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Can France keep its patients happy?

France's health system gets high satisfaction ratings but is becoming harder to fund. **Laurent Degos and colleagues** examine the challenges of keeping citizens content and improving cost effectiveness

Less than a year ago, when Nicolas Sarkozy was running for president, health was not a priority. Indeed *Le Monde*, a leading French newspaper, carried the headline: "Health, the missing item in Nicolas Sarkozy's reforms."¹ The reason for this omission may have been that the French health system is largely well perceived by citizens and users. However, the recent debate over the introduction of further non-reimbursable charges of €0.50 (£0.37; \$0.75) for each drug packet and paramedical services such as physiotherapy, which came into effect at the beginning of this year, suggests that this satisfaction could become eroded.² This article outlines the structure of France's health system, analyses patients' perceptions of it, and comments on the challenges it faces, not least with containing the high costs.

Overview of French health system

The French health system (box 1) is financed mainly by employers and employees through social contributions. It is characterised by ease of access to care, which could partly explain the high costs. General practitioners are self employed and get paid through a fee-for-service system. The number of healthcare professionals is fixed nationally by controlling admission to medical schools. This *numerus clausus* policy has been used to limit primary care expenditure and, as a result, a temporary shortage of doctors is expected in the next few years. Competition in areas with high numbers of general practitioners can sometimes compel doctors to give way to patients' demands to the detriment of overall provision of health care.

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Box 1 French health system³

- Total health expenditure: 11.14% of gross domestic product in 2005
- Financing in 2003:
 Public funds (national social insurance + health allocated taxes): 78%
 Complementary voluntary health insurance: 14%
 Out of pocket payment: 8%
- Regional planning:
 26 regional agencies (*Agences Régionale d'Hospitalisation*)
 Single data collection system (PMSI) used to report medical activity in public and private healthcare organisations
- Healthcare provision in 2005:
 3.4 doctors/1000 inhabitants (48.9% general practitioners, 51.1% specialists)
 7.8 nurses/1000 inhabitants
 1.1 pharmacists/1000 inhabitants
 22 700 pharmacies
 9.4 hospital beds/1000 inhabitants (2003 data)
 71% public hospitals
 11% private, not for profit hospitals
 18% private, for profit hospitals

French citizens' satisfaction

According to a survey carried out in 2004, 65% of French citizens feel very positive about their health system and only 6% consider it a serious concern (table 1).⁴⁻⁵ This fairly high satisfaction rate confirms the conclusions of the World Health Organization's 2000 report, which ranked France first among 191 countries on quality of health care.⁶ WHO studied five criteria: level and distribution of health outcomes, level and distribution of responsiveness, and fairness of financing. Although the

Countries across Europe have common health challenges but many different ways of tackling them. This article is the first in an occasional series that looks at what we can learn from each other.

Table 1 | Patient perception of health system in five European countries^{4,5,8}

	France	UK	Germany	Spain	Italy
Highly satisfied with health system ⁴	65	32	28	42	21
Consider the system a concern ⁵	6	24	20	4	5
Consider medical errors important ⁸	75	85	72	61	97

report had methodological flaws,⁷ its conclusions, which reflected French public opinion, hit the French headlines for several weeks.

How good is health care in France?

Health outcomes are not always better in France than in other European countries (table 2). Life expectancy is high (83.8 years for women, 76.8 for men in 2005),¹⁰ but the gap between men and women is greater than elsewhere (seven years), largely because of preventable causes such as smoking, drinking, road crashes, suicide, or AIDS.^{10–11} Cardiovascular mortality is much lower in France than in other European countries, partly because obesity is among the lowest in the European Union.¹²

However, in French eyes, better health care does not necessarily mean better outcomes. It tends to mean ease of access to standard care and to innovative products. Once a new medicinal product has been granted a marketing authorisation, the transparency committee of the National Authority for Health (*Haute Autorité de Santé*) assesses it within 90 days of application to determine the benefit provided relative to other treatments and eligibility for reimbursement. The price of the product is then set by the health products pricing committee (CEPS), also within 90 days. New medicines (mostly prescription only drugs) are prescribed to patients by 160 000 doctors and delivered by 22 700 pharmacies and 3000 healthcare organisations (box 1).

Access to innovative products may be even faster because these can be made available once their potential, and not actual, benefit has been assessed. The provisional approval scheme (*Autorisation Temporaire d'Utilisation*) provides access to medicinal products still under development when it has been shown that there is a genuine medical need for the product and when there is clear evidence for a clinical or public health benefit. This was used, for instance, for bevacizumab, an inhibitor of angiogenesis. In addition, the temporary treatment protocol (*Protocole Temporaire de Traitement*) provides access to approved drugs in as yet unapproved indications. For instance, French patients were able to get trastuzumab for the adjuvant treatment of breast cancer in October 2005, although the European marketing authorisation was not granted until May 2006.

Access to emergency care is also good. Emergency departments in public and private hospitals deal with all requests for medical help and are open around the clock. Mobile emergency care units (specially equipped ambulances or helicopters which are linked to hospitals and staffed by intensive care doctors and nurses) are readily available and are increasingly used to regulate admission

to intensive care units (box 2). In areas where permanent access to care is more difficult, general practitioners are usually on call throughout the night. As doctors are self employed, productivity is not an issue. However, remote areas are finding it increasingly difficult to recruit young doctors as the older generation retires.

Safer care?

Patient safety is fairly high on the European political agenda and also a cause for concern in France. Serious adverse events seem to be as common in France as in other European countries. In 2004, 120 000 to 205 000 hospital admissions (nearly 4% of all admissions) were due to preventable adverse events, and 120 000–190 000 adverse events occurring during a hospital stay were preventable.⁸ Overall, 75% of French citizens consider medical errors to be an important concern.¹⁴ However, France has fewer compensation claims concerning safety than elsewhere.

The French no-fault compensation scheme (*Office National d'Indemnisation des Accidents Médicaux*) set up in 2002 spent €36m of its €45m provisional budget in 2006. The number of claims is stable (about 2700 a year), and only 532 claimants have received compensation since 2002.¹⁵ Patients' concerns relating to hospital acquired infections were met in 2005 by the creation of a specific department (*Information et développement de la médiation sur les infections nosocomiales*) within the National Authority for Health. The department informs the public on preventive measures taken by public authorities and acts as an ombudsman for patients' complaints. In 2006, it received 4950 calls but only 215 concerned compensation claims.

The crises over blood contaminated with HIV, contaminated growth hormone extracts, and Creutzfeldt-Jakob disease led to hot debate on the precautionary principle.¹⁶ Whether this principle was actually used to defend decision makers or to protect patients seems rather immaterial; the crises do not seem to have dented public trust in the health system. This may be because an accusatory finger was pointed at certain politicians and senior civil servants.

Since then decision makers have improved healthcare organisation in order to avoid further mistakes. They created national safety agencies for health products, foods, public health surveillance, and health care to improve the scientific background for decision making and promote prompt, consistent decisions.^{17–19} Other improvements included developing an alert system,

Box 2 Emergency medical assistance (SAMU) in France¹³

100 call centres (SAMU) and 350 hospital mobile intensive care units (SMUR) in France receive 10 million calls a year

Telephone coordination—Patients dial 15 to contact the call centre. A doctor trained in emergency care deals with the call (providing information and advice, calling SMUR, an ambulance, referring the patient to a general practitioner, etc) and prepares the patient's admission to a suitable hospital if necessary

Coordinated resources—Local firefighters, private ambulance staff, general practitioners, and SMUR staff provide on-site emergency medical assistance

Intervention by hospital doctors—For example, in acute myocardial infarction, stroke, domestic injuries, or road traffic incidents

Responsibility—Hospitals are responsible for the call centres and SMUR

decentralising health administration, encouraging patient empowerment (such as the 2002 law relating to patients' rights), and instituting national surveillance of hospital acquired infections. The surveillance scheme (*comité de lutte contre les infections nosocomiales*), set up in 1989 and organised at national level in 1993-4, together with national campaigns on hand hygiene have led to a decrease in methicillin-resistant *Staphylococcus aureus* rates from 33% in 2001 to 27% in 2005 (table 3).²⁰

However, the French culture of apportioning blame in order to preserve public trust does not encourage pragmatic approaches such as learning from mistakes. French health professionals fear criticism. In a recent case in which a patient had surgery on the wrong leg, uncharacteristically a leading surgeon publicly declared himself wholly accountable for the error. Such accountability should not absolve the local patient safety committee from tackling the organisational issues needed to reduce risks and avoid recurrence of errors.

How to guarantee sustainability and fairness

Until recently, few doctors or patients in France were concerned with balancing the healthcare budget. Some doctors even consider that cost effectiveness is contrary to the precepts of the Hippocratic oath (to keep the good of the patient as the highest priority). Patients have high expectations in terms of access. Only 9.8% of visits end without a prescription in France compared to 27.7% in Germany, 16.9% in Spain, and 56.8% in the Netherlands.²¹ Drug consumption by volume in France is the highest in the world; 1.2 million people over 70 years of age take more than seven drugs a day. This explains the high rates of adverse events and antibiotic resistance despite campaigns to rationalise antibiotic prescriptions.^{8 17 22} It might also explain why France has the highest total health expenditure in the European Union, even after the decision was taken in 2006 to stop reimbursement for 262 drugs with insufficient benefit.²¹⁻²³ The social debt was €75.6bn in December 2006 (about €1250 per head).²⁴

100 call centres (SAMU) and 350 hospital mobile intensive care units receive 10 million calls a year

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Table 2 | Health outcomes in five European countries. Data are for 2003 unless stated otherwise^{9 12}

	France	UK	Germany	Spain	Italy
Life expectancy (years)⁹					
Women	83	80.5	81.4	82.8	82.5
Men	75.9	76.1	75.7	76.3	76.8
Cardiovascular disease (standardised death rate per 100 000 people, all ages)*¹²					
Women	128.3	194.1	236.5	159.2	179.3
Men	219.1	313.9	348.7	236.9	274
Obesity (BMI>30) in people aged 65-74 (% population)¹²					
Women	15	28.3	33.1	23.9	15.8
Men	19.4	26.4	22.5	22	14.1
Smokers (% population)¹²					
Women	21.2	25.7	27.9	24.7	17.6
Men	31.6	27.7	37.3	37.6	31.9
Suicide and self harm (standardised death rate per 100 000 people, all ages)*¹²					
Women	8.4	3	5.7	3.1	2.6
Men	25.6	10.7	18.2	11	9.8

BMI=body mass index. *2002 data.

Doctors have the freedom to practise wherever they wish. This has led to a higher concentration of doctors in urban than rural areas, and the gap may widen as the number of newly qualified doctors continues to fall.

The fee-for-service system does not encourage prevention, health education, and collective approaches to primary care, and general practitioners have not received any financial incentives for time consuming activities such as managing chronic disease, health education, and psychotherapy. This system is also associated with more hospital admissions, tests, and imaging studies than other systems and seems to be less efficient than combined modes of payment.^{25 26}

The French health system is beginning to introduce other methods of payment. General practitioners now receive a fixed sum for coordinating management of chronic disease. Nevertheless, large changes in work organisation, education, and training are needed before general practitioners become more public health conscious. Teamwork and shared care needs to be encouraged and medical school curriculums need to include subjects such as health economics, cost effectiveness analysis, and root cause analysis. The recent mandatory continuing professional development scheme focuses on continuous quality improvement, and the voluntary appraisal of professional practice helps health professionals to learn from errors.

Enhancing quality and efficiency in the system

Until recently, access to specialists in independent practice was not regulated in France. It was often possible to obtain an appointment with your chosen specialist within a few days. The few exceptions tended to be limited to specialties such as ophthalmology. Access is facilitated by the fee-for-service system. The copayment is usually small as 92% of French citizens have complementary insurance.²⁷

Reforms introduced in 2004 have tried to regulate access to specialist care. Each French citizen now has to choose a "gatekeeper general practitioner" (*médecin traitant*) who will refer them to a specialist, if necessary. Patients may, however, change their *médecin traitant* as often as they wish. The few exceptions to the gatekeeper

system are paediatrics (children under 16 years old), psychiatry for adolescents and young adults (16-25 years), gynaecology, and ophthalmology. Patients may also choose to sidestep the reform by making an extra out of pocket payment. The reimbursement rate for the doctor's fee then falls from 70% to 60%. Overall, the French National Health Insurance considers that the reform has been a success since 78% of French citizens have already chosen a *médecin traitant*.²⁸

The second pillar of the 2004 reform was to create the National Authority for Health, which has the remit to enhance quality throughout the French health system. It is an independent authority which reports directly to the French parliament. It provides public authorities with guidance on which type of care and which public health strategies should be reimbursed by national health insurance. It also carries out other activities aimed at improving health care, including assessing health technologies, producing good practice and public health guidelines, and implementing quality improvement initiatives (accreditation of healthcare organisations, continuing professional development, certification of health information software, and guidelines for managing chronic disease).

The scientific credibility of the authority is key to ensuring the acceptance and involvement of stakeholders. French doctors are willing to be persuaded but will not be coerced, as their past resistance to the now buried mandatory guidelines showed. However, concern is growing about the sustainability of the French health insurance system. A new law adding economic evaluation and cost effectiveness analysis to the National Authority for Health's remit was passed in December 2007. The scientific credibility and independence of the authority's medical assessments will need to be well guarded in order not to lose the trust of patients and healthcare professionals. Only when medical benefit has been assessed can economic, professional, and social dimensions be addressed if needed.

Future challenges

France's experience suggests that ease of access to medical care and to new technologies is key to patient satisfaction. However, freedom of access could also partly explain the high expenditure on health care and could jeopardise the sustainability of the health system. Greater transparency on issues such as how the health system is financed and on the funding of the social debt should improve the acceptability of reforms, provided that the grounds for these measures are not purely financial. However, reaction to the new non-reimbursable fees for drugs and care shows the potential difficulties.

SUMMARY POINTS

Most French citizens are satisfied with their health system

French citizens have easy access to care and freedom of choice

Despite higher expenditure, health outcomes in France are similar to those of other European countries

Quality improvement and efficiency are key to ensuring the sustainability and fairness of the system

Changes will need to be backed by good evidence to keep patients and doctors happy

Independent bodies such as the National Authority for Health can use their scientific authority to enhance quality through changing stakeholder behaviour and thus reconcile individual needs and collective concerns.

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Table 3 | Hospital *Staphylococcus aureus* infections in five European countries (2001-5)²⁰

Year	% of infections that are antibiotic resistant				
	France	UK	Germany	Spain	Italy
2001	33	44	16	23	41
2002	33	44	18	23	38
2003	29	43	18	24	39
2004	29	44	20	26	40
2005	27	44	21	27	37