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The Governance of Prevention in France

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Background

France's average life expectancy of over 80 years¹ is due to the powerful combination of good health care and good public health policies.² The French health system is ranked among the top ten worldwide, according to the main international reports on health-care systems (WHO, OECD Health at a Glance 2017, Numbeo Health Care Index 2017, Bloomberg 2016, Euro Health Consumer Index 2016).^{3,4,5,6,7}

The universal right to health enshrined in Article 25 of the Human Rights Declaration, ratified by the United Nations in 1948, is recognised in the preamble to the French Constitution. According to this text, every person has the right to an adequate standard of living conditions ensuring the health and wellbeing of that individual and his/her family.

Since its origins, the French health system has been oriented towards curative rather than preventive medicine. The initial years saw the most important achievements on the issue of prevention and an intersection policies approach. The development of prevention policies within a system built on a curative focus has actually been recent, starting in 2002 and increasing in scale over the following years, with the definition of a framework for actions to support prevention, health promotion and therapeutic education.

In 2012, using a participative approach, the Ministry of Social Affairs and Health promoted a National Strategy for Health (*Stratégie nationale de Santé*) to design future health policies in France.⁸ This valuable process produced the most recent French Health Reform Law, the "*Loi de modernisation de notre système de santé*", approved in January 2016,⁹ which gives a central role to the development of innovation for prevention and the care of chronic diseases.

In respect of this regulatory framework, the key services associated with primary and secondary prevention, such as immunisation, perinatal care and national screening programmes, appear to be well organised in a mixed network of public and private services. The system provides universal coverage based on residence, through public health insurance and universal medical coverage.

Health System Organisation

The French healthcare system has been built using a Bismarckian model, with a central role for social insurance but also with a strong role for the State, inspired by principles of universality and solidarity, which have driven an inspiration towards a Beveridge style for the system.¹⁰ This organisation has defined a particular approach for the health system that is different from other Bismarckian systems. The French health system is based mainly

on SHI (Statutory Health Insurance, *Assurance maladie*), which currently covers the French resident population.

- The administration of health policy and regulation of the healthcare system is provided by:
- The State (the Parliament and the Government, specifically the Ministry of Health);
- SHI;
- ARS (*Agence Régionale de Santé*) – regional health agencies;
- Local communities (department and municipality).

The management and financing of the French health system is mainly divided between the State and the SHI entities. SHI forms part of the French social security system, developed in France after World War II and covering the resident population by means of different schemes depending on type of employment. Social security consists of compulsory protection, with four branches related to health, work-related illnesses and injuries, retirement and family.¹¹ SHI is the insurance covering health (disease, maternity, incapacity and death) funded by contributions from both employers and employees, with benefits provided in cash and in kind. Reimbursement for co-payments required by the public system as well as coverage for medical goods and services that are not adequately covered by SHI (e.g. eyeglasses and dental care) is provided by complementary (voluntary) health insurance. This finances approximately 14% of total health expenditure and covers over 95% of the population. These mixed, complex and comprehensive public and private security systems result in limited out-of-pocket (OOP) costs and high utilisation of medical care.

Prevention services in France

The design and planning of prevention services are integrated into the organisational structure of the French health system, but without proper organisation, specifically, of prevention services at local level: there are many actors involved in prevention policy at different levels (national, regional and local), creating a system that is difficult to coordinate and govern.

However, the organisational model of the French health system, with a central role played by the Ministry of Health, is reaffirmed in terms of the organisation of and responsibilities for the issue of prevention. The Ministry of Health, with the negotiation and consultation of several stakeholders, institutional bodies and agencies, defines the objectives for public health and assesses the associated programmes. It coordinates annual monitoring of the application of the law, plans and prevention programmes.

Because of the involvement of numerous actors and sources of funding, public health and prevention policy and practice in France have historically been difficult to describe. Until April 2016, health promotion and education programmes were organised on the basis of the Law on Patients' Rights (2002),¹² which implemented an initial prevention policy through the creation of a government agency, the National Institute for Prevention and Health Education (*Institut national de prévention et d'éducation pour la santé* – INPES), for the implementation of prevention and health promotion. This body has now merged with the *Agence Santé Publique France* (France Public Health Agency) following the recent health reforms.

These reforms focused on three main strategies:

- 1) reducing social and geographic health inequalities;
- 2) developing the prevention and care of chronic diseases;
- 3) improving efficiency and equity of financing by reducing out-of-pocket payments.

These issues are addressed in the general health plans defined at central (Ministry of Health) and regional (ARs – Health Regional Strategic Plan) level. Specific plans are also defined on particular issues, such as immunisation of the population and the national screening programme in accordance with the cancer plan (see Cancer Plan 2014-2019).¹³

The planning and monitoring of the principal primary and secondary prevention interventions is defined at central level by the Government. Immunisation and screening programmes are determined by the Ministry of Health and Social Affairs and the health authorities and implemented by agencies and institutions within the Ministry and the regional and local authorities, at departmental and municipal level. The delivery of the services is mixed public and private, and financed over 75% by SHI and by public resources from taxes.

One point of weakness in the prevention system designed is associated with a lack of coordination because of the different and numerous levels of responsibilities involved.

Prevention activities are managed by a fragmented group of actors, including in fields associated with the main causes of avoidable mortality in the French population, such as alcohol and drug abuse.^{14,15}

Delivery of Healthcare Services

At local level, the ARs represent the health and social affairs administration as part of a clear geographical structure, at regional and departmental level, mainly focused on the care of elderly and disabled people.

These entities have the task of ensuring that healthcare provision meets the needs of the population, by establishing the connection between outpatient and hospital sectors, health and social care services, within the expenditure ceiling defined nationally. The regional authorities, through the Supervisory Council (*Conseil de Surveillance*), managed by the regional prefect and representing the Government locally but with independent authority, are responsible for the planning, delivery and financing of regional and departmental services, operating through local entities.

Local provision is mixed: providers of outpatient care are largely private, and hospital beds are predominantly public or private non-profit. Delivery of care is divided among private, independent physicians, public hospitals, private non-profit hospitals and private profit-making hospitals. A third type of entity is involved as a service provider, the “third sector” (charity sector), which combines health and social models, and supplies care and support services mainly to elderly and disabled people.

The most important services in primary and secondary prevention, defined centrally in national programmes, appear to be well organised: immunisation programme, perinatal care, national screening programmes, health education and promotion. Hygiene and public health services and interventions are managed by local authorities at local level (departmental and municipal).

The immunisation program

In January 2018, inspired by the Italian law introduced in summer 2017, the new immunisation law¹⁶ was passed, taking the number of mandatory vaccines from 3 to 11, excluding children from 0 to 6 years from kindergartens and providing penalties for 7-16-year-olds where they are not vaccinated. The mandatory vaccinations in France before this law was introduced were polio, diphtheria and tetanus, and the law added pertussis, measles, mumps, rubella, hepatitis B, haemophilus influenzae, pneumococcus and meningococcus C to the immunisation programme. It also included a specific recommended immunisation for girls aged 11 to 14 years against human papilloma viruses. For all people aged over 65 with at-risk pathologies, immunisation against seasonal influenza is recommended. Healthcare workers with different levels of exposure risks are subjected to some mandatory and recommended immunisations.

Free immunisation is offered by municipalities, which organise specific sessions and are responsible for monitoring the immunisation status of all children. Day nurseries and schools monitor the immunisation status of the population. Most immunisations are performed by independent GPs and all are funded by SHI.

Perinatal care

Mother and infant care is completely covered by SHI and is provided by independent GPs or institutions. In addition, departmental PMI (*Protection Maternelle Infantile*, Maternal Infant Protection) services managed by local entities offer free consultations for children up to the age of six years, with particular focus on families in difficulty, and run preventive health and social care interventions for children. In recent years, these PMI services have been extended to include home visits by midwives in the case of pathological pregnancies and to cover vaccinations for pregnant women and new mothers.

National screening programmes

National screening programmes in France are focused on cancer. The Ministry of Health decides which programmes will be carried out and shares responsibility for implementation with the National Cancer Institute. With the 2004 Public Health Law,¹⁷ local structures were created, at departmental level, to organise screening programmes. Almost all structures are private non-profit associations and nearly half are funded by general councils. The activities of the screening programmes are funded by SHI and evaluated by the national agency *Santé Publique France*.

In France, two national mass screening programmes are available, one for breast cancer and the other for colorectal cancer. All women between the ages of 50 and 74 are involved in breast cancer screening, and are invited by post to undergo a clinical examination and mammogram every two years. All people aged 50 to 74 are involved in colorectal cancer screening, and are invited by post every two years to go to their GP to undergo a free faecal occult blood test and receive information about the programme and the process used for the test. If people do not go to their GP within the three months following this notification, they receive a second letter. After two letters, the corresponding centre sends

them the test equipment at home, and they can perform the test and mail it back for interpretation.

Organised screening programmes for cervical cancer have been piloted in a number of departments. The 2014–2019 Cancer Plan called for a national screening programme for cervical cancer for all women aged 25 to 65 years.¹⁸ However, the National Health Authority (*Haute Autorité de Santé* – HAS) recommends opportunistic screening because of the difficulties in reaching populations of women who have not adhered to the recommended screening regimen.¹⁹ Public health programmes in France are focused either on the population (PMI services for women and children) or on disease prevention (mass screening programmes for breast cancer and colorectal cancer). Providing such services for free reduces financial barriers to access but does not ensure participation. In France over the last decade, breast cancer and colorectal cancer together account for 16% of cancer deaths.²⁰ For this reason, efforts to ensure early diagnosis and treatment are needed.

Health promotion and education programmes

The new agency *Santé Publique France* runs large-scale health education programmes and provides resources for regional and departmental committees that carry out field activities. The 2004 Public Health Law introduced objectives related to health education and created regional public health plans that incorporate health education activities.

Hygiene and public health

Local departmental and municipal providers of public health and prevention services are mixed public and private. At local level, municipalities are legally responsible for the main public health actions, such as monitoring and purifying the water supply, controlling air and noise pollution, waste disposal, protection against radiation, hygiene in residential areas, food hygiene and industrial hygiene. ARSs and their local offices support those municipalities that lack the resources to carry out these functions.

Financing

In France, health expenditure per capita in 2015 was €3,342 (adjusted for purchasing power parity), a rank of ninth among EU Countries. France was the second highest (after Switzerland) for percentage of Gross Domestic Product (GDP) allocated to health with 11.5% (EU average less than 10%) in 2017.²¹

The health spending share of GDP has increased by almost one percentage point since 2005. This increase began in a period characterised by chronic deficits, which required measures to contain the costs mainly on SHI cost and to ensure finance equity in order to keep the percentage of OOP expenditure stable. The results of these actions are that the public financing of healthcare expenditure is among the highest in Europe and out-of-pocket spending among the lowest (7% of total health expenditure, the lowest share across EU countries and below the EU average of 15%).²²

Over three-quarters of total expenditure (79%) is publicly funded through SHI, which is mainly funded from contributions by employers and taxpayers. Additional revenues come from complementary voluntary health insurance (VHI) and specific taxes, such as tobacco and alcohol taxes, or taxes on pharmaceutical companies.

Preventive care was 1.8% of total current expenditure on health in 2016, 0.2% of GDP. Expenditure per capita for preventive care is €74 (USD 85.5), compared to €118.7 (USD 137.3) in Italy and €140 (USD 162)¹ in Germany. In the OECD context,

Canada ranks top with USD 292.70. In percentage terms, expenditure on prevention and public health is below the European average.²³

Of total expenditure of about €5.9 billion, 51% can be considered as covering primary prevention, 11% secondary prevention, 7% collective prevention and the remaining 31% collective environmental prevention and health protection.

In 2014, regional expenditure for prevention, health education and health protection by ARSs was estimated as €368 million.

The large number of different funding sources was considered a weakness in prevention and health promotion activities.²⁴

Since 1996, a mechanism for resource allocation has been defined by the national ceiling for SHI expenditure (*Objectif National des Dépenses d'Assurance Maladie* – ONDAM), which governs total SHI expenditure and its distribution among six care subsectors (outpatient care, healthcare in hospitals paid on a DRG basis, healthcare in other hospitals, health and social care for the elderly, health and social care for the disabled, and other types of care). Each year, Parliament has approved the ONDAM allocation system. Fee-for-service is the main form of payment for self-employed professionals. SHI and representatives of health professionals negotiate fees, which are approved by the Ministry of Health. Pay-for-performance (P4P) was recently introduced by means of contracts with GPs in order to finance incentives to improve the quality and efficiency of doctors' practices.

Workforce

It is challenging in the French context to define who belongs to the public health workforce. In fact, public health professionals do not form a clearly recognisable professional group, because there are different institutions and organisations involved in delivering public health services or activities, and because various jobs in this field do not require a specific diploma in public health.²⁵ For this reason, there are no reliable data on the number and distribution of public health professionals in France. The bulk of practitioners in this field are physicians who are specialists in public health or medical inspectors. Postgraduate public health diplomas are offered by several universities, especially in epidemiology and biostatistics.

The French College of Physicians (*Ordre National des Médecins*) lists 1,698 physicians (693 men and 1,005 women, with an average age of 51 years) who have a specialty in public health and social medicine as at January 2016 (*Conseil National de l'Ordre des Médecins*, 2016).²⁶ National agencies, national ministerial offices and ARSs employ 389 medical inspectors in public health (state public health physicians). Approximately 200 physicians work with the national compulsory insurance authority (*praticiens conseils*), mainly within the ARSs. In the area of school health for the Ministry of Education (screening activities or preventive individual consultations), approximately 1,100 physicians and 7,500 nurses are involved.²⁷

Conclusions and Outlook

Prevention in France is in a phase of significant development. The strategies and policies in the health field over the last decade have shown an increasing focus on prevention. As has been extensively discussed above in this report, the most recent reforms approved in early 2016 place the focus of the health system on prevention, with particular reference to the promotion of health and wellbeing in young generations and prevention of health inequalities. This reform marks the passage towards a health system more centred on prevention and decentralised services, with

1 Change calculated at October 3rd, 2018

a more significant involvement by citizens in the planning and management of the health service.

The development of clear centralised primary and secondary prevention programmes (immunisations and screening) and a clear role in monitoring and evaluation by central agencies show a clearer structure than in other countries but not necessarily better results.

The integration of the main national agencies involved in surveillance, prevention, health promotion and emergency preparedness seems to be a good move. A single institution is able to collect various data necessary for monitoring of the health status of the population and to define epidemiological reports on prevention and health promotion intervention. Local authorities have the competence and responsibility in the monitoring of hygiene

and public health, and they define the interventions on the basis of actual local needs, in accordance with national guidelines.

The main point of criticism in the analysis of the French prevention system is associated with a lack of coordination between the numerous agencies. Specific challenges are represented by the prevention of the main causes of avoidable mortality, especially for men (smoking and alcohol), and prevention of health inequalities.

Considering the good health status of the French population, the low out-of-pocket expenditure required from citizens for health services and the very good ranking in the main system of international evaluation, and including measures of customer satisfaction, the French health system and the organisation of public health and prevention seem to guarantee a good level of care and intervention on the main health issues.

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