

2013 Emory Global Health Case Competition

“Le cœur et l'âme du système de santé en France”

(Translation: The Heart and Soul of France's Health System)

The Emory Global Health Institute Case Writing Team



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All characters, organizations, and plots described within the case are *fictional* and bear no direct reflection on existing organizations or individuals. The case topic and descriptions of circumstances in France, however, are accurate representations of what is available in the literature.

The case scenario is complex and does not necessarily have a correct or perfect solution, and thus encourages a judicious balance of creative yet perceptive approaches.

The authors have provided informative facts and figures within the case and exhibits to help the teams. The data provided are derived from independent sources, may have been adapted for use in this case, and are clearly cited such that teams can verify or contest the findings within their recommendations, if it is pertinent to do so. Teams are responsible for justifying the accuracy and validity of all data and calculations that are used in their presentations, as well as defending their assertions in front of a panel of knowledgeable judges representing different stakeholders.

Introduction

François Dubois was considered a leading health affairs strategist among the leaders of the recently defeated center-right Union for a Popular Movement (UMP) party. In the 2012 elections, France's citizens had voiced their dislike for the UMP and President Sarkozy's austerity measures to address the country's economic woes. He stood over the golf ball on his new office practice putting mat and smiled about the email he had just received from Jean-François Copé, the UMP's new leader. Copé had just invited him to design the party's platform for health as they looked forward to 2017 elections. Dubois' moment had arrived.

Notwithstanding his excitement, Dubois knew that France's current economic challenges were not insubstantial: leading forecasters and credit agencies had recently downgraded their outlook for France based on increasing government debt, poor GDP growth, and high unemployment rates. There was widespread fear among the population that France is heading towards economic challenges similar to those that Spain and Greece have recently encountered.

With healthcare costs escalating, Dubois knew that the party's health reform platform would need to be specific and describe the UMP's plan for how it would organize and finance the healthcare system. The plan would have to demonstrate that it is sustainable, could address the expected growth in healthcare costs, and of course, align with the French population's values of equity. On this last point, Dubois was concerned that the UMP had distanced itself from France's minority groups and shouldered much of the responsibility for the health disparities observed between France's regions and population subgroups. He also worried that the divisions were potentially fracturing France's cohesive social structure.

Copé had requested a meeting in a week. Dubois would have to think through these conflicting, yet politically important points of view. His goal was simple – he would have to demonstrate to Copé that the UMP would have a robust health manifesto that would appeal to the entire electorate. He sat down to phone his aides. Each of the aides had unique abilities and perspectives of how to approach this, and they would be working late nights this coming week to build the best manifesto possible...

France At a Glance [1]:

- Demography:
 - Population size: 65,630,692; 85% urban; 5.9% are non-nationals; 11.2% are foreign-born, 70% of which were born in non-EU countries [2]
 - Religions: Catholic 83-88%, Protestant 2%, Jewish 1%, Muslim 5-10%, unaffiliated 4%
 - Age Structure: 0-14 years: 18.7%, 15-64 years: 63.8%, ≥65 years: 17.5%
- Geography: 547,030 square kilometers (211,209 square miles); slightly less than the size of Texas. The largest country in Western Europe and European Union; 33.46% arable land
- Economy:
 - Gross domestic product (GDP): \$2.734 trillion
 - GDP (Purchasing power parity [PPP]): \$2.214 trillion
 - GDP per capita (PPP): \$35,100
 - Sector contributions to GDP: agriculture: 1.8%, industry: 18.7%, services: 79.5%
- Governance structure: Republic
 - President elected by popular vote for a five-year term (eligible for second term); last election April-May 2012 with next election expected in spring 2017;

- 2012 Elections: François Hollande (Socialist Party) defeated incumbent Nicolas Sarkozy (Union for a Popular Movement)

France has the fifth largest GDP in the world, and the second largest in Europe behind Germany.[3] France is an advanced industrialized country with the service sector accounting for almost 80% of GDP. France also has a strong tourism industry and is cited as the most visited country in the world.[1]

Historically, French society has placed high value on equality, secularism, and universal human rights.[4] The French have long cherished the concept of *laïcité* (separation of church and state), which has largely been interpreted as freedom to observe religious or other beliefs of one's choosing, free from hostility. However, over the past decade, religious symbolism (e.g., the right to wear a veil [burqa])[5] became a matter of public policy and the controversial nature of this topic has led to heated debates about national identity and solidarity. These social policy concerns overlap with France's changing demographics. There are concerns, for example, that successive waves of migration from North and West Africa since World War II have led to problems of integration and overburdening of France's social systems. Observers have noted that immigrants have had difficulties in assimilating, have experienced social stigmatization, poor living conditions, low educational attainment, increasingly restrictive immigration policies, and increasing risk of deportation in recent years.[5-8] Deportation was at its highest in Sarkozy's last year. Also, more than 40% of non-nationals have a low rate of educational attainment, and the proportion of foreigners at risk of poverty exceeds the national proportion by a 27% margin.[9] France is ranked second in the EU (behind Greece) in terms of foreign-born persons experiencing poverty and social exclusion.[9]

The Intersection of Economy and Politics:

Like much of Europe, France's rebound from the global recession of 2008 has been slow, with lower-than-expected economic growth (0.1%) in 2012.[10] GDP growth between 2000 and 2010 has varied from -3.15 to 3.68%.[3] Meanwhile, unemployment in the country remains high – 9.2% of the labor force are unable to find work, and the absolute number of people unemployed hit a 14-year high (3.1 million jobseekers) in 2012.[1, 11] Public debt has reached \$5.6 trillion (approximately 86.1 % of GDP)[1] – much higher than the EU average of 60% of GDP.[12] François Hollande believes France can fix its public debt problem without drastic changes in terms of public sector spending. However, Hollande has received significant pushback from conservative politicians who believe structural changes are needed to reduce public debt and increase France's global competitiveness.

The economic forecasts for France remain grim. In late 2011, the International Monetary Fund (IMF) cut growth forecasts for France from 0.3 to 0.1% for 2012 and from 0.8 to 0.4% for 2013.[10] Moody's, a leading credit rating agency, downgraded France's credit rating to AA1 in November 2012,[13] citing stagnant economic growth due to structural challenges such as lack of competitiveness, high unemployment, public debt, market rigidity, and a lack of confidence that President Hollande's government will be able to fix the problems of France's growing debt).[13]

With slow growth and high unemployment, the French public is unsettled and demanding more promises to fix the economy. President Hollande's popularity is waning – his approval rating is now 40%, down from 60% just six months ago.[14] Fearful of economic contraction observed in other European countries ([Exhibit 1](#)), economists and private sector businessmen have been demanding deep structural reforms, which have also been urged by the IMF. Though all parties want to increase growth and reduce unemployment, the proposed reforms tend to reflect the underlying political ideologies of the proposing individuals, agencies, and parties. For example, French industrialist Louis Gallois has

recommended slashing \$38.54 billion in payroll taxes, loosening labor laws, decreasing the amount of income contributed to social security collections, and increasing revenue using a Value Added Tax (VAT)¹ that taxes all consumers through their purchases.[15] This perspective supports private investments and increasing France's global competitiveness as the routes to economic growth.

President Hollande, meanwhile, believes that a singular focus on competitiveness ignores the plight and long-term security for lower and middle socioeconomic classes. On November 13th 2012, the president promised to cut the government's own deficit from 4.5% (2012) to 3% (2013) of economic output,[16] promising that his government would do more with less, and that planned increases in VAT rates could be reduced. The IMF applauded this pledge as a sign of improved credibility.[16] The government also cancelled previously-enacted tax cuts for highest earners (\geq €1.3 million [US\$1.7 million]), restoring a 75% tax rate for this group.[17] As a result, Standard & Poor's has maintained France's AA+ rating despite Moody's rating downgrade, citing the government's commitment to budget and structural reforms.[18]

Healthcare in the Midst of Europe's Economic Woes

Historically, European nations have favored governmental involvement in meeting social needs that might otherwise be the domain of private providers. For example, Western European nations generally have single-payer, publicly-funded health care systems that provide services for all residents. There is also more government oversight on working hours, wages, housing, and other social concerns. Recent economic woes in Europe have been a major obstacle for governments to maintain their involvement in social services. In particular, high national debt and slow economic growth have affected countries' abilities to maintain their provision of health benefits.

Spain's example has been one that has sent shivers down the spines of France's economists and leaders. Spain's universal healthcare system, touted as one of the best in Europe just five years ago, has become sidled with debt so large that it has, in turn, become a driver of the country's downward economic spiral.[19] Spain's decentralized, regionally managed health system earned the country one of the highest life expectancies on the continent in 2007 (82.2 years for women and 77.8 years for men), with a lower incidence of cardiovascular disease, cancers, and respiratory disease than its European neighbors.[20] Spain's health system is funded primarily through tax collections, and although healthcare spending in Spain has mirrored global trends (e.g., it was 8.5% of GDP in 2007), the drop in national revenues collected due to recession and high unemployment has exacerbated the challenges of financing healthcare. In 2011, drug companies and medical equipment suppliers were owed approximately €12 billion (US\$15.7 billion) by the Spanish government with average delays in payment exceeding 600 days in some regions of the country.[19] Spain's credit rating was downgraded from Aa1 to Aa2 in 2011 due to ballooning national debt.[21] Expansive overhaul of the healthcare system has been proposed including cost-controlling measures, tax increases, and/or user fees. As 2013 began, Spain's leaders were considering privatization of public health clinics and charging fees for prescription medicines, intended to discourage spending on costly drugs by healthcare providers. This has caused a public and uncharacteristic political split among Spain's leaders.[22]

Spain's experiences provide a grim outlook for France if economic growth continues to sputter, and puts the political spotlight on the healthcare system, which accounts for a large proportion of

¹ The Value Added Tax (VAT) is a consumption tax that applies to all local or regional commercial activities involving production and distribution. It does not apply to services or goods produced for export.

government spending in France. France's social security system² deficit reached an all time high in 2010 (€28 billion [US\$ 37.5 billion]). In 2012, cumulative debt for the social sector was €147 billion (US\$ 196 billion) and is projected to increase by €60 billion (US\$ 80.3 billion) by the end of the decade.[23, 24]

France's Health System

France's Social Security System was created in 1930 and since then, provision of health services have evolved into a government-funded universal health coverage program ([Exhibit 2](#)). Health equity is a major pillar on which the current health system is structured. The following sections provide detailed descriptions of the health system's financing, organization, and governance structure.

Healthcare Expenditures

In 2007, total health expenditures in France amounted to €208 billion (US\$ 272.3 billion), 11 % of GDP. The proportion of public expenditures allocated to different health system needs are shown in [Exhibit 3](#).^[25] An estimated 74% of all healthcare expenditures in France are paid for via Statutory Health Insurance (SHI); 13% are covered via Voluntary Health Insurance (VHI); out-of-pocket payments account for 7%; and the government directly pays for 5%.

SHI is composed of three schemes that covered approximately 99.9% of France's population in 2008. Employees account for 87% of beneficiaries, while 2.3% are individuals whose taxable income is less than €9,020 (US\$12,086) per year (Couverture maladie universelle or CMU plan),³ 6% are agricultural workers, and 5% are self-employed.^[25] For foreigners without residence cards, SHI's state medical help (Aide Médicale d'état; AME) covers access to consultations, hospital stays, and prescriptions for tests, etc. Prisoners and their families are covered by SHI for the duration of their incarceration.

SHI coverage levels vary from region to region. On average, SHI covers 80% of inpatient care costs, 70% of ambulatory care costs, 70% of dental care, 60% of medical auxiliaries (e.g., paramedical services like occupational therapy, physiotherapy, etc.), 60% of laboratory costs, and 15–100% (average 73%) for pharmaceuticals. The rest of health-related expenses are covered by either VHI or out-of-pocket payments.^[25] The only exemption for co-insurance or out-of-pocket payments is in the case of suffering from a long-lasting affliction or chronic illnesses (affections de longue-durée; ALD). In this case, SHI provides 100% coverage for 30 chronic conditions including diabetes, chronic liver disease and cirrhosis, Parkinson's disease, coronary heart disease, Alzheimer's, long-term psychiatric conditions, and disabling stroke.^[25] As a rule of thumb, patients receiving outpatient (aka ambulatory) care pay for services and get reimbursed after, while in the case of hospitalizations, occupational accidents, and CMU beneficiaries, payments are made directly from the insurance fund to the provider.

Most primary care is provided by private fee-for-service doctors and, in some cases, ambulatory hospital services. There are established tariff rates for the cost of services. In 2004, the preferred physician pathway was put into place to reduce demand and control moral hazard.⁴ This pathway ensures that all patients see a primary care physician before seeking care from a specialist. If patients skip this step, SHI coverage drops from 70% to 30% for ambulatory care.

² France's social security system consists of 2 sections: the so-called General Regime, which encompasses health-care and social services, and the Elderly Solidarity Fund, providing services and aid to the elderly.

³ CMU is the branch of SHI covering those with an income below the taxation threshold

⁴ The concern that people will, perhaps unnecessarily, use more healthcare resources with increased availability, because there is no consequence to overuse.

VHI refers to all forms of private or government insurance acquired to cover health expenditures not covered by SHI (approximately 20%). Almost 88% of the population has some form of VHI and 7% is covered by CMU.[25] This complementary insurance is usually used to cover some co-payments as well as increase coverage for services or areas not covered by SHI (e.g., private hospitalizations or non-essential drugs). In 2002 and 2004, the government instituted significant health reforms related to VHI. The government offered tax exemptions to insurers offering VHI coverage that did not require health questionnaires and did not exclude people with pre-existing conditions. Similarly, after creation of the preferred physician pathway, the government offered tax breaks to any VHI provider that restricts co-pay coverage to patients that respect the pathway. Furthermore, the new laws rewarded patients who respect the pathway by offering almost full coverage for all health services involved in that visit.[25]

Financing

SHI is financed through tax collections, though the sources of tax revenues have changed over the years ([Exhibit 4](#)). In 1990, employer and employee contributions accounted for 95% of SHI's resources. However, since 2000, the General Social Contribution (Contribution Sociale Généralisée [CSG], an 8% income tax on all individuals, except those enrolled in CMU) has accounted for over a third of SHI's revenues. Additional revenues come from "sin-taxes"⁵ and taxes on pharmaceutical company revenues (1%). Currently, employers pay 13% of gross earnings and employees contribute 0.85% of their earned income. In addition, companies with more than €760,000 (US\$ 995,000) in revenue contribute 0.03% of their total profits.[25] Financial flows within the French health system are depicted in [Exhibit 5](#).

CMU is financed through a tax on VHI contract premiums. Funding for long-term care, the elderly, and the disabled is supplemented by a dedicated fund created in 2004 – the National Solidarity Fund for Autonomy (CNSA) – paid for by SHI, plus additional revenues to cover this come from a "solidarity and autonomy contribution day," an unpaid work day.⁶

In 2004, co-payments were introduced and range from €1 to 8 (US\$ 1.31 to 10.47) per consultation and can be as high as €50 (US\$ 65) for laboratory and diagnostic tests. These co-payments amount to approximately €805 million (US\$ 1.05 billion) in collections every year and are used to finance palliative and long-term care. VHI can only cover these co-payments if they are part of the preferred physician pathway. In 2006, an additional co-payment (€18 [US\$25]) was introduced for care or procedures above the €91 statutory tariff.⁷ VHI can cover these payments.[25]

Organization and Governance

The organizational structure of France's health system is depicted in [Exhibit 6](#). Various stakeholders involved in governance and their roles are described briefly below:

Parliament: Responsible for the development of the yearly national ceiling for health insurance expenditures (objectif national des dépenses assurance maladie: ONDAM); approves contribution rates for employers and employees and CSG.

Alert Committee: Created in 2004, its role is to inform parliament if national healthcare expenditures have overshot the budget approved by parliament.

⁵ Sin taxes refer to taxes on alcohol or cigarettes

⁶ During the "solidarity and autonomy contribution day," all workers in France forego a day's pay that employers pay to SHI to fund long-term care and services for the elderly. An estimated €2 billion a year are retrieved

⁷ The statutory tariff is the price established by the Ministry of Health for different procedures and types of care

Ministry of Health: responsible for allocating budget expenditures across different health service providers (hospitals, outpatient care, mental health care, social and health provisions for the disabled); setting prices for specific medical procedures and drugs; defining priority areas for national programs (cancer, rare diseases, health and environment, unhealthy behaviors and addiction, people suffering from chronic illnesses, etc.); and determining the number of medical school entrants annually.

Statutory Health Insurance: Responsible for negotiating with health care provider unions (the level of fees, authorization of extra-billing, and referral patterns) as well as pharmaceutical company unions and hospital unions. SHI is comprised of the National Union of Health Insurance Funds (Union Nationale des caisses d'assurance maladie [UNCAM]) and their regional counterparts (Union Régionale des caisses d'assurance maladie [URCAM]).

Regional Health Agency: A regional authority which oversees all health services in the region and sets priorities plus budget allocations for the region. The Hospital, Patient, Health, and Territories law (Loi Hôpital, patients, Santé, Territoires; HPST) of 2009 was responsible for this arrangement.

France's Health Indicators

Overall, the health of the French population is considered “globally good.”[25] Health Department statistics have showed continually increasing life expectancy at birth (currently, 84.8 years for females and 78.1 years for males in 2010) and the highest life expectancy at age 65 in all of Europe.[26] Mortality prior to the age of 65, however, is also among the highest in Europe, accounting for about 20% of annual mortality. An estimated 70% of these premature deaths are in men, and the most common causes are cancer, violent death, or pulmonary diseases.[26] Infant mortality was 3.7 infant deaths per 1,000 live births in 2010.[25] Over 95% of children are vaccinated for diphtheria, tetanus, polio, and whooping cough, though vaccine rates for rubella, measles, mumps, and hepatitis B are below 95%.[26]

There are marked disparities in health indicators, between men and women, between different socioeconomic groups, and between territories in France.[26] Data show that “at equal age and gender, the existence and importance of health problems are above all linked to social position and level of education” (tr. French).[26] This starts from a young age, with children of laborers or those in rural areas experiencing higher levels of obesity and oral diseases, while the difference in life expectancy between a 35 year old male manager and a 35 year old male laborer is approximately seven years.[26] These data are inconsistent with France's ethos of equity.

In the 1990's, the “French Paradox”⁸ drew much global attention. In the past decade, however, France's cardiovascular disease and cancer rates have increased, weakening the validity of this notion. An estimated 30% of deaths in 2010 were due to cancer, 66% of the French population over the age of 50 had hypertension or diabetes, and 13-15% of those over the age of 18 were obese.[26] Health indicators are expected to continue to worsen with ageing and increased obesity in France's population.

Future Challenges

Despite its highly-ranked health system and indicators, there are major concerns regarding the sustainability of the health system in its present form. Despite the expenditure ceilings since 1996 and the Alert Committee set up in 2004, health expenditures have exceeded the ceiling almost every year

⁸ French Paradox – the phenomenon by which French people consumed foods with high fat content and smoked, but still had lower rates of cancers and cardiovascular diseases than other similarly developed countries

(Exhibit 7).[25] The Ministry of Health considered and/or attempted cost-containment strategies which appear to have been unsuccessful as deficit reduction deadlines continue to be extended.[21]

The continued growth in chronic diseases in France will make it increasingly more difficult to provide high quality care with 100% coverage for chronic care costs.[27] Furthermore, demographic changes such as ageing of the population and migration are leading to diversity of health needs and increasing health disparities.[28] In particular, health care consumption increases as the population ages. In addition to the costs required to meet current obligations, it is projected that an additional €250-450 million (US\$ 327 to 589 million) will be needed each year for the next 20 years to finance the expected health needs of the elderly.[25] Meanwhile, retirement funds and social contributions will decrease. This will lead to an imbalance between revenues collected and demands on the system.[29] Similarly, the French government's AME program covers 100% of health care costs for immigrants. Immigrants tend to have different health needs and present to health care providers later in the natural history of their conditions, leading to more severe illnesses and costly care.[8, 30, 31]

Dubois also recognized geographical disparities in health and service provision. For example, Alsace and Moselle were known to have higher contribution rates and consequently, better medical coverage, while other areas were considered medical deserts.⁹ These disparities represent one of the most important health equity challenges to date.[25]

Over time, a shortage of primary care physicians has also emerged in France due to a large number of retiring doctors that have not found successors to take over their practices. This has led to the importation of medical doctors from other countries, especially from francophone Africa.¹⁰ Young graduating doctors' choice of location of practice also perpetuates the regional discrepancies in the provision of health services with 'popular' locations enjoying high volume and better medical graduates than less popular locations.

Summary

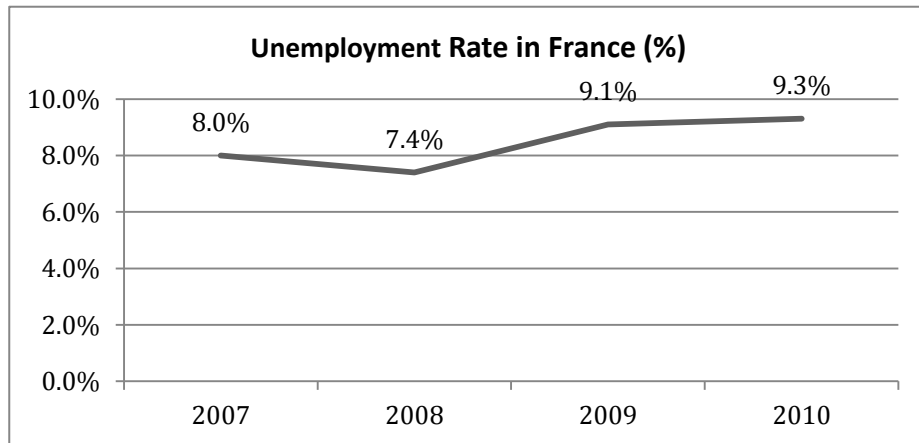
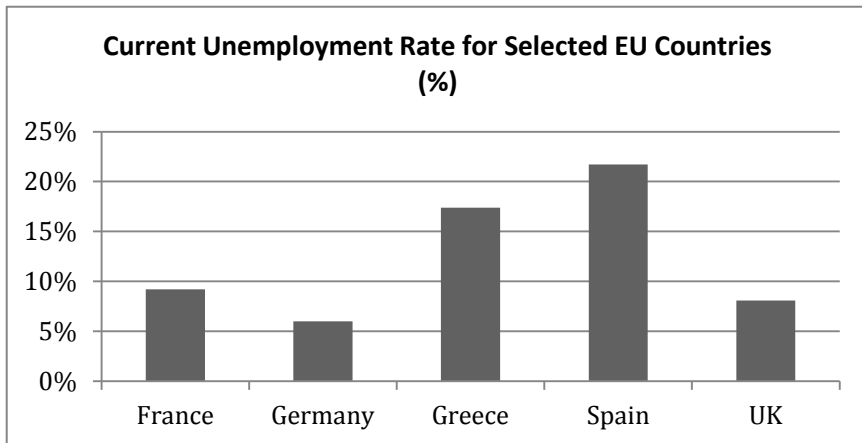
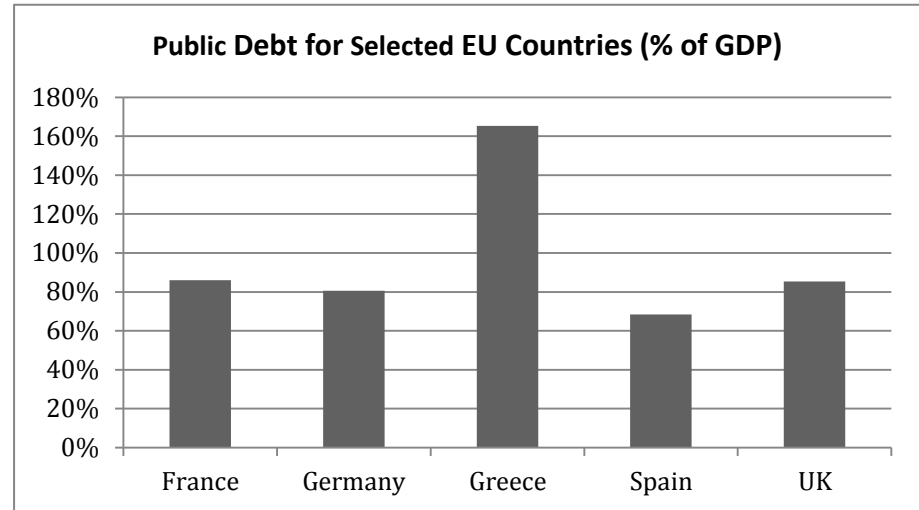
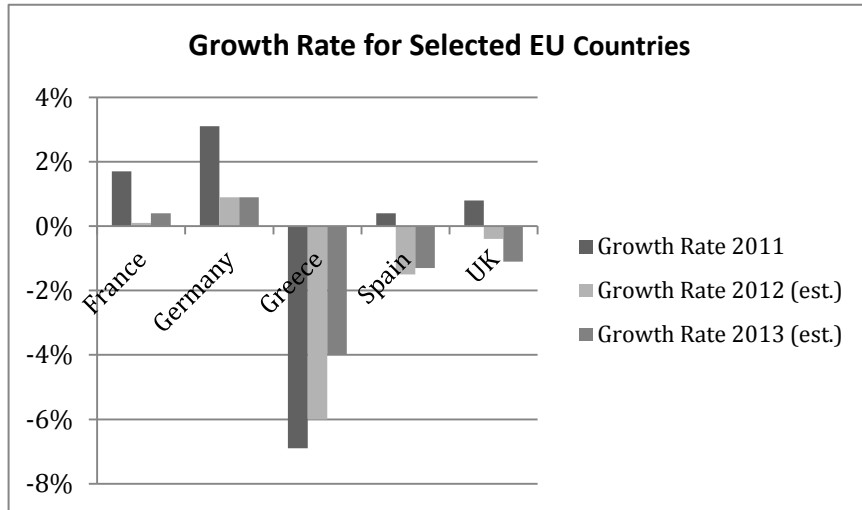
Late on Monday night, having read through the report on France's current economic, healthcare, and social challenges, Dubois felt exhausted just thinking about the complexities. Healthcare has long been considered a public good in France, but the current imbalances were unsustainable and could potentially perpetuate a collapse of France's economy, much like Spain's. Dubois knew that his platform would have to align with the UMP's conservative values, but also appeal to the electorate at large (at least, more than the Socialist Party's competing agenda). The parties were essentially competing on their interpretation of France's national identity in the 21st century.

Dubois thought about the current and anticipated health needs of France's population. He thought about cost reductions, regulations, disease prevention, system re-organization, and revenue generation. His aides would have to dig deep, provide a justifiable manifesto which provided specifics about the roles of *at least* some of these, and be able to defend their ideas in front of him. He had given them till Saturday morning and would listen to their presentations then. Dubois was an excellent chess player and eagerly sat down to think through the pitfalls of the presentations he would listen to. He intended on asking challenging questions and hoped that these well-trained young minds would rise to the challenge presented to them....

⁹ Areas of France where there is a shortage of health services

¹⁰ Countries in Africa where French is spoken widely

Exhibit 1. Growth, Unemployment, and Public Debt for Selected EU Countries



Data from CIA factbook; [1] Real Growth Rate for 2012, 2013 from World Economic Outlook (IMF) October 2012. [10]

Exhibit 2: History and Evolution of France's Health System

1930-1945: Health Insurance was offered by mutual benefit organizations¹¹ (MBO), which were mainly private. The Social Security Act was passed in 1930 and enforced compulsory protection paid for by employers for employees whose earnings fell below a certain level.

1945: Creation of Statutory Health Insurance (SHI), which is the branch of social security covering health (disease, maternity, incapacity and death). Due to reconstruction efforts at the end of WWII, insurance was initially given to reconstruction workers and their families. SHI was initially funded through taxes on employers and employees. MBOs were shifted from primary coverage to complementary coverage¹², and this complementary insurance was voluntary for patients and organizations. These organizations later became known as Voluntary Health Insurance (VHI).

1961-1974: Coverage extended to farmers, self-employed non-agricultural workers and other who did not fall into any of these categories. These individuals had to pay a contribution to be covered; the unemployed could request coverage through a local authority if they had insufficient means. The level of coverage for the unemployed was mainly a product of resources and policies of local councils, making it extremely heterogeneous across the country.

1996: Two reforms facilitated the Universal Health Coverage Act to be passed in 1999:

- a) The funding of SHI shifted from being primarily funded by contributions from employers and employees to an earmarked tax based on total income called the general social contribution (contribution sociale généralisée; CSG)
- b) Power for determining policy and expenditure targets were moved away from SHI and became part of Parliament's responsibilities.

2000: The Universal Health Coverage Act (Couverture maladie universelle; CMU Act) came into effect. It established universal health coverage on the basis of residence in France, rather than employment status, and the creation of one unique fund (CMU Fund) from which all health care would be financed. In addition to universal health coverage, to address health inequities for those not able to afford VHI, individuals with an income below a certain threshold were given free complementary health insurance coverage (CMU-C).

¹¹ A social organization that provides insurance to its members such as a group of miners that contribute to a fund to help miners and their families pay for healthcare. Before SHI, mutual benefit organizations were the sole providers of health insurance.

¹² By complementary coverage, we refer to coverage offered to individuals to cover expenses not covered by SHI

Exhibit 3. Public Expenditures for Health System Components, 1990 to 2007

	Percentage of total expenditure (million euros at 2000 GDP price)					
	1990	1995	2000	2005	2006	2007
Health administration and insurance	1.6 (1614)	8.2 (10 103)	8.2 (11 372)	7.1 (12 329)	7.0 (12 380)	6.9 (12 368)
Education and training	na	0.6 (722)	0.6 (817)	0.5 (922)	0.5 (940)	0.6 (1001)
Health research and development	na	1.8 (2232)	2.0 (2781)	3.5 (6042)	3.4 (6023)	3.4 (6046)
Investment in medical facilities at primary, secondary, tertiary, intermediate, social care levels	2.5 (2475)	2.4 (2999)	2.3 (3162)	2.8 (4858)	2.8 (4932)	2.9 (5233)
Public health and prevention	2.3 (2313)	2.9 (3631)	3.0 (4095)	2.1 (3605)	2.2 (3851)	1.9 (3478)
Medical devices and therapeutic appliances	3.2 (3215)	2.8 (3484)	3.0 (4126)	4.1 (7183)	4.2 (7352)	4.2 (7621)
Medicines	16.9 (16 703)	16.0 (19 814)	18.2 (25 218)	16.7 (9146)	16.4 (28 969)	16.3 (29 398)
Medical services						
<i>Hospital care</i>	45.7	42.4	40.2	42.4	42.3	42.5
Inpatient care	44.3 (43 897)	39.2 (48 422)	35.7 (49 437)	37.0 (64 419)	36.9 (65 278)	37.0 (66 595)
Day care	1.4 (1410)	3.2 (3999)	4.5 (6163)	5.4 (9376)	5.4 (9632)	5.5 (9919)
<i>Outpatient care</i>	33.5	30.4	30.0	29.4	29.7	29.7
Ambulatory physician services	23.7 (23 504)	21.6 (26 710)	21.4 (29 537)	17.4 (30 311)	17.5 (30 957)	17.5 (31 416)
Ambulatory dental services	5.7 (5609)	5.1 (6251)	4.8 (6668)	4.6 (7932)	4.6 (8075)	4.5 (8076)
Ancillary services	3.8 (3726)	3.3 (4058)	3.4 (4680)	5.0 (8776)	5.1 (9075)	5.0 (9032)
Long term nursing care at home	0.3 (268)	0.4 (433)	0.4 (504)	2.4 (4236)	2.5 (4504)	2.7 (4877)
Total expenditure on health	99 160	130 190	145 182	173 732	176 230	179 938

Sources: Eco-Santé 2009; OECD, 2009a.

Note: na: Not available.

Sourced from: World Health Organization report "France: Health System Review" 2010 [25]

Exhibit 4. Sources of Revenue for SHI's General Scheme in 1990, 2000, and 2007

Revenue	Percentage (billion euros)		
	1990	2000	2007
Employees contributions	32.2 (20.1)	3.4 (3.4)	2.9 (3.8)
Employers contributions ^a	63.1 (39.3)	51.1 (49.8)	46.6 (61.8)
Total contributions	95.2 (59.4)	54.5 (53.2)	49.5 (65.6)
General social contribution (CSG)	0.0	34.6 (33.8)	37.6 (49.8)
Specific taxes (for example, cars, tobacco)	1.6 (1.0)	3.3 (3.3)	3.4 (4.5)
Taxes on pharmaceutical companies	0.0	0.8 (0.7)	1.2 (1.6)
Total taxes	1.6 (1.0)	38.7 (37.8)	40.9 (54.2)
State compensation for the loss of contributions ^b	0.5 (0.3)	4.9 (4.8)	7.8 (10.3)
Adjustment between health insurance schemes	1.1 (0.7)	0.3 (0.3)	0.7 (0.9)
Other	1.5 (1.0)	1.6 (1.5)	1.1 (1.5)
Total revenue	100.0 (62.3)	100.0 (97.6)	100.0 (132.5)

Source: Commission des comptes de la sécurité sociale 2001, 2009.

Notes: ^aThis includes contributions paid by SHI on behalf of doctors; ^bthe state compensates SHI for the loss of contributions directly related to economic policy decisions; a recent example is the reduction of employers' contributions for employees working in support services at home.

Sourced from: World Health Organization report "France: Health System Review" 2010 [25]

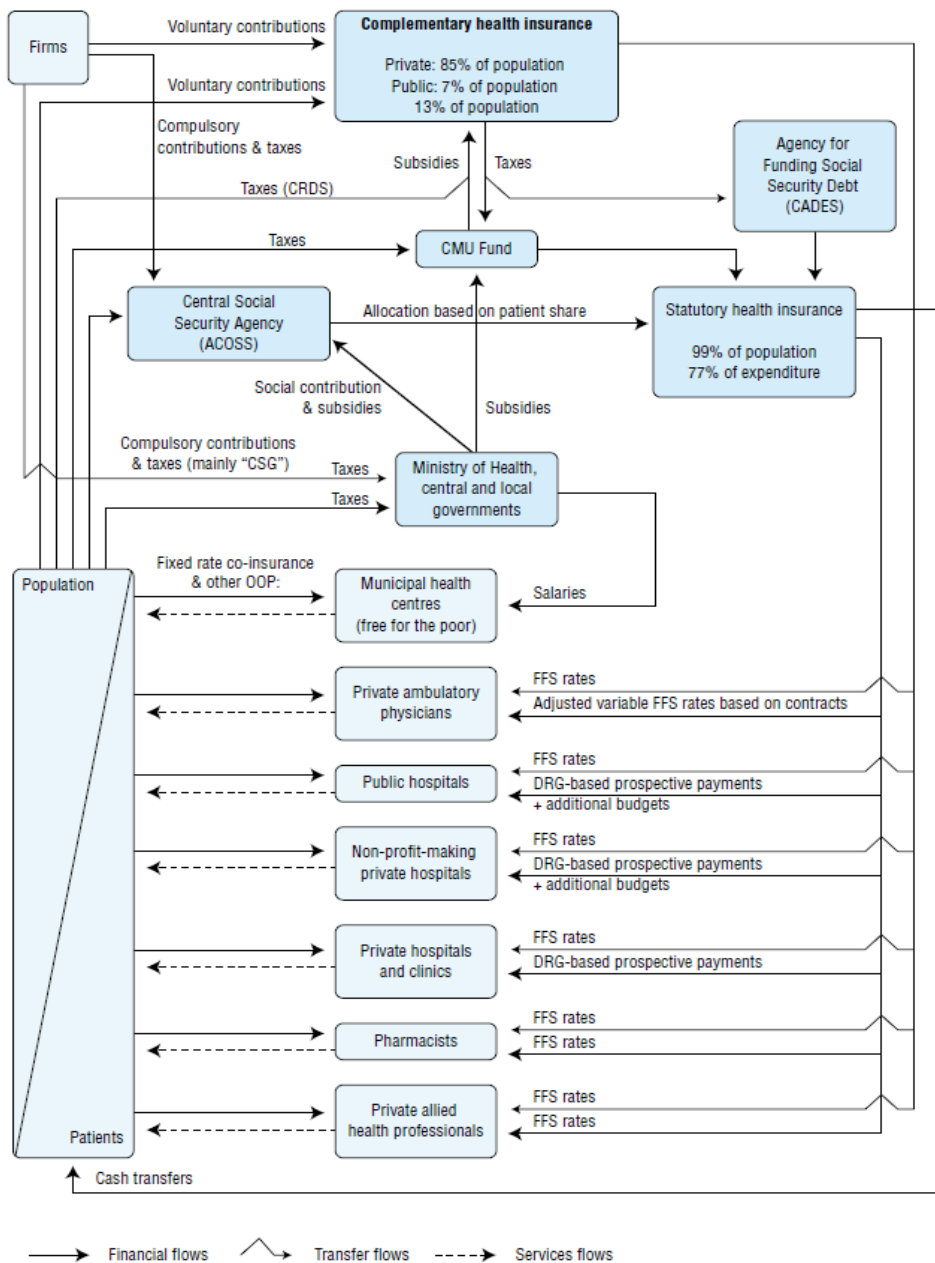


Exhibit 5. Financial Flows in France's Health System, 2008 (excluding long-term care and prevention)

The components of France's Healthcare System and their roles are described briefly below:

Central Social Security Agency (ACOSS): Main institution responsible for social security. SHI is a component of this agency focused on health care services. Main mechanisms of financing are through taxation and subsidies by the government.

Agency for Funding of Social Debt (CADES): a special fund created to manage social security debt. It is financed partially through taxes on VHI premiums and CRDS.

Contribution for the reimbursement of social debt (CRDS): A tax of 0.05% of revenue (earned income, benefits, capital, sale of assets, etc.) created to reimburse social security debt and prevent its transference to future generations

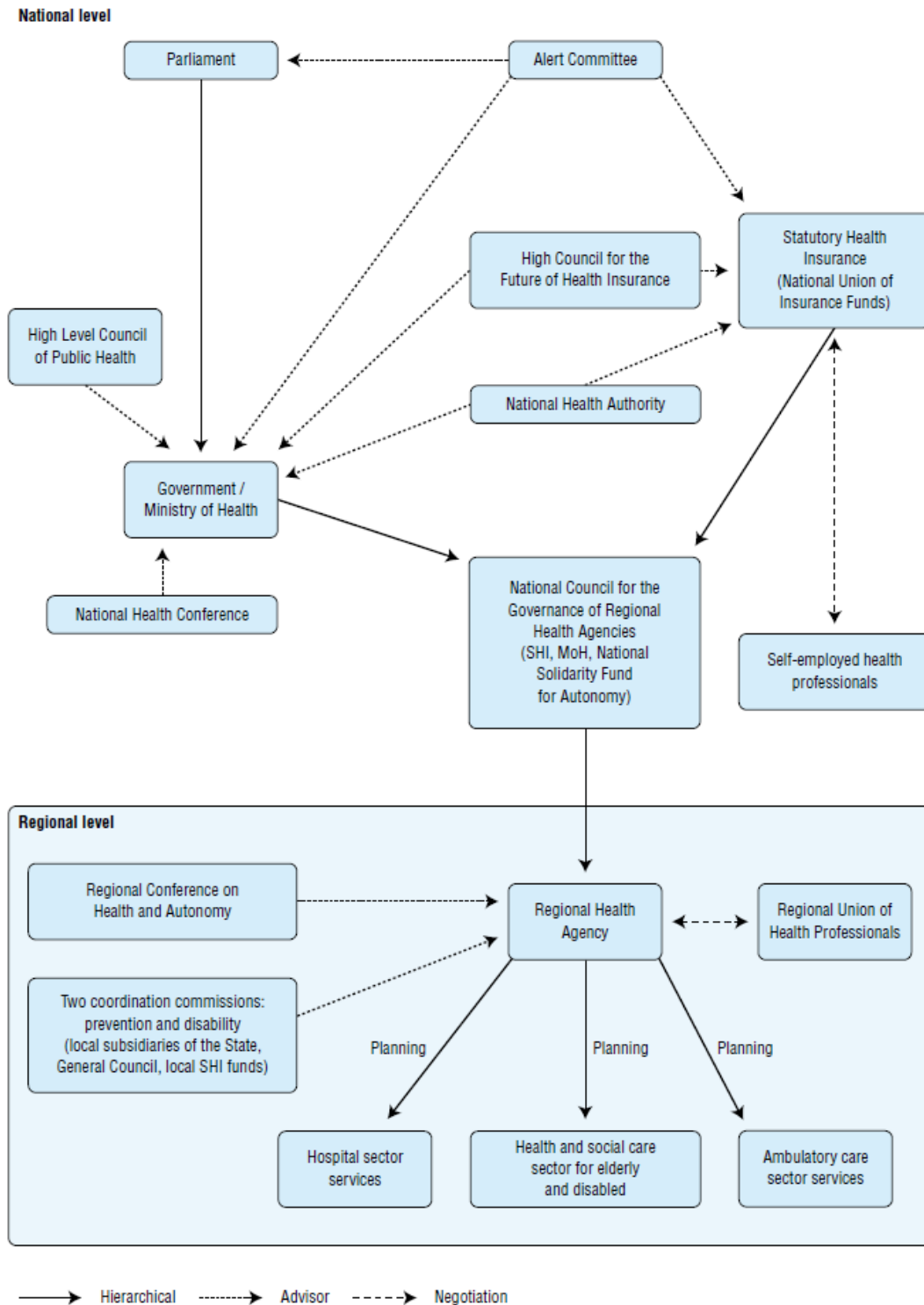
Statutory Health Insurance: Refers to traditional compulsory insurance (general, agricultural, self-employed and CMU schemes). Financed by the CMU fund ACOSS and CADES

Complementary Health Insurance: Refers to both VHI (private) and CMU-C (public). These are financed by premiums from the population and from firms offering coverage to their employees (mainly VHI). CMU-C if financed through tax premiums on VHI and by the CMU fund.

Sourced from: World Health Organization report "France: Health System Review" 2010 [25]

Source: OECD 2002 (data updated by IRDES in 2006 (Allonier et al. 2006) DREE in 2007 (Fenina et al. 2007) and URC Eco in 2008). Notes: FFS: Fee-for-service.

Exhibit 6. Organization of the Health System in France, 2010



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

Sourced from: World Health Organization report "France: Health System Review" 2010 [25]

Exhibit 7. Trends in National Ceiling for Health Insurance Expenditures and Actual Expenditures, 1997 to 2008

Variables	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
ONDAM (billion euros)	91.5	93.6	96.0	100.3	105.7	112.8	123.5	129.7	134.9	140.7	144.8	152.0
Actual expenditure (billion euros)	91.4	95.1	97.6	103.0	108.9	116.7	124.1	129.9	135.1	141.9	147.7 ^a	152.9 ^a
Actual expenditure ONDAM (billion euros)	0.1	-1.5	-1.6	-2.7	-3.2	-3.9	-0.6	-0.2	-0.2	-1.2	-2.9 ^a	-0.9 ^a
Growth rate for ONDAM (%)	1.7	2.4	1.0	2.9	2.6	3.6	5.3	4.5	3.9	2.3	2.1	2.8
Growth rate for actual expenditure (%)	1.5	4.0	2.6	5.6	5.7	7.2	5.8	4.7	4.8	3.1	4 ^a	3.4 ^a

Source: Eco-santé 2010.
Note:^a Provisional result.

Sourced from: World Health Organization report "France: Health System Review" 2010 [25]

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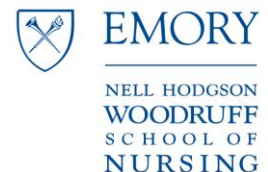
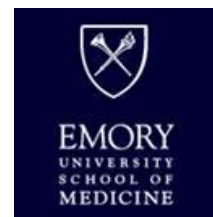
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