019 about 45% of CHI owners were covered by a collective contract (Pierre & Rochereau, 2022).

The French CHI market has been highly competitive, but the number of CHI providers has fallen sharply from about 1700 in 2000 to 439 in 2019 (HCAAM, 2022b). The CHI market is also increasingly concentrated: in 2017 the top 10 companies represented 35% of the market turnover (Barlet

et al., 2019). Insurers can be gathered into three types. First, there are non-profit mutual insurance companies (known as *mutuelles*), which are the main players in the health-insurance market and cover approximately 60% of the insured, with a high share of people over 60 years old, mostly under individual contracts. Second, there are non-profit institutions (*Institutions de prévoyance*), which are jointly managed by representatives of employers and employees and offer almost exclusively collective contracts; hence, they cover mainly working-age individuals (about 15% of the population). And last, there are private for-profit insurance companies, which have increased their market share in recent years and cover about 25% of the CHI beneficiaries (30% of the market turnover in 2017) (Barlet et al., 2019). These three types of providers operate under distinct regulatory schemes. However, differences between their premiums have diminished over time because of market competition (Or & Pierre, 2020).

While there is no restriction on what insurers can cover, to benefit from tax advantages and social contributions CHI contracts have to respect certain conditions. The CHI contracts, called '*contrats solidaires et responsables*', are designed to encourage responsible healthcare consumption and promote good medical practice aligned with efficiency objectives set by the SHI. For example, they are not permitted to reimburse OOP payments imposed when patients visit an outpatient specialist directly (instead of using a referring physician as a gatekeeper) to support the gatekeeping reform introduced in 2004 (see Section 5.2). Also, they cannot refund deductibles introduced in 2005 for controlling drug consumption, visits to health professionals and transportation. In 2016 new constraints were introduced to limit differences in coverage levels between individual and collective contracts to reduce the impact of generous collective contracts on healthcare prices. These contracts must now respect reimbursement ceilings for optical devices (to contain their prices which are poorly regulated by the SHI) as well as extra-billings (to cap excess fees). Today, almost all CHI contracts are defined as *solidaires et responsables* (Barlet et al., 2019).

■ 3.6 Other financing

Other sources of financing play a limited role in funding healthcare. They include departments which are involved in the funding of LTC through

the provision of a personal allowance for autonomy, which covers personal care and assistance needs not included in the SHI benefits basket (see Section 5.8.2). Municipalities fund some public health services at the local level (for example, sanitary and environmental management, collective health prevention and promotion activities, etc.).

■ 3.7 Payment mechanisms

Most healthcare providers in France are paid based on volumes: FFS for self-employed health workers and activity-based payments in the hospital sector (see Table 3.6). However, it is recognized that these types of payment contribute to increasing volumes of care without forcibly improving quality and coordination of care across settings. Therefore, in recent years new payment models have been implemented and piloted to encourage better quality, coordination and efficiency of care.

TABLE 3.6 Provider payment mechanisms

PAYERS/PROVIDERS	LOCAL HEALTH AUTHORITY	SHI FUND
GPs	–	FFS + P4Q + C or S (~ 35% of GPs)
Ambulatory specialists	–	FFS + P4Q
Other ambulatory providers	–	FFS (self-employed) or S (in healthcare centres)
Multidisciplinary group practices		FFS + BP + P4Q
Acute hospitals	–	ABP + P4Q (1%)
Post-acute and rehabilitation facilities		GB + ABP (10%)
Other hospitals (psychiatric)	–	GB (population-based allocation, main budget) + BP ($\pm 15\%$) + P4Q ($\pm 2\%$) (from 2022 onwards)
Hospital outpatient	–	FFS
Dentists	–	FFS or S (in dental care centres)
Pharmacies (community)		Mark-ups on regulated prices + dispensing fees + P4Q
Public health services	GB	FFS + S + P4Q

Notes: Salary (S), Capitation (C), Pay for Quality (P4Q), Bundled payment (BP), Global budget (GB), ABP (Activity-based payment)

■ 3.7.1 *Paying for health services*

3.7.1.1 PUBLIC HEALTH SERVICES

Funds allocated to collective public health services at the national level are set each year through a parliamentary debate and are mostly made up of fundings from the State and local authorities (*départements*), which funded 51% of public prevention activities in 2019 with some additional funds from the SHI (15%), and private or associative sources (34%) (DREES, 2020a). Funding is allocated at the regional level through ARS, which have the responsibility to develop health promotion and prevention activities on their territory (see Section 2.3). Public prevention funds are mainly spent on public health surveillance and disease monitoring (56%) and primary prevention such as occupational health and immunization (32%), followed by secondary prevention such as screening (7%) and public health campaigns (6%). The State is the principal funder of all these activities, except primary prevention, which is mainly funded by the private sector (49% in 2020) (DREES, 2021b).

Individual preventive care provided in ambulatory settings or hospitals is paid by the SHI as part of regular services, via FFS remuneration (for example, dental check-ups for children or young adults, smear tests by gynaecologists, patient education, etc.) (see Section 3.7.2). In addition, the SHI runs a network of 85 health examination centres (*Centres d'examen de santé*, CES), providing preventive health examinations primarily for people who are in a precarious situation, who do not use healthcare regularly and do not benefit from organized preventive measures such as cancer screening (CNAM, 2020a). The SHI additionally provides a budget to local authorities (*départements*) for supporting maternal and child health services, free of charge, in local maternity centres (Chambaud & Hernández-Quevedo, 2018). Specific funds can also be allocated to collective public health services by local authorities (*départements*) and municipalities depending on their priorities.

3.7.1.2 PRIMARY AND SPECIALIZED AMBULATORY CARE

Primary and specialized ambulatory services are mostly provided by self-employed health professionals working in solo or group practices. Self-employed physicians and allied health professionals working in the

ambulatory sector contract with the SHI fund and are mostly paid by FFS. The prices of the consultations, procedures and services they provide are set at the national level through formal negotiations between the union of statutory health insurance funds (UNCAM), the government, the union of complementary health insurance schemes (UNOCAM) and the unions of health professionals, which leads to a national collective agreement every five years (although amendments are possible in-between).

The MoH plays a significant role in negotiations between the UNCAM and physicians' unions, which have significant lobbying power. All health professionals are subject to the terms of the national agreement, except if they expressly choose to opt out, in which case their consultation fees are not reimbursed, but this concerned less than 1% of all physicians in 2019, less than 0.5% of all dentists and less than 0.1% of all midwives and allied health professionals (CNAM, 2021f).

The national collective agreement is a contract which sets the fees for health services in the ambulatory sector. The SHI pays the social contributions, including the pension of physicians who agree to charge patients the nationally negotiated fees (called sector-1 contractors). In 2019 around 72% of self-employed physicians (93% of GPs and 51% of specialists) were sector-1 contractors (CNAM, 2021f). They are generally not allowed to charge any extra fees. Some physicians are allowed by the SHI to charge higher fees (called sector 2 contractors) based on their level and experience. Physicians working as sector 2 contractors are free to charge higher fees but must purchase their own pension and insurance coverage. The amount exceeding the regulated price (i.e. extra-billing) is not covered by the SHI but can be covered by CHI. The creation of sector 2 in 1980 aimed to reduce the cost of social contributions for the SHI fund, but did not have the expected impact, and the demand for the sector was much higher than predicted. Consequently, access to sector 2 has been limited since 1990 mainly to specialist physicians with specific experience (Order of 20 October 2016). While the share of physicians working in sector 2 represented 48% of specialists and 6% of generalists in 2019, these proportions show strong variation across regions and medical specialties. For example, 76% of ophthalmologists were in sector 2 in the Parisian area vs. 43% in the Bretagne region (CNAM, 2021f).

The Code of medical ethics (Public Health Code of 22 December 2020; Code of Social Security of 23 December 2021) requires that extra-billing be of a 'reasonable' amount. However, until 2012 there was no regulatory

definition of the term ‘reasonable’. This changed in 2012, when the medical professional council defined it as a fee exceeding three or four times the regulated prices. Additional restrictions were also introduced to forbid extra-billing patients with C2S and for emergency care. In 2017 the SHI introduced a new optional and yearly contract to regulate prices charged by physicians in sector 2, called ‘controlled tariff option’ (*Option de pratique tarifaire maîtrisée*, OPTAM). Physicians in sector 2 who sign this contract commit to freeze their fees (at their average of the three previous years) and not to charge more than double the regulated tariffs. They are also asked to perform a share of their services at the regulated SHI tariff levels. In return, they receive a bonus proportional to the share of their activity respecting the rules. There is also a specific option, with similar modalities, dedicated to specialists performing surgical or obstetrical procedures in private practice or in hospitals (*Option de pratique tarifaire maîtrisée chirurgie et obstétrique*, OPTAM-CO). In 2020 more than 17 000 physicians, representing half of the eligible sector 2 contractors, signed these contracts (Tranthim, 2020).

3.7.1.3 INPATIENT CARE

Acute care

Until 2005 two different funding arrangements were used to pay public and private hospitals. Public and most private not-for-profit hospitals had global budgets, mainly based on historical costs, while private for-profit hospitals had an itemized billing system with different components: daily tariffs covered the cost of accommodation, nursing and routine care, and separate payments were made for each diagnostic and therapeutic procedure, with separate bills for costly drugs and physicians’ fees. In 2005 an activity-based payment (ABP) model (*Tarifcation à l’activité*, T2A) was introduced to pay all acute care services (including home hospitalization) in public and private hospitals. The ABP aimed at improving efficiency, creating a level playing field for payments to public and private hospitals, and improving the transparency of hospital activity and management (Or, 2014).

Under ABP, the income of each hospital is linked directly to the number and case-mix of patients treated, which are defined in terms of homogeneous patient groups (*Groupes Homogènes de Malades*, GHM). The classification system used in France was initially inspired by the US Healthcare Financing

Administration's Diagnosis Related Groups classification (HCFA-DRG) but adapted to the French system. The GHM classification has changed three times since the introduction of ABP, passing from 600 groups in 2004 to about 2300 in 2009, and has remained stable since. Assignment of patients to GHM is based on the primary diagnosis and on the surgical interventions provided. The last version (v11) of the classification, which was introduced in January 2009, accounted for 2291 groups (compared with 784 in the previous version), and represented a major change in classification with the introduction of four levels of case severity applied to most GHMs. Data on length of stay (LOS), secondary diagnoses and age are used in a systematic way to assess the level of case severity (Or & Bellanger, 2011).

Public hospitals (and private hospitals participating in education and research) receive additional payments (*Missions d'intérêt général et d'aide à la contractualisation*, MIGAC) to compensate for specific "missions", including education, research and innovation-related activities, as well as activities of general public interest such as meeting national or regional priorities (for example, developing preventive care). A restricted list of expensive drugs and medical devices is paid retrospectively, according to the actual level of prescriptions made (see Section 3.7.1.4). In addition, ARS provide on a contractual basis some funding to hospitals for investments aiming to achieve some quality and efficiency objectives. Finally, the costs of maintaining emergency care and related activities are paid by a fixed yearly grant to cover operating expenses of services for a minimum of 12 500 visits per year; the payment is increased by a certain amount at each additional 5000 visits. In addition, each emergency visit which is not followed by a hospitalization is paid by a fixed fee, which is topped up with payments for consultations and procedures carried out (such as radiology, biological tests, etc.). However, in 2022 the government announced that the payment model of emergency departments will be changed to consider the intensity and quality of emergency care and to improve the coordination of hospital and ambulatory emergency care. The new payment model will consist of a global budget for an estimated activity (which will be calculated considering the patient outflow, mortality and morbidity rates in the local area) and fees adjusted by the intensity of care (40% of the budget), with a small P4Q (2%), which will be based on new emergency quality indicators to be calculated (Order of 6 April 2021).

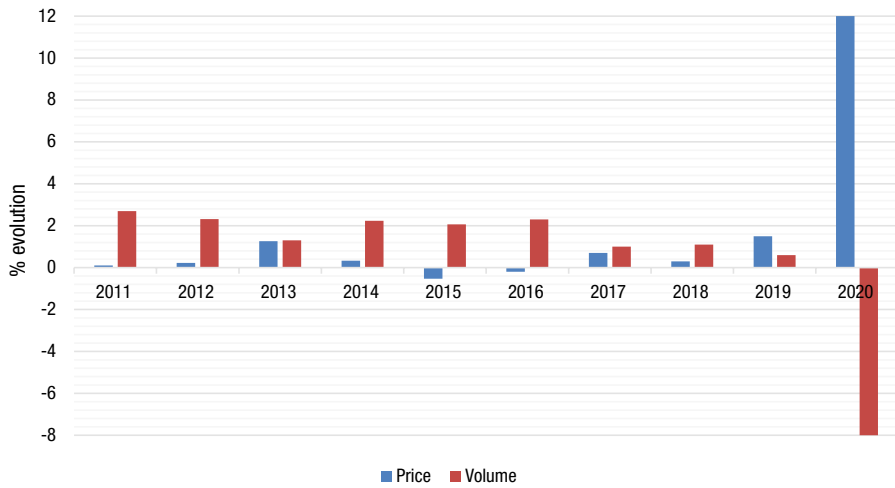
When the DRG-based payment system was introduced in 2005, the GHM prices were initially based on average costs per GHM (reference costs)

calculated from the national cost study (*Étude nationale de coûts à méthodologie commune*, ENCC), separately for public and private hospitals (Or & Bellanger, 2011). The ENCC provides detailed cost information for each hospital stay from about 150 voluntary hospitals (of which 45% are private for-profit institutions), which are able to produce detailed standardized accounting information (ATIH, 2021a). The GHM prices (tariffs) are set annually at the national level. There are two different sets of tariffs: one for public (including private non-profit) hospitals and one for private for-profit hospitals. Moreover, what is included in the price differs between the public and private sectors. The tariffs for public hospitals cover all of the costs linked to a stay (including medical personnel, all the tests and procedures provided, overheads, etc.), while those for the private sector do not cover medical fees paid to doctors (who are paid on a FFS basis) and the cost of biological and imaging tests, which are billed separately. The initial objective of achieving price convergence between the two sectors, which started in 2010 on about 40 GHMs (highly prevalent in both public and private hospitals) and was pursued until 2012, was abandoned afterwards.

However, the actual prices per GHM are not equal to reference costs. The GHM reference costs (“raw” tariffs) are adjusted, through a complicated and opaque process, to integrate various objectives set by the government each year, considering the overall budget for the acute hospital sector (ONDAM target, see Section 3.3.3) and public health priorities. To contain hospital expenditure, national-level expenditure targets for acute care (with separate targets for the public and private sectors) are set by the parliament each year. If the actual growth in total hospital volume exceeds the target, prices go down the following year to stay in the targeted budget. The growth of activity volumes is not regulated at individual hospital level but at an aggregate level (separately for the public and private sectors). Prices have been adjusted downwards regularly since 2006, as the increase in activity has been higher than the targets set (Fig. 3.6). This also meant that GHM prices were increasingly disconnected from actual costs of care in hospitals.

Despite a positive trend in productivity of public hospitals since 2004, with a strong rise in case-mix weighted production (Or et al., 2013; Studer, 2012), ABP has also created new problems related to quality and appropriateness of hospital care. Since 2004 both the number of beds per capita and the average length of stay have fallen significantly, with an increase in ambulatory surgeries (DREES, 2021d). However, avoidable hospital

FIG. 3.6 Evolution of total hospital consumption expenditure in price and volume in France, 2011–2020



Source: DREES, 2021a. Figure reproduced courtesy of Irdes

admissions, readmissions and emergency visits have increased visibly over this period, especially for older individuals (Bricard, Or & Penneau, 2020). The budgetary management of the sector, which is also adopted at the hospital level, led providers to concentrate on volume rather than on quality objectives. Moreover, there has been a gradual underinvestment in public hospital infrastructure since the hospital prices were intended to cover partly the cost of investment. Underinvestment in public hospital infrastructure and human resources contributed to the degradation of working conditions in public hospitals (DREES, 2019). The Covid-19 crisis aggravated existing problems and highlighted issues with public hospital funding. The MoH aims at progressively reducing the share of ABP in hospital funding, and alternative funding models will be tested (MoH, 2019d, 2020a).

Since 2016 a P4Q programme has been introduced in all acute care hospitals to improve the quality and safety of care (*Incitation Financière à la Qualité*, IFAQ). This was also extended to rehabilitation facilities in 2017 and to psychiatric facilities since 2021 (CNAM, 2022a). The additional funding is calculated on the basis of a limited number of process indicators (with one patient satisfaction indicator), taking into account the level of these indicators and progress over time. While the funding linked to IFAQ increased over time (0.5% of hospital funding in 2021) and the government aims to increase the share of payment linked to quality, the French National Authority for

Health (HAS) criticized recently the current P4Q model questioning the relevance of some indicators and the payment rules (HAS, 2022f).

Post-acute and rehabilitation care

Post-acute and rehabilitation services (*Soins de suite et de réadaptation*, SSR) were funded until 2017 through an annual prospective global budget for public and private non-profit hospitals and through a daily fixed rate for private for-profit hospitals. Since 2017 the global budgets have been adjusted considering the volume and case-mix of patients. A patient classification has been constructed since 2010, using the logic of GHM as in acute care. There are about 750 groups (*Groupes médico-économiques*, GME) for services provided in post-acute and rehabilitation services. The GME are determined based on several variables, including principal and secondary diagnoses coded at admission, the patient's age and level of dependency, post-surgical admission and medical procedures provided. Reference costs for different groups of patients have been estimated and updated annually. The process for fixing these reference costs is similar to the one for the GHM tariffs in acute care based on a cost database of a sample of voluntary hospitals (70 hospitals of which 30 were private) (ATIH, 2021b). The funding reform, which started in 2017, has been implemented very slowly. In 2020 only 10% of the budget came directly from activity-based payments using GME reference tariffs.

Psychiatric care

Until 2022 psychiatric care in public and non-profit hospitals was funded through an annual prospective global budget (*Dotation globale*), which was paid by the SHI and allocated by regional health agencies based on historical costs adjusted by the expected annual growth rate of hospital spending, which poorly considered the changes in local mental health needs and created strong geographical inequities. Private for-profit hospitals were paid by daily rates based on the type of care provided (full-time or part-time hospitalization). To reduce geographical and sector-wise inequities, a funding reform has been under way since 2022. The objective is to introduce a “combined” funding model including a population-based allocation to each hospital, based on: local indicators of care needs (poverty and social isolation rates, density of self-employed psychiatrists and social care providers, share of the population aged under 18, etc.); a retrospective budget based on the number of hospitalization days and ambulatory procedures performed per patient per

year; allocations for targeted cross-regional activities (for instance dedicated units for patients with complex needs); and a quality-based payment using a list of care quality indicators (under development) (Decree no. 2021-1255 of 29 September 2021).

3.7.1.4 PHARMACEUTICAL CARE

Outpatient pharmaceutical care is paid according to the official tariffs defined by the economic committee for healthcare products (CEPS) (see Section 2.7.4). Expected sales volumes are set for each product through negotiations with the pharmaceutical company, which can agree to refund any excess revenues to the SHI if sales exceed those forecast for the first year following commercialization. Furthermore, there is a short-term macro-level control of drug expenditures regulated by the LFSS (ONDAM; see Section 3.3.3), which sets targets of expenditure growth for the drugs reimbursed by the SHI in the following year. This is not a hard budget but a threshold beyond which companies pay discounts to the SHI. However, the total expenditure target does not consider the performance of different drugs in contributing to the overall health system goals and cost reductions (for instance by diminishing the need for hospital care). The costs of drugs that are not included in the list are not reimbursed and their prices are not regulated. These are paid OOP by patients and, sometimes, by CHI.

The prices of hospital drugs were set freely in negotiations between pharmaceutical companies and individual hospitals without any regulation until 2004. With the introduction of ABP, most drugs are now included in the GHM tariffs (see Section 3.7.1.3). While the prices are not regulated and are still negotiated between the pharmaceutical companies and hospitals, the reimbursement by the SHI is capped at the limit of a maximum fixed tariff which becomes in practice the regulated price. This reference tariff is set according to modalities similar to those used to set the prices of drugs in the ambulatory sector (see Section 2.7.4). Furthermore, there are some specific measures for regulating the costs of very expensive and innovative drugs. Their significant costs relative to the GHM tariffs, as well as the need to ensure access to innovation, justified setting a list of drugs for which payments are made on top of the GHM tariffs (*Liste des médicaments facturables en sus des prestations d'hospitalisation*). These drugs concern mostly the

treatment of cancer and autoimmune disorders, and are included on the list based on strict criteria: strong added therapeutic value, cost superior to 30% of the GHM tariff, and medical indication for less than 80% of the patients included in the GHM (DREES, 2021b; Sénat, 2021; MoH, 2021g). A specific targeted budget for these drugs is set in ONDAM (see Section 3.3.3), and their prices are regulated via negotiations between each pharmaceutical company and the CEPS mainly using European prices as a reference. In principle, this procedure is a temporary option for funding innovative drugs (once a drug is part of the regular treatment it should be included in the GHM tariff), but in practice very few drugs were dropped from the list over time (Gandré, 2011; Sénat, 2021). Expenditure for these drugs increased by around 40% between 2011 and 2017, reaching €3.5 billion; 10 drugs (out of 98) accounted for two thirds of this expenditure (DREES, 2021c). Some costly medical devices are also included in the list, representing a total cost of €1.9 billion in 2017.

■ 3.7.2 *Paying health workers*

Healthcare professionals are paid differently according to whether they are self-employed or employed in a facility. In the ambulatory sector payment modes of professionals have been diversified over time to align financial incentives with the objectives of care quality and coordination.

3.7.2.1 PRIMARY CARE PHYSICIANS

Most primary care physicians are self-employed and, historically, were paid by FFS. The SHI regulates closely the prices of services but there is no regulation of volumes of ambulatory services and prescriptions provided. Healthcare providers tend to increase the volume of services they provide to maintain or increase their revenues. Also, FFS payments give little incentive to GPs to provide health promotion and disease prevention activities, nor to comply with efficiency objectives. The 2004 gatekeeping reform (see Section 5.2), which aimed to reinforce GPs' role as primary care providers to improve care coordination and efficiency, did not alter the payment mode of GPs but added new payment mechanisms. GPs working as “referring physicians”

receive an annual payment of €40 for drafting a care protocol for patients with chronic diseases. Since 2013 they have also received €5/year for each patient in their list. The gatekeeping reform had, however, little visible impact on GPs' medical practice concerning prescription habits, preventive action and respect of guidelines (Cour des comptes, 2013; Dourgnon & Naiditch, 2010).

Therefore, in 2009 the SHI introduced a pay-for-quality (P4Q) contract (*Contrat d'amélioration des pratiques individuelles*, CAPI) to improve the clinical quality of care and encourage prevention and generic prescription. Initially proposed to primary care physicians and signed on a voluntary basis, this contract was generalized to all GPs in the 2011 national collective agreement, which stipulated that the payment of primary care providers could be related to their performance. Initial quality objectives included improving prevention rates (for example, flu vaccination uptake, breast cancer screening), reducing the prescription of benzodiazepine drugs (potentially dangerous and addictive) for individuals older than 65 years old, better management of diabetes and high blood pressure following clinical guidelines and better generic prescription rates (Bousquet, Bisiaux & Ling Chi, 2014).

The P4Q scheme was renamed in 2012 as the “payment for public health objectives” (*Rémunération sur objectifs de santé publique*, ROSP) and extended to specialists. Some objectives, such as organization of office practice and electronic records, are common to all physicians; others concern only GPs (CNAM, 2021g). Physicians are allowed to opt out of this scheme by writing to their local health insurance fund in the three months following the adoption of the national collective agreement (UNOCAM et al., 2016).

In 2020 the SHI fund reported that about 74 000 physicians (of whom more than two thirds were GPs) had received some performance payment of about €3700 on average that year (about €5000 on average for GPs) (CNAM, 2020b). It is estimated that P4Q accounted for 13% of GPs' remuneration in 2017 compared to 6% in 2008 (DREES, 2020a). However, the impact of these additional payments on quality of care has not been evaluated to date and the achievements in terms of prevention and efficiency of drug prescription remain modest (CNAM, 2022a).

GPs also increasingly work in healthcare centres on a salary basis (see Section 5.3). In 2021, 19% of GPs were salaried in hospitals and 16% in other healthcare facilities such as medical centres or long-term care homes for the older population and the disabled (DREES, 2021a).

3.7.2.2 OTHER AMBULATORY CARE PROVIDERS

Other ambulatory care providers, including self-employed specialists, dentists and allied health professionals, are also predominantly paid based on FFS. Even if the P4Q scheme (ROSP) has been extended to specialists (in particular, cardiologists, gastroenterologists, endocrinologists, diabetologists and nutritionists) with dedicated indicators (CNAM, 2021i), the share of P4Q in their remuneration remains small. Allied health professionals also often work in different forms of ambulatory care centres and are therefore paid on a salary basis.

3.7.2.3 COMMUNITY PHARMACISTS

Pharmacists in community pharmacies are paid by the SHI based on a mixed system combining a digressive sliding-scale margin based on the price of each drug, a fixed-sum per drug box sold and, since 2015, per prescription (with higher amounts for specific population groups, such as young children or older individuals, and for a higher number of drugs on the prescription). Since 2012 pharmacists have also been included in a P4Q scheme to incentivize, in particular, development of electronic pharmaceutical files, provision of advice to specific patient groups (asthmatic patients and those treated with anticoagulants) and generic substitution (CNAM, 2021b), for a total yearly amount estimated at around €7000 per community pharmacy in 2017 (Le Quotidien du médecin, 2018). Owners of community pharmacies may also employ salaried staff (including some pharmacists and pharmacy technicians).

3.7.2.4 HEALTH PROFESSIONALS WORKING IN HOSPITALS

Physicians and allied health professionals working in public hospitals are salaried civil servants. They are paid differently depending on whether they have an academic affiliation. Academics are remunerated for clinical practice as well as for teaching and research activities. Full- or part-time hospital practitioners and external practitioners with irregular/intermittent activities are remunerated based on the time worked, and receive allowances for being

on call. University hospital physicians are allowed to devote a part of their working time to private practice within the public hospital. These remunerations, based on FFS, are received by the hospital administration, which transfers them to the physician after withholding fees for use of facilities. The salaries in public hospitals are set on a national scale based on seniority and have long been criticized for being unattractive for health professionals. Recent reforms in 2021 increased the salaries of all hospital workers, between 15% and 20% on average, and eased the conditions of private parallel practice for physicians in public hospitals (see Section 6.1) (MoH, 2021h).

Physicians working in private hospitals are paid on FFS with often a possibility to extra-bill. Most other hospital professionals are paid on a salary basis.

Experiments with new payment models

Recently, there have been several attempts to modify the current payment models for supporting care coordination, teamwork, task shifting and more integrated care pathways.

In the ambulatory sector multidisciplinary group practices have been supported with bundled payments tied to certain quality objectives since 2010 (see Section 5.3). These include a lump-sum per patient, given to the practice, to remunerate care coordination, interprofessional cooperation, better accessibility (opening hours) and quality of care (Cassou, Mousquès & Franc, 2021; Mousquès & Daniel, 2015).

In 2019, to encourage new care models based on new payment modes, local healthcare experiments were launched with a dedicated budget (Article 51 of the 2018 Social Security Financing Act). Regulatory barriers to test innovations in payment and care organization are waived for encouraging bottom-up proposals. All health professionals and healthcare facilities were given the possibility to create and pilot new healthcare organizations and propose alternative funding models, provided that they aimed to improve quality of health and social care services and patient experience.

Three models are being piloted by the SHI, in a top-down approach. The first model (lump sum payments for teams of health professionals, *Paiement forfaitaire en équipe de professionnels de santé*, PEPS) is being piloted within multidisciplinary group practices (*Maisons de santé pluriprofessionnelles*, MSP) or healthcare centres interested in replacing FFS for GPs and nurses by a fixed annual payment per patient to follow all the patients of a referring

physician, or certain specific populations (older people, diabetic patients, etc.). This model is the one which could bring the most significant changes in the long term, as it aims to replace FFS in primary care by a type of capitation model (DGOS, 2021d). The second model (Incentive for shared care, *Incitation à une prise en charge partagée*, IPEP) is a P4Q-type payment to be shared between volunteering care providers across settings; a group of care providers from hospital ambulatory and social care sectors will receive extra payments to share, on top of their usual funding, based on their performance measured by a set of indicators of care quality, patient experience and cost control. Involved care providers must create a patient pool of at least 5000 patients and define joint actions to improve, for instance, access to care, care coordination and prevention. The P4Q does not replace but is additional to the traditional FFS (MoH & CNAM, 2019). Finally, the third model (*Épisode de soins*, EDS) is an episode-based funding system (for hip and knee replacements and cancer surgery) being piloted in selected hospitals for improving care pathways, coordination and efficiency (DGOS, 2021c). The episode-based payment covers the period of 45 days pre-surgery to six months post-surgery and include the remuneration of all involved professionals in the hospital and ambulatory setting, replacing FFS for each professional separately (DGOS, 2021c). These models are being piloted between 2019 and 2024 and will be evaluated before any conclusions are drawn (DGOS, 2021c; MoH & CNAM, 2019).

Physical and human resources

■ Summary

- The number of inpatient beds has decreased by 5% since 2013, whereas ambulatory and home hospital beds have increased in parallel over the same period. The hospital system demonstrated flexibility during the Covid-19 pandemic, with a rapid increase of intensive care capacity and public-private partnerships.
- Several digital innovations, such as e-prescriptions and shared medical files, are still in development, and major investments have recently been made to improve the eHealth systems. eHealth reforms were further accelerated by the Covid-19 pandemic.
- About 7% of the active population works in the healthcare sector. While the number of health workers has increased in the past 10 years in most professions (including specialist physicians), the number of general practitioners (GPs) per capita has decreased – and is predicted to continue decreasing at least until 2028. The number of nurses per capita is relatively high compared to the EU average, but their role and responsibilities in primary care remain limited.

- Physicians are free to choose their place of practice. Therefore the distribution of GPs and specialists across the country is very unequal, skewed to the well-off urban areas, unrelated to population needs. Financial incentives to attract physicians to underserved areas have had limited success so far, but other interventions, such as multidisciplinary group practices, have shown potential to attract especially younger GPs to underserved areas. Geographic disparities are less pronounced for other healthcare professionals who are, in most cases, subject to a form of regulation to practise in areas where density of providers is high.
- The Covid-19 crisis shed light on the underinvestment in public hospitals over the past 10 years as well as on the difficult working conditions of nurses and allied health professionals who were largely underpaid compared to other European countries. A health reform package in 2021 significantly increased the wages for 1.5 million health professionals, but difficult working conditions and lack of autonomy and recognition, especially in the long-term care sector, are still issues for securing recruitment.
- France has been slow in developing teamwork and task shifting between healthcare professionals. Despite the creation of an advanced nurse position in 2019, major obstacles for task shifting remain, including the remuneration modes of healthcare professionals.

■ 4.1 Physical resources

■ 4.1.1 *Infrastructure, capital stock and investments*

CURRENT CAPITAL STOCK

At the end of 2019 there were 3008 hospitals in France. Of these facilities, 45% were public, 33% private for-profit and 22% private non-profit hospitals (*Établissements de santé privés d'intérêt collectif*, ESPIC). All hospitals need an authorization, issued by the corresponding regional health agency (ARS) (see Section 2.3), to provide different types of care (DREES, 2021d).

Among these hospitals, 1834 were post-acute and rehabilitation services (*Soins de suite et de réadaptation*, SSR) delivering short-term rehabilitation and medical support services, mainly after a hospitalization (DREES, 2021d). Around 49% of these facilities were in the public sector, 25% in the private non-profit sector and 26% in the private for-profit sector (DREES, 2021d).

Some 13% of the 1354 public hospitals were regional hospitals (*Centres hospitaliers régionaux*) in charge of providing the most specialized care for the population of their region. More than 90% of the regional hospitals contracted with universities as teaching hospitals (*Centres hospitaliers universitaires*). Around 70% of the other public hospitals were general hospitals (*Centres hospitaliers*) providing mostly acute care and hospital care for the older population at a local level. A minority of public hospitals were psychiatric hospitals (*Centres hospitaliers spécialisés en psychiatrie*) (7%) or specialized in other areas (10%), mainly in long-term care (DREES, 2021d).

Most complex medical care and obstetric procedures, as well as long-term and psychiatric hospitalizations, take place in public hospitals, whereas elective surgeries mostly take place in private facilities. The 671 private non-profit hospitals – a number which remained stable between 2013 and 2019 – are mostly owned by foundations, religious organizations or mutual insurance associations. They contract with the statutory health insurance and are funded similarly to public hospitals if they adhere to the key principles of public hospital services: equal access to care for all, around-the-clock care and very limited extra-billing. Most private non-profit facilities are specialized in a few selected medical areas, such as palliative and cancer care, with 20 centres specializing in cancer treatment (*Centres de lutte contre le cancer*, CLCC) (one in each region) (DREES, 2021d).

In 2019 there were 697 emergency wards in France, located in 629 healthcare facilities, and more than 80% of all emergency visits took place in public facilities (DREES, 2021d).

Maternity units are classified into three levels, with subcategories. Level 1 units only have an obstetrical unit and take care of uncomplicated pregnancies; level 2 units need to have a neonatal ward (2a) and may have an additional neonatal intensive care unit (2b); level 3 units have the highest equipment capacity to monitor newborns with life-threatening conditions (HAS, 2009). There were 481 maternity wards, for a total of 740 000 births by the end of 2019, with 38% level 1 wards, 30% level 2a wards, 18% level

2b wards and 14% level 3 wards (DREES, 2021d). The number of maternity wards has been decreasing steadily since 1975, while the number of births, which increased in the 1990s, has been decreasing since the 2010s.

In addition to the 3008 hospitals, in 2019 there were 7519 medical residential nursing homes, (*Établissements d'hébergement pour personnes âgées dépendantes*, EHPAD) that accommodate people over 60 years old needing regular care and medical surveillance (CNSA, 2021).

Since 2016 hospitals have been encouraged to work collaboratively in local hospital groups (*Groupement hospitalier de territoire*, GHT) created by the 2016 Health Reform Law (Law no. 2016-41 of 26 January 2016). This represents a major reform (see Section 6.1) requiring public health facilities to define a shared local strategy around a common medical project and to jointly manage some cross-functions (for example, information systems, purchasing, training plans, etc.). By 2019, there were 136 GHTs in France of varying sizes (between 2 and 20 hospitals, and serving between 100 000 and 2.5 million inhabitants) and at varying levels of integration between health facilities (DREES, 2021e; MoH, 2019f).

Healthcare facilities in France must undergo an external assessment and are accredited by the French National Authority for Health (*Haute autorité de santé*, HAS) every four years based on 15 major criteria, such as patient safety, patient information, care coordination and governance quality. The HAS can retract accreditations from one year to another or endorse facilities on conditional criteria in publicly available evaluations (HAS, 2020b). However, there is no systematic assessment of the physical condition of facilities within the accreditation process. Instead, a tool (*Ophélie*) to help hospitals inventory their real estate assets and identify safety hazards, such as buildings which no longer comply with safety standards, was provided freely by the Ministry of Health (MoH) since 2014 (DGOS, 2021b).

REGULATION OF CAPITAL INVESTMENT

Healthcare capacity and investment planning is mainly implemented by the ARS through regional health plans (*Schéma régional de santé*, SRS), in line with the national health strategy (see Section 2.3). These plans are issued for five years based on an evaluation of regional needs for health and social care and include operational objectives (*Contrats pluriannuels d'objectifs et*

BOX 4.1 Are health facilities appropriately distributed?

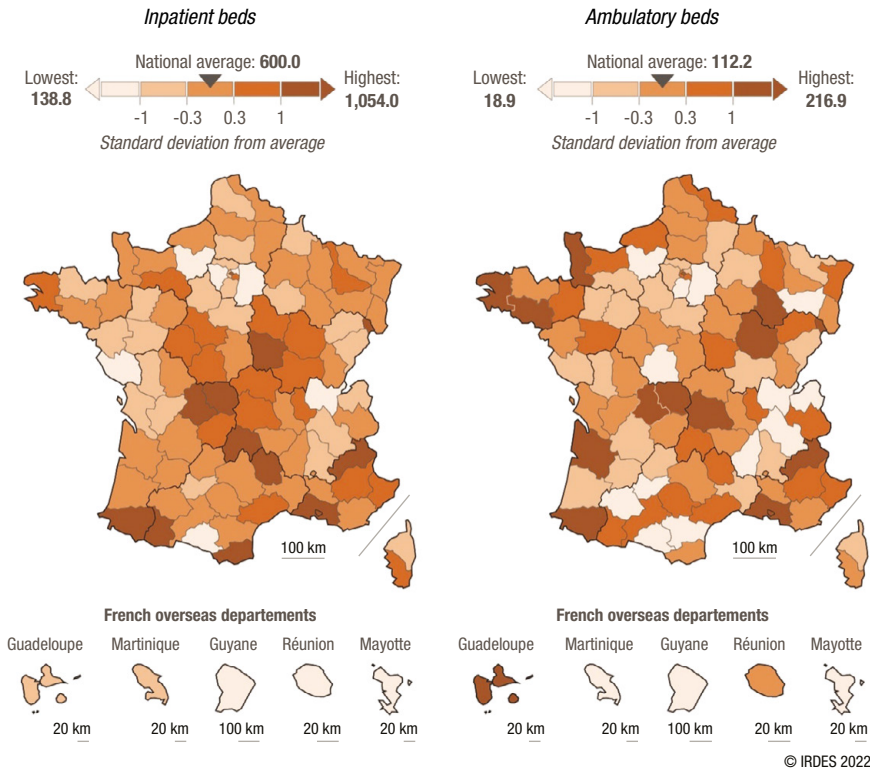
The density of hospital beds varies largely across French local authorities (*départements*) (see Fig. 4.1). In 2019 the density of total inpatient beds (*lits d'hospitalisation complète*) in acute, psychiatric, post-acute and long-term facilities varied from 139 per 100 000 inhabitants in the overseas areas of Mayotte to more than 900 in Cantal and Hautes-Alpes, while the number of ambulatory beds (*places*) varied between 19 per 100 000 inhabitants in Mayotte to 217 in Paris. Both New Aquitaine and Paca region (Côte d'Azur) are distinguished by a high density of both ambulatory and inpatient beds. Capacities for hospitalization at home (*Hospitalisation à domicile*, HAD) in the capital region were 2.6 times higher than in France as a whole, on average. Acute inpatient hospitalization rates tend to be higher in rural areas where the proportion of older inhabitants is higher and ambulatory alternatives are less well developed. Psychiatric hospital capacity (including number of inpatient beds and ambulatory beds) varied from 4 to 275 beds per 100 000 inhabitants in 2019, with a higher density in rural areas and in central France due to historical settlements of psychiatric hospitals in these areas (DREES, 2021d).

de moyens) established with local stakeholders (Public Health Code of 8 August 2018). The ARS are also in charge of providing the authorization for hospital care (including restructuring and merging of healthcare facilities) and for heavy medical equipment (imaging, hyperbaric chambers and cyclotrons) (Public Health Code of 26 February 2010). The 2019 law relating to the organization and transformation of the health system (*Loi relative à l'organisation et transformation du système de santé*, OTSS) simplified the administrative procedures for renewing authorizations for medical equipment (Bill no. 2021-583 of 12 May 2021).

INVESTMENT FUNDING

Since the introduction of activity-based payment (see Section 3.7), hospital tariffs are supposed to cover routine investment costs in acute hospitals. Public hospital investments have decreased over time: only 5% of the income of public hospitals was dedicated to investment in 2019, which is half of the percentage dedicated in 2009 (10%). A reduction in investment over the past decade has also been observed for private non-profit and private

FIG. 4.1 Density of hospital inpatient and ambulatory beds in French local authorities (*départements*), 2019



Source: Data from DREES, maps produced by Irdes

for-profit hospitals (except for psychiatry and SSR) (DREES, 2021d). In public hospitals this is largely explained by the degradation of their financial situation with increasing debts in recent years (see Section 3.7.1). As part of its 2020 investment plan for public hospitals (*Plan d'urgence pour l'hôpital public*) following hospital strikes in 2019, the government has decided to take over up to a third of hospital debts to support necessary restructuring (Gras et al., 2020; Vie publique, 2019).

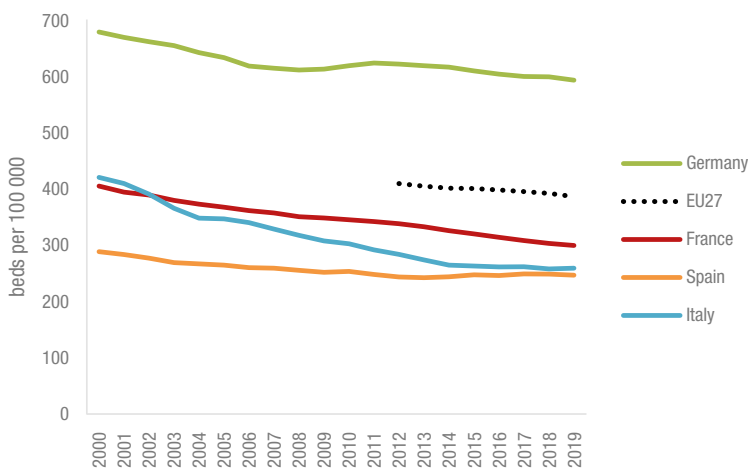
The Covid-19 pandemic triggered a much more substantial nationwide investment programme for hospitals and social care facilities, for the next ten years, starting at the end of 2020 (MoH, 2021g). Some of the funding covered public hospital debts in 2020/21, while other measures include 15 000 new recruitments in public hospitals, 4000 new beds which can be

allocated “on demand”, a significant salary increase for all health workers in hospitals and nursing homes, and investments in residential nursing homes (in particular, the renovation and modernization of existing infrastructures). Budgets dedicated to healthcare facilities are delegated to the ARS and integrated into an investment fund aimed at modernizing the health system, which can be used across sectors (*Fonds transversal pour la modernisation et l'investissement en santé*).

INFRASTRUCTURE

Despite the high share of health spending dedicated to hospital care (see Section 3.1), the number of inpatient beds has been decreasing over time in France (–5% between 2013 and 2019) (Boisguérin et al., 2020). Hence, the density of hospital beds also decreased from 406 beds per 100 000 inhabitants in 2000 to 300 per 100 000 in 2019, following the trends in other European countries. In 2019 the density was lower than the EU average (387 per 100 000 inhabitants) and lower than in Germany (595 per 100 000), but higher than in Spain and Italy (248 and 260 per 100 000, respectively) (Fig. 4.2).

FIG. 4.2 Beds in acute hospitals per 100 000 inhabitants in France and selected countries, 2000–2019



Source: Eurostat, 2021

The decrease in the density of inpatient hospital beds is explained by several parallel trends in the hospital sector (Table 4.1). First, owing to technological and medical advances, but also to financial incentives provided under an activity-based payment system (see Section 3.7), there has been a significant increase in ambulatory hospitalizations, which have also contributed to a sharp decline in the length of stay after surgery in hospitals. The number of ambulatory beds increased from 49 000 in 2003 to 79 000 in 2019 (DREES, 2021d). Furthermore, HAD have increased over time, from 2% of all short and medium-term hospitalizations in 2006 to 6% in 2019, mainly in perinatal and palliative care (Boisguérin et al., 2020; DGOS, 2018). Finally, the number of long-term care beds in hospitals decreased from 80 000 in 2003 to 31 000 in 2019. This is explained by the transfer of older patients to beds in medical residential nursing homes, which replaced long-term care in hospital settings by the end of the 2000s (see Section 5.8.1). The number of beds in these facilities has increased since 2009 (+2% a year), reaching 600 000 beds in 2019 (DREES, 2021d; INSEE, 2020a).

Post-acute and rehabilitation beds have also increased in the last decades (+14% between 2003 and 2019), in response to the growing needs of an ageing population. The increase is particularly marked for part-time hospitalization capacity in this sector (+50% between 2003 and 2019) (DREES, 2021d).

TABLE 4.1 Number of inpatient beds in acute, psychiatric and long-term care hospitals in France, per 1000 inhabitants, 2000–2019, selected years

	2000	2005	2010	2016	2019
Total number of hospital beds	8.2	7.4	6.6	6.1	5.9
Acute care beds	4.2	3.8	3.5	3.2	3.0
Psychiatric hospital beds	1.1	1.0	0.9	0.9	0.8
Long-term care beds	1.4	1.2	0.6	0.5	0.5
Post-acute and rehabilitation hospital beds	1.5	1.5	1.6	1.6	1.6

Sources: DREES, 2021a; Eco-Santé, 2014; INSEE, 2020b

Most of the hospital capacity (inpatient and ambulatory beds) is in the public sector (60% vs. 25% in the private for-profit sector and 15% in the private non-profit sector) (DREES, 2021d). The private for-profit sector

accounts for less than 13% of the bed capacity in the eastern regions, but more than 50% in the southern Mediterranean region (DREES, 2021d).

Between 2013 and 2019, before the Covid-19 pandemic, the global occupation rate in hospitals was stable at around 83%. In 2019 acute care beds had an occupancy rate of 78%, psychiatric and post-acute/rehabilitation hospital beds of 86% and long-term care beds of 93% (DREES, 2021d). During the early outbreak of Covid-19, the sufficiency of hospital beds, especially for critical intensive care, became a subject of debate. In 2019 France had 5400 permanent resuscitation beds (*Lits de réanimation*), which are defined by strict standards in terms of staff per bed and equipment (24hr presence of a specialist, nurses with specific training, particular monitoring devices, respirators and intravenous perfusion systems, etc.). Moreover, French hospitals had 6000 intensive care beds (*Lits de soins intensifs*) and 8200 beds for continuous monitoring (*Lits de surveillance continue*), for which there were also minimum staff ratios. While the number of resuscitation beds had only slightly increased prior to the pandemic (+1% between 2013 and 2019), the number of intensive and continuous monitoring beds increased more significantly (+10% and +8%, respectively, over six years) –even if their distribution on the French territory is unequal (Boisguérin et al., 2020). These beds, which are also part of critical care capacity, were quickly mobilized to address the growing strain of the pandemic on hospital beds. Moreover, the number of resuscitation beds was increased to reach 12 000 during the worst phase of the pandemic with temporary authorizations, which were also extended to private hospitals (HSRM, 2021).

■ 4.1.2 Medical equipment

The purchase of major medical imaging equipment requires authorization from the relevant ARS (DREES, 2021d). In 2019 there were 2885 major imaging units available in France, of which the majority were computed tomography (CT) scanners (42%) and magnetic resonance imaging (MRI) units (36%), while 16% were Gamma cameras and 6% were positron emission tomography (PET) scans (OECD, 2021c). The majority of imaging equipment is located in public facilities (DREES, 2021d). Approximately two thirds of CT scanners, PET scanners and Gamma cameras are in hospitals, whereas the majority (57%) of MRI imaging units are located in

the ambulatory sector (OECD, 2021c). However, there are administrative difficulties for counting equipment in private for-profit healthcare facilities, and the quantity of major imaging equipment may be underestimated (DREES, 2021d). The imaging equipment in the public and non-profit sector is unequally distributed across French local authorities (*départements*): the number of MRI units varies from 4 to 22 per 1 000 000 inhabitants, while the number of CT scanners varies between 4 and 25 per 1 000 000 inhabitants (DREES, 2021d). The local authorities with high bed density also tend to have high rates of medical equipment. The density of both CT scanners and MRI units in France is approximately half of that in Germany and Italy and lower than in Spain (Table 4.2), but the numbers of both MRI and CT exams per capita are almost 50% higher than the OECD averages (OECD, 2017). While there are no systematic data on waiting times, significant geographic disparities in access to imaging equipment have been observed in some studies (Detournay, Courouve & Graciet, 2018).

TABLE 4.2 Diagnostic imaging technologies per 1 000 000 inhabitants in France and selected countries, 2019

	FRANCE	GERMANY (2018 DATA)	ITALY	SPAIN
Magnetic resonance imaging units	15.4	34.5	30.2	17.6
Computed tomography scanners	18.2	35.3	36.5	19.2
Positron emission tomography units	2.5	–	3.6	1.8
Gamma cameras	6.9	–	7.9	6.7

Source: OECD, 2021a

■ 4.1.3 Information technology and eHealth

In 2019, 90% of all households had internet access, which is similar to the EU average and higher than in 2011 (76%) (Eurostat, 2021). Furthermore, in 2020, 84% of the French population had a smartphone, 66% had a computer and 56% had a tablet, facilitating regular use (CREDOC, 2021). Older people are also increasingly connected: 71% of over 70-year-olds had a smartphone, computer or tablet in 2020 (CREDOC, 2021). In 2019 one

in two people used the Internet to search for health-related information in France, which is higher than in 2011 (36%), but slightly lower than the EU average of 55% in 2019 (Eurostat, 2022).

Since December 2019 there have been two bodies dedicated to managing eHealth: the ministerial delegation for digital health (*Délégation ministérielle du numérique en santé*, DNS) and the digital health agency (*Agence du numérique en santé*, ANS). The DNS coordinates national and regional stakeholders related to eHealth and supervises eHealth development (MoH, 2021j), while the ANS has the operational responsibility to regulate, develop and promote the use of the national eHealth systems (<https://esante.gouv.fr/>).

Since 2018 teleconsultations with physicians have been reimbursed by the SHI as normal consultations under specific conditions (i.e., within recommended gatekeeping care pathways), but were limited to a maximum of 20% of the yearly activity of the physician (CNAM, 2022d). During the lockdown following the first wave of the Covid-19 pandemic, the SHI eased the conditions of teleconsultations (allowing phone consultations) and opened them to a larger range of healthcare providers (including nurses). In addition, all teleconsultations were reimbursed at 100% instead of 70% until mid-2022 (see Section 3.3.1). The number of health professionals joining the existing teleconsultation platforms increased rapidly and the government invested €2 billion into developing tele-medicine during the pandemic (MoH, Ministerial delegation for digital health & Digital health agency, 2021). Consequently, teleconsultations increased exponentially to account for 11% of all consultations in March 2020 and almost 30% in April 2020, compared to 1% before the Covid-19 crisis (CNAM, 2020a, 2020d). Following the expansion of eHealth, recommendations concerning eHealth practices are now issued by the HAS, and eHealth will be integrated into the continuous training of healthcare professionals (MoH, 2019e). The Covid-19 pandemic also acted as a catalyst for the use of online medical appointment booking systems, which are dominated by a private for-profit company, Doctolib, that was also instrumental in managing Covid-19 vaccination appointments.

France benefits from an exhaustive national health claims database where all healthcare consumption (for example, medical visits, procedures, prescriptions, etc.) reimbursed by the SHI fund is linked with a unique patient identifier. This database (*Système national des données de santé*, SNDS)

is used by the SHI fund to monitor healthcare utilization and expenditure and to make annual recommendations for improving the health system (CNAM, 2021n). A Health Data Hub (HDH) was set up in 2019 to serve as a one-stop shop for health data, and to allow the linking of administrative data with other data sources including clinical data and results of laboratory tests (MoH, 2021). However, by the end of 2021 the HDH had made little progress in linking different data sources and access to these data remains a challenge for researchers because of legal and technical barriers.

The priorities of the most recent reform (*Ma santé 2022*) have been to integrate eHealth systems used by different healthcare professionals into one national platform, to improve cyber security and patient access to eHealth systems, and to develop e-prescription (MoH, 2019e). In 2018 the SHI relaunched the “Shared Medical Record” (*Dossier médical partagé*, DMP), a tool for sharing patient information between health professionals which is accessible by patients themselves. It was first introduced in 2011 but with little success (Merlière, 2020). Despite a number of improvements made since 2016, such as letting patients create their own shared record, automatically filled health claims, and a mobile app (Séroussi & Bouaud, 2018), the uptake of the DMP remains low (Merlière, 2020). The latest measures include a “Digital Health Space” (*Espace numérique de santé*, “*Mon espace santé*”), which will be automatically created for all children born from 2022 onwards, giving access to the DMP (MoH, 2019e). E-prescriptions have been little developed in France in comparison to other European countries (Bruthans, 2020) but are part of the reforms supported by the 2019 OTSS law (Law no. 2019-774 of 24 July 2019). The objective is to generalize e-prescriptions at the national level by 2024 (MoH, 2019e; Vie publique, 2020). An electronic health insurance card (*e-carte vitale*) has also been piloted in several French local authorities and will be implemented nationally from 2023 onwards (Decree no. 2021-1014 of 30 July 2021).

■ 4.2 Human resources

■ 4.2.1 Planning and registration of human resources

According to the Public Health Code of 2021, there are three categories of health professionals in France:

1. medical professionals: physicians, midwives and odontologists/dentists (art. L4111-1 to L4163-10);
2. pharmacists (including assistants) and medical physicists (art. 4211-1 to 42); and
3. medical auxiliaries (also called allied health professionals): nurses, physiotherapists, chiropodists/podiatrists, occupational therapists and psychomotor therapists, speech therapists and orthoptists, medical laboratory technicians, hearing aid technicians, caregivers, childcare auxiliaries and ambulance attendants (art. 4311-1 to 4394-3).

Nurses, physiotherapists, chiropodists/podiatrists, occupational therapists, psychomotor therapists, speech therapists, orthoptists and medical radiology technicians are legally defined with a list of “procedures” that they are authorized to perform. Social care professionals such as social service assistants and psychologists, as well as professionals such as osteopaths and chiropractors, are not considered as health professionals according to the Public Health Code.

The MoH is responsible for human health resource planning at the national level, whereas the ARS are responsible for implementation and organization at the local level. The National Observatory of the Demographics of Health Professions (*Observatoire national de la démographie des professions de santé*, ONDPS), created in 2003, has the mission to collect data and provide guidance on human resources in the healthcare sector.

Training of medical professionals is carried out in 34 medical faculties, 24 pharmaceutical faculties, 15 faculties of dentistry and 34 midwifery schools (ONDPS, 2021). Several professions in the healthcare sector (physicians, pharmacists, dentists, midwives, nurses, paramedics, etc.) have been, for the past 50 years, regulated by the *numerus clausus* or by quotas, which both represent a fixed number of students that can be admitted to the first or second year of studies for health professions for each university. The last *numerus clausus* and quotas, set in 2020 by the ministries of Health and Higher Education, were 9361 medical, 1322 dentistry, 3265 pharmacy, 1039 midwifery, 31 764 nursing and 2865 physiotherapy students (OMK, 2021; ONDPS, 2021). The *numerus clausus* focused only on training capacity and lacked regional-level consultation, hence failed to oversee population needs and to remedy the disparities in healthcare provision across regions. The system was abolished in 2021 as part of the 2019 OTSS law, shifting

the focus of human resource planning to meeting anticipated population needs. For the first time the number of medical students (including physicians, pharmacists, midwives and dentists) to be admitted was determined in a national conference bringing together representatives from the ARS, professional unions, student associations, medical councils, local decision-makers and the ONDPS. The conference set the training objectives for the next five years (2021–2025) (ONDPS, 2021). Nevertheless, in practice, the criteria for determining the number of students have barely evolved from those previously used to set the *numerus clausus* (Dumontet & Chevillard, 2020) and this planning does not consider other local human resources such as nurses and allied health professionals.

Healthcare professionals are not formally licensed in France, but registration with the councils of professionals (*Ordre professionnel*) is mandatory to be able to practise according to the Public Health Code for the following professionals: physicians, dentists, midwives, pharmacists, nurses, physiotherapists and chiropodists/podiatrists. The councils keep professional registries, promote good medical practice and deontology, and can take disciplinary actions against their members (Adenot, 2012). However, some councils have difficulties functioning properly, in particular the Nursing Council, for which the registration rate is only about 50% (Cour des comptes, 2021b) since salaried nurses and facilities that employ them often ignore the obligation of registration. In 2022 the Nursing Council advocated for a more stringent control of the registration of active nurses by the State, as it is difficult to obtain robust estimations of their number, which has a negative impact in policy-making and workforce planning (ONI, 2022). Professionals are included in the national Directory of Healthcare Professionals (*Répertoire partagé des professionnels de santé*, RPPS) through their Council, which gives them a unique professional identifier. Nurses have been included in this directory only since October 2021. Most other professionals working in the health sector (such as psychologists) are also obliged by law to be registered, but via the ARS, with the noteworthy exception of nursing aides (ANS, 2021).

In France there was no compulsory recertification system in place for health professionals. However, as of January 2023 physicians, dentists, pharmacists, midwives, nurses, physiotherapists and chiropodists/podiatrists will be recertified every six years (with a longer delay of nine years for already practising physicians). This new certification process aims to guarantee that professional skills, care quality and scientific knowledge are upheld and will

rely on a list of criteria set up at the national level (including compulsory continuous training determined by professional councils) (Bill no. 2021-961 of 19 July 2021; Order of 7 September 2022). The professional councils will be responsible for the recertification, although this has been criticized by patient associations demanding an external evaluation.

■ 4.2.2 *Trends in the health workforce*

Approximately 1.9 million people, i.e. 7% of the active workforce in France, were working in the healthcare sector in 2016 (compared to 1.4 million in 2000) (DREES, 2016). The density of the health workforce is presented in Table 4.3 (latest year available).

Given the anticipated shortage of healthcare professionals as a result of an ageing workforce and population, the number of trained healthcare workers has increased over time for most healthcare professions, although for some professionals, especially GPs, the pace of increase is considered insufficient (CNOM, 2020a).

The number of women has been increasing in medical professions among younger generations: in 2021, 62% of physicians aged under 40 years were women, compared to 48% of all physicians (Anguis et al., 2021). Some professions have historically been female-dominated and remain so in 2021; the highest proportions of women can be found among midwives (97%) and nurses (87%), followed by pharmacists (68%) (DREES, 2021a). The majority of workers with a part-time professional activity in the health sector are women (ONP, 2021a), which is similar to other sectors, such as education and child care (Vie publique, 2021).

France has a relatively high number of nurses in relation to physicians. In 2020 there were 318 practising physicians and 1134 practising nurses per 100 000 inhabitants (Fig. 4.3). However, the distribution of nurses across sectors is unequal. In 2020 there were 4.3 nurses for one physician in the hospital sector compared to less than one (0.8) nurse per physician in the primary care sector (DREES, 2021a). The number of physicians per 100 000 inhabitants in France is lower than the EU average (393 per 100 000 inhabitants), and lower than in Germany, Italy and Spain, whereas the number of nurses per 100 000 inhabitants is higher than the EU average (837 per 100 000) and higher than in Italy and Spain, but lower than in Germany (Fig. 4.3).

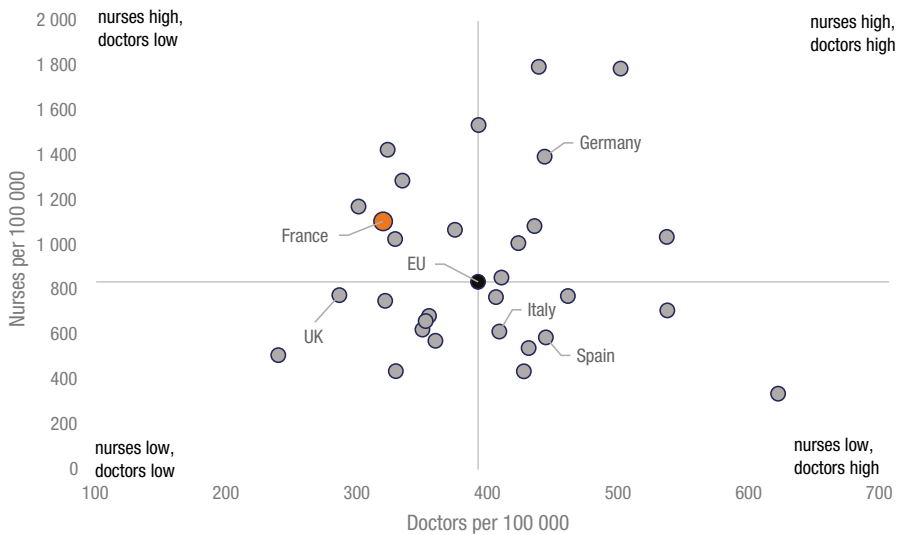
TABLE 4.3 Density of the health workforce in France, 2012–2021, selected years

	NUMBER PER 100 000 INHABITANTS		
	2012	2016	2021
Chiropodists/podiatrists*	19.2	21.0	–
Dentists	64.2	62.6	64.1
Dieticians	12.5	16.3	23.1
Hearing aid specialists	4.1	4.9	6.5
Medical laboratory technicians	–	60.8	74.6
Midwives	136.8	152.8	163.3
Nurses	899.6	995.2	1 135.8
Occupational therapists	12.8	15.7	21.6
Opticians	39.6	51.8	62.8
Orthoptists	5.8	6.6	8.7
Pharmacists	115.2	112.2	109.1
Physicians (total)	342.4	335.1	338.8
GPs	160.8	153.4	149.5
Specialists	181.5	181.8	189.2
Physiotherapists*	–	126.6	136.3
Psychologists	65.5	87.2	116.2
Psychomotor therapists	13.3	16.7	22.9
Speech therapists	33.6	36.9	41.1
Technicians specialized in electro-radiology	47.9	52.0	58.9

Note: * 2017 data.

Source: DREES, 2021a

The French health system has historically been physician centred. However, the roles and responsibilities given to allied health professionals have been increasing in recent years to meet the needs of an ageing population. Task shifting between GPs and other health professionals has been encouraged since 2009. In addition, for supporting the primary care workforce, a new health profession, named “medical assistant”, was created in 2019. Medical assistants can be hired by self-employed physicians (with financial aid from the SHI) to assist with administrative tasks and care coordination.

FIG. 4.3 Practising nurses and physicians per 100 000 inhabitants, 2020

Notes: Latest available year for UK is 2018.

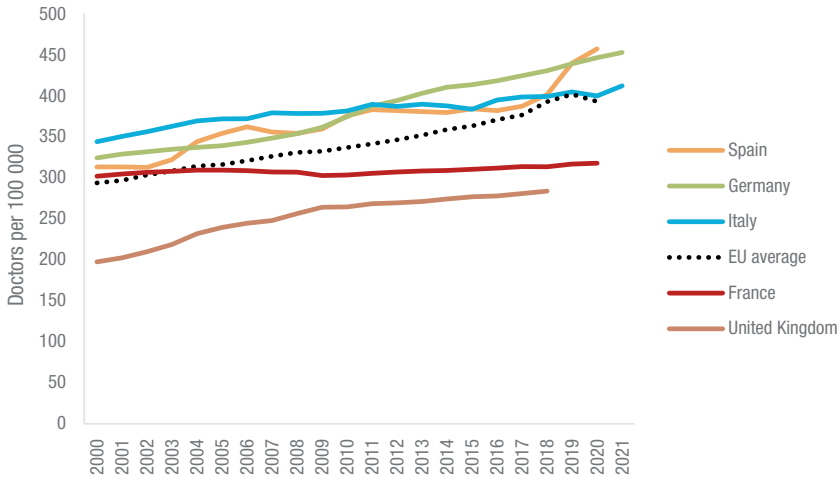
Source: Eurostat, 2022

These positions are open to both people with a health professional background (such as nurses or nursing aides) and those without (such as medical secretaries) (CNAM, 2019). By 2022, 3122 medical assistant contracts were signed, mainly by GPs (80%) or physicians working in underserved medical areas (around 50%) (CNAM, 2022a). Advanced nurse practice is also under development (see sub-section *Nurses*) to enhance task shifting. However, obstacles remain for task shifting among self-employed professionals paid on a FFS basis, since it represents an economic risk for physicians who can experience a loss in revenue when shifting tasks to nurses (Or & Gandré, 2021).

PHYSICIANS

In 2000 there were 302 physicians per 100 000 inhabitants in France, which was slightly above the EU average of 297 per 100 000 inhabitants. However, between 2000 and 2020 the number of physicians increased more slowly in France than in other EU countries. Therefore, while the density of physicians was higher in 2020 (318 per 100 000 inhabitants) than in 2000, it remained lower than the EU average (393 per 100 000 inhabitants) (Fig. 4.4).

FIG. 4.4 Number of physicians per 100 000 population in France and selected countries, 2000–2020



Source: Eurostat, 2022

In January 2021, 227 946 physicians were actively practising in France, including physicians with a regular activity (*activité régulière*), intermittent activity (mostly replacement physicians in the self-employed sector or with short-term salaried contracts), and retired physicians still in active practice. Of all active physicians, 44% were GPs and 56% other medical specialists (127 325 practising specialists against 100 621 GPs) (DREES, 2021a). The most common specialization is psychiatry, followed by surgery (Anguis et al., 2021). The majority (56%) of all active physicians are self-employed or combining their work with shifts or part-time employment in hospitals. Self-employment is more common among GPs (57%) than specialists (34%), and less common in younger generations and among women. In 2021 one third of all physicians were salaried in hospitals (19% of GPs and 41% of specialists), and 13% in other healthcare facilities such as healthcare centres or long-term care homes for the older population and the disabled (DREES, 2021a). The number of physicians who are exclusively salaried has increased by 12% since 2010 (CNOM, 2020a), partly as a result of different forms of group practices becoming more popular (see Chapter 5). In 2022, 69% of all self-employed GPs (87% of those under 50 years old) practised in a group. However, this mostly means that they share their office space with another GP; only 40% of them were in practices including other health professionals (Bergeat, Vergier & Verger, 2022). There are over 1300 multidisciplinary

group practices in France, employing an average of five GPs per practice (see Section 5.3) (Chevallard & Mousquès, 2021) and 2200 healthcare centres, of which 21% have a pluri-professional activity (DGOS, 2021a).

In January 2021 the mean age of practising physicians was 51 years, and one third of all active physicians were over 60 years old (DREES, 2021a). Due

BOX 4.2 Are health workers appropriately distributed?

Physicians in France are free to choose their place of practice, hence they are concentrated in well-off urban areas, creating large underserved medical zones in rural territories (Legendre, 2021). In 2019, in metropolitan France, the density of physicians varied from 377 in the *Provence-Alpes-Côte d'Azur* region and 354 in the capital area (*Ile-de-France*) to 241 per 100 000 in the Central region (Anguis et al., 2021).

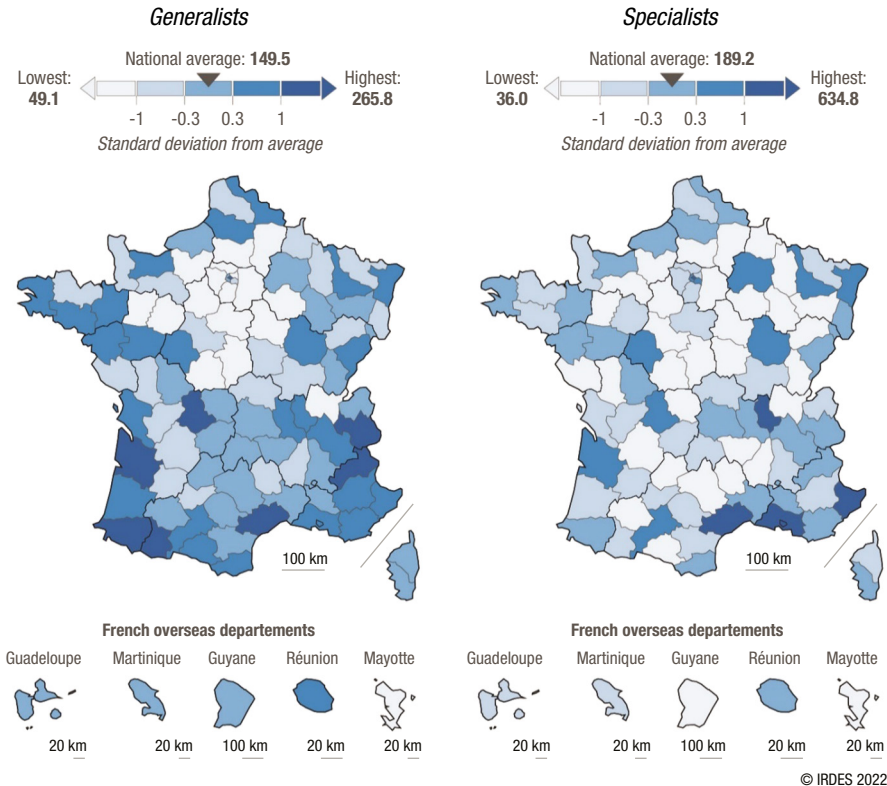
However, the distribution of specialists and GPs varies significantly within areas across French local authorities. For instance, in the capital area the number of GPs varies from about 100 GPs per 100 000 in *Seine-et-Marne* to 250 per 100 000 in *Paris* (Fig. 4.5). About 6% of the French population, mostly in the central region, live in areas where GP supply is considered insufficient (Legendre, 2020). Financial incentives for practising in underserved areas have had only a limited success (Dumontet & Chevallard, 2020), since young GPs seem to give higher priority to proximity to family, availability of other healthcare services and working conditions when choosing their place of practice (Chaput et al., 2020). The creation of multidisciplinary group practices has shown potential for reducing geographic inequities in GP accessibility by attracting and retaining younger GPs to medically underserved areas (Chevallard & Mousquès, 2021).

The distribution of specialists is also very unequal across metropolitan France with densities varying from 70 specialists per 100 000 inhabitants in *Eure* and in *Meuse* to more than 600 per 100 000 in *Paris*. While the geographic distribution of specialists has slightly improved over the past decade, inequalities – especially in access to those who do not extra-bill patients – remain significant (Cour des comptes, 2017). Hence, the lack of specialists in some areas has become a policy concern in the past decade. In 2018 the average waiting time for an appointment was 44 days for gynaecologists, 50 days for cardiologists and 80 days for ophthalmologists (Millien, Chaput & Cavillon, 2018).

Geographic disparities are less pronounced for other health professionals (Anguis et al., 2021). Pharmacists have long been subject to regulations for opening new community pharmacies, considering the needs, i.e. requiring a minimum number of inhabitants for each new pharmacy in an area. Midwives, self-employed nurses, physiotherapists and dentists are also subject to authorization from the ARS to set up a new practice (Legendre, 2021).

to changes allowing physicians to continue working after retirement (while keeping their pension) (CNOM, 2013), the share of retired physicians in active practice has increased, representing 9% of all physicians with a regular activity in 2020 (CNOM, 2020a). While the number and density of medical and surgical specialists have increased between 2012 and 2021, the number and density of GPs have decreased. Taking into account predicted changes in the demography and healthcare needs (such as population growth and ageing), the GP density is expected to decrease until 2028, and is predicted to return to 2021 levels in about 2035 (Anguis et al., 2021) (see also Box 4.2 and Fig. 4.5).

FIG. 4.5 Density of physicians (generalists vs. specialists) across French local authorities (*départements*), 2021



Source: ASIP-Sante RPPS – calculations by DREES, 2021a. Maps produced by Irdes

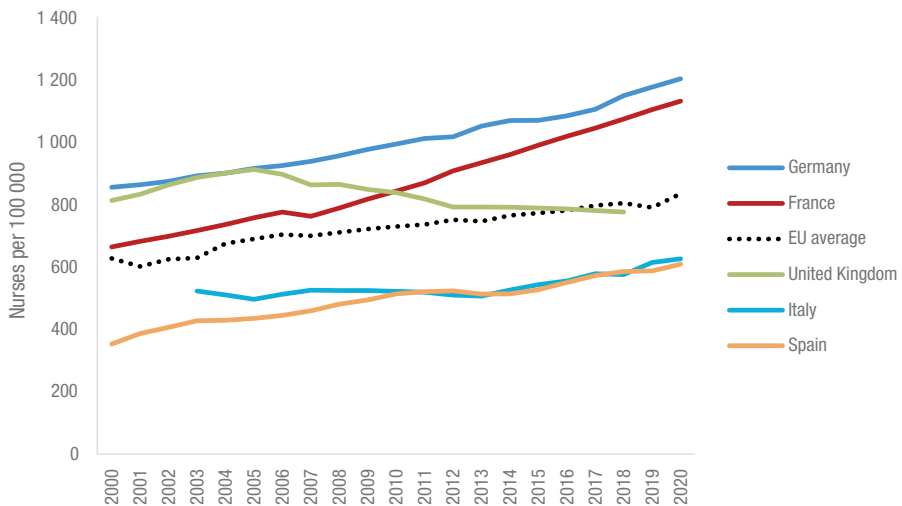
NURSES, NURSING AIDES AND MIDWIVES

Nurses

Nurses constitute the highest number of healthcare professionals in France. In January 2021 there were 764 260 nurses, with an average age of 46 years. However, this may be an over-estimation of actively practising nurses, since the number of nurses under 62 years old (average retirement age in France) was 637 000 at the same date. The fact that nurses are not systematically registered complicates the estimations of the active workforce. The majority of nurses work as salaried staff in hospitals (60%); about 20% are self-employed or have a mixed activity in the ambulatory sector, and the rest are salaried in other healthcare structures, especially in long-term care (DREES, 2021a).

Similar to Germany and Spain, the number of nurses per 100 000 inhabitants (based on Eurostat data) increased in France between 2000 and 2020, from 666 to 1134 (+70%). The increase has been steeper than for the EU average (from 629 to 837 per 100 000, +33%) (Fig. 4.6). However, the density of nurses (nurses per capita) should be compared with caution across countries, due to large differences in nursing education and roles.

FIG. 4.6 Number of nurses per 100 000 population in France and selected countries, 2000–2020



Source: Eurostat, 2022

According to national data, in 2021 the density of nurses was 1133 per 100 000 inhabitants (DREES, 2021a). While the number of nurses is high in the hospital sector (727 per 100 000 inhabitants), it is significantly lower in the primary and long-term care sectors (407 per 100 000) (DREES, 2021a) (see also Fig. 4.7).

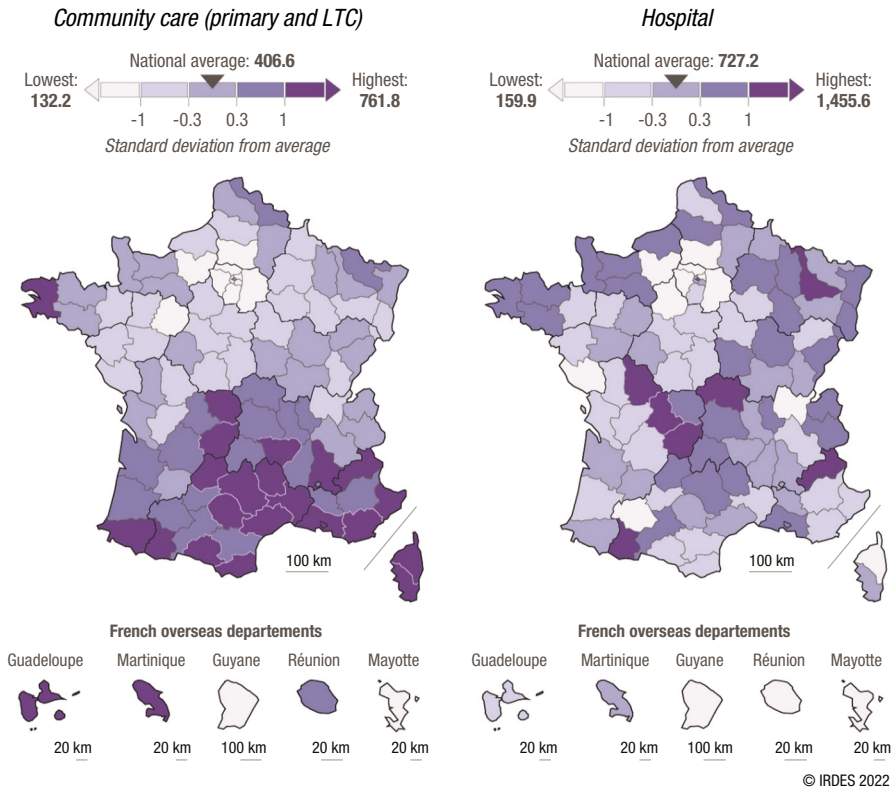
Since 2009, opening a new nurse practice in over-served areas⁴ is subject to restrictions for ensuring an equal distribution across French territory (ARS, 2021). Financial incentives are also used to attract nurses to underserved areas (CNAM, 2020b; Duchaine, Chevillard & Mousquès, 2022).

In 2019 the relative wages of nurses in public hospitals were among the lowest in the OECD countries (OECD, 2019a). There were several protests and strikes in public hospitals in the months before the Covid-19 pandemic denouncing the hard working conditions, especially of allied health professionals (Or et al., 2021). Following the pandemic the MoH launched a reform package (*Séjour de la santé*) for improving the working conditions of 1.5 million health professionals in acute and long-term care facilities. Wages of all categories of health professionals increased between, on average, 15% and 20% as of October 2021 (MoH, 2021k).

The role of nurses in healthcare provision is still restricted in France compared to many other countries, with limited responsibility and career options. However, this is slowly evolving. In the primary care sector pilot projects have been set up since 2004 to improve care for patients with chronic conditions (*Action de santé libérale en équipe*, ASALEE). In these pilots nurses are allowed to perform new procedures and tasks that are usually provided by GPs, including screening and therapeutic education for patients with some chronic diseases (such as diabetes) (Fournier, Bourgeois & Naiditch, 2018). An advanced nurse practice position (*Infirmier en pratique avancée*, IPA), broadening nurses' responsibilities and facilitating task shifting, was introduced in 2019. The advanced nurses can follow up and screen patients with common chronic conditions (such as diabetes and Alzheimer's disease), and from 2021 onwards patients with cancer, chronic renal disease or mental disorders. They are also able to specialize and work in emergency wards

⁴ Nurse practices in over-served areas are defined by ARS, mainly as a function of the age-sex adjusted number of full-time equivalent of nurses per 100 000 inhabitants.

FIG. 4.7 Density of nurses in the community and in hospitals across local authorities (*départements*), 2021



Source: ASIP-Santé RPPS – processed by DREES, 2021a. Maps produced by Irdes

from 2022 onwards (Nayrac, 2021b). Advanced nurses can renew medical prescriptions for their patients (Public Health Code of 20 July 2018). However, they can only see patients referred by a physician with whom they previously signed a formal agreement, which limits their autonomy and the attractiveness of this new profession. The advanced nurse training is designed for experienced nurses (at least three years of professional experience) and requires four additional semesters of full-time studies, equivalent to a master's degree (Code of Education on 18 July 2018). Yet their wages/tariffs are barely higher than those of regular nurses, and the fact that both these nurses and physicians are self-employed and are paid by FFS creates competition where physicians may be reluctant to delegate certain tasks. The first 63 advanced nurses graduated in 2019, another 920 graduated in 2020–2021 and 729

more were expected to graduate in 2022 (Bohic et al., 2021). However, at the end of 2021, only 674 IPAs were registered to the Nursing Council, of whom the majority (562) were salaried. A recent report from the public audit office pointed out the need for expanding the scope of responsibilities of advanced nurses with a possibility of direct patient access to their services, while indicating the positive impact of the first advanced nurses on quality of follow-up and patient care (Bohic et al., 2021).

NURSING AIDES

In 2017 the number of nursing aides was estimated to be around 390 000 (DGOS, 2018). The majority work in hospitals (around 245 000), primarily in the public sector (76% of all nursing aides working in hospitals) (DREES, 2021c). This profession suffers from a lack of attractiveness. The number of students enrolling to nursing aide training has been declining recently (−6% in 2018 compared to 2016) (Croguennec, 2019). In addition, recruitment difficulties have been underscored in nursing homes. Almost half of all residential nursing homes (44%) report difficulties in recruiting personnel: 9% of all nursing homes and 16% of private for-profit homes have vacant positions for nursing aides (vs. 4% in both cases for nurses) (Bazin & Muller, 2018). The *Ségur de la santé* reform was intended to increase the wages of nursing aides to the European average, with an immediate minimum monthly increase of €183 net after deducting taxes and a global long-term increase in salary scales (MoH, 2021h). While this represents a 15% wage increase for a nursing aide with less than one year of experience, the salaries remain very low considering their working conditions. A reform aiming to promote this profession is also under way, which will improve the curriculum by increasing the length of study from 41 to 44 weeks with more theoretical content (Order of 10 June 2021).

MIDWIVES

Midwives are distinct medical professionals; they have five years of training and are licensed by their professional council (*Ordre des sages-femmes*). In January 2021 there were 23 541 actively practising midwives in France with

an average age of 42 years. The majority of midwives (59%) are hospital employees, and approximately 23% are exclusively self-employed (DREES, 2021a). Midwives can also work in ambulatory child and maternal health centres performing screening and follow-up (Anguis et al., 2021). An increasing number of midwives are at least partially self-employed (34%) to have wider possibilities to exercise their profession, including involvement in gynaecological follow-up, abortion, vaccination, perinatal rehabilitation, contraception, health promotion and drug prescription (limited list) (Anguis et al., 2021; ONDPS, 2021). Recent reforms will also grant midwives the authorization to prescribe certain drugs and to refer their patients to specialists (Law no. 2021-502 of 26 April 2021).

In January 2021 there were 163 midwives per 100 000 women aged 15–49 years in France, and the density varied between 131 and 254 per 100 000 women across regions (DREES, 2021a). The number of midwives has steadily increased over the past decade (+3% a year between 2012 and 2017 and +1% a year since 2017) (ONDPS, 2021), faster than the number of potential deliveries, due to a high *numerus clausus* (Anguis et al., 2021). Similar to nurses, opening new practices in areas with a high density of midwives is restricted (CNAM, 2020c).

PHARMACISTS

In January 2022 there were 74 039 active pharmacists in France, with an average age of 47 years (ONP, 2022). Approximately 40% were self-employed. The majority (70%) of pharmacists work in community pharmacies (half own their pharmacy and half are salaried) (ONP, 2021a). About 10% of pharmacists work in hospitals or other healthcare facilities (DREES, 2021a) and 10% work in the pharmaceutical industry or in other sectors (Anguis et al., 2021).

The density of pharmacists, 109 per 100 000 inhabitants in 2021, exceeds the recent OECD average (86 per 100 000 inhabitants in 2019) (OECD, 2021a). Pharmacists are spread rather evenly across the metropolitan territory with a density varying between 92 and 126 pharmacists per 100 000 inhabitants, due to a strict regulation of authorizations for new pharmacies, but are more dispersed in the overseas departments (between 33 and 108 per 100 000 inhabitants) (DREES, 2021a).

PSYCHOLOGISTS

In January 2021 there were 78 197 actively practising psychologists in France (a number which has been steadily increasing), with an average age of 46 years. Approximately half of psychologists are at least partially self-employed (36%) or hospital employees (21%), whereas 44% work in other sectors, such as the social care sector (for instance, child welfare). In January 2021 the density of psychologists was 116 per 100 000 inhabitants, varying between 98 and 151 per 100 000 in metropolitan France and between 21 and 85 per 100 000 in overseas departments (DREES, 2021a). In France psychologists are not considered health professionals in the Public Health Code. As a consequence, consultations with self-employed psychologists in the ambulatory sector are not reimbursed by the SHI, they do not have a professional council and their practice is little regulated (Gandré et al., 2019). Self-employed psychologists have a limited role in the public mental care strategy, which has historically been hospital centred. However, the mental health consequences of the Covid-19 pandemic have triggered reforms in this area (see Section 5.11).

■ 4.2.3 *Professional mobility of health workers*

Recent workforce planning takes into account the flow of medical professionals emigrating and immigrating from/to France (OECD, 2019b). France is a net receiving country for foreign-trained health professionals, while emigration of French-trained professionals to other countries is limited. Of all active physicians under 70 years old in 2021, 10% had a diploma from a foreign country, compared to 7% in 2012 (Anguis et al., 2021). The proportion of physicians with a foreign diploma is higher among specialists (14%) compared to GPs (5%) (Anguis et al., 2021). More than half (53%) of all foreign diplomas were obtained in another EU country, primarily Romania (43%) – where training programmes are available in French – but also Belgium (15%) and Italy (14%). Physicians from non-EU countries come mainly from Syria, Morocco or Tunisia (Anguis et al., 2021), and they are more likely to work in underserved medical areas (OECD, 2019b). The proportion of foreign diplomas among active midwives is 8% (of whom 90% are French nationals), and 2% for pharmacists (Anguis et al., 2021).

The share of allied health professionals with a foreign diploma is relatively high among physiotherapists and speech therapists, mainly driven by French nationals who studied abroad (DREES, 2016; OMK, 2021), and very low for nurses (3%, compared to 15% in the United Kingdom and Switzerland) (DREES, 2020c).

Health professionals with EU diplomas are entitled to the same rights as French-trained professionals, while those with diplomas from outside the EU are subject to stricter standards and can only practise after passing an exam validating their professional mastery.

■ 4.2.4 Training of health personnel

The government (the ministries in charge of Health and Higher Education) decide the educational standards, how they are attained and the entry requirements for the initial training of health personnel.

All students who have successfully completed upper secondary education can apply to the first year of medical, pharmacology, midwifery or dentistry school (Law no. 2018-166 of 8 March 2018). Until 2020 all medical, dentistry, midwifery and pharmacy students had a common first year of studies in the medical field (*Première année commune aux études de santé*, PACES), followed by selective entry exams for the second and remaining years, with a limited number of places determined by the *numerus clausus* for each field. The PACES was abolished in the 2019 OTSS law (Law no. 2019-774 of 24 July 2019) and replaced by two options: a health-specific track (*Parcours spécifique accès santé*, PASS) and a possibility to study medicine as part of other bachelor's degree programmes with a health option (*Licence accès santé*, LAS). The PASS resembles the former first year of medical school with majors in health and a non-health minor. The LAS allows bachelor's degree students with other majors, such as law, to apply for the second year of medical school after one completed year of studies with a health minor. The LAS is available in all universities, thus improving the geographical access for entering medical school. Entry to the second year of medical school is based on grades obtained during the first year and oral exams (Decree no. 2019-1126 of 4 November 2019).

Medical school for physicians consists of three cycles. The first cycle lasts three years (including PASS or LAS). The second cycle, also lasting

three years, consists of theoretical and clinical practice (mainly in teaching hospitals), followed by a specialization after a selection process (third cycle). Recent reforms have changed this final selection process by abolishing the competitive national exam at the end of the second cycle (*Épreuves classantes nationales*, ECN). The selection now focuses more on students' clinical skills and experience in their specialty of choice (i.e. internship) (Law no. 2019-774 of 24 July 2019) (MoH & Ministry of Higher Education and Research, 2018b). The third cycle consists of 3–6 years of residency (*Internat*) depending on the specialization. During the last year of the third cycle, the students gain more autonomy and are considered as junior physicians (*Docteur junior*) and are allowed to work as short-term replacement physicians (*Médecin adjoint*) in underserved regions. Medical students in general practice must spend at least six months of their last year of post-graduate training in ambulatory care settings, which are primarily offered in medically underserved areas (Law no. 2019-774 of 24 July 2019). The measure will be extended to other medical specialties over time.

Training of pharmacists and dentists takes six to nine years at university, depending on the specialty chosen. Midwives undergo at least five years of university training while nurse training takes a minimum of three years. The competitive national entry exam to nursing schools was replaced in 2019 by an evaluation of applications by each faculty (MoH & Ministry of Higher Education and Research, 2018a). There are not many specialized nurses in France, but specialization is possible in a few areas (operating room, nursery, anaesthesia and, more recently, advanced nurse practice) with one or two additional years of study at university (see Section 4.2.2). In addition to the initial training, nurses must have two years of clinical experience in a hospital setting to qualify for self-employed status.

In France the training of allied health professionals has traditionally been fragmented across secondary schools, training institutes and universities. As opposed to many other European countries, allied health professionals were not awarded a standard university degree until 2006, when the training of these professionals was aligned with the European university system (Brunelle & Queneau, 2015). Physiotherapists, whose training passed from three to five years in 2015 (Nayrac, 2021a), were the first to be granted a master's degree in 2021 (Decree no. 2021-1085 of 13 August 2021). The training of psychologists, who are not considered as health professionals by the Public Health Code, is not well regulated. Therefore, there is heterogeneity in

curriculums across universities, sometimes with insufficient clinical training (Emmanuelli & Schechter, 2019; Gandré et al., 2019).

Continuous training of health professionals will progressively become compulsory in the framework of the new recertification system, which has been introduced since January 2023 (see Section 4.2.1).

■ 4.2.5 *Physicians' career paths*

After graduation, physicians can choose to set up a practice as self-employed practitioners, for whom the career paths are limited, or become salaried employees in hospitals or in other healthcare facilities.

To pursue a career within public hospitals, physicians are employed as hospital practitioners. New reforms, accelerated by the Covid-19 pandemic, aim to improve the working conditions, remuneration and career paths of physicians working in public hospitals (*Ségur de la santé*). The reforms significantly increased the wages of hospital physicians, especially the youngest ones, diversified their career paths, simplified the recruitment process in public hospitals and facilitated the recruitment of physicians working in private hospitals. Physicians in public hospitals were also given the possibility to engage in private practice (Bill no. 2021-292 of 17 March 2021). The reform also increased the income of hospital physicians (+€1500) who commit 100% to public service without any private practice.

■ 4.2.6 *Other health workers' career paths*

Most other health professionals can work either as self-employed practitioners or as salaried employees, except for nursing aides who can only be salaried. The share of professionals who are self-employed varies according to the health profession. For instance, while nurses (64%) and midwives (59%) are mostly working as hospital employees, most dentists are exclusively self-employed (79%) (DREES, 2021a). Recent reforms aim to evolve the career paths of all healthcare professionals, including medical auxiliaries, who will be able to mix self-employment with salaried positions (Law no. 2019-774 of 24 July 2019).

Academic and research career paths have long been mainly limited to physicians, dentists and pharmacists. Involvement of other professionals in research activities is slowly increasing but remains marginal despite a dedicated hospital research programme for projects coordinated by nurses and allied health professionals since 2011. Dedicated academic career tracks (assistant professor and professor positions) for nurses and midwives were created officially only in 2019 (Decree no. 2019-1107 of 30 October 2019) (MoH, 2019g). The recent changes allowing allied health professionals to obtain a university degree also allow these professionals to pursue an academic career.

Provision of services

■ Summary

- Healthcare provision is highly fragmented in France with a segmented approach to care organization and funding across primary, secondary and long-term care.
- The system is hospital centred, with many public and private providers competing for patients who have freedom of choice. While a voluntary gatekeeping system has been in place since 2004, primary care providers have little connection with care providers in other sectors and are not very active in health promotion and prevention.
- Recent reforms aim to strengthen primary care by encouraging multidisciplinary group practices, introducing financial incentives for better care coordination and prevention, and expanding the roles and responsibilities of allied health professionals. Concurrently, cooperation between healthcare providers in different settings is supported by the creation of local care networks.
- Accessibility of pharmaceuticals is high due to an extensive public benefits basket and a well distributed network of pharmacies on the French territory. Around 80% of pharmaceutical expenditures is covered by SHI, which pays for prescription medicines based on their effectiveness. However, France has high volumes of pharmaceutical consumption with an overuse of certain medicines such

as antibiotics and low generics utilization rates despite several measures aiming to improve prescribing patterns.

- Long-term care is funded and managed by different levels of government. While the SHI system allows a unified and relatively good coverage of medical LTC needs, the type and funding of personal and social LTC services vary depending on the local authority (*département*). Almost 10% of people over 75 years old, and one in three individuals over 90 years old, live in a residential nursing home. Home care nursing and home support services are developing slowly but are not always well articulated with secondary care. Low attractiveness of the LTC sector is a growing problem for securing sufficient staff to deliver these services.
- Mental health care has historically been organized around hospitals which have the main responsibility for providing public mental health care (including outpatient care) to the population in their catchment areas. Therefore, mental health care provision has remained very hospital-centred with a lack of adequate supply in community settings for people with mild to moderate mental disorders. Recent reforms aim to improve the coordination of services across all sectors and to increase access to psychologists.

■ 5.1 Public health

■ 5.1.1 *Principal public health institutions and authorities*

The French Public Health Agency (*Santé publique France*, SPF) is the principal agency responsible for public health policy and expertise in France. Its missions, defined in the Public Health Code (Public Health Code of 1 May 2016), include health promotion and education, public health surveillance, and disease prevention and monitoring, as well as alert and response to disease outbreaks and other public health emergencies. The agency was created in the 2016 Health Reform Law (Law no. 2016-41 of 26 January 2016) under the umbrella of the Ministry of Health. The SPF regrouped four former public agencies: the National Institute for Health Monitoring (*Institut de Veille*

Sanitaire, InVS), the National Institute for Prevention and Health Education (*Institut National de Prévention et d'Éducation pour la Santé*, INPES), the Agency for Health Emergency Response and Preparedness (*Etablissement de Préparation et de Réponse aux Urgences Sanitaires*, EPRUS), and a non-profit drug and alcohol addiction prevention service (*Addictions drogues alcool info service*, ADALIS). The SPF relies on regional branches (*Cellules d'intervention en région*, Cire) located within the regional health agencies (ARS) to support them with scientific expertise on health monitoring, surveillance and alerts at the local level (ARS Pays de la Loire, 2021).

The ARS are in charge of coordinating all health-related agencies and care providers in their region (Section 2.3). Their public health responsibilities include implementing national policies at the regional level, such as organizing and financing disease monitoring and surveillance, health promotion and disease prevention activities, and managing public health emergencies at the local level (ARS, 2014).

In France the MoH is responsible for public health policies, including prevention (such as the national vaccination programme) and health promotion (MoH, 2015a). The French National Authority for Health (HAS), an independent, scientific, administrative authority, oversees the development of guidelines of good practice for medical care. The HAS is also in charge of providing guidance on national screening and prevention programmes. It has a Technical Commission on Vaccinations (*Commission technique des vaccinations*, CTV) which issues recommendations on vaccination strategy and schedule (HAS, 2017a).

The High Council for Public Health (HCSP) provides the government with expertise for developing and evaluating public health policies and for managing public health risks and safety (Public Health Code of 1 May 2016) (Milon et al., 2020).

Municipalities have a limited role in public health, apart from sanitary and environmental management (of water supply, waste disposal, food and industrial hygiene) for which they are responsible (Code of Local Authorities of 23 August 2021). However, municipalities can engage in health prevention and promotion on a voluntary basis – for instance through “local health contracts” signed with the ARS for implementing joint health prevention and promotion projects (ARS, 2012), or by participating in the World Health Organization Healthy Cities Network (WHO, 2021).

■ 5.1.2 *Response to disease outbreaks*

The National Prevention and Management Plan against influenza pandemics (SGDSN, 2011) is used as a guide for all infectious disease outbreaks. The plan has four stages adapted to the severity of the spread. The first stage consists of preventing the virus from entering the national territory through limiting international travel and quarantining individuals arriving from affected countries. Once the virus is in the national territory, the second stage seeks to limit the spread of the virus (for instance through limiting public gatherings and quarantine of infected individuals and their contacts). In the case of a national epidemic, the third stage aims to limit its effects (for instance through closing schools and reinforcing health personnel treating infected patients). The fourth and last stage consists of a recovery phase (for instance with financial aids to vulnerable populations, and evaluations of the disease outbreak response) (SGDSN, 2011). Several agencies share the active response to a disease outbreak. The SPF manages the centralized monitoring and response to infectious diseases, while the HAS provides guidance and directives for health professionals on the treatment of patients. The medical products and clinical trials related to the epidemic are evaluated and approved by the National agency for medical and health product safety (*Agence nationale de sécurité du médicament et des produits de santé*, ANSM).

During the Covid-19 pandemic the national prevention and management plan was mobilized. The SPF oversaw the monitoring of the epidemic and published statistics on the spread of Covid-19, including the numbers of daily cases, hospitalizations and tests performed, etc. However, the SPF and its local branches were slow in developing a public health response, and in defining the prevention strategy. The SPF was criticized for being under-sized in terms of skills and staff, and for being unprepared for a pandemic. The agency had difficulties in building up and managing strategic stocks (including protective materials), but also in developing a quick operational response to the health crisis (Borowczyk & Ciotti, 2020; Or & Gandré, 2021).

■ 5.1.3 *Immunization*

The MoH is responsible for the national vaccine programme, which is issued and updated based on recommendations established by the HAS (MoH, 2021f).

Eleven vaccines are mandatory for children and free of charge in France: diphtheria, tetanus and polio since 1938, 1940 and 1964 respectively, and eight since 2018 (Pertussis, Haemophilus influenza type B, Hepatitis B, pneumococcal infections, invasive meningococcal infections of serogroup C, measles, mumps and rubella) (MoH, 2021f). Children who have not received these vaccines are not allowed in day care and schools (Service public, 2021). A twelfth vaccine – against yellow fever – is mandatory in the overseas territory of French Guyana.

In addition to the 11 mandatory vaccines, there are some recommended vaccines for specific population groups, of which the cost is partly (65%) covered by the SHI. This is for instance the case for vaccination against the Papilloma virus, which is recommended for teenage girls, and, since 2021, for boys. Complementary vaccination protocols exist for vulnerable populations and emergency vaccination responses, such as to Covid-19 (MoH, 2021f).

Vaccination of the general population mainly relies on general practitioners (GPs) and paediatricians. However, since 2022 nurses are allowed to inject a large number of vaccines to adults and children aged over 16 without a medical prescription (Decree no. 2022-610 of 21 April 2022) (previously they were limited to tuberculosis and influenza vaccines) (Public Health Code of 2021). Since 2022 pharmacists can also carry out such vaccinations upon a medical prescription (Order of 21 April 2022a). They could vaccinate older people against seasonal influenza without a medical referral since 2019. Midwives have been allowed to vaccinate women and infants against specific diseases since 2016 (Order of 10 October 2016) and the list of vaccines they can administer was extended in 2022 (Order of 21 April 2022b). Maternal and child protection services (*Protection maternelle et infantile*, PMI) and occupational physicians can also deliver vaccinations (Public Health Code of 2022).

While vaccine coverage has increased over the last decades (SPF, 2020), in 2019 the percentage of children vaccinated against Hepatitis B, pneumococcal and meningococcal infections, and measles was still below the WHO recommendation of 95% (MoH, 2021f). France has a high prevalence of vaccine hesitancy; in 2016, 25% of the population had negative views towards vaccination in general and 41% had a negative opinion on at least one vaccine (SPF, 2017). Given this well-known vaccine hesitancy, the government put significant effort in developing an efficient vaccination campaign against Covid-19 with emergency legislation allowing more professional groups to

carry out vaccination (such as firemen, dentists, veterinarians and physiotherapists) (Order of 7 July 2021). Large *ad hoc* vaccination centres, which recruited retired health professionals, nurses and students, were also set up (HSRM, 2021). Despite all these measures, vaccination rates were low in the first half of 2021, especially amongst the most deprived populations (Spire, Bajos & Silberzan, 2021). The government hence applied unprecedented restrictions and incentives to support the uptake of the Covid-19 vaccination. These measures included suspension, without remuneration, of unvaccinated professionals who were in close contact with the public (health and social care workers, firemen, the army, etc.), and an obligation to show a Covid-19 certificate with proof of vaccination or antibodies against Covid-19 (or a negative Covid-19 test but this possibility was later suspended) for employees, customers and visitors in public and commercial places (such as restaurants, cinemas, museums, sports facilities and shopping malls) and in long-distance public transport (Law no. 2021-1040 of 5 August 2021). These measures significantly increased vaccination rates, with an estimated 72 151 additional doses per million inhabitants, or 4 874 857 additional doses in absolute terms 40 days after the announcement (Mills & Rüttenauer, 2022). Despite initial resistance, vaccination rates were also boosted for health professionals, especially in nursing homes, and the share of staff being suspended was estimated to be very low. The Covid-certificate was also used for encouraging a third booster dose in early 2022, but it is not envisioned for other vaccination campaigns.

■ 5.1.4 *Primary prevention and health promotion programmes*

The SPF runs the major national information campaigns and health promotion services, for instance, tobacco cessation services (<https://www.tabac-info-service.fr/>), nutritional and physical exercise campaigns (<https://www.mangerbouger.fr/>) and information campaigns for expecting parents and parents of newborns (www.agir-pour-bebe.fr).

Implementing a health promotion and prevention policy throughout the life course was one of the first priorities of the French national health strategy for the years 2018–2022, a strategic document setting health system priorities (MoH, 2017). The subsequent prevention plan targeted different

population groups (MoH, 2019c). For infants measures focused on the perinatal period (reducing alcohol, smoking and drug use in pregnancy and introducing postnatal home visits). For children and adolescents measures mainly targeted obesity (for instance through food education in schools), risky sexual behaviours and addictions (easier access to outpatient clinics for young substance users). For the adult population the plan focused on tobacco consumption by providing extensive SHI coverage of smoking cessation treatments. The national prevention plan also introduced measures for improving access to preventive care for individuals with reduced autonomy, such as systematic annual medical and dental check-ups in residential institutions for the elderly and for people with disabilities (MoH, 2019c). Nevertheless, the investment in the national prevention plan remains modest – €400 million over five years (CIS, 2018).

In 2017 a specific fund was created to prevent tobacco smoking, to help smokers quit and to finance research on tobacco policies. Taxes on cigarettes have also significantly increased since 2017 (Order of 6 November 2017). Prevention of alcohol abuse consists mainly of public campaigns in the general population with also a focus on reducing alcohol consumption during pregnancy (MILDECA, 2018). Measures promoting physical activity remain limited to legally enforced prompts for physical activity in commercials for soft drinks and food with added sugar, salt or artificial colourants, since 2007 (Order of 27 February 2007). Furthermore, since March 2017 GPs can prescribe physical activity to patients suffering from diabetes, heart problems or cancer (Decree no. 2016-1990 of 30 December 2016). The efficiency of prescribed physical activity for these groups is under evaluation before generalizing the policy more broadly. One of the most important investments in promoting healthy food choices includes a front-of-pack scoring system for food products, the *Nutri-Score*, which rates the calorie, sugar, salt, saturated fat, fibre and protein content of packaged products from A (best nutritional quality) to E (worst nutritional quality). This rating became mandatory for all food commercials in 2021. Food manufacturers may, however, opt-out from this obligation by paying a fee to the SPF (National assembly, 2019).

Despite an increasing political focus, France ranks low for spending on health promotion and prevention among OECD countries (OECD, 2021b). In 2019 only 1.9% of health expenditure was spent on organized prevention, compared to 3% on average in the EU (OECD, 2021b). The

historical orientation of the French health system towards curative medicine was identified as a major constraint for developing effective prevention strategies during the Covid-19 pandemic (Borowczyk & Ciotti, 2020). It has also been recognized that the medical curriculum could be strengthened by integrating more training in disease prevention. Therefore, since 2018 all students on health-related training tracks (including medicine, dentistry, nursing, midwifery, physiotherapy and pharmacy) have to participate in three months of health promotion and prevention activities, such as health-related workshops and information campaigns in schools, workplaces, nursing homes and prisons (MoH & Ministry of Higher Education and Research, 2018c).

■ 5.1.5 *National screening programmes*

Three national cancer screening programmes are in place in France: for breast, cervical and colon cancer (MoH, 2018d). These screening programmes have been established by the National Cancer Institute (*Institut national du cancer*, INCa), a scientific expertise and coordination agency dedicated to cancer under the umbrella of the ministries of Health and Higher Education and Research. Since 2004 all women between 50 and 74 years old are invited for a mammogram and a clinical examination with a radiologist, free of charge, every two years (INCa, 2017). Moreover, since 2009 all adults aged between 50 and 74 years are systematically invited to colon cancer screening every two years (INCa, 2021a). The screening programme for cervical cancer, implemented in 2018, offers a smear test every three years to all women aged between 25 and 30 years and every five years for women aged 31–65 years (INCa, 2021b). The rate of timely access to cervical cancer screening for women in France is estimated to be 82%, compared to 73% on average in OECD countries (OECD, 2019d). Screening for other types of cancer, such as skin cancer, is at the discretion of patients and GPs. The 10-year ambitions of the new Cancer Plan (2021–2030), include improving screening adherence (from 9 to 10 million tests per year), reducing avoidable deaths by 50 000 cases per year, improving survival of patients with the poorest prognoses, and ensuring equity in access to the newest cancer treatments. The new plan has received €1.7 billion over five years to attain these objectives, which is 20% more compared to the previous Cancer Plan (2016–2021)

(INCa, 2021c). However, a recent public evaluation suggested that, despite the investments made over the past two decades, cancer screening rates have slightly dropped, notably owing to geographical and social difficulties in accessing preventive services and the inefficient use of dedicated funding (Dupays, Leost & Le Guen, 2022).

Screening and follow-up of pregnant women is mainly provided by self-employed GPs, gynaecologists and midwives, or gynaecologist-obstetricians. The follow-up is 100% reimbursed by the SHI and includes seven medical consultations, a minimum of three ultrasounds, and screening of maternal health and risk behaviours (such as tobacco and alcohol consumption). Prescription of folic acid, assessment of protein and glucose in the urine, urinary tract infections, and antibodies against high-risk infections and Down's Syndrome are also systematic, and covered 100% by the SHI (CNAM, 2021q; HAS, 2016).

■ 5.1.6 *Organization of occupational health services*

In France occupational health and safety involves several actors and has undergone important changes over the past decade. The latest reform, part of the August 2021 law, aimed to reinforce prevention and modernize occupational health and prevention services (Law no. 2021-1018 of 2 August 2021). It reinforces the responsibility of employers to guarantee employees' physical and mental health at work and to prevent work-related accidents, illnesses and psychosocial risks via information, training and workplace arrangements. This law also gives more weight to employees' representatives for improving employees' well-being and safety in the workplace. Employers have the obligation to provide occupational health and prevention services. Large firms finance and host their own occupational health services, whereas smaller firms work with external health services. Occupational physicians have the mission to monitor employees' health status and ability to do their job and to ensure that their physical and mental health is not altered by their work. In practice, the number of occupational physicians has strongly diminished over time due to the lack of attractiveness of this specialty for physicians (Chastel, Blemont & Siahmed, 2017). In parallel, a number of new occupational health professions have been developed, such as occupational

health nurses and prevention experts, coordinated by occupational physicians. E-health solutions are also increasingly supported (Decree no. 2022-679 of 26 April 2022). While occupational prevention and health services are well developed, and it is mandatory for employers to provide such services to their employees, there are no equivalent services for self-employed workers.

BOX 5.1 Are public health interventions making a difference?

In 2019 approximately one third of all deaths in France were related to behavioural risk factors such as smoking, alcohol consumption and diet (IHME, 2021a) (see Section 7.5). In 2018 the €1 increase in tax on cigarettes resulted in a 9% drop in sales (OECD, 2020a). The public campaign “#TobaccoFreeMonth” (“#MoisSansTabac”), which has taken place each November since 2016, is also considered a success, with around 200 000 participants signing up to the campaign to support smoking cessation each year (SPF, 2019). Nevertheless smoking rates remain high in France compared to the OECD average: 24% vs. 17% in 2019 (OECD, 2021a).

France also has one of the highest alcohol consumption rates (ranked fourth) among OECD countries, with an average consumption of 11 litres per adult in 2019 compared to 9 litres on average in the OECD (OECD, 2021a). The OECD estimates that France needs to invest an additional €2 per person per year to tackle harmful alcohol use (OECD, 2021e).

The rate of self-reported obesity and overweight among adults in France was 49% in 2019, which was lower than the OECD average of 56% (OECD, 2021a). Although the proportion of overweight or obese 15-year-olds was also lower than the EU average in 2018 (14% vs. 19%) (OECD, 2020a), it has been steadily increasing (12% in 2010) (OECD, 2021a). The nutritional labelling on food packaging (*Nutri-Score*) shows some promising results on food choices; out of 1001 surveyed people in 2020, 57% reported having changed their food purchasing behaviour thanks to the label (SPF, 2021c).

Low physical activity, especially among teenagers, remains an important issue. The share of French 15-year-olds who reported doing at least one hour of physical activity daily was the second lowest across EU countries in 2018 for both girls (4%) and boys (11%), compared to the EU-26 averages of 10% and 18% respectively (OECD, 2020a). Despite these numbers, there are not many interventions for encouraging physical activity for young people, including in school. In general, information on the efficacy of different prevention measures is limited in France due to lack of systematic evaluations.

■ 5.2 Patient pathways

In France there is no compulsory gatekeeping, but the 2004 SHI reform encourages patients to choose a “referring physician” (*Médecin traitant*) – a GP or a specialist – who should act as a gatekeeper. In practice, patients are expected to see their referring physician before visiting a specialist physician (Fig. 5.1), otherwise the SHI reimburses only 30% of the regulated consultation fee (instead of 70%) (CNAM, 2021c). There are a few exceptions: patients under 16 years old are not subject to these rules and patients are allowed to visit some specialists without GP referral. This is the case for gynaecologists, ophthalmologists, psychiatrists (for patients aged 16–25 years) and stomatologists (for minor procedures only) (CNAM, 2022e). Direct access to physiotherapists working in multidisciplinary group practices has also been piloted at the local level since 2022, while a similar pilot is under discussion for advanced practice nurses (Bruant-Bisson, Laffon & Marty, 2021). According to the SHI fund, about 90% of the insured declare a “referring physician”. Therefore, most of the time the first point of contact with the health system is a GP (or paediatrician for minors), who follows-up patients and provides referrals when necessary (see Box 5.2). There is no need for a referral to access inpatient hospital care, but usually patients are referred by outpatient specialists or generalists or go through hospital emergency departments. Rehabilitation after hospitalization can take place in post-acute and rehabilitation facilities (either in inpatient or outpatient settings) or is provided by self-employed physiotherapists in the community or at the patient’s home. Patients can freely choose their healthcare provider (in the private or public sector) throughout the care pathway, with possible extra-billing by some providers (see Section 3.7.1).

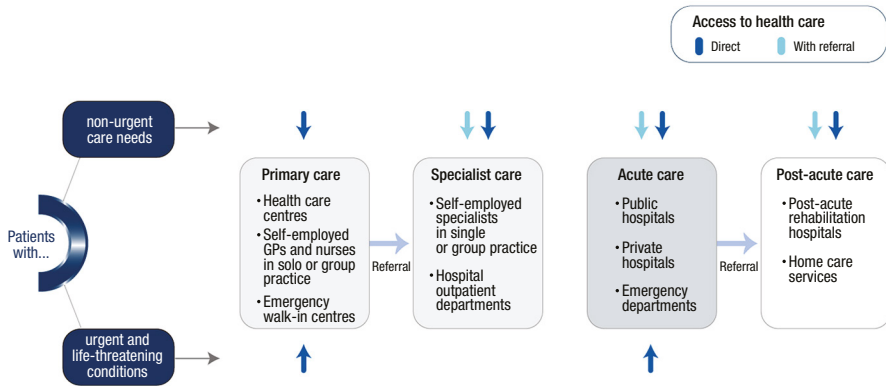
The lack of coordination between ambulatory, hospital and social care has long been recognized as a major drawback both in terms of cost-control and quality of care (Larcher, 2007). The fact that most providers work independently – with little collaboration between hospital, primary and social care services – means that care is fragmented and patients need to navigate a complicated system. Moreover, uncoordinated care, coupled with the high degree of independence and choice both for providers and patients, has been identified as a key driver of healthcare costs (Or & Gandré, 2021).

Strengthening care coordination between different specialists as well as between specialists and other care providers, including long-term care providers, has become a policy priority due to a growing number of patients with multiple diseases. To improve continuity and coordination of care across different settings, recent policies aim to improve care pathways considering the principle of gradation of care. The gradation of care is the organization of care processes that meet these objectives: the delivery to everyone, at the right time, of the “right care”, the “right response” according to their needs (HCAAM, 2020a). In this new approach the regular follow-up of patients with chronic conditions should take place in primary care with *ad hoc* advice from specialists when necessary, while more complex conditions are treated by specialists, in or out of hospitals (HCAAM, 2020a).

BOX 5.2 Typical pathway of patients at risk of Type 2 diabetes

GPs – most often self-employed in a solo or group practice – are responsible for screening and following up with adult patients at risk of or with Type 2 diabetes. Adult patients would primarily consult their referring physician, who prescribes a diagnostic assessment. In certain cases screening and diagnostic testing can also be performed by an occupational physician or in emergency/hospital services. The referring physician also prescribes the initial medical treatment, should guide the patient in lifestyle changes, and assure regular follow-up of patients with diabetes. Nurses may be involved in the treatment and patient education for supporting the patient with lifestyle changes. In the case of complications the referring physician makes a referral to relevant specialists for more specialized assessments, often in the hospital setting. However, patients can freely choose a specialist in the ambulatory or hospital outpatient setting, either in the public or private sector. Although referring physicians are responsible for the care coordination and follow-up of their patients, patient information is not systematically shared between GPs, hospitals and medical laboratories. Primary care physicians often struggle to access patient information, such as laboratory test results or diagnosis and treatments provided at hospitals. The responsibility to share such information usually lies with the patient. eHealth tools for information sharing have been developed over the past decade but remain largely underused (see Section 4.1.3).

FIG. 5.1 Patient pathways



Source: Authors' elaboration

5.3 Primary care

Primary care refers to the first level of care and services, including comprehensive general medical care (i.e., acute and chronic care, health promotion, prevention and therapeutic education) for common conditions and injuries, provided in the community near the patients' place of residence. In France primary care is provided by GPs and some medical specialists practising in ambulatory settings (especially paediatricians, gynaecologists and ophthalmologists), as well as allied health professionals such as dentists, pharmacists, midwives, nurses and physiotherapists.

The responsibility of the local strategy for primary care capacity and investment planning relies on the ARS through a component of regional health plans (*Schéma régional de santé*, SRS) dedicated to ambulatory care (see Section 2.3) (Public Health Code of 8 August 2018).

Self-employed primary care physicians are free to choose where and how they practise. This raises issues of access to both primary and specialist care since they are concentrated in well-off urban areas (see Box 5.3).

Historically, GPs have worked in solo practices, with limited collaboration with other health professionals. However, in the past decade it has been largely recognized that organizational changes which contribute to better service delivery, such as formal collaboration between different health professionals, are less likely to occur in solo practices. Therefore, France has encouraged different forms of group practice in primary care settings with

an appropriate funding model. Despite a slow takeoff initially, the proportion of GPs practising in a group has increased regularly over the past decade: 69% of GPs were working in a group practice in 2022, compared to 54% in 2010 (Bergeat, Vergier & Verger, 2022).

Different primary care structures have been created over the past decades through various legal frameworks and payment schemes (Barroy et al., 2014). They include healthcare centres (*Centres de santé*) where professionals are salaried, mono-disciplinary group practices (mostly self-employed GPs sharing a private practice) and multidisciplinary group practices (*Maisons de santé pluriprofessionnelles*, MSP) where different self-employed primary care professionals share a practice (Afrite & Mousquès, 2014). Traditionally, healthcare centres mainly provide primary care, but they can also deliver specialist services. MSPs involve self-employed medical and allied health professionals (mostly nurses and physiotherapists), who are paid on a fee-for-service (FFS) basis (Afrite & Mousquès, 2014). Thus, collaborative work is not usually rewarded in these practices. It was shown that working in MSPs has a positive impact on GPs' willingness to practise in underserved medical areas (Chevallard & Mousquès, 2021), as well as on productive efficiency and quality of care (Cassou, Mousquès & Franc, 2021; Mousquès & Daniel, 2015).

Therefore, to encourage the shift towards better integration and coordination of care, a new remuneration model providing add-on payments for MSPs (*Expérimentation des nouveaux modes de rémunération*, ENMR) has been tested since 2010 (see Section 3.7.2). The payment, a lump-sum per patient, is given to the MSP, which, in return, engages in care coordination and interprofessional cooperation (with a healthcare project involving all professionals, skill-mix protocols, etc.), as well as improving accessibility (longer opening hours, etc.) and quality of care (following clinical recommendations, better patient information, etc.). These additional payments, initially piloted in a few practices, were generalized for all MSPs in 2015 on a voluntary basis. In 2020 there were 1612 MSPs registered (1300 new MSPs since 2008) and more than 50% of them benefited from the additional payments (Cassou, Mousquès & Franc, 2021). During the Covid-19 crisis health professionals working in group practices appeared to demonstrate more resilience in assuring continuity of care, with higher rates of remote consultations and patient follow-up procedures than traditional solo practices (Zaytseva, Verger & Ventelou, 2021).

The 2016 health reform law has also supported the development of health professional communities at the local level (Law no. 2016-41 of 26 January 2016). Local health professional communities (*Communautés professionnelles territoriales de santé*, CPTS) are voluntary networks of healthcare professionals, from the primary, secondary and long-term care sectors, who come together to develop a common medical project for attaining specific public health objectives, improving care coordination and evaluation at the local level. They are granted an associative status and can contract with ARS and local SHI funds, and they set objectives at the population level rather than for a given patient list. Currently, the objectives concern mostly better care protocols rather than patient outcomes. In 2021, 670 CPTS were registered (FCPTS, 2021) but their level of implementation remains variable. Their creation is associated with an important administrative burden which may be a barrier to their development, and an assessment of their organization is necessary to increase local efficiency in the longer term (HCAAM, 2022a).

Compared to many other European countries, nurses and other allied health professionals have little responsibility and power in primary care provision in France. This is partly because each professional has legally defined tasks and procedures that they can deliver and professionals are paid by FFS (Brissy, 2020). Therefore, attempts to promote task transfer from physicians to other professionals, such as nurses, have had little success. However, in recent years the roles and responsibilities of allied health professionals have been extended for strengthening primary care provision. New positions (such as medical assistants for GPs) were created in 2019 and the competencies of allied health professionals, especially nurses, were upscaled (see Section 4.2.2). Moreover, since 2019, following successful local pilots, pharmacists are allowed to carry out flu vaccinations (France is one of the last countries in Europe to allow pharmacists to vaccinate patients). Since 2021 patients can also choose an “attending pharmacist” (*Pharmacien correspondant*), who is part of the local multiprofessional care team. Attending pharmacists are allowed to renew prescriptions and adapt the dosages for their patients (Decree no. 2021-685 of 28 May 2021) and follow up specific patient groups (such as persons with asthma or oral anticoagulant prescriptions) (ONDPS, 2021). The Covid-19 pandemic has consolidated the new responsibilities given to pharmacists as they have been instrumental, first in coordinating the distribution of protective equipment to health professionals, then in providing antigen tests and Covid-19 vaccinations (Gandré &

Or, 2021). These new measures give community pharmacists an enhanced role in primary care, which can help facilitate access to care in medically underserved areas (OECD, 2020c). Other health professionals in the primary care sector, in particular nurses and physiotherapists, remain dependent on physicians, as their services have to be prescribed by a physician to be reimbursed. Recent reforms have, however, allowed direct access to orthoptists for specific categories of patients and direct access to speech therapists and physiotherapists working in multidisciplinary group practices. Finally, the prescription by advanced nurses of some procedures which were previously only available upon a medical prescription will also be tested in three regions (Law no. 2021-1754 of 23 December 2021).

BOX 5.3 What are the key strengths and weaknesses of primary care?

Patient satisfaction with primary care provided by GPs is relatively high in France, including with care quality (88%), communication of medical information (87%) and time spent with the GP (84%) (Castell & Dennevault, 2017) (see Section 7.4). Financial accessibility of primary care services is facilitated by a universal health insurance system which offers free coverage for populations with low incomes (*Complémentaire santé solidaire, C2S*) (Code of Social Security on 14 December 2020) (see Section 3.3).

One major weakness of the French primary care system is the strong reliance on self-employed physicians who are not integrated in multiprofessional care teams and who are weakly connected with care providers in other sectors. Moreover, wide inequalities in the geographical distribution of GPs (see Box 4.2) hinder equitable access to care. While 50% of GP appointments are obtained within 48 hours (Millien, Chaput & Cavillon, 2018), there are wide geographic variations across regions, and 6% of the French population are estimated to live in areas with insufficient access to GPs (Legendre, 2020). About 20% of the French population expressed difficulties in accessing at least one primary care provider and around 10% in accessing several professionals (Legendre, 2021). Moreover, the role and responsibilities of allied health professionals, especially nurses, in patient treatment and follow-up remain limited. This aggravates access to care issues and impedes the possibilities of task shifting and better care coordination. However, recent policies encouraging multiprofessional group practices and local professional communities (CPTS), as well as those supporting new roles for allied health professionals (nurses, pharmacists, etc.) should strengthen primary care and help address current issues.

■ 5.4 Specialized care

■ 5.4.1 *Specialized ambulatory care*

Specialized care in France is commonly referred to as care provided by physicians specialized in other areas than general medicine (HCAAM, 2017). The number of specialist physicians increased by 6% between 2012 and 2021, while the number of GPs decreased by 6% during the same time period (Anguis et al., 2021). In parallel, the number of medical specialties has been increasing: in the 1990s there were 22 recognized specialties in France (Order of 4 May 1988) compared to 45 in 2021 (Bouet, 2021). This increased “granularity” of specialties is considered to contribute to the fragmentation of care provision in France (HCAAM, 2020a).

Certain specialties such as internal medicine, haematology, infectious diseases and genetic medicine are predominantly hospital-based. In other specialties, such as anaesthesia, surgery, geriatrics, gynaecology-obstetrics and nephrology, the share of ambulatory consultations (paid on a FFS basis) is high (HCAAM, 2020a). Physicians practising in private hospitals often have both inpatient and outpatient practices.

While specialist group practices are increasingly common, they are mostly driven by economic and technological reasons, in very specialized practices requiring expensive equipment. The multiprofessional group practices encouraged in the primary care sector rarely involve specialists, and mono-disciplinary practices tend to develop little collaboration with other primary and long-term care providers.

■ 5.4.2 *Day care*

In France day care or specialized ambulatory care can be provided in community settings by self-employed specialists in solo practice, in healthcare centres or in hospital outpatient departments. Some specific procedures such as chemotherapy, radiation therapy and dialysis are mainly performed in hospital outpatient settings. About 14 million ambulatory treatments were performed in hospital in 2019 (an increase of 19% since 2013) (DREES, 2021c).

The average length of hospital stay has been decreasing in the past 15 years with a strong increase in ambulatory hospitalizations (without overnight stay). In 2019 about 60% of all hospitalizations were without overnight stay (18 million ambulatory hospitalizations) (DREES, 2021c). About half of these were in acute care while 27% were in psychiatric hospitals and 26% were in post-acute and rehabilitation facilities (DREES, 2021c). Almost 40% of all day hospitalizations took place in private for-profit hospitals (DREES, 2021c). Between 2018 and 2019 only, day hospitalizations in such hospitals increased by 5% while it only increased by 0.1% in the public sector (DREES, 2021c).

BOX 5.4 Are efforts to improve integration of care working?

Several recent policies have aimed to increase local coordination between healthcare providers. These include the creation of local hospital groups (GHT) and the development of local health professional communities (CPTS) incorporating hospital and primary care physicians, nurses, and allied health and social care professionals. The GHTs were created in 2016 to pool certain functions (purchasing, information systems, training, etc.) and share resources across public hospitals working in the same territory. GHTs include a so-called “support” hospital, responsible for overseeing different functions and coordinating the collaboration between hospitals. The idea is to encourage hospitals to have a shared vision of local care needs and supply, and to encourage specialization and complementarity of services in the area, as well as to improve patient care pathways by using shared patient files. However, currently, these groupings concern only public hospitals while half of surgeries are provided by private clinics. Concerns have also been raised regarding the varying sizes and levels of medical integration of the GHTs which risk the creation of monopolistic markets and reinforce hospital-centred care provision (Cour des comptes, 2020; HCAAM, 2018).

Since 2018 a new legal framework (Article 51 of the Social Security Financing Law) provides a consolidated budget for local pilot studies in the health and social care sectors, to support innovative care models and new funding methods to encourage integration. New payment models, such as bundled payments or budgets for health teams, have been tested locally with the aim of improving care quality and efficiency through better collaboration and prevention. These pilots are expected to facilitate structural transformations in care delivery and bring forward a paradigm shift for health and social care providers to have a holistic and integrated approach to care. It is too early to predict if they will bring the change hoped for.

■ 5.4.3 Inpatient care

The inpatient hospital sector (acute and rehabilitative care excluding long-term care facilities) in France represents a high share of the GDP (2.7% in 2019) compared to most other OECD countries (ranging between 1.1 and 3.3%) (OECD, 2021b). In 2019 there were over 10 million acute inpatient hospitalizations and over 1 million inpatient rehabilitation stays (DREES, 2021c). Hospitalization rates are also high (184 per 1000 inhabitants in 2019 compared to other OECD countries (146 per 1000 on average in 2019) (OECD, 2021a).

Since 2015 local hospitals (*Hôpitaux de proximité*) have the mission to serve populations within a 20-minute radius by car, mainly in socially deprived areas where the density of physicians is low and the share of older adults in the local population is higher than the national average (Milon, 2019). Local hospitals mostly follow up older patient groups and provide less technical procedures, but are also equipped to hospitalize patients with conditions that are not life-threatening and that do not require surgery or

BOX 5.5 What do patients think of the care they receive?

In France patient experience surveys are scarce outside of acute hospital settings. A patient-reported experience and satisfaction survey (e-Satis) is mandatory for large acute care hospitals (over 500 patients annually) and optional for smaller ones (HAS, 2021a). The 2019 survey included 1123 acute hospitals (representing 97% of all large and 35% of all smaller hospitals), 35% of all inpatient and 27% of all ambulatory surgery patients. The global satisfaction score was 73/100 for patients with overnight stay, and less than half (47%) of hospitals were classified as having satisfactory ratings (74/100 or more). In terms of experience, care delivered by staff (attentive listening, pain management, respect of privacy, etc.) received the highest ratings by patients, while discharge organization and information on possible complications after discharge had the lowest (HAS, 2019). The French population also reports high satisfaction with the care provided by GPs (see Box 5.3) and with the quality of healthcare for infants born preterm (Seppänen et al., 2021). In 2021 there were no publicly available patient-reported outcome measures (PROM) in France, and no routine assessment of patient outcomes and experience (PREM) in primary and long-term care settings. However, satisfaction surveys are planned for people in nursing homes and residential care facilities for individuals with disabilities (HAS, 2021b).

obstetrical care (Milon, 2019). These facilities serve as a link between primary care providers such as healthcare centres, higher level hospitals and the social care sector (Bill no. 2021-582 of 12 May 2021) (Milon, 2019). In 2018 there were 243 local hospitals, and the government aims to have 600 before the end of 2022 (Milon, 2019). In addition, hospital groups were created to increase collaboration in the hospital sector (see Box 5.4).

■ 5.5 Urgent and emergency care

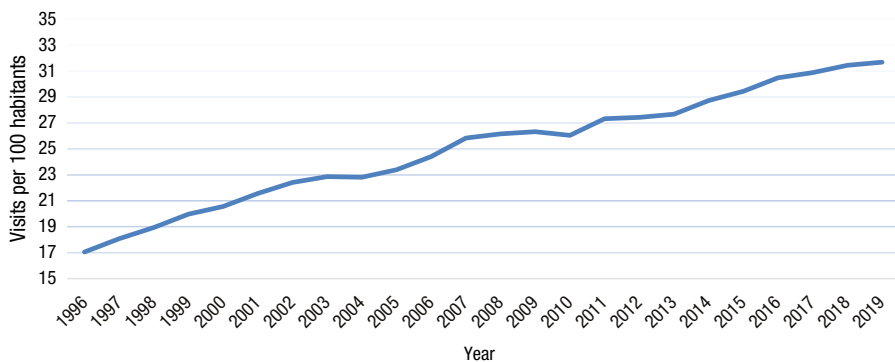
Emergency care services can be accessed by dialling one of the national emergency numbers: 18 for accidents (where firefighters make the first medical intervention), 15 for medical emergencies (ambulance), or 114 for accessing these services for people with hearing difficulties. The call centre for medical emergencies (15) assesses the urgency and medical needs of the patients and directs them towards appropriate care providers (primary care professionals or the nearest emergency department, ED) (MoH, 2018c). The emergency call centre (*Service d'aide médicale urgente*, SAMU) receives approximately 30 million calls annually, a number that has increased by 4% since 2013 (Hémery, 2021). The European emergency number uniting all emergency services (112), which is frequently used in some European countries (including the Kingdom of the Netherlands, Portugal and the Nordic countries), is not widely used in France (European Commission, 2020a). A unique national telephone switchboard dedicated to suicide prevention has been implemented since October 2021, and is similar to systems that have been successfully tested in other European countries (MoH, 2021e).

Patients can also go directly to a hospital ED. Hospital EDs are categorized as general EDs, geriatric EDs, paediatric EDs and psychiatric EDs (Baier et al., 2019). EDs deliver around-the-clock access to immediate care, by emergency specialists, for conditions that are life-threatening or may have major functional consequences for the patient. EDs can be opened by both private and public hospitals with the permission of the ARS considering three criteria: involvement in regulating calls made to the emergency centre (SAMU), provision of hospital ambulance services (*Structures mobiles d'urgence et de réanimation*, SMUR) and provision of specific treatments at the hospital (Public Health Code of 1 April 2010). About 18% of EDs are located in private for-profit facilities while 77% are in public hospitals. In 2019 there

were 100 SAMUs, 387 SMURs and 697 EDs in France; 100% of SAMUs are public and 99% of SMURs are part of public facilities (DREES, 2021c).

ED visits have been continuously increasing over the past decades, by 3.5% on average per year since 1996, reaching 22 million visits per year in 2019 (Fig. 5.2). A small share of ED visits, about 20%, result in hospitalization (ATIH, 2019). Many visits are related to medical reasons which could have been treated in the primary care setting (Berchet, 2015). Up to two thirds of ED patients in France report using emergency services because of their easier access compared to ambulatory services (geographic proximity, wide opening hours and perceived absence of OOP costs) (Boisguérin & Valdelièvre, 2014; Naouri et al., 2020). Furthermore, a study estimated that approximately 12% of ED patients report using these services because it is faster or easier than obtaining a GP appointment (Naouri et al., 2020). In recent years reducing inappropriate ED visits has become a policy priority for improving the overall efficiency of the health system. Two types of admission are targeted: visits identified as “non-urgent”, substitutable by outpatient or primary care, and visits potentially preventable by adequate and regular upstream management of risk factors and chronic health problems (Or & Penneau, 2018) (see Box 5.6).

FIG. 5.2 Number of visits to emergency services in France



Notes: Mainland France excluding army health services.

Source: Or, Gandré & Wharton, 2022, based on data from DREES, 2021c

In France GPs performing home visits or working in out-of-hours health centres (*Maisons médicales de garde* and *Centres d'accueil et de permanence des soins*) can also provide emergency care. These out-of-hours health centres are only open in the evenings, on weekends and during public holidays. Their

number has increased by 4% per year on average since 2000, and in 2019 there were 464 such centres in France (CNOM, 2020b). However, these centres are poorly regulated (concerning opening hours and rules for access) and have no coordination with EDs and emergency call centres (CNOM, 2020b). To reduce non-urgent visits to EDs, the government proposed in 2020 to establish an out-of-hours health centre close to each ED with more than 50 000 annual visits (Mesnier & Carli, 2019). Emergency home visit services are provided by different networks of physicians, called *SOS Médecins*, in urban and suburban areas. Research has shown that the number of ED visits is lower in areas where home visits are more prevalent (Or & Penneau, 2018).

BOX 5.6 Patient pathways in an emergency care episode

The ED can be accessed by self-admission, by referral from a GP, via ambulances dispatched from emergency call-centres or, in less accessible areas, by helicopter. In medical emergencies patients are stabilized on site by firefighters or ambulance staff, or in the ambulance. On arrival at the ED, patients are triaged by nurses based on severity. Patients with life-threatening conditions are sent directly to assessment and treatment in the ED (Fédération hospitalière de France, 2015). Patients with non-urgent and non-life-threatening conditions are registered and are either asked to wait in the waiting room or given first aid, for instance a splint for a fracture, and are monitored in case of any degradation of health, while waiting for an available physician. When available, an ED physician first examines the patient and may further consult a specialist (from another department in the hospital) which may require additional waiting time. After the examination the patient can be discharged home with a notice for the referring physician, a prescription or a referral to a specialist, or, if necessary, admitted to hospital. Patients may be prescribed medical transportation or a medical taxi to their home if their health status requires it. Patients who are not hospitalized receive a bill after discharge (by post) for the consultation and diagnostic tests performed, of which 20% is paid OOP unless covered by patients' complementary health insurance. Hence, 80% of emergency care costs, or 100% for persons with administratively recognized long-term illnesses, are directly covered by the SHI. However, in practice almost 70% of these bills are never paid (Quéguiner, 2020). By 2022 the 20% contribution will be replaced by a fixed lump-sum of nearly €20 per patient which can be covered by CHI (Law no. 2021-1754 of 23 December 2021). This aims to simplify ED billing and discourage inappropriate ED visits but risks aggravating inequalities in access to care by penalizing those who do not have CHI.

The current funding of emergency care is mainly based on activity volumes (see Section 3.7.1.3), which does not encourage a reduction in ED activity nor cooperation with ambulatory care providers.

■ 5.6 Pharmaceutical care

France is Europe's fourth largest pharmaceutical manufacturer, accounting for 3% of the global pharmaceutical market. The revenue generated by the pharmaceutical industry was about €62 billion in 2020, with half consisting of exports. It is estimated that less than 10% of this revenue was invested in research and development in France. In 2019 nearly 99 000 individuals were directly employed by pharmaceutical companies, mostly working in production (35%) and sales and marketing (23%) (Leem, 2021).

There are three types of medication in France: over-the-counter (OTC) medicines for which prescription is not required, medicines subject to mandatory prescription, and medicines reserved for hospitals. Both OTC and prescription pharmaceuticals are dispensed exclusively through community pharmacies but there is an intense demand, especially from supermarkets, to extend OTC sales to other places. Online sales of OTC pharmaceuticals is allowed but only by registered community pharmacies (ONP, 2021b).

Sales through community pharmacies amounted to €21 billion in 2019, with a decrease over time in the volume of medicines not reimbursed by the SHI (considered ineffective), which still represents sales of nearly €2 billion (DREES, 2020a; Leem, 2020).

The average pharmaceutical consumption expenditure per capita was €589 in 2019 and 80% of these expenses were covered by the SHI (OECD, 2021a) which pays for prescription pharmaceuticals based on their assessed medical benefits (see Section 2.7.4). For people in the long-term illness scheme (*ALD*, see Section 3.3.1), the SHI reimburses 100% of the costs of the pharmaceuticals related to the chronic illness concerned (but not other pharmaceuticals).

Generic pharmaceutical utilization is quite low in France despite multiple policies aimed at encouraging it (see Box 5.7). Since 1999 pharmacists have been authorized to substitute prescribed medicines with generic alternatives unless judged non-substitutable by the prescribing physician (which has to be justified by medical reasons since 2020) (CNAM, 2020e).

In the 2010s France introduced financial incentives for GPs, with a pay-for-quality (P4Q) scheme encouraging generic prescription rates, as well as for pharmacists by giving bonuses to those with high generic substitution rates (see Section 3.7.2). Furthermore, patients are discouraged financially from using non-generic pharmaceuticals when a generic alternative is available with lower reimbursement rates. Nevertheless, in 2019 only slightly more than one third (38%) of medicine packs sold in France were generic pharmaceuticals (Gemme, 2021).

BOX 5.7 Is there waste in pharmaceutical spending?

Several policies are in place in France to reduce waste in pharmaceutical spending (see Section 7.6). They include de-listing medicines with insufficient or low medical benefits; incentives for prescribing generic medicines; and efforts to reduce inappropriate prescription and overuse of certain medicines, such as antibiotics. While generics have enabled significant cost reductions (an estimated €3 billion in 2018 and more than €27 billion since 2000) (Leem, 2021), their use remains limited compared to other European countries. Generics represented only 30% of the market volume of reimbursed pharmaceuticals in France in 2019 compared to 83% in Germany and 85% in the United Kingdom (OECD, 2021a). This suggests that public funds currently spent on these pharmaceuticals could be more beneficially geared towards newer treatments. There is also margin for improving prescription patterns as France still reports high rates of inadequate prescriptions (OECD, 2020b). Despite national education campaigns and a dedicated objective of reducing antibiotic prescription rates by GPs in the P4Q scheme, France reports higher rates of antibiotic prescriptions than the EU average (OECD, 2020a). Moreover, in 2019 the volume of pharmaceutical consumption per capita was one of the highest in the OECD area. Recently, pharmacies were given the possibility to dispense a few types of medicine by unit (instead of boxes) to reduce waste from 2022 onwards (Law no. 2020-105 of 10 February 2020).

Accessibility of pharmaceuticals is high due to a large number of pharmaceuticals included in the public benefits basket, coverage of most patient co-payments by CHI and a well distributed network of pharmacies on the French territory. However, there are growing concerns regarding pharmaceutical shortages. Shortages reported to the ANSM have multiplied by 20 over

the past decade, particularly affecting vaccines, antibiotics, and medicines for Parkinson's disease and cancer. In 2019 the MoH presented a four-year roadmap to tackle pharmaceutical shortages, including the development of a platform allowing pharmacists to notify shortages to manufacturers and wholesalers in real time; the possible substitution of out-of-stock medicines with equivalent alternatives; and controls of the distribution of pharmaceuticals facing shortages (MoH, 2019b). During the Covid-19 pandemic the ANSM issued a warning regarding potential shortages of certain medicines used in intensive care units. Consequently, an action plan was launched, including setting up an information system allowing managers to oversee stocks in all hospitals, the State purchasing of available stock from pharmaceutical companies, and increasing temporary capacities for national pharmaceutical manufacturing. This appears to have avoided major shortages of ICU pharmaceuticals during the peak of the pandemic (Borowczyk & Ciotti, 2020).

■ 5.7 Rehabilitation/intermediate care

In France post-acute and rehabilitation services (*Soins de suite et de réadaptation*, SSR) provide rehabilitation, patient education and medical support services, usually after a hospitalization. They mostly support people who need short-term assistance with medical and personal care (Activities of Daily Living, ADL). They can also specialize, especially in elderly care, provide palliative care and take care of people with severe mental or cognitive problems. The staff consists mainly of allied health professionals (nurses, nursing aides and physiotherapists). SSR provides both inpatient and outpatient services, but inpatient care is dominant (88% of the capacity).

In 2019 there were 120 000 inpatient and ambulatory beds for intermediate care, representing 25% of hospitalization capacity in France. More than 1 million patients were treated in SSR, representing 28% of the hospital case-load (DREES, 2021c). Almost three quarters (73%) of patients were over 65 years old (ATIH, 2021c). The average length of stay in these services was 35 days, and three quarters of the admissions were after an acute hospitalization (DREES, 2021c).

■ 5.8 Long-term care

Long-term care involves a variety of services, provided in different places by different caregivers (Table 5.1), to help people live as independently and safely as possible when they can no longer perform everyday activities on their own (NIA, 2017). LTC in France cuts across healthcare and social care sectors and involves different levels of governance (Or & Penneau, 2021) (see Section 2.7.2). Medical and nursing LTC services, which include diagnosis and treatment of long-term conditions, covering health counselling, palliative care, pain relief and rehabilitation, are mostly managed and funded by the SHI. Personal and social care services, which provide help with ADL such as eating, bathing and dressing, and instrumental ADL such as shopping, cooking, housework and recreational activities, are managed and funded by local authorities (*départements*).

■ 5.8.1 Long-term care providers

Medical and personal LTC services are mainly provided in residential nursing homes or at home. There are two types of residential care facility for the elderly: those which provide medical care with personal and social care (medical residential facilities), and those that provide only personal and social care (non-medical residential facilities) (Or & Penneau, 2021).

MEDICAL RESIDENTIAL FACILITIES

Medical residential facilities take care of older persons with complex medical, personal and social care needs. There are two types of medical residential facility: residential nursing homes and hospital LTC departments.

Residential nursing homes (*Établissements d'hébergements pour personnes âgées dépendantes*, EHPAD) accommodate persons over 60 years old (with some exceptions) (CNSA, 2020) who need regular care and medical surveillance as well as assistance with ADL. This is the most common form of residential care for older persons in France. In 2019 there were 7519 residential nursing homes, of which 44% were public, 31% private non-profit

and 24% were private for-profit (CNSA, 2021). Care providers in nursing homes are mostly allied health professionals (mostly nursing aides with a few nurses), working with a part-time physician and sometimes with a psychologist. Almost 10% of people over 75 years old, and one in three people over 90 years old, live in a residential nursing home in France (Muller, 2017). More than 100 000 additional individuals are expected in nursing homes by 2030 (Miron de l’Espinay & Roy, 2020). The average age on arrival at nursing homes is 86 years, and the average length of stay is about two years and five months (Muller, 2017). To avoid repeated hospitalizations and improve the quality of care at the end of life, nursing homes have been slowly investing in palliative care in recent years (see Section 5.10). Recent reforms (announced for 2022 onwards) aim to widen the missions of nursing homes, encouraging them to work as a “geriatric resource centre” that provides services in the community, such as support to older persons living at home (while waiting for a place in a nursing home) or support to health professionals taking care of older populations in the community (MoH, 2021d). Moreover, there are plans for reinforcing the medical workforce in nursing homes with more regular presence of GPs and night nurses (MoH, 2021d).

There are also 600 LTC units in hospitals (*Unité de soins de longue durée*, USLD) which function like nursing homes in a hospital setting, targeting patients with higher medical needs (Jeandel & Guérin, 2021; Score santé, 2021). The average age on arrival at the USLD is 84 years, and the average length of stay is approximately one year and seven months (Muller, 2017). Between 2003 and 2019 the number of LTC beds was reduced by 60%, from 80 000 to 31 000 as a consequence of policies aiming to shift older patients to residential nursing homes (DREES, 2021c).

NON-MEDICAL RESIDENTIAL CARE FACILITIES

Some residential facilities provide personal and/or social services for the elderly. The most common facilities are social residences (*Résidences autonomie*), which are regulated and partly funded by the local authorities. Persons living in these facilities are able to perform their personal ADL but require help with instrumental ADL and recreational activities (Law no. 2015-1776 of 28 December 2015). There were around 119 830 places available in 2291

publicly funded social residences at the end of 2018 (Miron de l'Espina y & Roy, 2020; Score santé, 2021). More than two thirds of these facilities were in the public sector, 28% in the private non-profit sector and 4% in the private for-profit sector (DREES, 2021b).

In addition, there are private “care homes” (*Résidences services séniors*), for which prices are not regulated by local authorities. In 2017 there were around 620 residences and roughly 50 000 apartments, with a rapid development of the private care home sector in recent years (40% more places since 2013) (Mure, 2018).

LTC SERVICES AT HOME

In 2015 between 4% and 10% of people aged 60 or over living at home in France needed some help with their ADL (Brunel & Carrère, 2017). LTC services at home range from hospitalization at home to nursing and domestic help provided by different providers (Or & Penneau, 2021).

Self-employed independent nurses can provide both medical nursing and personal care at home upon prescription. While they provide all types of care for all age groups, more than 60% of spending for these nurses concerns diseases mostly prevalent in older populations such as heart failure or neurological and degenerative diseases (Cour des comptes, 2018).

There are also two home care service structures which provide LTC for older populations and people with disabilities. Home nursing care services (*Services de soins infirmiers à domicile*, SSIAD) are mostly non-profit associations or public organizations which provide medical/technical nursing services, prescribed by a physician, such as injections, preparation of pharmaceuticals, and basic hygiene and comfort care, for which the cost is covered by the SHI. There were more than 120 000 home care nursing places in 2018 (Score santé, 2021). Home care and support services (*Service d'aide et d'accompagnement à domicile*, SAAD), which are authorized and regulated by local authorities, provide personal and social care services, helping both with ADL and instrumental ADL for older populations and people with disabilities. There are about 6000 SAAD representing 75% of the domestic help supply in France (Libault, 2019). Most of them are private non-profit organizations (60%), with only 11% public and 29% private for-profit services.

Services provided by SSIAD, SAAD and independent nurses are not always well articulated, and older persons or people with disabilities often receive services from many different providers who do not coordinate well. Therefore, there have been efforts to integrate services provided by SSIAD (nursing) and SAAD (personal care) under the same structures (*Services polyvalents d'aide et de soins à domicile*, SPASAD), which are multipurpose services for home care. Nevertheless, despite being created more than 10 years ago, SPASAD have not been effectively developed until now. In 2017 there were fewer than 100 integrated SPASAD services in France (FEHAP, 2017).

Similarly to nursing homes, LTC service providers at home have difficulties recruiting staff, and have high turnover rates (Libault, 2019). Although the number of home LTC services has increased, low attractivity of the LTC sector poses a risk to securing sufficient staff, with a growing number of patients needing such services (Libault, 2019). In addition, these difficulties are combined with geographical disparities in access to LTC facilities and services for older individuals (Carrère, Couvert & Missègue, 2021).

FACILITIES AND SERVICES FOR PEOPLE WITH DISABILITIES

About 3 million people have an administratively recognized disability in France, of whom 1.8 million have a severe disability which limits their functional autonomy (Espagnacq, 2015).

There were nearly 540 000 places available in residential care or in specific services dedicated to individuals with disabilities in the health and social care sectors in 2020 (Bohic & Le Morvan, 2021).

Specialized reception centres (*Maison d'accueil spécialisé*, MAS) and medical reception centres (*Établissement d'accueil médicalisé*, EAM) cater for adults with disabilities who need permanent or a high level of support, while several non-medical facilities (*Établissements d'accueil non médicalisé pour personnes handicapées*), including dedicated residential care homes (*Foyer d'hébergement; foyer polyvalent*) and assisted living centres (*Foyer de vie*), provide accommodation for adults with disabilities that do not prevent them from working. In 2020 around 30 000 persons were hosted in specialized reception centres, 24 000 in medical reception centres, 36 000 in residential care homes and 48 000 in assisted living centres (Bohic & Le Morvan,

TABLE 5.1 Description of major LTC providers and their users, 2019 or latest available year

	PROVIDERS			USERS			
	NUMBER OF FACILITIES	PUBLIC (%)	PRIVATE NON-PROFIT (%)	PRIVATE FOR-PROFIT (%)	NUMBER OF USERS (PERSONS)	MEAN AGE	MEAN LENGTH OF STAY
Residential care facilities							
Residential nursing homes	7 519	44	31	24	600 000	86*	2 years and 5 months
LTC departments in hospitals	600	n/a	n/a	n/a	32 000	84*	1 year and 7 months
Social residences	2 291	68	28	4	119 830	81*	5 years and 1 month
Private care homes	620	0	0	100	55 000 apartments	n/a	n/a
LTC services at home							
Hospitalization at home	300	42	41	17	122 000	63	42 days for women; 49 days for men
Self-employed nurses	124 000	0	0	100	n/a	n/a	n/a
Home-care nursing services (SSIAD + SPASAD)	2 100	36**	63**	1**	126 000	82**	2 years and 3 months**
Home-care and support services (SAAD)	6 000	11	60	29	n / a	n / a	n / a

Notes: *Mean age upon arrival to facility; ** Most recent data are from 2008
Sources: DREES, 2021c; Score santé, 2021; Or & Penneau, 2021; Miron de l'Espinaay & Roy, 2020; Libault, 2019; Mure, 2018; Muller, 2017; Chevreul et al., 2009

2021). As for older populations, LTC services at home are provided by self-employed independent nurses, SSIAD and SAAD. There are also specific LTC services at home for this population (*Service d'accompagnement médico-social pour adultes handicapés*, SAMSAH) and various social support services facilitating professional and social integration of adults.

For children there are different types of residential facility depending on the type of disability: educational centres for children with mental disabilities (70 435 places in 2020), therapeutic and educational centres (16 989 places), educational centres for children with physical disabilities (7570 places) or multiple disabilities (5742 places), and centres for children with sensory disabilities (6182 places). Home care and education services offer 53 754 places (Bohic & Le Morvan, 2021). Finally, there are around 300 medico-psycho-educational centres that screen and follow up children with mental health-related disabilities (FDCMPP, 2021). However, there are significant geographical disparities across the French territory in services provided for people with disabilities, and in particular for services for children and adolescents, even if geographical disparities tend to decrease over time (Coldefy & Gandré, 2020; Rapegno & Ravaud, 2015).

■ 5.8.2 Coverage of long-term care

The funding for LTC comes from a mixture of sources including social security contributions and local taxes. The SHI covers medical LTC services and guarantees universal access to a large basket of healthcare but imposes significant co-payments for all services. Co-payments for medical LTC are largely alleviated by a specific exemption scheme for certain chronic conditions (see Section 3.3.1). Medical LTC policies are implemented at the local level via the ARS (see Section 2.3).

The funding for personal and social LTC services is based on a cash-for-care scheme, “Personal allowance for autonomy” (*Allocation personnalisée d'autonomie*, APA), providing benefits to meet personal care and assistance needs which are not covered by the SHI. APA is a needs- and means-tested allowance for people aged over 60 who need assistance with ADL or continuous monitoring. The allowance can be received for care at home or in a residential facility, and the amount depends on the level of dependency

determined through a dependency score (*Groupe iso-ressources*, GIR) based on physical and mental capacity. The allowance is allocated to finance a care plan for the patient elaborated by an interdisciplinary team (usually consisting of social workers and nurses) working for the local authorities (*départements*). In 2018, 1.3 million people benefited from APA, representing 8% of people over 60 or one in three people over 85 years old (DREES, 2020b). About 60% of APA funding comes from local taxes and 40% from national contributions. Both the eligibility for APA and the payment amount are defined by the local authorities which have gained greater responsibility for social care policy since 2014. Therefore, the level of funding for personal and social LTC varies largely across localities depending on their wealth (resources) and policy priorities. In order to improve the equity in funding of LTC across local authorities, funding mechanisms and reallocation rules have been gradually reformed since 2002. In 2004 the National Solidarity Fund for Autonomy (*Caisse nationale de solidarité pour l'autonomie*, CNSA) was created to finance a common LTC policy for older populations and people with disabilities. A part of LTC funding is provided via a national formula that considers the patient case-mix in LTC facilities and the local population's health and social conditions.

A disability compensation allowance (*Prestation de compensation du handicap*, PCH), funded by local authorities, is available for people with disabilities. This can cover the costs of technical aid equipment, housing adaptations (for instance, wheelchair accessibility) and human aid services (such as pay for informal carers or professional day carers at home) (DREES, 2020b). Compensation Funds at the local authority (*département*) level (*Fonds de compensation départementaux*) can also provide additional funding to decrease OOP payments for people with disabilities. Local authorities also provide allowances for care in health and social care facilities (such as nursing homes, assisted living centres, etc.) for persons with disabilities who do not have the resources to finance such services (DREES, 2020b).

Since 2005 each local authority (*département*) has provided a local home for persons with disabilities (*Maison départementale pour les personnes handicapées*, MDPH). The MDPH assesses and determines the eligibility and level of allowances for people with disabilities, considering the degree of disability and difficulty with ADL. The MDPH informs and guides people on the services and allowances available and assists with administrative issues (MoH, 2015b).

CREATION OF A FIFTH BRANCH FOR LTC INSURANCE

In 2020 the government recognized ageing as a new branch (the autonomy branch) for social insurance, in addition to the first four (health, family, employment and retirement). This law shifts the responsibility for national regulation and funding of medical LTC from the SHI to the CNSA and increases the power of the CNSA in piloting the LTC policy in France (see Section 6.1). However, the creation of the fifth branch does not modify the structural weaknesses of LTC funding in France, and it does not help to reduce regional inequalities in financing LTC. The funding of personal and social LTC services remains the responsibility of local authorities.

■ 5.9 Services for informal carers

It is estimated that between 8 and 11 million individuals provide informal care for a relative who needs care because of age, disability or a chronic or disabling illness in France. This number is expected to increase over the next decades given the ageing population (MoH, 2019a). The rate of informal carers is high compared to other countries: approximately 18% of the population over 50 years of age report providing informal care daily or weekly compared to 14% on average among OECD countries (OECD, 2019a).

Historically, informal carers have been mainly supported by non-governmental organizations and associations which offered services such as respite care programmes that temporarily support caregivers or social activities, training programmes and peer support groups. These organizations have also contributed to the development of a dedicated legislative framework (Argoud, 2020). The 2015 law on adapting society to an ageing population formally acknowledged the role of informal carers for the first time and extended the definition to include all carers regardless of their relationship with the person who needed care and the place of residence, covering those who support someone in a nursing home (Law no. 2015-1776 of 28 December 2015; Decree no. 2016-1554 of 18 November 2016). At the end of 2019 the government launched the first comprehensive national strategy for informal carers supported by a three-year budget of €400 million (MoH, 2019a). The measures focus on improving information support for carers (with a national helpline and a network of information hubs); rolling

out and diversifying respite care services – which are still weakly developed – with a budget of €105 million and simplifying the rules for taking care leave (since 2017). Moreover, since October 2020 carers who have to stop their professional activity can be compensated (with a daily allowance for three months, renewable up to one year) (Argoud, 2020; MoH, 2019a). Finally, in 2022 the HAS issued a framework paper on respite care as a preamble to the development of care guidelines (HAS, 2022e), while a national roadmap for informal care – notably to support respite care – is expected in 2023.

■ 5.10 Palliative care

In France the main palliative care providers are acute care hospitals which provide palliative care in specific palliative care units (*Unités de soins palliatifs*, USP) as well as in beds dedicated to palliative care in other hospital units (*Lits identifiés en soins palliatifs*, LISP). In 2019 there were 160 USP with 2.8 beds per 100 000 inhabitants and 8.4 LISP per 100 000 inhabitants. It is estimated that less than 7% of the patients who died in hospitals in 2019 died in a USP and about 13% in a LISP (Cousin & Gonçalves, 2020).

Palliative care can also be provided, although less commonly, in post-acute and rehabilitation facilities (SSR). Moreover, hospitalization at home (HAD) is proposed as an alternative for receiving palliative care at home. Residential nursing homes can also propose HAD to their residents, since 2007 (Decree no. 2007-241 of 22 February 2007). The law of February 2016, which strengthened patients' rights in end-of-life care, introduced that health professionals should inform each patient of the possibility of receiving palliative care at home (or in a nursing home), if their situation allows. In France certain medications used for easing pain at the end of life can only be prescribed in hospitals or during hospitalization at home, hence nursing homes can only provide these pain medications by establishing HAD protocols. Palliative care in nursing homes can improve the quality of the end-of-life period but has not been widely developed. It is estimated that in 2017 less than 8% of nursing home residents who died benefited from palliative care by dedicated providers in their residence or in hospital (Penneau, 2022).

Finally, there are mobile palliative care teams (*Équipes mobiles de soins palliatifs*, EMSP), which do not provide palliative care, but assist and

train in palliative care the healthcare providers involved in end-of-life care in hospitals, at a patient's home or in residential nursing homes. These are multiprofessional teams, usually involving physicians, nurses and part-time psychologists and physiotherapists, hired by a hospital, often a palliative care unit (Bohic et al., 2019). These teams also provide psychological and social support to families. In 2019 there were 428 mobile teams, or 0.7 teams per 100 000 inhabitants (Cousin & Gonçalves, 2020).

Altogether, palliative care supply is quite limited and unequally distributed in France, despite an increasing number of providers over time (Cousin & Gonçalves, 2020; DREES, 2021c). The latest national plan for palliative care, launched for the period 2021–2024 with a budget of €171 million, aims to create palliative care units in hospitals in the 26 local authorities without any palliative care services, to increase collaboration between professionals in the hospital and primary care sectors, and to reinforce palliative care at home and in nursing homes by creating additional mobile teams (MoH, 2021b).

■ 5.11 Mental health care

In 2019 about 8 million individuals had at least one contact with the healthcare system for a mental health disorder or had a prescription for psychotropic pharmaceuticals, accounting for 14% of the total SHI spending in France (CNAM, 2021n).

The French mental health system has historically been organized around public and private non-profit hospitals, which have had the main responsibility for providing mental health care to the population in administratively defined catchment areas called “psychiatric sectors” (*Secteurs psychiatriques*). Psychiatric sectors, defined by the local authorities, aimed to ensure equal access to mental health care, to treat patients in close proximity to their residence and to integrate mental health care at the territorial level. In 2019 there were 612 healthcare facilities providing mental health care, among which 61% were specialized in psychiatry. Two thirds of hospital capacities for mental health care are found in the public sector (DREES, 2021d). Hospitals provide services ranging from full-time inpatient care to outpatient care provided in 3100 dedicated outpatient care centres (*Centres médico-psychologiques*, CMP) (Coldefy & Gandré, 2020; DREES, 2021d).

Historically, the hospitals had little cooperation with other stakeholders involved in mental health care such as health professionals working in the ambulatory and social care sectors. In recent years several initiatives have aimed to increase the collaboration between different care providers. Since 2020 all hospitals providing psychiatric care are required to be part of a formal territorial network (*Projet territorial de santé mentale*, PTSM) involving all mental health care providers at the local level. These networks, which are monitored by ARS, are expected to define prevention strategies and organize diagnosis, treatment, rehabilitation and social integration of patients with mental disorders across different settings in the territory (MoH, 2018e).

Despite these recent reforms, mental health care provision remains very hospital-centred with a lack of gradual care planning and adequate supply of alternative structures in ambulatory settings. Hospitals are usually the main entry point to the health system for persons with mental disorders. The CMPs struggle to face the high demand from patients with very diverse care needs (Cour des comptes, 2021c). Self-employed psychiatrists are the main mental health care providers in ambulatory settings but they are mostly clustered in urban areas, which results in long waiting times and lengthy journeys for patients in more rural areas (Coldefy & Gandré, 2020). In addition, GPs, who are more easily accessible, are not well trained for detecting and managing mental disorders in primary care (Dumesnil et al., 2012; Norton et al., 2009, 2016), and in particular in providing psychotherapies which are recommended as first-line treatment for mild to moderate mental disorders (HAS, 2017b). Self-employed private psychologists could provide support in delivering this type of care in the community but they have not historically been included in the SHI benefits basket and are not recognized as health professionals (see Section 4.2.2). Generally, mental health promotion and prevention services, which could help to reduce the demand on the mental health care system, have been little developed in France (CESE, 2021).

The negative impact of the Covid-19 pandemic on the mental health of the general population (Gandré, Coldefy & Rochereau, 2020; Hazo & Costemalle, 2021) has shed light on the limitations of the current mental health care provision, in particular for people with mild to moderate mental disorders. The pandemic triggered a national public consultation on the mental health care system involving all stakeholders (*Assises de la santé mentale et de la psychiatrie 2021*) which, in turn, has led to the announcement of several reforms (see Section 6.1). One key measure is the reimbursement of

consultations with self-employed psychologists by the SHI when prescribed by a physician (from spring 2022 onwards). Other measures include better development of mobile psychiatric teams for intervening at the residence of at risk population groups, such as older persons living alone or in nursing homes, and a stronger emphasis on mental health promotion and prevention (training of the population in mental health first aid, launch of a unique national telephone switchboard dedicated to suicide prevention, etc.) (MoH, 2021c).

■ 5.12 Dental care

Dental care in France is mainly provided by self-employed dentists (81% in 2021), with a few salaried dentists in hospitals (2% of all dentists) and in dental care centres (15% of all dentists) which are commonly run by private insurance companies (DREES, 2021a). In January 2021 there were 42 000 practising dentists in France (Anguis et al., 2021) with a density close to the European average (0.7 vs. 0.8 per 1000 inhabitants) (OECD, 2020a).

Patients have direct access to dental care and are free to choose their dentists. All children, adolescents and young adults between 3 and 24 years old are offered free dental check-ups every three years for preventing and treating cavities and improving oral hygiene (CNAM, 2021r).

SHI coverage of dental care varies widely according to the type of care. Urgent and routine care are covered at 70% by the SHI, whereas non-routine care, including orthodontics and dentures, have historically been little covered. However, the reform “*100% Santé Dentaire*” has significantly improved dental care coverage since 2020: basic bridges and crowns as well as dentures (since 2021) are covered at 100% by the SHI within a regulated price range (Decree no. 2019-1107 of 30 October 2019). In general, OOP costs for dental care remain low in France compared to other OECD countries, because of the wide coverage by CHI which usually reimburses dental care relatively well (Lan et al., 2018; Winkelmann et al., 2022).

However, there are geographical inequities in access to dental care across the French territory, with a higher concentration of dentists (up to 86 per 100 000 inhabitants) in the capital and southern regions compared to the northern and central regions (between 22 and 44 dentists per 100 000 inhabitants) (DREES, 2021a). Prices, in particular for dentures, can also

vary largely across the country, adding to disparities in dental care access (CNAM, 2020f). It is estimated that 17% of the French population forgo dental care (CNAM, 2020f) but the number of dentist consultations per person in France was higher than the European average in 2018 (1.5 vs. 1.2) (OECD, 2020a).

Principal health reforms

■ Summary

- Recent reforms in France have focused on four main areas: improving financial access to care to avoid forgone care; improving physical access, particularly in underserved areas; reinforcing prevention; and reforming payment methods for care providers.
- Improving financial access to care meant improving coverage with the “100% Health” reform tackling high OOP payments in optical devices, dental care and hearing aids, and improving coverage for mental health care by reimbursing psychologist visits under certain conditions.
- Improving physical access meant increasing the number of medical students, improving care delivery through better territorial organization of services, introducing task sharing and forming new professions to address health workforce shortages.
- Measures for reinforcing more prevention in the system included mandatory practice in prevention training for all healthcare students, introducing free health check-ups for critical age groups (teenagers, people who just retired, etc.), extending mandatory vaccinations for children, and extending the list of those who are allowed to vaccinate. However, these measures have not been associated with major increases in collective prevention funding.

- Future reforms target promoting better coverage and equity, improving access to care and prevention, and continuing the reform of primary care and provider payment.

■ 6.1 Analysis of recent reforms

Table 6.1 lists the most recent health system reforms that have occurred in France since 2016. These have focused on four main areas: improving financial access to care in order to avoid forgone care; improving physical access, particularly in underserved areas; reorienting the healthcare system towards prevention; and reforming payment funding methods for care providers.

■ *Improving financial access to care*

In line with previous reforms the French healthcare system has continuously tried to decrease OOP payments in order to avoid forgone care for financial reasons. It has simplified access to coverage mechanisms, including coverage by complementary health insurance for the less well-off, by implementing the universal health protection (*Protection maladie universelle*, PUMA) in 2016 and the “*complémentaire santé solidaire*” (C2S) in 2019 (see Section 3.3.1).

However, even though France had managed to achieve the lowest level of OOP payments among OECD countries, OOP spending by household had remained particularly high in three areas: optical devices, dental care and hearing aids. A major reform was therefore launched in 2020, the “100% Health” reform (*100% Santé*). After negotiation between providers, the SHI and CHI, a basic benefits basket was defined for these three types of care that are 100% covered by the SHI and CHI when the patients have opted for a “responsible contract” (see Section 3.5), as is the case for 95% of cases. As a new recent development, *100% Santé* will now include hair prosthesis for patients with cancer.

Access to mental health care has also been improved. Consultations with self-employed psychologists in ambulatory settings were not covered by the SHI until April 2022. Since then, the SHI covers 60% of up to eight visits to a psychologist when prescribed by a medical doctor for given conditions such

TABLE 6.1 Major health reforms

YEAR	REFORM
2016	Law of 26 January 2016 for the modernization of the healthcare system (<i>LOI no. 2016-41 du 26 janvier 2016 de modernisation de notre système de santé</i> , 2016) In particular: creation in the hospital sector of local hospital groups, and in the ambulatory sector of health territorial professional communities, primary care teams and territorial support platforms; creation of the status of advanced practice nurse
2017	Law no. 2017-1836 of 30 December 2017 for the financing of the SHI for 2018 (<i>Loi no. 2017-1836 du 30 décembre 2017 de financement de la sécurité sociale pour 2018</i> , 2017) In particular: increasing the number of mandatory vaccinations for children under 2 years of age from 3 to 11
2018	Decree no. 2018-472 of 12 June 2018 creating the health service for all healthcare students (<i>Décret no. 2018-472 du 12 juin 2018 relatif au service sanitaire des étudiants en santé</i> , 2018)
2019	Law no. 2019-774 of 24 July 2019 for the organization and transformation of the healthcare system (<i>LOI no. 2019-774 du 24 juillet 2019 relative à l'organisation et à la transformation du système de santé</i> , 2019) In particular: reform of medical studies; creation of proximity hospitals; creation of territorial health projects; extension of vaccination rights to pharmacists and midwives
2020	"100% Health" reform: for full coverage of optical devices, dental care and hearing aids by SHI and CHI
2021	"Ségur de la santé" reform: reform package for improving working conditions of 1.5 million health professionals in acute and LTC facilities. Wages of all categories of health professionals increased between, on average, 15% and 20% as of October 2021 (MoH, 2021k)
2021	Decree no. 2021-216 of 25 February 2021 regarding the funding reform of emergency departments (<i>Décret no. 2021-216 du 25 février 2021 relatif à la réforme du financement des structures des urgences et des structures mobiles d'urgence et de réanimation et portant diverses dispositions relatives aux établissements de santé</i> , 2021)
2021	Law of 26 April 2021 to improve the healthcare system through trust and simplification (<i>LOI no. 2021-502 du 26 avril 2021 visant à améliorer le système de santé par la confiance et la simplification</i> , 2021, p. 26) In particular: increasing authorization to prescribe medications to midwives, physiotherapists, occupational therapists and speech therapists
2021	Law no. 2021-1017 of 2 August 2021 regarding bioethics (<i>LOI no. 2021-1017 du 2 août 2021 relative à la bioéthique</i> , 2021) In particular: extension of assisted reproductive technology to all women, including single women and lesbian couples
2021	Decision of 13 September 2021 fixing the pluriannual national objectives for the number of healthcare professionals to be trained between 2021 and 2025 (<i>Arrêté du 13 septembre 2021 définissant les objectifs nationaux pluriannuels de professionnels de santé à former pour la période 2021–2025</i> , 2021).
2021	Decree no. 2021-1255 of 29 September 2021 regarding the funding reform of psychiatric care; article 34 of the 2020 law of financing of the social security system (<i>Décret no. 2021-1255 du 29 septembre 2021 relatif à la réforme du financement des activités de psychiatrie</i> , 2021)

as mild depression or anxiety symptoms, the remaining 40% being covered by CHI. However, by mid-2023, only a few psychologists had participated in this program which meant regulated consultation fees for psychologists, which will limit the impact of this measure.

■ *Improving physical access to care*

Multiple measures have been put in place in order to address shortages in human resources. University tracks for physicians, pharmacists, midwives and dentists were reformed in 2021 to abolish the *numerus clausus*, which limited the number of students in the healthcare sector, and to shift the focus of human resource planning to meeting anticipated population needs, which could theoretically increase the number of trained professionals in the mid-term (see Section 4.2.2).

Task sharing and task shifting have also been piloted to better spread the workload between health professionals, in particular for professions facing the most shortages. As a result, new professions have also been created. The status of advanced practice nurse (*Infirmier en pratique avancée*, IPA) was created by the 2016 law for the modernization of the healthcare system (see Section 4.2.2). IPAs may work in a hospital setting or in primary care and are tasked with patient referral, along with providing education and preventive services, technical services (for example ECG, spirometry) or other activities allowing for patient evaluation, prescription of medications for which a medical prescription is not required, ordering laboratory tests, radiology, etc. As of 2022, five fields are open to IPAs: stabilized chronic diseases, oncology, chronic renal disease, psychiatry and mental health, and emergency medicine. A pilot involving direct access to these nurses during a three-year period has just been approved in the law financing the SHI for 2023 (Law no. 2022-1616 of 23 December 2022). Orthoptists may also now carry out eye exams and prescribe glasses or contact lenses without a prior medical prescription under some circumstances.

Finally, because of budget constraints and a decrease in occupational quality of life, there has been a drain of professionals in public hospitals. To aid retention, the *Ségur de la santé* reform package increased wages for all categories of health professionals as of October 2021 (MoH, 2021k; see also Chapter 4). However, this measure has not yet proven its efficacy.

■ *Improving organizational efficiency and access in underserved areas*

Regarding the territorial organization of care, the 2016 Health Reform Law (Law no. 2016-41 of 26 January 2016) created local hospital groups (*Groupement hospitalier de territoire*, GHT) to encourage cooperation between hospitals and improve the management of resources. All public hospitals have to join a GHT and work towards a shared medical project, which details the organization of care for patients by medical specialty. For example, they may choose to regroup some activities in a given hospital to avoid duplication. The lead hospital also provides a number of functions on behalf of the hospitals included in the GHT, in particular in terms of purchasing resources, hospital information systems, medical and paramedical training, etc. There are currently 136 GHTs in France (see Box 5.4).

In 2019 the Law on the organization and transformation of the health system (Law no. 2019-774 of 24 July 2019) introduced the concept of local hospitals (*Hôpitaux de proximité*) – public or private hospitals which are responsible for given specific services shared with ambulatory structures and professionals within a given territory. They must be designated by the regional health agency and receive dedicated funding to ensure their missions. The first designation occurred in 2022.

In ambulatory care the 2016 Health Reform Law also created health territorial professional communities (*Communautés professionnelles territoriales de santé*, CPTS), primary care teams (*Équipes de soins primaires*, ESP) and territorial support platforms (*Plateformes territoriales d'appui*, PTA) to improve care pathways. CPTSs regroup health professionals from a geographical area who wish to structure themselves (out of their own initiative) around a shared health project. ESPs regroup a team of health professionals around a GP, also sharing a health project to improve coordination and access to care. Finally, PTAs are established by the regional health agencies and provide support to healthcare professionals caring for patients with complex care needs. The 2019 law then added the concept of “territorial health projects” (*Projet territorial de santé*), initiated by CPTSs and validated by the regional health agency (see above).

Finally, following previous reforms that have developed incentives to attract medical doctors to underserved areas, the number of internships in ambulatory care during medical training has been increased, with further financial incentives since 2019 for interns who choose 6-month internships

in underserved areas (MoH, 2022d). There has also been heavy investment in eHealth, with both a national strategy for digital health, whose main focuses are developing and implementing infrastructures while ensuring proper governance, ethics, security and interoperability, and a national strategy for eHealth, which aims to improve access through telemedicine, improving services to increase autonomy, and to help train healthcare professionals on these topics.

■ *Prevention*

While successive national plans have put an emphasis on prevention (see, for example, the generalization in 2011 of payment-for-performance (P4P) for general practitioners based on public health objectives (see Section 3.7.2), in effect this has been associated with little if any increase in funding allocated to primary preventive services. Still, some measures have been put in place to improve prevention efforts in the population.

In September 2018 the French Government introduced the requirement for all healthcare students to carry out a practical exercise of health promotion or primary prevention as part of their initial training. This mainly targets young people with four priority prevention themes: nutrition, physical activity, addictions and sexual health. This is based on numerous data showing the deleterious impact of health behaviours adopted in adolescence and early adulthood, and French youths showing a high frequency of risky behaviours (Le Roux et al., 2020). Each year 47 000 students are expected to take part, with the hope that this will reduce risk behaviours but also educate future health professionals on primary prevention and encourage interprofessional exchange.

Another measure introduced in the 2018 national plan for public health is to offer free health check-ups for recent retirees (people who have retired 6–18 months ago) to anticipate and accompany the effects of ageing, diagnose chronic diseases and identify their risk factors (MoH, 2018b). These consultations are set up directly by the SHI and target people who are considered high-risk: in particular, people with no CHI, no referring physician or no recent contact in ambulatory care. The agricultural scheme (*Mutualité sociale agricole*, MSA) was the first to put it into practice in 2020.

The number of mandatory vaccinations for children under 2 years old was extended from 3 to 11 in 2018. This was because vaccination coverage was low in recommended (but not mandatory) vaccinations, for example, only 80% in 2017 for the measles, mumps, rubella (MMR) vaccine (Santé publique France, 2022). In addition, the human papillomavirus (HPV) recommended vaccine was extended to boys in 2021. Measures were also implemented to simplify access to vaccination, ending the need for a first consultation with a GP to get a prescription for the vaccine, acquiring the vaccine at the pharmacy and a second consultation with a GP to administer the vaccination. The 2018 national plan for public health allowed pharmacists, nurses and midwives to vaccinate. In April 2022 decrees were published to allow nurses to administer 15 vaccines without prior medical prescription to people over 16 years old, and pharmacists to do the same but following a medical prescription, while midwives may prescribe and administer vaccines to pregnant women, newborns and their relatives (see Section 5.1.3).

Finally, the law of 23 December 2016 for the financing of the SHI in 2017 led to the creation of a fund dedicated to fighting tobacco consumption through the funding of local, national and international actions. Its remit was first extended in 2018 to all psychoactive substances and in 2021 to all addictions (gambling, screens, videogames, etc.).

The political emphasis on prevention was further promoted in May 2022 when the Ministry for Health was rebranded the Ministry for Health and Prevention.

■ *Funding care providers*

In acute care there has been increasing criticism of activity-based payment (ABP) as it provides incentives to increase the volume of hospitalizations and it is not adapted to the financing of chronic diseases, and collaborations with ambulatory care. In psychiatry historical funding methods have introduced major territorial disparities, stifled innovation and, in the private sector, led to an increase in length of stay. In home hospitalization and post-acute and rehabilitation services the nomenclatures were ill-equipped to reflect activity.

The “My health 2022” (*Ma santé 2022*) plan announced in 2018 made multiple propositions to reform hospital funding, some of which are still being

piloted (MoH, 2018a). In July 2020 the *Séjour de la santé* recommendations reinforced the need to decrease ABP within hospital funding (MoH, 2020a).

As of 2022, the following reforms have been implemented (for other proposed reforms still in the piloting phase, see Section 6.2):

- The funding for post-acute and rehabilitation services was the first to undergo reform, with plans to switch from its historical funding of annual prospective global budgets for public and private non-profit hospitals and daily fixed rates for private for-profit hospitals to an activity-modulated budget with additional allocations financing specific activities in 2017. The ABP started at 10% of the total funding, but soon met many technical difficulties, as the nomenclature used for coding was not precise enough to properly reflect activity. The reform was then put on hold until a new nomenclature was developed, which was put in place in 2022. Meanwhile the reform proposal underwent multiple changes following the aforementioned government announcements on reducing the role of ABP and is still not implemented (see Section 6.2).
- In 2019 a bundle payment was implemented in acute care hospitals for patients with chronic renal disease (stages 4 and 5). The objective is to slow down the progress of the disease with prevention, by providing coordinated care with a multidisciplinary team including nephrologists, nurses and dieticians, along with other professionals. The bundle covers outpatient visits and services delivered at the hospital and requires that the patient is followed by each type of health professional over a year. Similar measures were meant to be implemented for diabetic patients but were delayed by the COVID-19 pandemic.
- In 2021 the funding for emergency departments was moved from a mix of ABP (per ED consultation) and an annual budget based on the number of consultations the previous year to a capitation system (53% of the total budget) alongside ABP (45%) and a P4P scheme that includes quality of care aspects, as well as organization of care (2%). Capitation is decided at the regional level based on the characteristics of the population and of the region, and access to ambulatory care and other EDs within that region. Funding is then funnelled to each hospital by the regional health agency.

Activity-based payment is based on a fee scale which varies with age, whether patients were brought by ambulance, and their criticality, whether a specialist is consulted, and whether biological tests and radiology exams are necessary. Finally, starting 1 January 2022, patients now have to pay a fixed fee of €19.61 if their ED visit does not lead to a hospitalization. This fee can be covered by CHI (see Box 5.6).

- On 1 January 2022, the reform for psychiatric hospital funding came into effect. With time, this will include a capitation payment calculated at the regional level (based on the number of inhabitants, their characteristics, the number of psychiatrists and the health and social care dedicated to psychiatric patients), ABP (depending on the number of patients seen the previous year and the intensity of the care received), a bundle payment for specific activities, and additional payments to support research, quality of care, new activities, etc. Similar to the ED reform, the capitation payment is allocated to the regional health agency and then directed to psychiatric hospitals.
- New payment methods have been trialled within primary care to improve coordination of care. In particular, in multidisciplinary group practices an add-on lump-sum payment per patient was generalized in 2015 to improve care coordination and accessibility but it remains voluntary (see Section 5.3).

■ 6.2 Future developments

Future developments – whether only discussed or already announced by the government and/or under experimentation – follow the same direction as those detailed in Section 6.1, focusing mainly on promoting better coverage and equity, improving access to care and prevention, and continuing the reform of primary care and provider payment.

■ *Improving financial access to care*

The law for the financing of the SHI for 2023 included a new financing model for innovative and expensive medications administered in hospitals,

to ensure equity in access to those medicines. This includes a risk-sharing model between the pharmaceutical company and the SHI, with two new parameters: payments in instalments, and based on the efficacy of the medication in real life (*LOI no. 2022-1616 du 23 décembre 2022 de financement de la sécurité sociale pour 2023, 2022*).

■ *Improving training and physical access to care*

Starting in 2023, physicians, pharmacists, dentists, midwives, nurses, physiotherapists and podiatrists will be required to recertify every six years. The aims are to improve knowledge, quality of care, and relations with patients, as well as professionals' own health (*Ordonnance no. 2021-961 du 19 juillet 2021 relative à la certification périodique de certains professionnels de santé, 2021*) (see Section 4.2.1).

It is also planned to allow patients to directly access certain healthcare professionals (nurses, physiotherapists and speech therapists), for whom a prescription by a physician is currently required, so as to improve access and streamline care pathways.

A reform of medical studies for GPs was also passed into law in the financing law of the SHI for 2023, with a fourth year of internship required to graduate (vs. three currently), which would need to be performed in an ambulatory care setting, and preferentially in a medically underserved area.

To improve territorial access, there have been multiple attempts to make practising in underserved areas mandatory for newly graduated physicians for a period of three years. However, this proposition faces fierce resistance from healthcare professionals and is unlikely to be voted into law.

■ *Prevention*

The law for the financing of the SHI for 2023 has introduced multiple measures to improve disease prevention. For one, it plans for free prevention consultations starting in 2023 for key age groups: at 20–25 years old for primary prevention to encourage healthy behaviours throughout life, at 40–45 years old for the prevention of chronic disorders, and at 60–65 years old for the diagnosis of first frailties or loss of autonomy. Free access to screening

of sexually transmitted diseases and free contraception for young women (under 25 years old) was also approved by parliament since 2022.

■ *Funding care providers*

As mentioned in Section 6.1, multiple reforms are under way regarding hospital funding to diversify their sources of revenue and, in acute care, to reduce the weight of ABP in the overall funding.

In acute care episode-based payments are being piloted for patients requiring hip and knee replacement as well as colectomy surgery in cancer patients. The bundle would cover acute care admissions, post-acute and rehabilitation services, at-home hospitalization, surgical and anaesthesia consultations, nursing care and physiotherapists for 45 days prior to the intervention and 90 days afterwards (180 days for knee replacement). An increase in existing P4P in hospital payment and the introduction of capitation have also been announced in successive plans but have yet to be formally implemented.

Regarding post-acute and rehabilitation services, the new funding model should include both ABP (50%) and capitation (30%), and other, smaller, payments for specific activities (research, transformation, P4P, specialized equipment, etc.).

Finally, regarding at-home hospitalization, there have been calls to reform the nomenclature to better reflect the activities carried out and their costs, which is on-going. Plans have been announced to include payment for specific activities, in particular for hospitals operating in isolated or socially deprived areas, and incentives to both decompartmentalize its funding from acute care and to encourage GPs to address patients to at-home services directly.

7

Assessment of the health system

■ Summary

- The accountability and transparency of the French health system have improved over the past decade, following major adverse events which exposed deficiencies in healthcare governance. While patients' rights and their position in the health system have also strengthened, there is little information for guiding patients within the system and their participation in treatment decisions remains low.
- Financial accessibility of healthcare is generally high in France. All residents are covered by universal health insurance giving access to a broad benefits basket. OOP payments and catastrophic health spending are among the lowest in the EU. However, there are significant geographic inequalities in access to care because of the unequal distribution of the health workforce across the country.
- France performs well in terms of all-cause mortality, life expectancy and amenable mortality. However, the limited focus on health promotion, prevention and behavioural risk factors is reflected in high preventable mortality rates. In addition, there are large inequalities in health outcomes between regions, socioeconomic classes and genders.

- While there has been progress in routine reporting of quality of care, especially in acute hospitals, available data are not used for benchmarking quality by disease categories and across settings. Major international quality indicators, including readmission and complication rates, patient experience and safety, and inappropriate prescriptions, are not monitored systematically across providers. Available data, mostly outdated, suggest a mixed picture on quality of care, with good results for cardiovascular diseases but low performance for ensuring care continuity for chronic disorders (such as respiratory diseases). Data on care quality are lacking in the primary and long-term care settings.
- France devotes a high share of its gross domestic product to health-care but has improved the technical efficiency of the healthcare system in the past decade via the implementation of macro-level spending targets by sector, which have successfully contained overall expenditure. However, this strict budgetary process with a segmented approach to healthcare has also become a barrier for improving allocative efficiency.
- The lack of a national health system performance assessment framework to monitor and evaluate health system performance reduces France's capacity to identify problem areas as well as good practices to push forward policies for improving care quality and efficiency.

■ 7.1 Health system governance

■ 7.1.1 *Transparency and accountability of the healthcare system*

Accountability in the French health system has improved over the past decades, mainly following major adverse events that have exposed deficiencies in healthcare governance, notably regarding conflicts of interest between major public health agencies and pharmaceutical industries. Since 2012 industry representatives have been excluded from the board of directors and from the commission of the Agency for medical and health products safety (ANSM) in charge of marketing authorizations. Instead, patient representatives and parliamentarians were given seats in the commission. Funding of the agency was also renewed, to be based uniquely on state funding and no longer on

taxes from the pharmaceutical industry (Law of 29 December 2011; Decree no. 2012-597 of 27 April 2012). In addition, a public transparency database was created in 2013 (Order of 3 December 2013), where information on all declared links and interests between actors in the healthcare sector and industry, including agreements, benefits and remunerations, are publicly available (MoH, 2022c).

The governance of the health system is strongly centralized and is shared between the State (parliament and the Ministry of Health) and the SHI. The MoH pilots the development and implementation of public health policies, sets out sector-level expenditure targets, regulates care quality and the level and training of the health workforce, and defines priority areas for national programmes. The union of SHI funds plays the main role in defining the public benefits basket and the levels of co-payment, and participates in regulating the price of services, drugs and devices. The dual management of the health system is visible in the fragmented management of healthcare services. The SHI is mainly in charge of managing the ambulatory care sector, ensuring the efficiency and quality of care provided by self-employed professionals. The hospital sector is managed by the MoH, and at the local level by de-concentrated state services: regional health agencies (ARS). Policy formulation is mostly done in a top-down manner but relies on several advisory committees, including the High Council for the Future of Health Insurance (HCAAM) and the High Council for Public Health (HCSP) (see Section 2.3). Several institutions, including the HCSP, the General Inspectorate of Social Affairs (*Inspection générale des affaires sociales*, IGAS) and the Court of Auditors, have the evaluation of health policies among their missions. However, they often carry out retrospective evaluations and proper impact evaluations of policies are rare. Since 2019 piloting of organizational innovations by health professionals at the local level (bottom-up policy formulation) has been encouraged with targeted funding (MoH, 2022a). This may contribute to improving policy adoption, evaluation and accountability in the system.

During the Covid-19 pandemic the transparency of the overall healthcare governance was criticized since the emergency legislation, adopted in early 2020, allowed the government to temporarily bypass parliamentary procedures to issue new policy decisions and to further restrict local level

decision-making (Or et al., 2021). These criticisms were supported by the National commission on human rights (Burguburu, 2020; CNCDH, 2020; Observatoire de l'état d'urgence sanitaire et du confinement, 2020), and gave rise to several independent evaluations (Borowczyk & Ciotti, 2020; Lizurey & Puccinelli, 2020; Pittet et al., 2021). This resulted in a relatively high number of official assessments of all Covid-19 measures in France from early 2020 onwards (OECD, 2022c).

■ 7.1.2 Population participation

Patient participation was first introduced as an essential part of “health democracy” (*Démocratie sanitaire*) in the Law no. 2002-303 of 4 March 2002, and largely focused on patients’ autonomy as well as on their rights in relation to healthcare providers and participation in treatment decisions (see Section 2.8). However, in practice, patient involvement in healthcare remained low and their role in the health system is still weak. To reinforce patient involvement in the health system, the 2016 Health Reform Law (Law no. 2016-41 of 26 January 2016) created a national union of patient associations (France Assos Santé), made patient representation mandatory in all national health agencies, introduced training and remuneration for patient representatives, and improved patients’ rights on several points (such as the right to information on care prices and data privacy). In addition, the law created regional health councils (*Conseil territorial de santé*, CTS) to ensure patient participation in local decisions concerning health and social care policies through patient representatives and consultations with the public (Public Health Code of 10 November 2021). Furthermore, a national fund to support health democracy was established in 2016 (Article 70 of law no. 2016-1827 of 23 December 2016) to finance patient associations and training of patient representatives, as well as innovation and research projects on health democracy.

Nevertheless, these institutions representing patients still need to find their proper place and play a more active role in the French health system, which is known for being fragmented, complex and administratively heavy for patients (Fonds de la C2S, 2019; HCAAM, 2022b). It can be difficult

for patients to navigate the system, find the right care providers and be fully aware of their rights (Blanchon et al., 2021).

■ 7.1.3 *Patient involvement in treatment decisions*

Patients have the legal right to be informed about diagnoses, treatment options and their prices, and to make decisions about their health in consultation with physicians, including refusal of care, and to have free choice of healthcare provider (Public Health Code of 11 March 2020). Since 2005 patients can also decide on their own end-of-life treatments in advance (Law no. 2005-370 of 22 April 2005). In principle, persons with mental disorders can also plan treatment decisions in advance to anticipate the conduct to follow in case of a severe mental health crisis and to avoid involuntary care, but this is still rarely proposed in mental health care settings in France.

Although patient involvement has increasingly been supported by legislative texts, there is no systematic assessment of patient involvement in treatment decisions. Nevertheless, some data from international surveys suggest that it remains low in comparison to other countries: approximately 74% of the French population thought that doctors rightly involved patients in decisions about care and treatment in 2020, against an average of 84% among OECD countries (OECD, 2021a).

In addition, patients lack information regarding good healthcare practices. Clinical guidelines are mainly developed for healthcare professionals, while there is little information for guiding patients and facilitating patient participation in treatment decisions. Despite a few government websites providing information to the general public on their rights, the system remains complicated to navigate for patients (see Section 2.8.1).

eHealth tools to facilitate information sharing, such as electronic medical records, are numerous but poorly coordinated (Cour des comptes, 2021d) and surveys suggest that their use remains lower in France compared to neighbouring European countries (Commonwealth Fund, 2020). Similarly, the implementation of e-prescriptions has been slow in France (Bruthans, 2020; Cour des comptes, 2021d).

■ 7.2 Accessibility

■ 7.2.1 *Population coverage and benefits basket*

Overall, healthcare accessibility is high in France, with universal health insurance coverage and a broad and unique benefits basket for all residents. Financial accessibility is supported by a state-funded insurance which avoids cost-sharing for the poorest part of the population and for those with high healthcare needs (see Section 3.3.1).

Nevertheless, the existence of cost-sharing for most services creates the need to pay for a private complementary health insurance, which can constitute significant spending for low-income households. Recent reforms have pushed for increased regulation of CHI contracts so that they cover 100% of the cost of a range of services with regulated prices, including basic dentures, hearing aids and optical care, resulting in a better coverage of these services (see Section 7.3).

■ 7.2.2 *Availability of services*

Despite the relatively high number of healthcare providers in France, geographic accessibility of healthcare, in particular primary care, remains a persistent problem for ensuring equal access to care (see Box 4.2). Healthcare professionals are free to decide where to establish their practice and are highly concentrated in urban and coastal areas. Financial incentives to attract physicians to underserved areas have had limited success. While the creation of multidisciplinary primary care group practices has shown potential to attract younger physicians to underserved areas (Chevillard & Mousquès, 2021), these measures have not been sufficient for increasing primary care accessibility.

Hospital bed capacity is high in France compared to the OECD average (OECD, 2021a). The overall accessibility of hospital care is also high despite variations in the density of different types of hospital bed across regions, with, for instance, a higher hospitalization at home capacity in the capital region, and higher psychiatric hospital capacity in rural areas. Around 95%

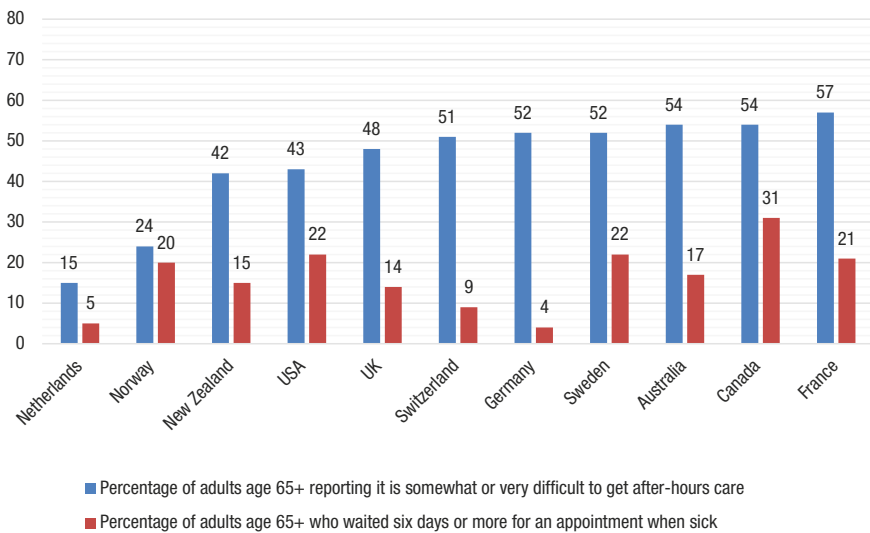
of the French population can equally access hospital care in less than 45 minutes by road (75% in less than 25 minutes) and 90% of the population has access to emergency care in less than 30 minutes (AMRP, 2021; Coldefy, Com-Ruelle & Lucas-Gabrielli, 2011). Nevertheless, there are inequalities in access to healthcare for both common and rare medical specialties. In particular, rural regions with a low population density, but also certain economically deprived urban areas, combine remoteness of both primary care and specialists (Bagein et al., 2022).

There is no systematic collection of waiting times for access to primary and specialist care in France. While there are a few surveys to estimate access times in ambulatory settings, there is no information on waiting times for surgery for different health problems (such as orthopedic or cancer surgery). The most recent data, from the 2016 Commonwealth Fund international survey carried out in the general population, suggest that the accessibility of ambulatory care varies according to the type of care needed (Commonwealth Fund, 2016). The share of the French adult population who did not get a same day or next day appointment with their regular physician last time they needed care was 44%, which is much higher than in the Kingdom of the Netherlands (19%), New Zealand (22%) or Australia (31%), even if most EU countries had rates above 40%. Moreover, the share of adults having difficulties in getting after-hours care without going to an emergency department in France is 64%. In contrast, France was among the countries with the lowest percentage of the population needing to wait two months or more for a specialist appointment (4%, with only Germany presenting a lower rate of 3%) (Commonwealth Fund, 2016). However, data from a national survey carried out in 2016/2017 suggest that waiting times can be longer for certain specialists: the average waiting time for an appointment was 44 days for gynaecologists, 50 days for cardiologists and 80 days for ophthalmologists (Millien, Chaput & Cavillon, 2018).

A more recent Commonwealth Fund survey on older adults (over 65 years old) in 2021 confirms that timely access to primary care has not improved over time and can be a problem for vulnerable/older adults. Older people in France had one of the longest waiting times for a general doctor appointment and the highest difficulties in getting after-hours care without going to an emergency department (Doty et al., 2021) (see Fig. 7.1). In 2013 it was also estimated that a fifth of 75-year-olds used emergency services for non-urgent care due to a lack of alternative after-hours care (Naouri et al., 2020).

Despite additional payments for multidisciplinary group practices in primary care to extend opening hours, the number of ED visits per capita has almost doubled since 2000, reaching 32 per 100 inhabitants in 2019 (see Fig. 5.2). In the summer of 2022 exceptional policy measures were introduced to alleviate the pressure on emergency departments. These included information campaigns for encouraging people to contact first the emergency telephone number (for better triage of patients), higher consultation fees for GPs accepting less severe patients sent by this number, simplifying the recruitment of retired and self-employed physicians in hospitals, and better funding of extra hours (French Government, 2022). These short-term exceptional measures were maintained in the autumn of 2022, and following a positive assessment by the General Inspectorate of Social Affairs (IGAS) they will be generalized.

FIG. 7.1 Percentage of adults aged 65 years or older reporting difficulties getting after-hours care and waiting six days or more for an appointment when sick

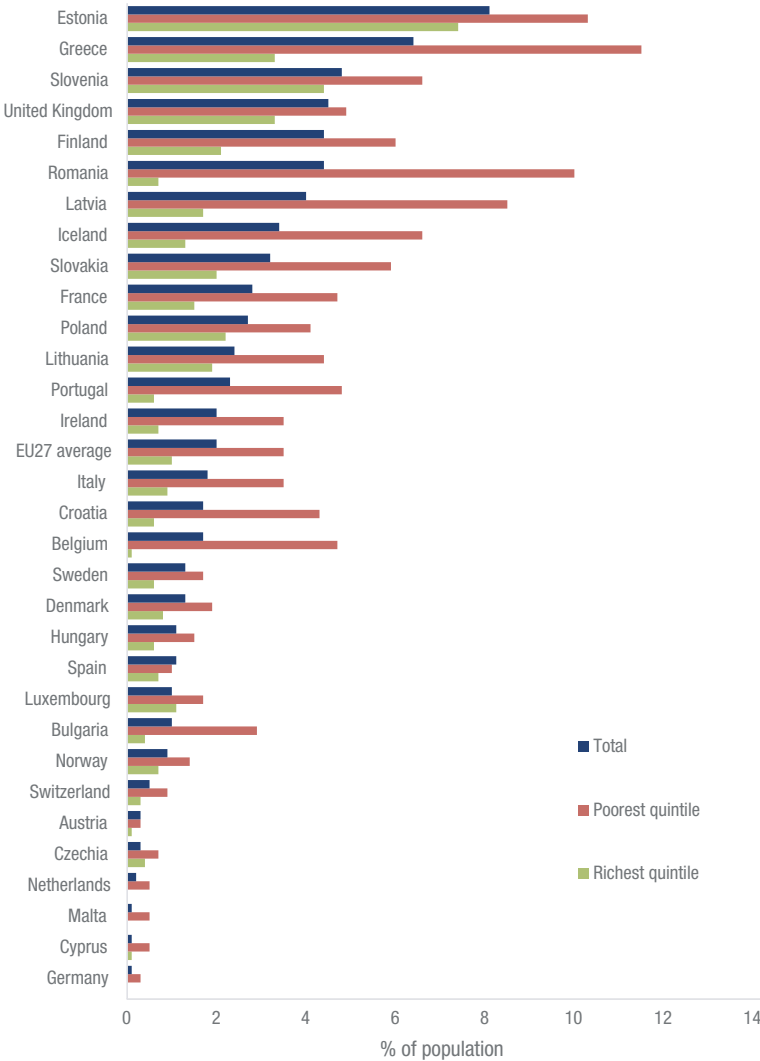


Source: Doty et al., 2021. Figure reproduced by Irdes

■ 7.2.3 Unmet care needs

The level of estimated unmet care needs for medical examinations (due to cost, waiting time or travel distance) in 2021 was slightly higher in France (2.8%) compared to the EU average of 2% (Fig. 7.2). This may be partly due

FIG. 7.2 Unmet needs for a medical examination (due to cost, waiting time or travel distance), by income quintile, EU/EEA countries, 2021 or latest available year



Notes: Norway, Slovakia, Switzerland – data for 2020; Iceland, United Kingdom – data for 2018.

Source: Eurostat, 2022

to the restrictions over the period 2020–2021 to contain the spread of the Covid-19 pandemic, which also increased the pressure on the healthcare system, as well as to inequalities in geographic access to care. Moreover, France has one of the highest income inequalities in unmet care needs: 4.7% of individuals in the poorest income quintiles reported unmet medical care needs compared to 1.5% of those in the highest income quintile in 2021

(vs. 3.5% and 1% respectively in the EU overall) (Fig. 7.2). Despite the mechanisms in place to protect populations with low income and high care needs (see Section 3.3.1), there are significant and persisting socioeconomic differences in unmet care needs in France. In 2018 the proportion of unmet dental care needs was 6.7% in the lowest income groups (vs. 6.0% in the EU on average) compared to 1.0% in the highest income groups (vs. 0.8% in the EU on average) (OECD, 2020c). Since then, France has made progress in increasing the financial accessibility for a selection of dental treatments (see Section 7.3) (MoH, 2021a).

About 18% (approximately 1 million) of surgeries were postponed in 2020 during the Covid-19 pandemic. While the delays were nearly caught up, the volume of surgical procedures was still 5.5% lower than expected at the end of 2021, a rate which varied by specialty and region (CNAM, 2022a). For example, the delays caused by the first lockdown were largely reduced for breast cancer screening and surgery by the end of 2021 thanks to a higher annual activity in the second semester. However, colorectal cancer screening and treatment had not reached their pre-pandemic levels at the end of 2021 (CNAM, 2022a). In addition, more than 35% of LTC recipients at home reported forgone or postponed care during the Covid-19 crisis, which was one of the highest percentages among OECD countries (OECD, 2021d). On a positive note, the deficiencies in care organization at the beginning of the pandemic were addressed over time with, for instance, e-Health solutions to increase the capacity of the health system (Webb et al., 2020). Well-defined care pathways in hospitals for Covid-19 patients allowed for a reduction in pressure on other services and gave space for patients with other conditions (MoH, 2020b). GPs adapted their working practices, and teleconsultations were rapidly expanded to improve access to all care providers (CNAM, 2020g, 2020h).

■ 7.3 Financial protection

France offers a high level of financial protection for health, with universal population health insurance coverage for all persons working or residing in the country. The statutory health insurance, funded by income-related contributions and earmarked taxes, covers a large benefits basket and contributes significantly to the reduction in income inequalities at the national

level (Fouquet & Pollak, 2022). There are specific schemes for protecting very low-income and chronically ill populations from cost-sharing and up-front payments. Therefore, direct OOP payments in France are amongst the lowest in OECD countries (9% of current expenditure and 2% of final household expenses) (see Section 3.4).

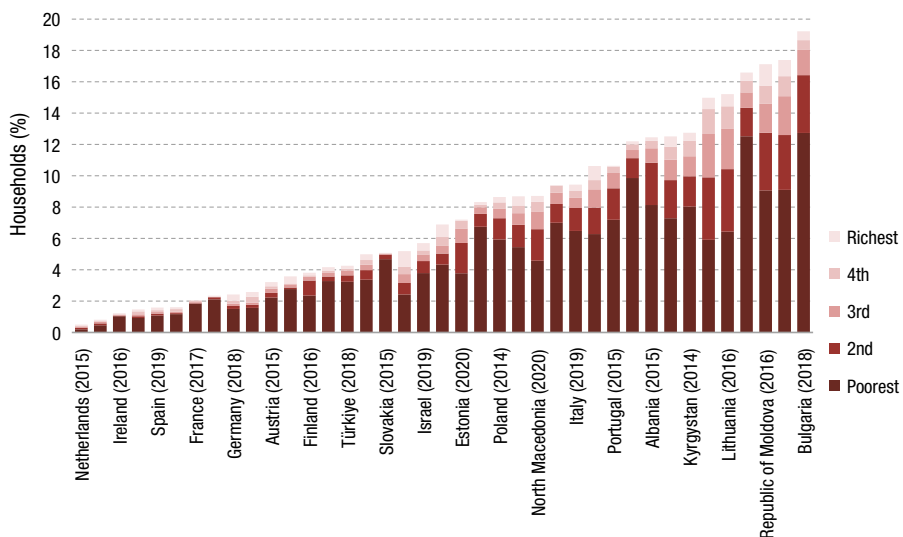
However, most of the population relies on private CHI to avoid cost-sharing. Unlike the SHI, private CHI premiums are independent of income, and adjusted upwards by age. The poorest and sickest populations are likely to have less advantageous contracts, and have a higher share of their income spent on healthcare (Jusot et al., 2017; Perronnin & Louvel, 2018). Moreover, CHI coverage is lower in vulnerable populations: 14% of the unemployed and 11% of individuals in the lowest income decile do not have CHI in comparison to 4% of the general population (Pierre & Rochereau, 2022). Despite the existence of a unique state-funded CHI scheme for the financially most vulnerable populations, the need for CHI raises concerns about the equity of access to care since the generosity of contracts varies by income, age and work status (salaried employees have collective CHI, partly paid by the employer, which is often more advantageous than individual contracts). Moreover, the management of the double SHI-CHI system is very costly. Therefore, the role of private CHI in health funding is increasingly questioned, and propositions for abolishing cost-sharing for essential health services were under discussion in 2022 (see Box 3.1) (HCAAM, 2022b).

While direct OOP payments by households are generally low, a relatively important share of these relate to long-term care, on average 43% of OOP costs, compared to 12% in OECD countries (OECD, 2021a). Optical, dental and audiology care used to be associated with high OOP costs, but since 2021 a selection of basic treatments and aids with regulated prices are covered 100% by the SHI and CHI as part of the “100% Santé” reform (MoH, 2021a) (see Section 3.3.1 and Section 6.1). The impact of the reform could already be observed in 2022 for people targeted in an outreach program (about 100 000 people). The SHI fund estimates that rates of forgone dental care (for protheses) dropped from 29% in 2019 to 18% in 2021 and that forgone optical aids decreased from 12% to 6%, while the number of persons acquiring a hearing aid increased drastically, by 73%, between 2019 and 2021 (CNAM, 2022a). An early assessment of the reform by the Court of auditors also concludes that it led to a decrease in overall OOP costs for dental and audiology care (Cour des comptes, 2022). Measures exempting

patients from paying the full cost of care at the point of use (*Tiers payant*) are also increasingly being developed, even if direct payment is still common in the ambulatory sector.

The share of households that experience catastrophic health expenditure in France is estimated to be among the lowest in Europe (Fig. 7.3). The share of households with catastrophic spending was 2.1% in France in 2017 compared to an OECD average of 5.4% (see Section 3.4). Similar to other countries, catastrophic payment is mostly a problem for the lowest income groups; the proportion of catastrophic health expenditure is nearly two-fold in the poorest quintile compared to the richest (Bricard, 2023; OECD, 2021a).

FIG. 7.3 Share of households that experienced catastrophic health expenditure, latest year for all countries with data available



Source: WHO Barcelona Office for Health Systems Financing, forthcoming

7.4 Healthcare quality

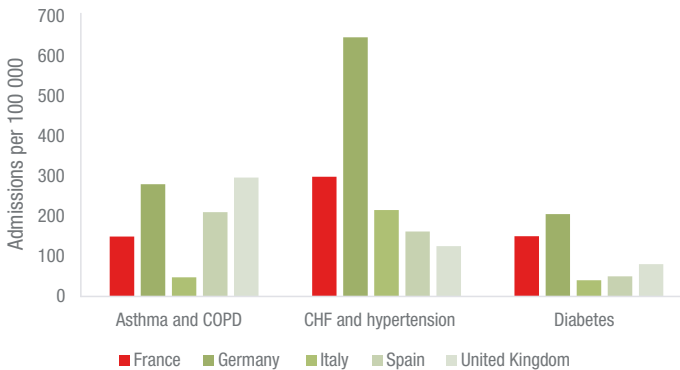
France lacks a comprehensive assessment of the quality of care delivered in different care settings and there is no routine publication of data on care quality. Patient surveys are rare, and no patient-reported measures are regularly monitored, except in acute hospitals where patient-reported experience measures (PREM) have been routinely collected in most facilities since 2016.

7.4.1 Primary care

There are few data on the quality of primary care in France. However, *ad hoc* surveys in the general population show that people declare high satisfaction with the care provided by their GPs (see Box 5.3).

The rare data available on primary care quality date from 2015 and include rates of avoidable hospital admissions, i.e., admissions for causes that could be avoided if adequately followed-up in primary care. France has contrasting outcomes for this indicator according to the cause of hospitalization. The avoidable admission rates for congestive heart failure (CHF) and hypertension, as well as for diabetes, were very high compared to neighbouring countries (Germany, Spain and the United Kingdom) (Fig. 7.4). In contrast, the avoidable hospital admission rates for asthma and chronic obstructive pulmonary disease (COPD) were lower in France than in neighbouring countries (Fig. 7.4). Research also shows that somatic avoidable hospital admission rates are higher in certain segments of the population, such as people living with a mental disorder (Gandr  & Coldefy, 2020).

FIG. 7.4 Avoidable hospital admission rates for asthma, chronic obstructive pulmonary disease, congestive heart failure, hypertension and diabetes-related complications, France and selected countries



Notes: Age-sex standardized rate per 100 000 population (15 years and older), 2019 or latest available year. France – data for 2015.

Source: OECD statistics, 2021

The fee-for-service payment, common in ambulatory care, gives little incentive to primary care providers to focus on health promotion and prevention (HAS, 2022a). In 2019 only 49% of women aged 50–69 years reported

having mammography screening over the past two years, which is lower than the OECD average of 62% (OECD, 2021a). In addition, cancer screening rates are estimated to be lower in vulnerable populations, such as people living with a disability (Gandr  & Coldefy, 2020; Lengagne et al., 2015) and in people facing economic deprivation (Bagein et al., 2022; Menvielle et al., 2014). Overall, regardless of the investments made over the past two decades, cancer screening rates have not increased, and have even slightly dropped due to geographical and social difficulties in accessing preventive services and inefficient use of dedicated funding (Dupays, Leost & Le Guen, 2022). Similarly, Type II diabetes screening and smoking cessation treatments are rarely proposed by primary care physicians (Cour des comptes, 2021a). Only 52% of the population aged 65 years and older were vaccinated against the seasonal influenza in 2019, which is well below the WHO recommendation of 75%, but higher than the OECD average of 46% (OECD, 2021a). The latest national prevention plan (covering the period 2018–2022) suffers from the same weaknesses as previous plans, lacking both clear objectives that could be evaluated and monitored over time, and a clear division of responsibilities between national and local stakeholders (Cour des comptes, 2021a).

France is known for the high level of pharmaceuticals prescribed in primary care and had one of the highest daily doses of antibiotics prescribed in 2019 amongst the OECD countries: 23 per 1000 inhabitants vs. 17 per 1000 inhabitants in the OECD average (OECD, 2021a).

■ 7.4.2 *Hospital care*

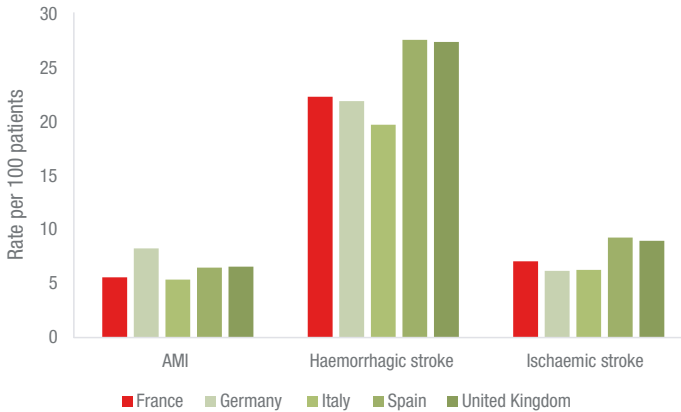
Quality of hospital care in France is monitored by the French National Authority for Health (HAS). The HAS carries out hospital quality certifications for all public and private hospitals every four years, and publishes the certification level and all measures of quality and safety for each hospital (HAS, 2022b). Hospitals that do not attain a certain level, or that are not certified, are reassessed in the following 6 to 24 months.

The HAS also develops indicators for monitoring quality of care in different care settings. However, major indicators such as 30-day readmission rates, complications, and mortality rates after surgery are not monitored regularly over time, and there is no systematic quality benchmarking across hospitals. Since 2016 a patient experience and satisfaction survey (e-Satis)

has been obligatory for large hospitals (with over 500 patients annually). Currently, no patient-reported outcome measure (PROM) data are available, although collection of this type of indicator is being piloted at the local level under the supervision of the MoH and the SHI fund (HAS, 2021d).

Based on the latest data available from the OECD (from 2015), the quality of cardiovascular care appears to be rather good. France has relatively low mortality rates after hospitalization for acute myocardial infarction (AMI) (5.6 per 100 000 persons over 45 years old), haemorrhagic stroke (22.4 per 100 000) and ischemic stroke (7.1 per 100 000) compared to other OECD countries, and in particular neighbouring countries (Fig. 7.5).

FIG. 7.5 In-hospital mortality rates (deaths within 30 days of admission) for admissions following acute myocardial infarction, haemorrhagic stroke and ischaemic stroke, France and selected countries in 2019 or latest available year

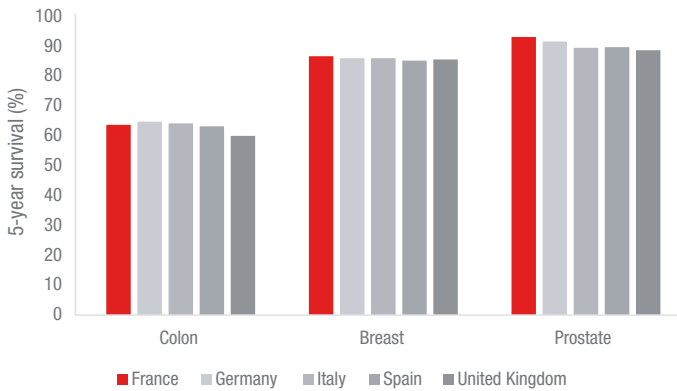


Notes: France and Italy – data from 2015

Source: OECD statistics, 2021

In addition, cancer survival rates are high in France. The most recent internationally comparable data from 2010–2014 show that the five-year cancer survival rates were above the EU average for several cancers: 64% for colon cancer (vs. 60% on average), 87% for breast cancer (vs. 83% on average) and 93% for prostate cancer (vs. 87% on average) (Fig. 7.6.), but lower for cervical cancer (65% vs. 66% on average) and oesophageal cancer (14% vs. 16% on average) (OECD, 2021a; Allemani et al., 2018). Generally, prognosis of cancers associated with alcohol and tobacco use (oesophagus, liver and lung cancers) remains poor (Coureau et al., 2021).

FIG. 7.6 Five-year survival rates for colon, breast (among women) and prostate (among men) cancer diagnosed in 2010–2014



Source: Allemani et al., 2018

This global picture hides persistent socioeconomic inequalities in survival rates: excess mortality from certain cancers can be up to twice as high in the most economically deprived areas (Tron et al., 2021). Recently, the National Cancer Institute has coordinated efforts to improve cancer prognosis through continuous updates of clinical guidelines and development of routinely measurable indicators of quality and safety of cancer care (Houzard et al., 2022; Inca, 2019a, 2019b). In addition, minimum volume thresholds were set up for hospitals to be allowed to provide cancer care (Order of 29 March 2007), based on the observation that low volume hospitals have systematically higher mortality and readmission rates and use more invasive techniques (Or & Renaud, 2012).

The national indicators on hospital quality hide significant variations in medical practice across both providers and local authorities (*départements*) (Gandré et al., 2018; Le Bail & Or, 2016; Lecarpentier et al., 2022). These practice variations are not systematically monitored or benchmarked across hospitals. In addition, the significant increase in the number of hospital admissions in the past 10 years created a visible pressure on acute care hospitals where working conditions have degraded over time. The Covid-19 pandemic exacerbated this situation and the lack of nurse staffing in some hospitals risks having a negative impact on care quality (HAS, 2022a).

■ 7.4.3 *Patient safety*

France has a strong regulatory framework, tools and methods to support care safety. However, they remain poorly known and implemented by healthcare professionals, and the national patient safety programme lacks measurable indicators and objectives (HCSP, 2018). In addition, the programme appears to be insufficiently communicated to healthcare professionals, resulting in a lack of awareness and ownership by stakeholders.

The performance of the French healthcare system varies across different indicators of adverse medical events. Between 160 000 and 375 000 serious adverse medical events occur in hospitals each year, of which around half could be avoided (HAS, 2022a). France also has particularly high rates of pulmonary embolisms or deep vein thrombosis after hip and knee surgery (two adverse events that are preventable), reaching a rate of 1595 per 100 000 hospital discharges, compared to 546 per 100 000 on average among OECD countries in 2019 (OECD, 2021a). Overall, it is also estimated that 20 000 to 30 000 deaths are related to adverse care events each year (HCSP, 2018).

However, the rates of patients reporting a medical or a medication-related mistake in the past two years are relatively low compared to some other OECD countries: 4.3% and 4.1% respectively among the general population in France, compared to, for instance, Norway (12.6% for medical and 7.4% for medication-related mistakes) and Sweden (8.7% for medical and 6.3% for medication-related mistakes) (OECD, 2021a). The proportion of hospitalized patients with at least one hospital-acquired bacterial infection in France is similar to the EU average with a rate of 5.8% in 2016–2017, and the proportion of these infections that were antibiotic-resistant was lower than in the EU (21.4% vs. 32.3%) (OECD, 2020a).

■ 7.4.4 *Overall quality of care*

The French National Authority for Health (HAS) is the main institution supporting and assessing quality in the health and LTC sectors. It is responsible for the development and dissemination of clinical guidelines (HAS, 2020a). However, clinical guidelines are not often respected by health professionals who claim that they are not always applicable in practice (HAS, 2022a).

The HAS is also responsible for the development of indicators to monitor care quality across care settings. Quality of care in France is particularly problematic for patients who require follow-up and care in multiple settings, owing to problems of care coordination and integration. For instance, only a minority of individuals with COPD have care pathways in line with the guidelines for this disorder (HAS, 2022c), patients living with a mental illness receive poorer somatic care than the general population (Gandré & Coldefy, 2020), and it is estimated that two thirds of thyroidectomies are carried out without prior cytopunction, leading to a lifelong need for thyroid hormones for up to half of all individuals with a benign nodule (HAS, 2021c).

While there has been some progress in public reporting of quality indicators in the acute hospital settings, there is almost no public information on the quality of care in LTC settings. The HAS proposed a reference framework for assessing the quality of care in LTC settings only after the Covid-19 crisis in 2020, and yet without suggesting any specific indicators for monitoring it (HAS, 2022d). In this context, the High council for public health has recently advocated for routine collection of self-assessed health and quality of life indicators for LTC patients (HCSP, 2022).

■ 7.5 Health system outcomes

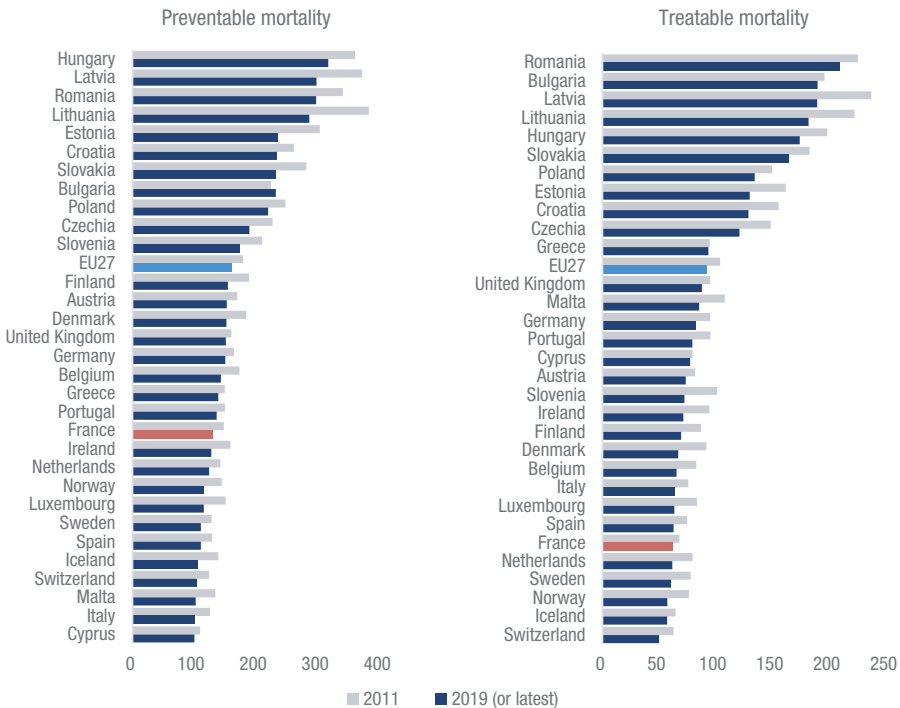
France performs well in terms of all-cause mortality: 659 deaths per 100 000 inhabitants in 2019 compared to 770 per 100 000 inhabitants on average among OECD countries (OECD, 2021a). Life expectancy at birth steadily increased until 2019 and was more than two years higher than the OECD average before the Covid-19 pandemic (82.9 years vs. 80.6 on average in 2019) (OECD, 2021a). Although life expectancy decreased by eight months in 2020, it had almost attained pre-pandemic levels again in 2021, at 82.5 years (OECD, 2022a). Infant mortality rates are also below the OECD average (3.8 deaths per 1000 live births vs. 4.2 in 2019) (OECD, 2021a) but there has been a slight increase in the past 10 years and France has a higher infant mortality rate than its neighbours (Germany, Italy and Spain) and than the EU average of 3.4 deaths per 1000 live births (Eurostat, 2022).

7.5.1 Treatable and preventable mortality

France has one of the lowest age-standardized treatable mortality rates amongst EU countries, i.e., deaths that could have been avoided if the population had access to timely and effective care. The treatable death rate was 62.1 per 100 000 inhabitants in 2017 (latest year available), which was significantly lower than the EU average of 92.1 per 100 000 (Fig. 7.7), and lower than those of Germany (81.7), the United Kingdom (87.4), Italy (63.7) and Spain (62.6) (Fig. 7.7). The leading causes of death in 2017 were cancer (28.4%), circulatory diseases (23.8%) and respiratory diseases (7.4%) (OECD, 2020a).

France performs less well in terms of preventable mortality, i.e., deaths that could have been avoided with timely public health interventions focusing

FIG. 7.7 Mortality from preventable and treatable causes in France and selected countries, 2011 and 2019 (or latest year available), all persons, age-standardized death rates per 100 000 population



Notes: Data are for 2011 and 2019 or latest available year. Data for France are from 2017; and from 2018 for Malta and the United Kingdom.

Source: Eurostat, 2022

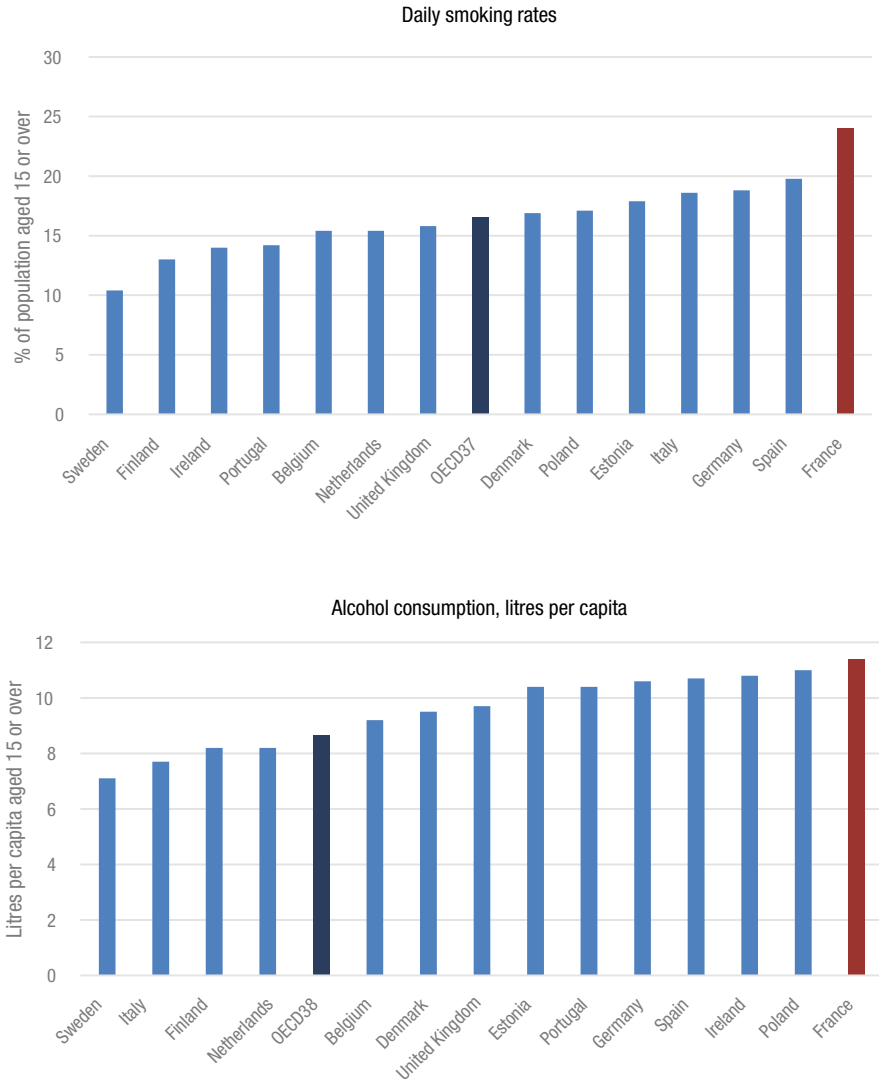
on the wider determinants of health such as lifestyle factors, socioeconomic status and environmental factors (Fig. 7.7). France had 129.9 preventable deaths per 100 000 inhabitants in 2017 (latest year available), above Spain (110.0) and Italy (101.2) but below the EU average of 160.0 deaths per 100 000 inhabitants (Eurostat, 2022).

The main causes of preventable mortality in France in 2017 were driven by behavioural risk factors including alcohol and tobacco-related deaths, accidents and suicides (OECD, 2022b). The suicide rate in France is among the highest in the OECD countries: 12.3 per 100 000 inhabitants in 2016, compared to an average of 11.0 per 100 000 (OECD, 2021a), and is especially high in middle-age groups (for example, 50–54 year-olds: 21 per 100 000 vs. the EU average of 16 per 100 000) (Eurostat, 2022). However, there are large geographical differences, with a nine-fold variation in standardized suicide rates across local areas (CépiDc, 2022), as well as variations according to socioeconomic status (ONS, 2022).

In 2019 it was estimated that approximately one third of all deaths were related to behavioural risk factors such as smoking, alcohol consumption and diet (IHME, 2021a). Yet France invests modestly on collective health promotion and disease prevention activities, while actual access to individual prevention services remains difficult to evaluate. Prevention measures through tax increases for tobacco products and advertising campaigns have had limited success in reducing smoking and alcohol consumption over the past decades. Smoking rates remain high in France (24%) compared to the OECD average (17% in 2019) (Fig. 7.8) with a high rate of smoking also among 15-year-olds (OECD, 2021a). Alcohol consumption also remains high despite slight progress in the past decades; in 2019 per capita alcohol consumption was 11 litres per year, compared to 9 litres in OECD countries on average (OECD, 2021a) (Fig. 7.8). The measured overweight (including obesity) rate among adults, at 49%, is one of the lowest in OECD countries (after Japan and Korea) and much lower than the OECD average of 60%, but self-reported data suggest that rates are increasing amongst adolescents (OECD, 2021a). To tackle the growing obesity rates, measures have focused on educating consumers on healthy eating and less so on physical activity, which remains among the lowest among EU countries, especially among adolescents. Only 7.5% of 15-year-olds reported practising at least 60 minutes of moderate to

vigorous physical activity daily in 2017–2018, compared to 13.7% in the EU on average (OECD, 2021a).

FIG. 7.8 Daily smoking and alcohol consumption rates in the population aged 15 and older in 2019 or latest available year in France and selected countries



Source: Data from OECD, 2021a

Healthy life expectancy in France was above the EU average for women (64.9 vs. 64.2 years) but below the EU average for men (62.9 vs. 63.5 years) in 2017 (Moisy, 2018). It has slightly increased for both men and women over the past 10 years (DREES, 2022a).

■ 7.5.2 *Equity of outcomes*

Challenges remain in attaining equitable health outcomes across population groups, defined by socioeconomic status and geographic place of residence, as well as belonging to minority groups.

Although reducing health inequalities has been a public health priority for decades, large inequalities across socioeconomic groups remain unchanged. Over the period 2012–2016, life expectancy differed by 13 years between men in the lowest and highest income groups: among the wealthiest 5% of men, life expectancy at birth was 84.4 years, compared to 71.7 years among the poorest 5%. The difference was 8 years for women (Blanpain, 2018). Morbidity, measured by chronic disorders, was also much higher in more deprived populations: for comparable age and sex, the lowest 10% income group had 2.8 times more diabetes, 2.2 times more liver or pancreas diseases and 2.0 times more psychiatric disorders compared to the richest 10% (Allain & Costemalle, 2022).

Health outcomes also vary largely across French regions (Bagein et al., 2022). In 2016–2018 mortality rates for men with cancer varied between 227 and 270 annual deaths per 100 000 across regions, while mortality from cardiovascular diseases varied between 193 and 295 deaths per 100 000 men (INSEE, 2021c). In 2017 standardized mortality rates were lowest in the capital region and highest in the Hauts-de-France region (in the north) (CépiDc, 2022). Some of these differences can be attributed to differences in socioeconomic situations but other factors include differences in lifestyle, occupational exposure to risk factors and availability of healthcare resources across areas (Blanpain, 2018). For example, cancer survival varies according to the level of social deprivation of the area where patients live: individuals diagnosed with cancers between 2006 and 2009 (followed-up until 2013) had an excess mortality from cancer up to twice as high in the most deprived areas compared to the least deprived areas (Tron et al., 2021). While recent data on the causes of mortality are lacking, inequalities across regions and socioeconomic groups appear to persist over time.

Data on ethnic and religious background and sexual orientation cannot legally be collected in France. The monitoring of health equity and discrimination in the healthcare sector is therefore reliant on surveys, often conducted by private institutions. Those that are available suggest that discrimination

can be experienced by individuals belonging to minorities based on ethnicity, religion, sexual orientation and disability. In France in 2019, 20% of lesbian women and 17% of gay men reported experiencing discrimination related to their sexual orientation by healthcare providers at least once during their lifetime (IFOP, 2019); depression was twice as frequent and suicide attempts three times more common in gay, lesbian and bisexual individuals compared to heterosexual (SPF, 2021b). In 2022 the data on health and health-related behaviours in the LGBTQ+ community are outdated or completely lacking, and questions on sexual identity are often omitted from health surveys (SPF, 2021b).

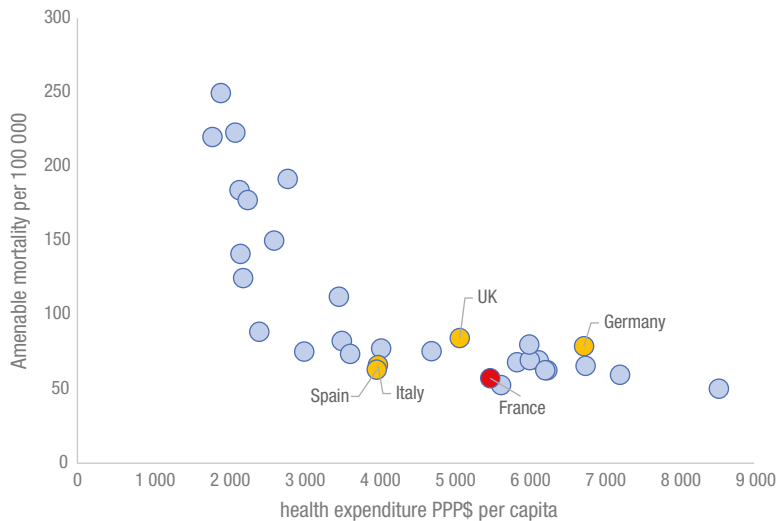
Overall, the monitoring of health inequalities remains partial in France, especially concerning inequalities in minority groups. Furthermore, there is no regular data collection of socioeconomic determinants of healthcare access, which makes it difficult to address and follow the evolution of unmet medical care needs in socially vulnerable populations. Therefore, there is a lack of knowledge on how to achieve a real reduction of social inequities in health including research covering a number of areas, such as the association between social and geographic inequities in health, the role of gender in healthcare provision, and how to improve care delivery to reduce stigma and improve care for minority groups. However, since 2020 a new information system allows the linking of individual healthcare utilization data with socioeconomic characteristics of a representative sample of the French population (EDP-Santé). This will provide new insights into socioeconomic gradients in health and healthcare utilization in France (Allain & Costemalle, 2022; Dubost & Leduc, 2020).

■ 7.6 Health system efficiency

Health system efficiency concerns maximizing desired outcomes of the health system while optimizing the level of resources devoted to it (Cylus, Papanicolas & Smith, 2016). France has the third lowest treatable mortality rate (i.e., premature deaths that should not occur in the presence of timely and effective healthcare) per 100 000 population in Europe, closely after Switzerland and Iceland, but Switzerland spends 50% more on healthcare per capita than France. Although France devotes a high share of its GDP to healthcare, health expenditure per capita at the international level is lower

than in many other European and neighbouring countries. Therefore, as depicted in Fig. 7.9, the French health system is one of the most efficient in Europe in terms of treatable mortality. For example, Belgium, Germany and the United Kingdom have both higher treatable mortality rates and higher health expenditure per capita.

FIG. 7.9 Treatable mortality per 100 000 population vs. health expenditure per capita, 2019



Sources: WHO, 2022a, 2022b

Nevertheless, the efficiency of public health interventions focusing on the wider determinants of health such as lifestyle factors is rather low in France, considering the high rates of preventable mortality (Fig. 7.7). It has been estimated that 48% of deaths before the age of 75 years in men have preventable causes, mainly related to risky behaviours (INSEE, 2021c), and about 13% of annual deaths are attributable to tobacco consumption (SPF, 2021a).

■ 7.6.1 Allocative efficiency

The implementation of macro-level targets, the National objective for health insurance spending (ONDAM), has been successful in containing overall expenditure in the past decade, reducing the annual growth rate of health expenditure from more than 3% in the mid-2000s to under 2% from 2015

to 2019 (Barroy et al., 2014; OECD, 2021a). However, this strict budgetary process with a segmented approach to healthcare also became a barrier for improving allocative efficiency (Deroche & Savary, 2019; HCAAM, 2020b). The fact that healthcare budgets are set and monitored separately for ambulatory care providers, hospitals and LTC facilities creates a form of impermeability between different sectors (see Box 3.3) and hinders the potential efficiency gains (for example, through shifting resources from hospital to social care by reducing the number of hospitalizations). This reinforces the division of healthcare supply at the local level and reduces the capacity to improve care coordination across sectors and to shift care in the community. More importantly, the indicative budgets are set at the national level without reflection on resource allocation across regions, and without considering the healthcare needs of the population and health priorities at the local level.

Therefore, the current budgeting process has little modified the balance of allocation between different care sectors in the past decade. The system is highly hospital-centric: France has one of the highest hospital discharge rates (184 per 1000 inhabitants in 2019) in the OECD (OECD, 2021a), representing almost half of total health spending. Moreover, the lack of coordination between ambulatory, hospital and social (long-term) care providers has been recognized as a major drawback in terms of cost-control and quality and efficiency of care provision. The major reforms aiming to strengthen primary care provision, such as a voluntary gatekeeping scheme and pay-for-performance (P4P) remuneration for ambulatory physicians, do not appear to have had any significant impact on improving care patterns (Naiditch & Dourgnon, 2009; Bras, 2020).

Evaluations showed that compared to traditional (solo) general practice, the implementation of multidisciplinary group practices in France has improved the quality and efficiency of care provision with more emphasis on prevention and care coordination (Mousquès & Daniel, 2015). Therefore, several initiatives and financial incentives have been introduced in the past decade for encouraging such practices. Despite the slow uptake and variations across regions as to the size and distribution of these practices, in 2022 4 self-employed general practitioners out of 10 shared a practice with non-physician health professionals (Bergeat, Vergier & Verger, 2022) vs. about a quarter in 2019 (Chaput et al., 2019). More teamwork integrating a diverse mix of professionals may facilitate the innovation of care models to improve service delivery in the future.

France has had success in controlling prices of healthcare services and pharmaceuticals through formal negotiations with healthcare providers and value-based pricing of pharmaceuticals. Nevertheless, healthcare providers tend to compensate for reduced revenues by increasing the volume of services they provide. While healthcare prices are well below the OECD average (23% less on average), France has the third highest healthcare volume per capita in OECD countries, 50% above the average (OECD, 2021a). The fact that most healthcare providers are paid based on volumes (FFS in the ambulatory sector and ABP in the hospital sector) provides an incentive to increase the quantity of care without necessarily improving quality and coordination across settings. Therefore, over the past few years new payment models have been implemented or piloted, including an additional P4P remuneration based on the achievement of public health objectives for self-employed primary care physicians (see Section 3.7.2). The SHI also plans to improve the current P4P scheme by introducing new quality indicators based on patient experience, simplifying and extending the P4P scheme to a greater number of medical specialties, and introducing incentives for collaboration between primary and hospital care providers (CNAM, 2022a). The SHI also aims to provide a benchmarking of results among medical professionals to support change in practice, but this may be difficult due to resistance from health professionals.

■ 7.6.2 *Technical efficiency*

France has significantly improved the technical efficiency in the hospital sector in the past decade (2010–2020), measured using classical indicators such as average length of stay in hospital, day-case surgery rates or hospital volume over hospital resources, and the country performs well internationally (DREES, 2021d; OECD, 2021a). In 2021 a relatively high proportion of surgical procedures, such as eye surgeries (95%), orthopaedic surgeries (53%) and digestive procedures (43%) were performed as day cases rather than inpatient procedures (Scansanté, 2021). While the percentage of ambulatory surgery increased significantly over the past five years, there are significant variations across regions and hospitals. Moreover, over the last decade avoidable hospital admissions, readmissions and visits to emergency departments have also visibly increased, especially for the older population (Bricard, Or & Penneau, 2020). Financial pressure on hospitals with declining prices

over time encouraged hospitals to focus on increasing activity volumes to balance their accounts (see Section 3.7.1.3). Indicators such as staff turnover and sickness absence rates, while not available internationally, were already alarming before the Covid-19 pandemic, as, despite the significant increase in case volumes over time, the number of nursing staff in hospitals stagnated and even decreased in some areas. In 2019 professionals working in hospitals were already reporting an excess workload (57% of all hospital professionals vs. 40% in other occupational sectors) (Pisarik, 2021). The gap between the workload and demands associated with the work and the means available to do so appeared to fuel frustration amongst 60% of the nurses and nurse assistants, a situation that worsened during the pandemic (Parent, 2022).

Recent policies aiming to reduce avoidable hospitalizations and improve local care coordination include the development of regional/local healthcare networks (CPTS) which bring together hospital and primary care physicians, nurses and other professionals (including social workers, administrative staff, etc.). Since 2019 new payment models have also been tested on an experimental basis, including bundled payments, which allow for funding to be shared between primary care providers and hospitals. Moreover, local hospital groups (GHT), introduced in 2016, aim to facilitate reorganization of hospital services around the local population by encouraging hospitals to share their resources and activity and to specialize on certain services. Compulsory for public hospitals, these groups can also include private clinics as partners on a voluntary basis. Finally, a new type of care facility, certified as local hospitals (*Hôpitaux de proximité*), was introduced in 2015 to enable a stepped-care approach – mostly by following up older patient groups and providing less technical procedures in socially deprived areas where the density of physicians is low and the share of older adults in the local population is high (Milon, 2019). Local hospitals are supposed to serve as a link between primary care providers, higher level hospitals and the social care sector and to facilitate prevention and continuity of care to avoid acute hospitalizations (Order no. 2021-582 of 12 May 2021).

While generic pharmaceuticals have enabled significant cost reductions (an estimated €3 billion in 2018 and more than €27 billion since 2000) (Leem, 2021), their use remains limited in France compared to other European countries. Generics represented only 30% of the market volume of reimbursed pharmaceuticals in 2019 (vs. 83% in Germany and 85% in the United Kingdom) (OECD, 2021a). There is also margin for improving

prescription patterns as France has high rates of inappropriate prescriptions (OECD, 2020c), and in particular higher rates of antibiotic prescription in primary care which are well above the EU average (23 defined daily doses per 1000 population per day vs. 17.4 on average) (OECD, 2021a). In 2022, to reduce waste in pharmaceutical consumption, community pharmacies were given the possibility to dispense a few types of medicines by unit (instead of boxes) (see Box 5.7). Moreover, medicines with insufficient or low medical benefits (including homoeopathic medicines since 2021) have been de-listed from the benefits basket over time. Efforts to reduce inappropriate prescription (for example, of benzodiazepines for the older population, certain cholesterol medicines and antibiotics) are supported by national education campaigns and a specific P4Q scheme in primary care which has had limited success so far (CNAM, 2022f).

In France all health professionals have legally defined tasks and procedures that they can deliver (Brissy, 2020). This legal approach reduces the technical efficiency of the health system since it gives little possibility for developing competencies and task shifting between different providers and for modifying care models to look after an ageing population. Therefore, attempts to promote task transfer from physicians to other professionals, such as nurses, have had limited success, especially as it can also impact the revenues of the professionals involved, who are mainly paid FFS. Therefore, compared to many other European countries, nurses have little medical responsibility and power both in primary care and in hospitals and their competencies are underutilized (Or & Gandré, 2021). While an advanced nursing track has recently been created (see Section 4.2.2), nurses still have little autonomy in their practice. Given the persistent shortage of GPs in some areas, recent policies also opened the possibility of devolving some medical tasks to other health professionals (such as vaccination for pharmacists, nurses and midwives).

Overall, France lacks a national health system performance assessment (HSPA) framework to monitor and evaluate health systems performance. Major quality indicators across care settings are not systematically monitored and publicly reported. While important progress has been made for collecting data on quality, in particular concerning safety of care in hospitals, most indicators are focused on processes. Major indicators such as 30-day readmission rates, waiting times for treatment and adverse events after surgery are not monitored regularly across providers or across regions/territories.

Generally, benchmarking of efficiency and care quality is discouraged even when data are available. This reduces France's capacity to identify problem areas as well as good practices to push forward policies for improving care quality and efficiency.

Nevertheless, in the frame of the latest national health strategy 2018–2022, a set of outcome indicators was defined for the first time to monitor over time the achievement of objectives set in the strategy (for example, reducing alcohol and tobacco consumption in the adult population, increasing satisfaction with care quality, etc.) (MoH, 2022b). This may constitute a first step for building a performance evaluation system in the long term.

Conclusions

The French health system is universal in terms of population covered and provides a generous benefits basket combining a social health insurance system with a national health system approach.

France promotes equity in access to healthcare through a number of regulatory tools and policies. All legal residents have access to statutory health insurance, which provides a broad benefits basket with rapid uptake of innovation, based on the principle of equal access to care depending on the needs of the population, not on their income. Coverage is also available to undocumented migrants under certain conditions. While the SHI requires cost-sharing for all services covered, some people are exempted from user charges (for example, people with chronic conditions, pregnant women, among others). As a whole, France presents the second lowest rate of user charges among the OECD countries.

To reach this position, private complementary health insurance is a vital part of the social protection system. About 96% of the French population holds a CHI, mainly to cover the co-payments. The government subsidizes private CHI for wage earners and there is a public CHI scheme for the less well-off.

As a result, France shows low rates of unmet care needs for financial reasons and high patient satisfaction. Nevertheless, social inequities in access remain particularly high when it comes to access to specialists and optical and dental care, which are less well covered by SHI and CHI. To ensure financial access, a recent reform has introduced a basic benefits basket with

full coverage for optical devices, dental care and hearing aids (known as “100% Santé”).

Regional inequalities in access to care are also an issue that is slowly being addressed by successive reforms. While the number of most health workers has increased in the past decade, the number of general practitioners per capita has decreased, and the decreasing trend is expected to continue in the years to come. As physicians are free to choose their place of practice, certain areas, mainly rural and less affluent areas, remain medically underserved. Policies aiming to address this issue have been implemented for two decades. Some have focused on making underserved territories more attractive to physicians, with limited success. Policies such as mandatory practice in these areas for new medical graduates – which have been put forward by some – have never been attempted due to fierce opposition by health professionals, which no government has yet been willing to face. Other reforms have tended to shift some medical tasks to nurses and allied healthcare professionals to alleviate the workload of physicians. However, this is a slow process and progress is incremental. For instance, medical responsibilities and autonomy of nurses in France remain lower than in some other European region countries such as Sweden and the UK.

The issue of access to doctors in ambulatory care has resulted in a growing number of emergency admissions. This is an important source of pressure on (mainly public) hospitals that are facing cumulative problems including negative financial balances for a good share of them and staff shortages (nurses, in particular), linked to difficult working conditions and low remuneration.

Improving the efficiency of the French healthcare system is therefore increasingly important in order to respond to population needs and ensure equity of access in the context of an ageing population and of growing economic and environmental challenges. Recent reforms have focused on encouraging multidisciplinary group practices and task sharing in primary care, with new financial incentives for better care coordination and prevention. The creation of local care networks, uniting different types of healthcare providers, including hospitals, around population-based health objectives, is also sought to support collaboration between providers. To ensure the sustainability of its health workforce and reduce geographic inequalities, France will need to improve the working conditions in the health and social care sectors by providing appropriate remuneration and career perspectives

for all health workers (especially nurses), and by reinforcing recognition of their competencies and missions. Investments have been made to increase salaries from 2021 onwards, but it is yet too soon to know how successful those measures have been.

An attempt to improve efficiency can also be made through a strong investment in health promotion and disease prevention. Historically, because of its strong medical culture, the French healthcare system has been centred around curative services, with a low emphasis on public health and prevention. As a consequence, while France has a high life expectancy and low all-cause and treatable mortality rates, it also has high preventable mortality rates, largely driven by behavioural factors. The prevalence of alcohol and tobacco consumption remains one of the highest in Europe and suicide rates are above the OECD average. In the last decade the national strategy for health was orientated towards disease prevention and health promotion. In a rebranding effort sending a strong signal, the Ministry of Health was renamed the Ministry of Health and Prevention in May 2022. Efforts need to be sustained further by allocating sufficient funding to support this objective. Recent experimentations with performance-, collaboration- or outcome-based payment models (rather than volume-based payments such as fee-for-service) also can help to encourage better prevention, task shifting and innovation for improving care models.

Additionally, to improve the French health system and its performance over time, systematic monitoring of outcomes is essential; it will require improvements in regular collection and reporting on some of the major international quality indicators, particularly to compare across providers or across regions/territories, to facilitate benchmarking of efficiency and care quality, and increase capacity to identify problem areas as well as good practices.

As in many other health systems in Europe, the Covid-19 pandemic has brought to light some structural weaknesses within the French health system, but it has also provided opportunities for improving its sustainability. There has been a notable shift in the will to give more room to decision-making at the local level involving healthcare professionals and to find new ways of funding healthcare providers to encourage care coordination and integration.

Appendices

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■ 9.2 Principal legislation

■ 2022

Decree no. 2022-610 of 21 April 2022 relating to the vaccination skills of nurses and community pharmacists (*Décret no. 2022-610 du 21 avril 2022 relatif aux compétences vaccinales des infirmiers et des pharmaciens d'officine*)

Decree No. 2022-679 of 26 April 2022 relating to the delegation of tasks by occupational physicians to occupational health nurses and occupational telehealth (*Décret no. 2022-679 du 26 avril 2022 relatif aux délégations de missions par les médecins du travail, aux infirmiers en santé au travail et à la télésanté au travail*)

Law no. 2022-1616 of 23 December 2022 (<https://www.legifrance.gouv.fr/jorf/id/JORFTEXT000046791754>)

Order of 21 April 2022a setting the list of vaccines that community pharmacists are authorized to administer according to 9° of Article L. 5125-1-1 A of the Public Health Code and the list of persons who may benefit (*Arrêté du 21 avril 2022 fixant la liste des vaccins que les pharmaciens d'officine sont autorisés à administrer en application du 9° de l'article L. 5125-1-1 A du code de la santé publique et la liste des personnes pouvant en bénéficier*)

Order of 21 April 2022b amending the Order of 1 March 2022, setting the list of vaccinations that midwives are authorized to prescribe and perform (*Arrêté du 21 avril 2022 modifiant l'arrêté du 1er mars 2022 fixant la liste des vaccinations que les sages-femmes sont autorisées à prescrire et à pratiquer*)

Order of 7 September 2022 defining the multi-year priorities for continuous learning activities for the years 2023 to 2025 (*Arrêté du 7 septembre 2022 définissant les orientations pluriannuelles prioritaires de développement professionnel continu pour les années 2023 à 2025*)

Public Health Code of 2022 (*Code de la santé publique de 2022*)

■ 2021

Bill no. 2021-292 of 17 March 2021 aimed at promoting the attractiveness of hospital medical careers (*Ordonnance no. 2021-292 du 17 mars 2021 visant à favoriser l'attractivité des carrières médicales hospitalières – Dossiers législatifs, 2021*)

Bill no. 2021-582 of 12 May 2021 relating to the labelling, governance and operation of local hospitals (*Ordonnance no. 2021-582 du 12 mai 2021 relative à la labellisation, à la gouvernance et au fonctionnement des hôpitaux de proximité*)

Bill no. 2021-583 of 12 May 2021 amending the system of authorizations for healthcare activities and heavy material equipment (*Ordonnance no. 2021-583 du 12 mai 2021 portant modification du régime des autorisations d'activités de soins et des équipements matériels lourds*)

Bill no. 2021-961 of 19 July 2021 periodic certification of certain healthcare professionals, (*Ordonnance no. 2021-961 du 19 juillet 2021 relative à la certification périodique de certains professionnels de santé*)

Code of Local Authorities of 23 August 2021 (*Code général des collectivités territoriales, le 23 août, 2021*)

Code of Social Security of 23 December 2021, Article L162-14-1 (*Code de la sécurité sociale le 23 décembre 2021: Article L162-14-1*)

Decree no. 2021-216 of 25 February 2021 regarding the funding reform of emergency departments (*Décret no. 2021-216 du 25 février 2021 relatif à la réforme du financement des*

- structures des urgences et des structures mobiles d'urgence et de réanimation et portant diverses dispositions relatives aux établissements de santé)*
- Decree no. 2021-685 of 28 May 2021 relating to the corresponding pharmacist (*Décret no. 2021-685 du 28 mai 2021 relatif au pharmacien correspondant*)
- Decree no. 2021-1014 of 30 July 2021 regarding the extension of the trial of an “e-health insurance card” (*Décret no. 2021-1014 du 30 juillet 2021 prorogeant et étendant l'expérimentation d'une «e-carte d'assurance maladie», 2021*)
- Decree no. 2021-1085 of 13 August 2021 relating to the State diploma of physiotherapist masseur conferring the master's degree (*Décret no. 2021-1085 du 13 août 2021 relatif au diplôme d'Etat de masseur kinésithérapeute conférant le grade de master*)
- Decree no. 2021-1255 of 29 September 2021 relating to the financing reform for psychiatry (*Décret no. 2021-1255 du 29 septembre 2021 relatif à la réforme du financement des activités de psychiatrie*)
- Decision of 13 September 2021 fixing the pluriannual national objectives for the number of healthcare professionals to be trained between 2021 and 2025 (*Arrêté du 13 septembre 2021 définissant les objectifs nationaux pluriannuels de professionnels de santé à former pour la période 2021-2025*)
- Law no. 2021-502 of 26 April 2021 aiming to improve the health system through trust and simplification: Chapter II, Articles 6 to 16 (*Loi no. 2021-502 du 26 avril 2021 visant à améliorer le système de santé par la confiance et la simplification: Chapitre II, Articles 6 à 16*)
- Law no. 2021-1018 of 2 August 2021 to strengthen occupational health prevention (*Loi no. 2021-1018 du 2 août 2021 pour renforcer la prévention en santé au travail*)
- Law no. 2021-1040 of 5 August 2021 relating to the management of the health crisis (*Loi no. 2021-1040 du 5 août 2021 relative à la gestion de la crise sanitaire*)
- Law no. 2021-1754 of 23 December 2021 financing of the Social Security for 2022 (*Loi no. 2021-1754 du 23 décembre 2021 de financement de la sécurité sociale pour 2022*)
- Law of 2 August 2021 regarding bioethics (*LOI no. 2021-1017 du 2 août 2021 relative à la bioéthique*)
- Order of 6 April 2021 relating to the financing methods mentioned in article L. 162-22-8-2 of the Code of Social Security for hospital emergency and ambulance services (*Arrêté du 6 avril 2021 relatif aux modalités de financement mentionnées à l'article L. 162-22-8-2 du code de la sécurité sociale des structures des urgences et des structures mobiles d'urgence et de réanimation*)
- Order of 10 June 2021 relating to training leading to the State diploma of nursing assistant and provisions relating to the operating procedures of paramedical training institutes, 2021 (*Arrêté du 10 juin 2021 relatif à la formation conduisant au diplôme d'Etat d'aide-soignant et portant diverses dispositions relatives aux modalités de fonctionnement des instituts de formation paramédicaux*)
- Order of 7 July 2021 amending the order of 1 June 2021 on general measures necessary for managing and ending the health crisis (*Arrêté du 7 juillet 2021 modifiant l'arrêté du 1er juin 2021 prescrivant les mesures générales nécessaires à la gestion de la sortie de crise sanitaire*)
- Ordinance no. 2021-582 of 12 May 2021 regarding local hospitals (*Ordonnance no. 2021-582 du 12 mai 2021 relative à la labellisation, à la gouvernance et au fonctionnement des hôpitaux de proximité*)
- Ordinance no. 2021-961 of 19 July 2021 regarding the recurring certification of health professionals (*Ordonnance no. 2021-961 du 19 juillet 2021 relative à la certification périodique de certains professionnels de santé*)
- Public Health Code of 2021 (*Code de la santé publique de 2021*)

Public Health Code of 10 November 2021, Article L1434-10 (*Code de la santé publique, le 10 novembre 2021: Article L1434-10*)

2020

Code of Social Security on 14 December 2020, Articles L862-1 to L862-8 (*Code de la sécurité sociale le 14 décembre 2020: Articles L862-1 à L862-8*)

Law no. 2020-105 of 10 February 2020 relating to the fight against waste and to the circular economy (*Loi no. 2020-105 du 10 février 2020 relative à la lutte contre le gaspillage et à l'économie circulaire*)

Public Health Code of 11 March 2020, Articles L1111-1 to L1111-12 (*Code de la santé publique, le 11 mars 2021: Articles L1111-1 à L1111-12*)

Public Health Code of 22 December 2020: Article R4127-53 (*Code de la santé publique, le 22 décembre, 2020: Article R4127-53*)

2019

Social welfare and family code on 28 December 2019, Article L251-1 (*Code de l'action sociale et des familles, le 28 décembre, 2019: Article L251-1*)

Decree no. 2019-1107 of 30 October 2019 amending Decree no. 87-31 of 20 January 1987 relating to the National Council of Universities for the medical, odontological and pharmaceutical disciplines (*Décret no. 2019-1107 du 30 octobre 2019 modifiant le décret no. 87-31 du 20 janvier 1987 relatif au Conseil national des universités pour les disciplines médicales, odontologiques et pharmaceutiques*)

Decree no. 2019-1126 of 4 November 2019 relating to access to the first cycle of medical, pharmaceutical, dentistry and midwifery school (*Décret no. 2019-1126 du 4 novembre 2019 relatif à l'accès au premier cycle des formations de médecine, de pharmacie, d'odontologie et de maïeutique*)

Law no. 2019-774 of 24 July 2019 relating to the organization and transformation of the health system (*Loi no. 2019-774 du 24 juillet 2019 relative à l'organisation et à la transformation du système de santé*)

2018

Code of Education on 18 July 2018, Chapter VI, Articles D636-1 to D636-81 (*Code de l'éducation, le 18 juillet 2018: Chapitre VI, Articles D636-1 à D636-81*)

Code of Social Security on 22 December 2018, Article L380-2 (*Code de la sécurité sociale le 22 décembre 2018: Article L162-14-1*)

Law no. 2018-166 of 8 March 2018 relating to the admission and success of students (*Loi no. 2018-166 du 8 mars 2018 relative à l'orientation et à la réussite des étudiants*)

Decree no. 2018-174 of 9 March 2018 relating to the implementation of the reform of social protection for self-employed workers proposed in Article 15 of the Social Security Financing Act for 2018 (*Décret no. 2018-174 du 9 mars 2018 relatif à la mise en œuvre de la réforme de la protection sociale des travailleurs indépendants prévue par l'article 15 de la loi de financement de la sécurité sociale pour 2018*)

Decree no. 2018-472 of 12 June 2018 creating the health service for all health students (*Décret no. 2018-472 du 12 juin 2018 relatif au service sanitaire des étudiants en santé*)

Public Health Code of 20 July 2018, Chapter I, Articles R4301-1 to D4301-8 (*Code de la santé publique, le 20 juillet 2018: Chapitre Ier, Articles R4301-1 à D4301-8*)

Public Health Code of 8 August 2018, First part, Book IV, Article L1434-2 (*Code de la Santé Publique, le 6 août 2018: Première partie, Livre IV, Article L1434-2*)

2017

Law no. 2017-1836 of 30 December 2017 financing of the Social Security for 2018 (*Loi no. 2017-1836 du 30 décembre 2017 de financement de la sécurité sociale pour 2018: Article 51*)

Order of 6 November 2017 amending the Order of 24 June 2016 approving the retail sale prices of tobacco manufactured in France, excluding the overseas departments (*Arrêté du 6 novembre 2017 modifiant l'arrêté du 24 juin 2016 portant homologation des prix de vente au détail des tabacs manufacturés en France, à l'exclusion des départements d'outre-mer*)

2016

Decree no. 2016-524 of 27 April 2016 regarding local hospital groups (*Décret no. 2016-524 du 27 avril 2016 relatif aux groupements hospitaliers de territoire*)

Decree no. 2016-919 of 4 July 2016 regarding territorial support platforms (*Décret no. 2016-919 du 4 juillet 2016 relatif aux fonctions d'appui aux professionnels pour la coordination des parcours de santé complexes*)

Decree no. 2016-1554 of 18 November 2016 relating to informal carer leave (*Décret no. 2016-1554 du 18 novembre 2016 relatif au congé de proche aidant*)

Decree no. 2016-1990 of 30 December 2016 relating to the conditions for providing physical activity prescribed by a referring physician to patients with a chronic condition (*Décret no. 2016-1990 du 30 décembre 2016 relatif aux conditions de dispensation de l'activité physique adaptée prescrite par le médecin traitant à des patients atteints d'une affection de longue durée*)

Instruction no. DGOS/R5/2016/392 of 2 December 2016 regarding primary care teams and health territorial professional communities (*Instruction no. DGOS/R5/2016/392 du 2 décembre 2016 relative aux équipes de soins primaires (ESP) et aux communautés professionnelles territoriales de santé (CPTS)*)

Law no. 2016-41 of 26 January 2016 for the modernization of the healthcare system (*LOI no. 2016-41 du 26 janvier 2016 de modernisation de notre système de santé*)

Law no. 2016-1827 of 23 December 2016 financing of the Social Security for 2017: Article 70 (*Loi no. 2016-1827 du 23 décembre 2016 de financement de la sécurité sociale pour 2017: Article 70*)

Order of 10 October 2016 establishing the list of vaccinations that midwives are authorized to administer (*Arrêté du 10 octobre 2016 fixant la liste des vaccinations que les sages-femmes sont autorisées à pratiquer*)

Order of 20 October 2016 approving the national agreement structuring the relations between self-employed physicians and the statutory health insurance, signed on 25 August 2016: Article 38 (*Arrêté du 20 octobre 2016 portant approbation de la convention nationale organisant les rapports entre les médecins libéraux et l'assurance maladie signée le 25 août 2016: Article 38*)

Public Health Code of 1 May 2016, Article L1413-1 (*Code de la Santé Publique, le 1 mai 2016: Article L1413-1*)

2016 Health Reform Law (Law no. 2016-41 of 26 January 2016)

■ 2015

Law no. 2015-1776 of 28 December 2015 relating to the adaptation of society to ageing (*Loi no. 2015-1776 du 28 décembre 2015 relative à l'adaptation de la société au vieillissement*)

■ 2013

Order of 3 December 2013 relating to the operating conditions of the public webpage mentioned in article R. 1453-4 of the Public Health Code (*Arrêté du 3 décembre 2013 relatif aux conditions de fonctionnement du site internet public unique mentionné à l'article R. 1453-4 du code de la santé publique*)

■ 2012

Decree no. 2012-597 of 27 April 2012 relating to the National agency for medical and health products safety (*Décret no. 2012-597 du 27 avril 2012 relatif à l'Agence nationale de sécurité du médicament et des produits de santé*)

■ 2011

Law of 29 December 2011 relating to the reinforcement of health and medical products' safety (*Loi du 29 décembre 2011 relative au renforcement de la sécurité sanitaire du médicament et des produits de santé*)

■ 2010

Public Health Code of 26 February 2010, Sixth part, Book I, Article L6122-1 (*Code de la Santé Publique, le 26 février 2010: Sixième partie, Livre Ier, Article L6122-1*)

Public Health Code of 1 April 2010, Articles R6123-1 to R6123-12 (*Code de la santé publique, le 1 avril, 2010: Articles R6123-1 à R6123-12*)

■ 2007

Decree no. 2007-241 of 22 February 2007 relating to the intervention of home hospitalization in residential nursing homes, amending the Public Health Code (regulatory provisions) and the Social Security Code (second part: Decrees in Council of State) (*Décret no. 2007-241 du 22 février 2007 relatif à l'intervention des structures d'hospitalisation à domicile dans les établissements d'hébergement pour personnes âgées et modifiant le code de la santé publique (dispositions réglementaires) et le code de la sécurité sociale (deuxième partie: Décrets en Conseil d'Etat)*)

Order of 27 February 2007 establishing the conditions for health-related information that must appear on advertising or promotional messages for certain foods and drinks (*Arrêté du 27 février 2007 fixant les conditions relatives aux informations à caractère sanitaire devant accompagner les messages publicitaires ou promotionnels en faveur de certains aliments et boissons*)

Order of 29 March 2007 setting the minimum annual activity thresholds applicable to cancer treatment activities (*Arrêté du 29 mars 2007 fixant les seuils d'activité minimale annuelle applicables à l'activité de soins de traitement du cancer*)

■ 2005

Law no. 2005-370 of 22 April 2005 relating to the rights of patients and end of life (*LOI no. 2005-370 du 22 avril 2005 relative aux droits des malades et à la fin de vie*)

■ 2002

Law no. 2002-303 of 4 March 2002 relating to patients' rights and the quality of the healthcare system (1) (*Loi no. 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé (1)*)

■ 1999

Law no. 99-641 of 27 July 1999 creating universal health coverage (*Loi no. 99-641 du 27 juillet 1999 portant création d'une couverture maladie universelle*)

■ 1988

Order of 4 May 1988 establishing the list of diplomas for complementary specialized studies in medicine (*Arrêté du 4 mai 1988 fixant la liste des diplômes d'études spécialisées complémentaires de médecine*)

■ 9.3 Useful websites

Ministry of Health

<http://www.sante.gouv.fr/>

French National Authority for Health

http://www.has-sante.fr/jcms/r_1455134/fr/about-has

High Council of Public Health

<https://www.hcsp.fr/Explore.cgi/Accueil>

Institute for research and information in health economics

<https://www.irdes.fr/english/home.html>

Institute for research in public health

<https://iresp.net/en/presentation-english/>

National Agency for Public Health

<https://www.santepubliquefrance.fr/>

■ 9.4 HiT methodology and production process

HiTs are produced by country experts in collaboration with the Observatory's research directors and staff. They are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources and examples needed to compile reviews. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. The latest version of the template (2019) is available on the Observatory website at <https://eurohealthobservatory.who.int/publications/i/health-systems-in-transition-template-for-authors>.

Authors draw on multiple data sources for the compilation of HiTs, ranging from national statistics, national and regional policy documents to published literature. Furthermore, international data sources may be incorporated, such as those of the OECD and the World Bank. The OECD Health Data contain over 1200 indicators for the 34 OECD countries. Data are drawn from information collected by national statistical bureaux and health ministries. The World Bank provides World Development Indicators, which also rely on official sources.

In addition to the information and data provided by the country experts, the Observatory supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the European Health for All database. The Health for All database contains more than 600 indicators defined by the WHO Regional Office for Europe for the purpose of monitoring Health in All Policies in Europe. It is updated for distribution twice a year from various sources, relying largely upon official figures provided by governments, as well as health statistics collected by the technical units of

the WHO Regional Office for Europe. The standard Health for All data have been officially approved by national governments.

HiT authors are encouraged to discuss the data in the text in detail, including the standard figures prepared by the Observatory staff, especially if there are concerns about discrepancies between the data available from different sources.

A typical HiT consists of nine chapters.

1. Introduction: outlines the broader context of the health system, including geography and sociodemography, economic and political context, and population health.
2. Organization and governance: provides an overview of how the health system in the country is organized, governed, planned and regulated, as well as the historical background of the system; outlines the main actors and their decision-making powers; and describes the level of patient empowerment in the areas of information, choice, rights, complaints procedures, public participation and cross-border healthcare.
3. Financing: provides information on the level of expenditure and the distribution of health spending across different service areas, sources of revenue, how resources are pooled and allocated, who is covered, what benefits are covered, the extent of user charges and other out-of-pocket payments, voluntary health insurance and how providers are paid.
4. Physical and human resources: deals with the planning and distribution of capital stock and investments, infrastructure and medical equipment; the context in which IT systems operate; and human resource input into the health system, including information on workforce trends, professional mobility, training and career paths.
5. Provision of services: concentrates on the organization and delivery of services and patient flows, addressing public health, primary care, secondary and tertiary care, day care, emergency care, pharmaceutical care, rehabilitation, long-term care, services for informal carers, palliative care, mental health care, dental care, complementary and alternative medicine, and health services for specific populations.
6. Principal health reforms: reviews reforms, policies and organizational changes; and provides an overview of future developments.

7. Assessment of the health system: provides an assessment based on the stated objectives of the health system; financial protection and equity in financing; user experience and equity of access to healthcare; health outcomes, health service outcomes and quality of care; health system efficiency; and transparency and accountability.
8. Conclusions: identifies key findings, highlights the lessons learned from health system changes; and summarizes remaining challenges and future prospects.
9. Appendices: includes references, useful websites and legislation.

The quality of HiTs is of real importance since they inform policy-making and meta-analysis. HiTs are the subject of wide consultation throughout the writing and editing process, which involves multiple iterations. They are then subject to the following.

- A rigorous review process (see the following section).
- There are further efforts to ensure quality while the report is finalized that focus on copy-editing and proofreading.
- HiTs are disseminated (hard copies, electronic publication, translations and launches).

The editor supports the authors throughout the production process and in close consultation with the authors ensures that all stages of the process are taken forward as effectively as possible.

One of the authors is also a member of the Observatory staff team and they are responsible for supporting the other authors throughout the writing and production process. They consult closely with one another to ensure that all stages of the process are as effective as possible and that HiTs meet the series standard and can support both national decision-making and comparisons across countries.

■ 9.5 About the authors

Zeynep Or is a research director at the Institute for Research and Information in Health Economics (IRDES) and affiliated professor of economics at University Paris Dauphine-PSL. She specializes in comparative policy

analysis and health economics. Her research interests include health system performance assessment, analysis of efficiency, public policy evaluation and international health policy.

Coralie Gandré (PharmD, PhD) is a senior research fellow at the Institute for Research and Information in Health Economics (IRDES) and a public health practitioner in the Robert Debré university hospital (*Assistance Publique-Hôpitaux de Paris*, AP-HP). Her work focuses on health services and policy research, with a special interest in mental health and health equity.

Anna-Veera Seppänen is a research fellow at the Institute for Research and Information in Health Economics (IRDES). She has a PhD in Epidemiology and a Master's Degree in European Public Health. Her research focuses on fairness of healthcare systems and international comparisons, including equitable care for vulnerable populations, environmental sustainability of healthcare systems and health service use and organization.

Cristina Hernández-Quevedo is Research Fellow at the European Observatory on Health Systems and Policies, based at the London School of Economics and Political Science. Cristina works on a range of projects on health systems' monitoring, international healthcare comparisons and performance assessment at European level. She has published numerous articles and book chapters on these topics.

Erin Webb has been a member of the Observatory's Berlin hub since January 2019 and is based at the Technical University of Berlin's Department of Health Care Management. Erin supports a variety of Observatory projects, including the State of Health in the EU programme, the COVID-19 Health System Response Monitor, and rapid responses. She serves as a Health Systems and Policy Monitor editor for Estonia and Hungary.

Morgane Michel (MD, PhD) is an associate professor in public health at Université Paris Cité, Inserm, Assistance Publique-Hôpitaux de Paris, and a member of the ECEVE research team at Inserm. Her work focuses on health services research and health economics, with a special interest in health inequalities and hospital funding.

Karine Chevreul is a medical doctor and Professor in Public Health at the Université Paris Cité, Inserm, Assistance Publique-Hôpitaux de Paris. She specializes in health policy and health economics. She has been a technical adviser to ministers of health and of social security. She is the head of an Inserm (National Institute of Health and Medical Research) and University Paris-Cité research team, ECEVE, and of the health services research domain in the health economics and health services research unit at AP-HP. She was involved in the production of the four HiTs published on France, the first as an editor and the next three as an author.

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(1999, 2002^{a,g})

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(2004)

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(2001^g, 2006, 2013)

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(2002, 2006)

Austria

(2001^e, 2006^g, 2013^g, 2018)

Azerbaijan

(2004^g, 2010^g)

Belarus

(2008^g, 2013)

Belgium

(2000, 2007, 2010, 2020)

Bosnia and Herzegovina

(2002^g)

Bulgaria

(1999, 2003^b, 2007^g, 2012, 2018)

Canada

(2005, 2013^c, 2020)

Croatia

(1999, 2006, 2014, 2022)

Cyprus

(2004, 2012)

Czechia

(2000, 2005^g, 2009, 2015, 2023)

Denmark

(2001, 2007^g, 2012)

Estonia

(2000, 2004^{g,i}, 2008, 2013, 2018)

Finland

(2002, 2008, 2019)

France

(2004^{c,g}, 2010, 2015)

Georgia

(2002^{d,g}, 2009, 2017)

Germany

(2000^g, 2004^{g,g}, 2014^g, 2020)

Greece

(2010, 2017)

Hungary

(1999, 2004, 2011)

Iceland

(2003, 2014)

Ireland

(2009)

Israel

(2003, 2009, 2015)

Italy

(2001, 2009, 2014, 2022)

Japan

(2009)

Kazakhstan

(1999^g, 2007^g, 2012)

Kyrgyzstan

(2000^g, 2005^g, 2011^g, 2022)

Latvia

(2001, 2008, 2012, 2019)

Lithuania

(2000, 2013)

Luxembourg

(1999, 2015)

Malta

(1999, 2014, 2017)

Mexico

(2020)

Mongolia

(2007)

Netherlands

(2004^g, 2010, 2016)

New Zealand

(2001*)

North Macedonia

(2000, 2006, 2017)

Norway

(2000, 2006, 2013, 2020)

Poland

(1999, 2005^k, 2011, 2019)

Portugal

(1999, 2004, 2007, 2011, 2017)

Republic of Korea

(2009*)

Republic of Moldova

(2002^g, 2008^g, 2012)

Romania

(2000^f, 2008, 2016)

Russian Federation

(2003^g, 2011^g)

Serbia

(2019)

Slovakia

(2000, 2004, 2011, 2016)

Slovenia

(2002, 2009, 2016, 2021)

Spain

(2000^h, 2006, 2010, 2018)

Sweden

(2001, 2005, 2012)

Switzerland

(2000, 2015)

Tajikistan

(2000, 2010^g, 2016)

Türkiye

(2002^{g,i}, 2011ⁱ)

Turkmenistan

(2000)

Ukraine

(2004^g, 2010^g, 2015)

United Kingdom of Great Britain and Northern Ireland

(1999^g, 2015, 2022)

United Kingdom (England)

(2011)

United Kingdom (Northern Ireland)

(2012)

United Kingdom (Scotland)

(2012)

United Kingdom (Wales)

(2012)

United States of America

(2013, 2020)

Uzbekistan

(2001^g, 2007^g, 2014^g)

Veneto Region, Italy

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Print ISSN 1817-6119, ISBN 978 92 890 5949 7 Web ISSN 1817-6127, ISBN 978 92 890 5944 2

