

Research programme 2009-2011

December 2008

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Research Fellows	Thierry Debrand, Paul Dourgnon, Nathalie Grandfils, Véronique Lucas-Gabrielli, Georges Menahem, Julien Mousques, Zeynep Or, Marc Perronnin,
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Projects

Tools and surveys

- ⇒ A104 - The Health and Social Protection Survey (ESPS) 2008
- ⇒ A175 - A176 - The Health and Social Protection Survey (ESPS) 2010
- ⇒ A002 - ESPS-EPAS data linking 2006
- ⇒ A003 - SHARE survey
- ⇒ A010 - Eco-Santé
- ⇒ A193 - Collaboration with the SFMG to develop a representative panel of General Practitioners

Research themes

Area 1

Organisation and financing of ambulatory care, regulation of health professionals, professional practice

- ⇒ A189 - PROSPERE Project to set up an emerging multi-institutional and multidisciplinary team to develop research on primary care services
- ⇒ A180 - Evaluation of multi-disciplinary health centres (MSPs) in the Franche Comté and Bourgogne Regions
- ⇒ A179 - Evaluation of the effect of health centres on access to care and reducing health inequalities - EPIDAURE - CDS Project
- ⇒ A164 - The relationship between the working hours of self-employed medical specialists and perceived level of earnings
- ⇒ A194 - International seminar in Paris on primary care in France : current situation and perspectives (seminar planned mid-2009)
- ⇒ A162 - AO NIVEL : Primary Healthcare Activity Monitor for Europe - PHAMEU
- ⇒ A135 - Euromap / Home care : Comparative study of home care
- ⇒ A043 - The context for general practitioner consultations and patient satisfaction - trends 2004-2006
- ⇒ A067 - Travel times to health services
- ⇒ A215 - Study of waiting lists for medical care in France
- ⇒ A042 - Multiple pathologies and multiple prescribing in General Medicine (SFMG-polychrome survey)
- ⇒ A195 - Current invitation to tender: AIR CEE : Addressing Inequalities in Regions

Area 2

Organisation, financing, quality and demand for hospital care and alternatives to hospitalisation

- ⇒ A138 - Access to hospital care (SROS 3)
- ⇒ A161 - Long term care in Europe (INTERLINKS)
- ⇒ A204 - The economics of long term care LEGOS-IRDES research project for the MiRe - 2009 programme
- ⇒ A150 - The relationship between volume of activity and quality in health care establishments
- ⇒ A181 - Financing public and private hospitals: reflections on price convergence
- ⇒ A196 - Euro-DRGs
- ⇒ A139 - PMSI HAD study
- ⇒ A140 - Participation in a working group on the HAD/SSIAD continuum: what frontier and what mode of financing for « intensive SSIAD »?

Area 3

Health status, demand for care and their determinants

- ⇒ A117 - Asthma by level of severity: prevalence and demand for care
- ⇒ A005 - Survey on alcohol and young people in France
- ⇒ A201 - The influence of family circle on alcohol consumption in young persons
- ⇒ A091 - Alcoorama
- ⇒ A197 - European survey of alcohol consumption in young persons
- ⇒ A202 - The impact of the alcohol risk factor on health status and use of health care
- ⇒ A198 - Detailed morbidity of supplementary CMU beneficiaries in 2006
- ⇒ A184 - Access to care for handicapped people
- ⇒ A203 - How to account for unmet care needs, a methodological study of self-reported refusal of care in the ESPS survey
- ⇒ A157 - Integration, health and access to care in France
- ⇒ A030 - The health of adults and social origin : the intergenerational transmission of social inequalities in health
- ⇒ A026 - Differences in attitudes to health risks and health inequalities
- ⇒ A153 - Inequalities in health and difficult life events
- ⇒ A031 - Intermediate study: The interaction between doctors and patients, a cause of social inequalities in health?
- ⇒ A205 - Dynamics of Employment, Health and Work
- ⇒ A136 - PENSARE : Arduous Work, Health and Retirement - Health status and arduous work: two explanatory variables for retirement
- ⇒ A170 - Analysis of drug consumption by therapeutic class, sociodemographic characteristics, health status and social protection
- ⇒ A171 - International comparison of administrative drug databases
- ⇒ A126 - Preparation of a reference document on pharmaceutical reimbursement in France
« Arzneiverordnungs-report French version » in collaboration with CNAMTS.

Area 4

Health systems, financing, insurance and regulation

- ⇒ A033 - Analysis of «excess charges» paid by MGET beneficiaries
- ⇒ A006 - A034 - Company health insurance: employer-employee survey
- ⇒ A187- Supplementary health insurance cover in businesses: a survey following implementation of the Fillon law
- ⇒ A188 - Level of supplementary cover offered by businesses: the relationship between salary levels and health status of employees
- ⇒ A186 - the Evin law: How well-informed are employees? How do they behave following retirement?
- ⇒ A166 - Analysis of the causes of underutilisation of Assistance for Supplementary Health Insurance (ACS)
- ⇒ A167 - Utilisation survey of Assistance for Supplementary Health Insurance
- ⇒ A206 - Refusal of care by Supplementary CMU beneficiaries: A study of a representative sample of Parisian doctors and dentists
- ⇒ A087 - Micro simulation : Study of expenditure behaviour during the life cycle
- A199 - AMARE : Sickness Insurance : Between Acceptability, Redistribution and Equity
- ⇒ A039 - The determinants of daily allowances
- ⇒ A130 - Analysis of individual and contextual determinants of AT/MP
- ⇒ A169 - International comparison of baskets of reimbursable drugs
- ⇒ A191 - The market for me-too drugs)
- ⇒ A172 - Access to care and choice in Bismarkian and Beveridgian systems
- ⇒ A085 - The Bertelsmann Collaboration : Health Policy Monitor

- ⇒ A159 - AO IRESP - The impact of the organisation and financing of health systems on the degree of inequality in preventive care
- ⇒ A083 - The Franco-Quebec Health Observatory
- ⇒ B018 - Monitoring indicators for the objectives of public health law
- ⇒ A064 - Evaluation of the General Practitioner system
- ⇒ A200 - The impact of on pharmaceutical consumption
- ⇒ A190 - Evaluating the cost of psychiatric illness

Theses and Research Supervision

A143 - An approach to the social and territorial construction of the treatment of mental illness, by analysing the history of the process of localisation and fragmentation shaping the supply of psychiatric care in France

F008 - The social dimension of development: individual social investment strategies and their impact on health and well-being

F008 - Analysis of the effectiveness of the insurance system against professional risk

F008 - Authorisation to supervise research «The impact of public policy on individual behaviour: Employment - Housing - Health»

The work programme described in this document presents all of the studies and research which are currently planned, whether they are financed exclusively by working grants awarded to IRDES or by additional contractual finance (the latter being identified for the studies concerned).

The research process, from initial feasibility study to presentation of findings in scientific publications, is lengthy: hence the projects presented here are for 2009, 2010 and in some cases 2011, and provide information on the current stage of development and the project timetable. The projects have not been formally prioritised, but those starting in 2010 are either considered less urgent, or require access to data which will not be available until next year. The programmes for 2010 and 2011 will of course be described in full in future editions.

The first section of this document sets out the key research themes addressed in each of the main areas of surveys and research. In addition to this a series of themes which are common to several of the research areas are described.

1. Tools and surveys

1.1. National survey of health and social protection (ESPS)

Creating data has always been one of IRDES' strengths. The National Survey on Health and Social Protection and the maintenance and distribution of the Health Data software package are the main focus of this activity, which now includes our participation in the SHARE survey¹. In addition the management of several other important surveys, as well as one-off surveys for individual research projects, requires an ongoing coordinated policy of managing and archiving our databases.

Analysis and dissemination of ESPS 2008

The 2008 ESPS survey will be validated and disseminated to project partners during 2009. At the end of 2008 we plan to carry out initial exploratory work on the first wave of the survey, on the new questions on franchises and on implementation of the Evin Law. Purely descriptive summary studies based on this work may be published in the first half of 2009. More analytical work on these questions is planned for late 2009 on the Evin law, and in 2010 for franchises, as soon as matching data for 2007-2008 is available (see Area 4).

The ESPS 2010 Project, sampling in the EPIB and experimenting with matching the AMO-AMC²

In terms of methods the ESPS survey will be significantly updated. A new sampling plan will be used, not only for EPAS³ but also for EPIBAM⁴ (new permanent sample of sickness insurance beneficiaries). This is a very important development, because this sample is changing from one of persons insured with their dependants to persons insured on an individual basis. However procedures have been put in place with the sickness insurance funds to ensure the collection of data on reimbursement for the dependants of people in the sample.

Apart from this investment, the survey will also use an improved tool for recording and evaluating health regulation policies. In the 2010 survey it will also be possible, as part of an agreement with

¹ *Survey of Health, Ageing and Retirement in Europe*

² *Compulsory health insurance - Supplementary health insurance*

³ *Permanent sample of socially insured*

⁴ *Inter-scheme permanent sample for sickness insurance beneficiaries*

IDS⁵, to experiment with data on reimbursements for voluntary and complementary health care providers. For the first time this will provide information on final out-of-pocket expenditure paid for health care. The possibility of matching this data with administrative data (DGI⁶) on income, as does INSEE⁷, will be explored for the 2012 survey, together with INSEE.

At this stage the work is being organised bilaterally within the IDS framework. The procedures are yet to be validated and tested and the complementary operators to be defined. New questions will be added and the procedures and timetables with the three sickness insurance regimes will be adjusted.

1.2. ESPS-EPAS data linking

During the first quarter of 2009, the report matching the 2004 ESPS survey with EPAS data which contains actual health care provided in 2004 will be made available. The 2006 matching will be finalised and the 2008 matching will begin in the second half of the year. These matching exercises are continually added to with new information in addition to that on health expenditure, particularly on volumes of activity and the composition of hospitalisations. In 2009 they will also take into account the sickness insurance reform and integrate developments in terminology and pricing policy. We aim to complete the matching of ESPS data with SPAS data, for both survey and non-survey years.

1.3. The SHARE survey

The SHARE survey became a European panel with the second wave of data collected in 2006. The official data were made public on November 28, 2008. The publication of *First Result Book wave 2* accompanied this event. IRDES will promote SHARE 2006 in scientific articles, *Questions d'économie de la Santé*, and current invitations to tender (ANR⁸ young people on ageing - HEAPS⁹).

The third wave of SHARE (SHARELIFE) is again considering the idea of a panel on essential questions (perceived health, socio-economic variables, income, etc.) but is focussing on an approach based on life trajectories. Retrospective questions are asked in the domains of health, professional activity, housing, etc., from childhood up to the present. An “end of life” questionnaire is planned. The survey will be carried out in 13 European countries (Sweden, Denmark, Netherlands, Belgium, France, Germany, Austria, Switzerland, Poland, Czech Republic, Spain, Italy and Greece). Each of the pilots has produced good results.) The French survey should take place during 2009.

More generally, the SHARE project has been selected by the European Union for its “European road map” and is starting the initial phase of construction of a European research infrastructure. This phase, financed by the European Commission (SHAREPREP), aims to get the project to a level of financial, legal, technical and governance development which will enable the creation of a European infrastructure (ESFRI¹⁰).

⁵ *Health Data Institute*

⁶ *General Directorate for Taxation*

⁷ *National Institute of Statistics and Economic Studies*

⁸ *National Research Agency*

⁹ *Health Economics of Ageing and Participation in Society*

¹⁰ *European strategy forum on research and infrastructures*

During the period 2010-2020, SHARE should be carried out every two years in European Union countries, in Switzerland and in Israel. The European Union is financing the preparatory phase for establishing the infrastructure within the framework of the 7th PCRD¹¹. After this stage the formal establishment of the infrastructure will be financed entirely from national contributions. If France enrolls in SHARE as part of ESFRI, the Commission undertakes to finance the survey for 10 years. An ESFRI meeting of European governments was held in Versailles in December 2008.

1.4. Eco-Santé

The partnership between DREES¹², CNAMTS¹³, RSI¹⁴, MSA¹⁵ and the Mutual sector means that we can continue to make Eco-Santé available free on the internet. Monthly updates enable us to monitor developments in the sector more closely and to increase both visibility and consultation on our data. For the versions for France, and for Regions and Departments, it is planned to phase in PMSI data, to reformulate data on elderly handicapped people and to improve data from the annual statistics of health establishments. It is highly likely that Eco-Santé Québec will move towards a comparison of results for provinces with OECD¹⁶ country results. The sickness insurance database is about to be made available online, and should be accessible during 2009

1.5. Collaboration with SFMG¹⁷ to develop a panel of General Practitioners

This work, which is being carried out in close collaboration with SFMG and with the recently formed PROSPERE project team (see below), aims to put together a technically robust proposal during 2009 with which we can seek finance to develop a nationally and regionally representative Observatory of General Medicine (OMG) in the medium term .

¹¹ *The Seventh Framework Programme (FP7)*

¹² *Directorate of Research, Studies, Evaluation and Statistics*

¹³ *National Health Insurance Agency For Wage Earners*

¹⁴ *Social Scheme for Independent Professionals*

¹⁵ *Agricultural Social Mutual*

¹⁶ *Organisation for Economic Cooperation and Development*

¹⁷ *French Society of General Medicine*

2. Area 1 - Organisation and financing of ambulatory care, regulation of health professionals, professional practice

Work in this area will largely be organised around the projects of the **developing PROSPERE team**. This developing team is a key project for work in this area. It brings together within a common approach various studies conducted over several years in the field of primary care. We are hoping, indeed aiming, to develop an infrastructure which will enable us to develop this research area and to supervise and train researchers in this area in the future. Hence this project aims both to increase our knowledge of the different forms of organisation of primary care and to develop a collective and multidisciplinary approach to research on the functioning of the primary care system in France. It is bringing together 13 researchers from varied disciplines from three different and complementary organisations (IRDES, SFMG and CERMES¹⁸).

There are four specific objectives for this research programme during the next four years, and these will underpin several research projects. The first is to develop an analytical framework for primary care organisations to facilitate evaluative research on the links between different types of organisations and their impact. The second aims to analyse the organisational forms of primary care using microeconomic concepts and methods to analyse provider incentives, revealed preference methods for users and health economic evaluation. The third objective is to analyse organisational forms for primary care using the concepts and methods of sociology to look at the redistribution of roles and activities between professions and users, in a micro and macro analytical analysis of the care system. The fourth objective is to construct a research tool consisting of a database of matched medical and reimbursement data. This will enable us to test methods and analytical indicators for primary care organisations and to establish a “control” sample for evaluative research on primary care organisations.

The work which will be carried out within the PROSPERE framework will therefore produce useable results in the short term, help to define expectations and objectives for experimental initiatives and to generalise about approaches to remuneration, or both. It will also help to evaluate experiments by using the analytical frameworks produced and tested in a comparative perspective. We will use different methods to disseminate research results so that knowledge can be transferred to actors in the health care system, and to validate findings from an academic perspective. The PROSPERE team will be further consolidated, as we strengthen our research training capacity by producing two doctoral theses and through two authorisations to supervise research (HDR¹⁹); and develop supervision and training in conjunction with university institutions and those involved in general medicine. The nature of the institutions involved in this partnership makes it feasible to consider maintaining this team in the long term, in a form still to be decided.

Some of the team’s projects begun in 2008 fit naturally into this framework. We present them under three traditional themes:

2.1. What is the most efficient way of organising primary care?

The first theme involves an analysis of the efficiency of different current approaches to organising primary care, some of which are attracting increasing interest. Specifically these are multidisciplinary health centres and health centres. In 2008 we began analyses of the efficiency of both types of organisation using common criteria by combining methods for analysis of data on payments with

¹⁸ *Centre for Medical and Health Study and Research*

¹⁹ *Authorisation to supervise research*

methods to analyse and describe the structure of primary care in our previous studies of group practice. An initial project, being carried out at the request of CNAMTS together with URCAM²⁰ and the federations of the **multidisciplinary health houses (MSP) in the two regions of Bourgogne and Franche-Comté**, aims to specify how, in associating different types of professional within the same project, they function with regard to group medical practice, or individual practice within general medicine. A project to **evaluate the contribution of health centres to reducing health inequalities**, begun in 2008 with the National Liaison Committee for Health Centres following an Invitation to Tender on social experimentation initiated by the High Commission for Active Solidarity, is examining the relationship between inequalities in health care and the efficient organisation of care. These evaluation studies of the efficiency of health care organisations will generate research questions in the medium term for the PROSPERE project. They also produce material for complementary analysis. These studies will also be enriched by an ongoing study, in collaboration with CNAMTS, on the **relationship between working hours of self-employed medical specialists and perceived level of income**, by analysing doctors' daily schedules.

By convening an international seminar in Paris on primary care we will be able to explore issues and questions raised by the organisation of primary care. It will be based on the studies carried out by IRDES in 2007 and 2008 on organisational models for primary care in Europe, and also on work carried out within the PHAMEU framework. It will include the observations of actors from several different European countries.

2.2. Analysis of primary care policy and delivery

Analysis of primary care policy and how it is delivered constitutes a second major research theme, both in terms of area based planning and of practice. We consider that it is essential to look at the parameters of territorial planning and methods for assessing need at the local level within this research area. Research on **primary care policy in Europe, PHAMEU**, continues. The objective of this project is to develop an observatory on primary care (systems, professional practice - both delivery and organisation - user evaluation) in 30 European countries including France. For France this consists of documenting the following aspects: general characteristics of the system, accessibility, continuity, coordination, extent and universality of the services available, and user perceptions. Within the framework of European research projects, IRDES, in collaboration with NIVEL²¹, is participating in the **EUROMAP study, a European comparative analysis of home care**.

2.3. How the health care system works

A third and more traditional research theme consists of studies to analyse how the health system works, based largely on analysis of ESPS survey data, but also of large administrative databases. It includes **evaluation of patient satisfaction in general medicine, trends in use of medical consultations by patient characteristics and a study of geographic access to health care**, and also a **study of the feasibility of measuring waiting lists or waiting times for access to care in France**. In addition, research with SFMG aims to develop tools for identifying and alleviating drug-related risks arising from **multiple prescribing in general medicine**.

²⁰ *Regional Unions of Sickness Insurance Funds*

²¹ *Netherlands Institute for Health Services Research*

2.4. Current invitation to tender: AIR CEE²²: Addressing Inequalities in Regions

The main objective of this project is to assist European policy makers to develop policies at the local level to reduce health inequalities in primary care, in line with a number of common rules. Hence the project aims to exchange good practice by carrying out a literature review and a review of innovatory practice using information from surveys. It will also review the range of measures of health inequality used in Europe and develop recommendations in this area. A further objective is to improve the efficiency of expenditure, and to improve approaches to health promotion, prevention and education about health risk behaviour. This project is being piloted by the Regional Council of Aquitaine, pre-selected by the European Commission.

²² *Centre for Unemployment Research*

3. Area 2 - Organisation, financing, quality and demand for hospital care and alternatives to hospitalisation

The second major research theme addresses hospital care from various perspectives, with a common focus on performance. Global performance may be considered from various angles, in terms of organisation, financing and quality of care, with accessibility included in the latter.

This theme includes research projects all of which address supply as well as demand for care, both in terms of traditional hospital care and alternatives to hospitalisation²³. The ageing of the population with its related increase in poly pathology and dependency, together with ongoing reform of the health care system itself, makes it logical to extend this field of investigation to long term care and hence the medico-social care sector.

In the following presentation of research projects for 2009-2011, we focus in particular on themes of accessibility and the territorial organisation of hospital care, the accessibility and financing of long term care, and more specifically projects looking at financing, activity and demand for care and at quality (outwith access).

3.1. Accessibility and organisation of care

We are addressing questions of accessibility to hospital care, particularly of geographic accessibility, and of the economic impact of different approaches to managing illness with hospital treatment, by examining the feasibility and methodology for a study of accessibility to hospital care within the third generation regional schemes for organising care (SROS²⁴ III) and the multiannual contracts for objectives and resources (CPOM) agreed in 2007. We are aiming for a publication in 2009 based on a working document containing an analysis of methods for determining health areas, the criteria used and the extent and range of services available in each region. Other health geographical projects relating to hospitals are described below under 6.1 (cross cutting themes).

In addition a doctoral thesis developed at IRDES is exploring the **social and territorial construction of treating mental illness**. This project is continuing in 2009.

3.2. The organisation of long term care

With regard to the organisation of health care at the European level, IRDES has proposed an **INTERLINKS project on long term care** with 16 other partners within the seventh Framework Programme FP7. This project has been agreed and will begin in 2009. As well as organisational aspects it will look at finance and governance. Related to this, a new project has been established for 2009-2011 in association with LEGOS²⁵ on the **economics of long term care**, under an agreement with the MiRe. It has four components: an international comparative approach, the current status of the long term care population in France, trends in demand for long term care and in supply in the market for institutional provision of this care (costs, management practices, quality).

²³ *Traditional hospitalisation includes complete or partial hospitalisation (by week, day or night). Alternatives to hospitalisation include day cases for ambulatory surgery (CA) and hospitalisation at home (HAD).*

²⁴ *Regional health plans*

²⁵ *Health Economics, Management and Organisation Laboratory*

3.3. Financing, activity and quality

The introduction of a new method for funding hospitals (activity-based funding, known as T2A) for short term care (MCO²⁶) as well as home hospitalisation (HAD²⁷), together with the availability of the corresponding PMSI²⁸ databases, opens new perspectives for research on better use of available resources. Studies of the effect of this new funding method on costs, activity and quality of care are planned or have started.

The quality of health care services in general is a major concern for the organisation of health systems, related to economic and financial pressure to contain costs on one hand, and lengthening patient waiting lists on the other. We are investigating the subject of quality of hospital care in particular with an analysis of the **relationship between volume and quality of care**, in response to an invitation to tender from the High Health Authority (HAS)²⁹, based on a systematic review of the literature and empirical analysis of PMSI data. An initial IRDES publication appeared in 2008 and will be followed by a publication based on the second phase of the study in 2009.

A project which started in 2008 in response to an invitation to tender from the French Hospital Federation (FHF)³⁰ is looking at **public/private T2A tariff convergence**. The main objective of this work is to inform the debate on convergence of public/private hospital tariffs in the context of activity-based funding, drawing on economic theory and database analysis. Theoretical analysis will clarify the economic basis and adjustment parameters implied in activity payments, drawing on overseas experience. This phase is key to understanding the consequences of the different choices being made following the reform of activity-based funding in France. In conjunction with this, we will establish the differential impact of certain parameters in the French context by synthesising data which is already available. In addition, we are carrying out a detailed analysis of hospital activity using PMSI, SAE³¹ and the BDSF³². This first phase was carried out in the second half of 2008 and should result in publication in 2009. **A second phase is planned for 2009**, in which we will explore as far as possible, **sickness insurance data to compare costs by DRG³³ between the public and private sector**.

IRDES has also proposed to participate in an **international comparative study of costs and quality of hospital care**, with 10 other European partners, in the Seventh Framework Programme.

As part of our work on alternatives to hospitalisation, we are **studying the first PMSI HAD data**, in collaboration with DREES, with the aim of describing developments in type of care provided, and of analysing the potential impact of activity-based funding on the management of length of stay, of patient care episodes and the extent to which it complements traditional hospitalisation. The first phase of the study is complete with a publication appearing at the end of 2008. The second phase has been put back to 2009 because of delays in the availability of 2007 PMSI data. It will result in a publication in 2009. This collaboration is likely to continue during the years following PMSI-HAD.

²⁶ *Short term care*

²⁷ *Home hospitalisation*

²⁸ *Programme for the medicalisation of information systems*

²⁹ *High Health Authority*

³⁰ *French Hospital Federation*

³¹ *Annual statistics of health organisations*

³² *Statistical and financial database*

³³ *Diagnosis Related Groups*

An IRDES researcher is participating in a project piloted by the Créteil l'URC³⁴-Eco in collaboration with DGAS³⁵ and CNAMTS. This project will investigate the SSIAD³⁶/HAD continuum, with the objective of identifying patients appropriate for intensive home nursing (« SIAD lourds ») and the potential cost of their care, based on a survey of an organisation offering the three types of care, namely HAD, intensive SIAD and traditional SIAD. Work on this project in 2009 must take into account the proposal for a **new SSIAD pricing policy** based on patient dependency.

³⁴ *Clinical Research Unit*

³⁵ *General Directorate for Social Action*

³⁶ *Home nursing service*

4. Area 3 - Health status, demand for care and their determinants

Researchers working in this area have a common interest in understanding the need and demand for care and for health.

4.1. Health status and its determinants

In common with last year, projects on health status are focussing on major diseases and risk factors. They aim to document the prevalence and determinants of the major diseases and their risk factors, and their impact on the consumption of health care.

In 2006 and 2007 a series of studies of asthma began. The first study was carried out by the asthma surveillance group together with l'InVS³⁷, l'INSERM³⁸ and DREES. It aims to measure asthma prevalence and comorbidity, asthmatics' quality of life and use of health services. In 2008 IRDES began a study of changes in **asthma prevalence by degree of severity**, together with an analysis of asthma control using GINA³⁹ 2006 criteria. This study using ESPS 2006 survey data will enable us to measure in identical conditions, the prevalence of asthma at an interval of 8 years. It will continue in 2009 and 2010 with a study of treatment episodes in asthmatics.

The research programme on prevalence and problems of alcoholism in the population will continue in 2009 with the final analysis of a survey of **young people and alcohol in France**. Fieldwork for this survey which is collecting data on young persons' attitudes to alcohol and on their health and use of health services was carried out in 2007. It follows a series of similar surveys of young persons aged between 13 and 20 carried out since 1985 by IREB⁴⁰, but introduces some new questions on the behaviour of young persons and is extending the age range to 24. In 2009 we will renew our participation in **Alcoorama**, a survey of the opinions, knowledge and attitudes of the French to alcohol carried out by IREB. The survey of **alcohol-related behaviour among young European adults**, carried out by a group of European experts organised by the Cavour Group, began in 2008 with a pilot study. It will continue with a full scale study, first in three countries at the end of 2008 and extended in 2009. The first phase will be analysed in 2009. Finally, analysis of the **relationship between alcohol and health**, carried out in late 2007 by INPES⁴¹, will recommence with an analysis of the use of health services and an examination of longitudinal factors. From the middle of 2009, the availability of data covering four rounds of ESPS (2002, 2004, 2006 and 2008) will make longitudinal analysis possible. A working paper on this study is planned in 2009.

4.2. Inequalities in health and health care use

In France, social inequalities in health have been clearly demonstrated (see for example, Leclerc et al, 2000). There is a social gradient in health, in which health status improves right to the top of the social hierarchy. However these inequalities are still poorly understood. In fact, the "traditional" explanations of social inequalities in health, such as poverty, housing and working conditions, alcohol and tobacco consumption, poor diets and sedentary life styles, demand for health care or the influence of health status on socio-economic status (the selection effect), explain the magnitude of health inequalities and how these vary in time and space very imperfectly. Furthermore we need to give

³⁷ *The National Institute of Health Surveillance*

³⁸ *The National Institute of Health and Medical Research*

³⁹ *Global Initiative for Asthma*

⁴⁰ *Institute for Scientific Research on Drinks*

⁴¹ *National Institute for Prevention and Health Education*

much more thought to the tools used to measure social inequalities in health: both in terms of the characterisation of health status itself and the effect of different indicators on the measurement of inequality; and in terms of measuring social status and the relevant variables for doing this.

We will continue our research in this area in 2009, both in order to describe social inequalities in health and to explore the determinants of these inequalities.

Describing inequalities in health and use of health services

Work to describe inequalities in health is of two types: on one hand methodological work to develop a tool to describe inequality based on refusal of care and on the other studies of specific disadvantaged populations. Hence we will carry out a detailed study of the morbidity of supplementary CMU beneficiaries⁴² in 2006. These studies will be carried out together with teams from DREES and will complement those DREES is carrying out on the health status of CMU beneficiaries.

Other work to explore health inequalities and the needs of vulnerable populations includes some new avenues of research begun in 2008 on **access to health care of disabled persons**. It is now recognised that access to care for this population is more problematic than for the non-disabled for many reasons, relating in part to their disability, but also to a less favourable environment and to barriers related to health professionals and the health system. However few French studies have examined these difficulties in access. Following exploratory studies in 2008 on the ESPS survey and the decennial health survey, we will explore the 2008 HID⁴³ survey.

Finally, we will investigate ways of measuring unmet need for health care, in a **methodological study of self-reported refusal of care** in the ESPS survey. Despite an increasing interest in the literature, the stability and meaning of responses to this question in different social groups has not yet been investigated.

Determinants of health inequalities and use of health care

Apart from the « conventional » explanatory variables described above, we have considered other variables in order to understand how social inequalities in health arise and persist. The current and future programme of work is based on hypotheses in this area, empirically testing several explanatory models using survey data:

- ⇒ we will continue to explore the role of social capital, of social support and of social position relative to health status. Specifically we will examine the relationship between **integration, health status and use of health care** as determined by nationality of origin (first and second generations) and of religion in the formation firstly, of social capital and then their relationship with health status and use of health care;
- ⇒ the role of nationality, with an analysis of **health status and use of health care in immigrants**. This study which started in 2007 will be completed and disseminated in 2009;
- ⇒ the role of the **intergenerational transmission of health inequalities**, in particular the role of background of origin on health status in adulthood and, more generally, in the development of inequalities of opportunity in health in France (in collaboration with IDEP⁴⁴);
- ⇒ the role of **different attitudes to risk** in the occurrence of accidents, in preventive behaviour, and in differences in health status ;

⁴² *Universal Supplementary Sickness Insurance*

⁴³ *Handicap, Disability and Dependency Survey*

⁴⁴ *Institute of Public Economics*

- ⇒ different statistical and sociological analyses of the role of **difficult life events** in the development of health inequalities will be synthesised in order to identify the influence of emotional problems, of mourning and of life trajectories on one hand, and on the other of attitudes to health in the generation of health risk behaviour;
- ⇒ the potential role of use of health care and of the health care system in the development of these inequalities; as part of a pilot study on the role of the **interaction between doctors and patients** in the production of social and health inequalities (INTERMEDE survey) the first results of which were analysed in 2008, a series of doctor-patient interviews were filmed. These interviews will be analysed in 2009 with the assistance of NIVEL in the Netherlands.

4.3. The relationship between health and working conditions

At the international level, many studies have shown the link between investment in health and participation of individuals in the labour market. Even if the relationship between health status and labour market participation appears obvious, the causal relationship is not clear. We propose, assuming that we get access to the data, to analyse on the basis of the Professional Health Journey survey, the **dynamics of employment and health related to health characteristics, career trajectories and working conditions**, using a retrospective questionnaire.

4.4. Drug consumption and prescribing

The level of pharmaceutical consumption in France has been a major preoccupation for years. It represents approximately 20.6% of total medical expenditure and continues to increase. Although the characteristics of this consumption in terms of expenditure and therapeutic classes is well-known, few studies have analysed this **pharmaceutical consumption in terms of the individual characteristics of consumers** and their social groups. By linking ESPS survey data with that from EPAS and the pharmaceutical data which it contains, we will describe the main individual and social characteristics of this consumption. This work, which began in 2008 with hormone replacement therapy (HRT), will continue in 2009 with an analysis of the characteristics of HRT consumers.

In recent years, national and international drug information systems have improved considerably and should enable the field of investigation in this sector to expand.

Hence more and more **international comparative** work is being done. Many comparisons are now being made using commercial databases such as IMS-Health, but there are also national data sources, for the most part in administrative databases. The use of commercial sources, which are very expensive, is very often limited to near neighbours of France. We plan to document the existence, availability and content of the public databases on drug consumption in countries further away, within and beyond Europe.

The new pharmaceutical information systems (Medic'am, Medicmsa, and Medicanam) which have been developed during the last five years provide detailed annual information on pharmaceutical consumption in France. However this information is still rather fragmented, dispersed as it is between the three main sickness insurance schemes, and largely underused for purposes of analysing the evolution of drug consumption. We propose to assess the feasibility of **publishing these data collectively** in the form of a series of summary articles on overall drug consumption and developments in each therapeutic class. This work began in 2008: Medic'am data were explored and data on DDDs⁴⁵ were obtained. This will continue in 2009.

⁴⁵ *Daily defined dose*

5. Area 4 - Health systems, financing, insurance and regulation

5.1. Compulsory and supplementary health insurance: financing and expenditure

Until now most IRDES work on supplementary health insurance has focussed on the relationship between demand for cover and demand for care, seeking to evaluate the phenomena of market inefficiency (adverse selection and moral hazard) and the role of supplementary cover in equity of access to care. These studies have shown a significant impact of cover on demand for ambulatory care. However data on the influence of level of cover among insured persons is relatively rare. Furthermore, our understanding of the effect of cover on demand for care (moral hazard and /or better access to care) is still limited. Finally, data on the existence of adverse selection is sometimes contradictory. The **study being carried out for the General Mutual for Equipment and Territories (MGET)**, for which a publication project is planned for 2009, should throw new light on these questions.

Demand for supplementary insurance in France has not yet been looked at in any depth. Some essentially descriptive work (Couffinhal, Perronnin, 2004, Kambia-Chopin et al, 2008) has underlined the importance of disparities in cover by socio-economic group. This will be looked at further in 2009, both for individual and group cover. We will look in particular at individuals' capacity to pay as a function of their income, for given states of health. Firstly several studies will be organised using data from the **survey of supplementary social protection for businesses (PCSE)**. This double survey of employees and organisations will take place in the first quarter of 2009, with preliminary analysis before the end of the year. The priority will be to produce descriptive data on **changes in cover** since the previous survey in 2003, and particularly on developments in facilitative contracts in the aftermath of the Fillon law, which abolished tax exemptions for employers for group contracts.

Then we will take forward a more general research theme on the demand for **supplementary cover and the level of guarantees underwritten by businesses**, as a function of business characteristics, type of employment and salary levels, and health status and the working conditions of employees.

The consequences of retirement for beneficiaries of group contracts are poorly understood; following work carried out in 2008 on changes in supplementary insurers amongst the recently retired, some complementary elements on the **application of the Evin law by employees** will be analysed using a module of specific retrospective questions put to employees in the 2008 ESPS survey, as well as some questions on the expectations of employees used in the PSCE survey.

We will continue our analysis of the demand for individual supplementary insurance and inequalities in access as well as its redistributive aspects, specifically to clarify the issue of inequalities in cover.

Studies to evaluate mechanisms for improving equity of access to supplementary health insurance, CMU and ACS⁴⁶, carried out during the last few years, will be extended by research on reasons for non-utilisation of ACS. In February 2008, 360,000 persons had this cover, which is a small proportion of the potential beneficiaries. Research will continue to **construct a theoretical model of demand**, using varied sources of empirical data: the CMU funds survey, the ESPS survey and the **ad hoc survey of use of ACS**, which will be carried out among social beneficiaries in collaboration with LEGOS.

⁴⁶ *Financial assistance for health insurance*

Further testing on the **refusal of care by CMU beneficiaries** is also being discussed with the CMU fund.

We are continuing our research on the **role played by Public Sickness Insurance**. Because affiliation is compulsory, this has a redistributive as well as an insurance function. In contrast to private insurance, the compulsory nature of public insurance means that it extends insurance over the course of the lifecycle. By separating the financial contribution from the level of risk, it also ensures redistribution between persons in different classes of risk or with different incomes. The purpose of this study is to try to distinguish these two functions of public insurance: the insurance function over time and that of redistribution between individuals. To analyse these behaviours over the course of the lifecycle, we will use a **DESTINIE model of dynamic microsimulation**. We will also study the impact of demographic change on medium and long term expenditure.

Finally we will consider the development of a new microsimulation model in an attempt to integrate IRDES studies on compulsory and supplementary insurance in a combined study of the impact of existing systems on equity, redistribution and acceptability.

5.2. Sickness insurance and the labour market

We will take forward our analysis of the matched IJ⁴⁷-DADS⁴⁸ database and may repeat the matching exercise after an evaluation of the costs and benefits of the exercise. The eventual aim of IRDES is to analyse **individual and contextual mechanisms for withdrawal from the labour market** and the resulting payment of daily allowances, by pursuing two main research themes with many related questions: microeconomic and sectoral determinants of short and long term withdrawal from the labour market, and the specific issue of daily allowances in employees under 50. This is a complex and multidimensional subject: it relates to health, to working conditions, to social protection and to how businesses function. At present no data are available in France for the simultaneous analysis of these different dimensions.

Another study aims to investigate the **individual and contextual determinants of AT/MP⁴⁹ and of employment termination related to AT/MP**, within two research themes. We will study the determinants of AT/MP: apart from the relationship between declaration and the individual characteristics of employees, this will pay particular attention to the management of AT/MP and the types of business and employer involved. We will also try to establish whether there are different dynamics between AT/MP and overall health expenditure of individuals (paying particular attention to the payment of daily allowances). Then we will analyse the question of incentive mechanisms, and more specifically, how behaviour within the businesses changes following modification of tariffs for professional risks.

Finally, the PSCE survey will enable us to complete the analysis with an assessment of daily allowance cover and the impact of the level of cover on their frequency and length (2009-2010).

⁴⁷ *Daily allowances*

⁴⁸ *Annual declaration of social data*

⁴⁹ *Work accidents /Occupational diseases*

5.3. Drug regulation

For several years IRDES has been investigating **drug regulation** policy, the various mechanisms available for this, how they are used in the national context and the strategic reactions of the pharmaceutical industry.

Within this area, it is important to analyse the reimbursement status of drugs and to look at international experience in this area. The regulator must both control costs and maintain quality and accessibility of care, and also support the growth and competitiveness of the pharmaceutical industry. Analysis of policy in other countries may be informative here. An initial study on **baskets of reimbursable drugs** carried out by IRDES in 2005 (Nguyen-Kim et al, 2005) compared reimbursement policies for three classes of drugs in France, Germany and England. This work concluded that differences in expenditure between these countries were essentially explained by differences in prescribing behaviour and not by availability of products. Further examples of medicines reimbursed in France, sometimes with high increases in therapeutic value and reimbursed at 100%, which are not reimbursed in other countries, confirm the conclusions reached in our earlier study. We propose a new approach to this issue, in which we examine the approach taken in other countries to reimbursement of new and sometimes very costly drugs.

For many years there has been a sustained increase in pharmaceutical expenditure, driven principally by innovation. However the classic segmentation of the pharmaceutical market into generic and innovatory drugs is no longer adequate to explain the structural developments of the last few years. In the innovatory products market, an increasing number of me-too drugs have appeared, molecules from an existing class, treating the same illness and differing only slightly, whether clinically or pharmacologically, from molecules already on the market. In 2009 we will carry out a study of this little known market. After defining the field of this **me-too drug market** and reflecting on a classification which would enable us to identify these drugs, we will assess the importance of this market in France, its contribution to increasing pharmaceutical expenditure, both in terms of price and volume, and we will consider the implications of their development.

5.4. Macro-economic studies, comparisons of health systems

The final theme of research in this area focuses on comparative analysis of the organisation of health care systems in France and elsewhere, particularly in Europe. We will continue work to develop an area of research to compare the organisation and performance of the French system with that in other countries. A comparative study of change in access to care and choice resulting from recent reforms in different Bismarkian and Beveridgian systems will be published in 2009. We will continue to collaborate actively with the European Health Policy Group network of researchers. We will also continue to participate in the **Health Policy Monitor** (Bertelsmann) which synthesises information on health system reform in 22 countries. Finally, following an invitation to tender from IRESP⁵⁰, we will analyse socio-economic differences in use of preventive health services in France and compare this with other European countries using new databases, in order to establish the effect of the **organisation and financing of health systems on the extent of inequality in preventive care**.

⁵⁰ *Public Health Research Institute*

5.5. Franco-Quebec Health Observatory

IRDES will continue its involvement in the Franco-Quebec Health and Solidarity Observatory, for which it assures French logistical and scientific support. Apart from continuing to publish its review and new developments in Health Data Quebec, the Observatory will organise a **biannual forum** in Quebec in 2009 on the theme of “cancer, the multiple faces of this burden”.

6. Cross cutting themes

In addition to our work organised within particular areas, a number of IRDES research themes cut across all of them. Here the approaches and methods used in each of our main research areas are applied to one particular topic.

6.1. Policy evaluation

Various evaluations of public policy have been described above. Hence the law of August 2004 on reform of sickness insurance is examined in several evaluative studies on the episode of care, pharmaceutical regulation, work on financial assistance for supplementary insurance; the public health law is examined through our work to develop monitoring indicators; the regulation of hospital services is examined by looking at regional planning (SROS), and norms of production (volume and quality in the hospital), and its financing; possible approaches to regulating ambulatory care are assessed by evaluating collective care structures (health homes, health centres, networks etc.) and perhaps in the future through an evaluation of different approaches to funding foreseen in the Social Security Financing law.

More specifically, in terms of the reform of sickness insurance, the following studies are taking place:

- ⇒ **the episode of care:** work to evaluate the reform of sickness insurance and the episode of care, which have already been examined in several studies of patient declarations following the 2006 ESPS survey, will continue using 2008 ESPS matched data;
- ⇒ **the microsimulation of user co-payments in the care system:** this study which is currently being disseminated, was carried out as an end of study assignment in two different places: the High Health Authority (HAS) and the Institute for Research and Documentation in Health Economics (IRDES); the objective was to test various avenues of reform of financial participation by health system users, using a microsimulation model to evaluate the impact in terms of political feasibility and equity; for the latter indicator of impact we used indices of concentration together with the work of the European “Ecuity” group;
- ⇒ in the same vein, a study may be developed on the **effect of new co-payments on the consumption of care**, using 2008 (2010) matched ESPS data; this work aims to measure the overall size of their effect on the consumption of care and to assess the nature of their effect: is this a positive phenomenon of reduction in moral hazard or a negative phenomenon of reduced accessibility to care?
- ⇒ And finally, we are participating in an **evaluation of the cost of mental illness in Europe:** more precisely our work will measure the extent of expenditure on hospital and outpatient care and on drugs for mental illness (excluding dementia) for the year 2006; this work is using a similar approach to that of disease-based accounts in which, using a similar methodology, mental illness was estimated to account for 10.6% of medical goods and services (equivalent to 16.6 billion Euros in 2002); this project led by the Créteil URC⁵¹-Eco, is aiming to produce a comprehensive estimation of the cost of mental illness, including social costs and loss of production and quality of life.

⁵¹ *Unité de recherche clinique*

6.2. The geography of health

Various geographic aspects of health are examined in projects in the different areas. See for example Area 1 (primary care) and 2 (hospital care). The main emphasis in 2009 will be on work to update analysis of travel times to health services, which will be carried out in partnership with DREES.

6.3. Pharmaceuticals

Whether prescribed within ambulatory or hospital care settings, or considered from the point of view of regulators or consumers, pharmaceuticals constitute another cross-cutting scheme. Projects starting or continuing this year bring together analyses of consumption, overall or for certain therapeutic classes (THM), debate on some aspects of pharmaceutical regulation policy (baskets of reimbursable drugs), at the national and international level, and a new approach to market structuring through an analysis of me-too drugs.

7. Documentation and dissemination

7.1 Documentation

Documentation at IRDES supports internal document-based research and information for the general public (by phone, email and access to IRDES for the public three half-days per week). There has been a considerable increase in internal and external requests for information in recent years. Many tools are now available on the IRDES website, which has changed the nature of external demands for information somewhat.

⇒ <http://www.irdes.fr/english/Doc/docucenter.htm>

Monitoring and documentary research

The documentation service is one of IRDES' main activities, monitoring all relevant documentation for each of IRDES' principle research themes, as well as recent developments in health.

We monitor most of the resources available in health economics and related areas: 300 collections of reviews, research works, grey literature, databases and the internet.

Software for monitoring documentation - *WebsiteWatcher* - will be tested to improve monitoring of websites and the grey literature.

A systematic literature review is carried out for each research theme using international databases on the Datastarweb server and the CD-ROM Econlit (350 databases in health, social sciences and economic sciences).

Putting the IRDES documentation database on line

We aim to put this database on the IRDES website as soon as possible for the benefit of internal staff and the general public.

The first stage at the beginning of 2007 was designed to identify the most appropriate approach: for example an internally programmed application, a partnership with the Public Health Database team (BDSP), or acquiring a Cindoc web module, and a pre-project was presented to IRDES' Administrative Council.

The BDSP solution was chosen in 2007 but frozen in 2008 because of a lack of finance from IRDES and merging of the BDSP with the EHESP.

7.2 Dissemination

The diffusion service is charged with using any means possible to publicise IRDES work. In 2009 it will continue to publicise and disseminate our work:

⇒ « **Questions d'économie de la santé** » : « Issues in health economics » , a bulletin summarising the research work of IRDES; since 2005 most of these documents have been translated into English;

<http://www.irdes.fr/EspaceAnglais/Publications/IheSummary.html>

⇒ **Lettre info** : an electronic information source reporting IRDES news each month (new publications, monthly data, interviews etc.) and news from elsewhere in the sector (from other sites);

<http://www.irdes.fr/LettreInfo/Sommaire.htm>

- ⇒ **Communiqués de presse** : press releases for each new publication (QES, reports, scientific articles) or specific events (survey launches, colloquia, nominations). The dissemination service is responsible for writing press releases, sending these to the press and putting them online; <http://www.irdes.fr/EspacePresse/CommuniquésDePresse.html>
- ⇒ **Site web** : now the main dissemination tool, the IRDES website is updated regularly (putting Health Economics Questions and some reports, statistical data, press releases etc. online.) <http://www.irdes.fr/EspaceAnglais/home.html>

Glossary

ACS: Financial Assistance for Health Insurance
 ANR: National Research Agency
 ASMR: Increase in therapeutic value
 AT/MP: Work accidents /Occupational diseases
 BDSF: Statistical and Financial Database
 BDSP: Public Health Database
 CEE: Research Centre on Employment
 CERMES: Centre for Medical and Health Study and Research
 CMU: Universal Sickness Insurance
 CMUC: Universal Supplementary Sickness Insurance
 CNAMTS: National Health Insurance Agency For Wage Earners
 CPOM: Multi annual objective and resource contracts
 DADS: Annual declaration of social data
 DDD: Daily defined dose
 DGAS: General Directorate for Social Action
 DGI: Directorate General for Taxes
 DREES: Directorate of Research, Studies, Evaluation and Statistics
 DRG: Diagnosis Related Groups
 EHPG: European Health Policy Group
 EPAS: Permanent sample of socially insured
 EPIBAM: Inter-scheme permanent sample for sickness insurance beneficiaries
 ESFRI: European strategy forum on research and infrastructures
 ESPS: National survey of health and social protection
 FHF: French Hospital Federation
 GINA: Global Initiative For Asthma
 HAD: Hospitalisation at home
 HAS : High Health Authority
 HCSA: The High Commission for Active Solidarity
 HEAPS: Health Economics of Ageing and Participation in Society
 HID: Handicap, Disability and Dependency Survey
 IDEP: Institute of Public Economics
 IDS : Health Statistics Institute
 IJ: Daily allowances
 INPES: National Institute for Prevention and Health Education
 INSEE: The National Institute of Statistics and Economic Studies
 INSERM: The National Institute of Health and Medical Research
 INVS: The National Institute of Health Surveillance
 IREB: Institute for Scientific Research on Drinks
 IRESP: Public Health Research Institute
 LEGOS: Health Organisation Economics and Management Laboratory
 MCO: Short term care: medicine, surgery, obstetrics
 MGET: General Mutual for Equipment and the Territories
 MSA: Agricultural Social Mutual
 NIVEL: Netherlands Institute for Health Services Research
 OECD: Organisation for Economic Co-operation and Development
 OMG: Observatory for General Medicine
 7ème PCRD : The Seventh Framework Programme (FP7)
 PMSI: Programme for the medicalisation of information systems
 PSCE: Supplementary Social Protection for Businesses Survey
 RSI : Social scheme for independent professionals

SAE: Annual statistics of health organisations
SFMG : French Society of General Medicine
SHARE : Survey of Health, Ageing and Retirement in Europe
SROS : Regional health care plans
SSIAD: Home nursing service
T2A : Activity based funding
THM: Hormone replacement therapy
URC: Clinical research unit
URCAM : Regional Unions of Sickness Insurance Funds