Health care reforms in France :

between centralism and local authorities

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SOMMAIRE

Among the reforms proposed by the French goverment last year, many measures had geographical dimension: role of regional authorities, resource allocation project. Traditionally, the entire health care system has been characterized by a top-down style of management and decision-making, despite the existence of regional and local health bodies.

It is impossible to understand those geographical perspectives without some knowledge of the system as it was. In a first part, we shall explain the system architecture (organization, financing and payment). After a survey of performance indicators and health inequities (particularly geographical), we shall examine in a second part proposed reforms, especially in their geographical perspectives.

Part 1

SYSTEM ARCHITECTURE

1.1. Principles

The French health care system comes from the « *Welfare state* », which implies government responsibility for protecting all citizens against having to pay a large out-of-pocket sum for health care [Fielding, Lancry, 1993]. Three principles characterize the French health system: *solidarity, liberalism and pluralism* [Rodwin, Sandier, 1993].

The first principle of *solidarity* provides universal coverage, and refers to intergenerational solidarity [Fielding, Lancry 1993]: the working generation subsidizes the older generation, and people with good health status pay for sick people, active for inactive. Moreover, health insurance payroll taxes are calculated on the basis of ability to pay, not on actuarial risk [Rodwin, Sandier 1993]. Solidarity involves intergroup subsidization [Fielding, Lancry 1993]: for example, the agricultural health insurance fund receives subsidies from the general insurance fund in view of the fact that the number of agricultural workers has declined while the number of agricultural pensioners has increased.

Liberalism (called *la médecine libérale*) is characterized by fee for service payment (*paiement à l'acte*), complete freedom of provider choice; freedom for physicians to choose their patients' treatment and direct payment between patients and doctors in private practice.

Pluralism exists not only in the provision of health care with a public/private mix, especially for hospitals, but also in the financing system, with the coexistence of multiple health insurance schemes, supplementary and private health insurance coverage, and significant out-of-pocket expenditures.

Much of the difficulty in shaping the health care system come from the contradiction between « socialist » principles inherent to the National Health Insurance framework and the free enterprise system of providers [OECD 1992].

1.2. National Health Insurance

The French national system of social security includes many chapters:

- family benefits,
- old age and pensions,
- health coverage.

Coverage against the financial costs of illness is provided mainly by National Health Insurance (NHI, in French *l'assurance maladie*), one of the three tenants of Social Security. This protection is based on occupation (for the active labor force and retirees) and the type of occupation determines the fund to which contribution is made. The occupational segmentation of the NHI led to a management shared by employers and trade-unions in 1945 when it was created. After 1967, the parity in representation was modified, and the participation of the Health Minister in NHI was added, which illustrates another aspect of the mix between joint management (*cogestion)* and administration by state.

There are three important Sickness Insurance Funds (*Caisse d'assurance maladie).* The general fund covers salaried workers and their families and represents 80 percent of the population. The agricultural fund for farmers and salaried agricultural workers covers 9 percent of the population. The third fund comprising professionals and other self-employed persons covers about another 6 percent. In addition, many specific funds exist covering specialized occupational workers and their dependents such as miners, railway, subway workers. These funds are all managed separately.

People who are not covered through employment access to the NHI through individual contributions. For the unemployed, social security covers payments for them during a given period of time. After this period, unemployed have access to the NHI through individual contributions.

However, since 1988, a law requires that all persons older than 25 years with « insufficient resources » receive a subsidy to bring them to a defined minimum monthly income (currently $440 for one person with additional subsidies for each child). For those people, premiums for health care are paid by local governments. Concurrently, special funds are provided by the State to guarantee coverage of homeless, unemployed and disabled persons.

Finally, coverage is nearly universal, with less than 1% of the population still without health insurance coverage. This percentage could eventually be further reduced if the pending reforms succeed in providing truly universal coverage and meeting the needs of formerly marginalised populations.

1.3. Organization of health care system

The health care system is a public/private mix, with ambulatory care mainly private and a dominant public sector for hospital care.

Ambulatory care is organized around office-based fee-for-service practice. Physicians are free to establish a practice anywhere. Consequently, great differences in liberal physicians density exist on the French territory, between the North and South of France, center and suburb, or rural and urban areas [see part IV]. For example, a twofold variation in the density of general practitioners is observed between the North and South, and even more for specialists. A patient who needs health

care can see the physician of his choice : general practitioners are not expected to also be gate keepers.

Hospital care is mixed, but public facilities are dominant, with two thirds of all beds and three fifths of short-stay beds. Patient can choose between both without consequences on health care reimbursements.

Public and private hospitals differ in mission, technical level and management. Public hospitals must accept all patients and provide emergency care. Research and teaching are integral parts of theirs missions. Public hospitals include general and specialized hospitals of variable size, ranging from regional centers with high technology services and highly trained physicians dedicated to medical education and research to smaller local hospitals. Public hospitalization is more important than private hospitalization in medecine and psychiatry but is more restrained in surgery or obstetrics.

Private hospitals are smaller on average than public ones. They include overall acute care facilities, medium and long-term stay facilities and psychiatric hospitals. This sector accounts for about 35 percent of hospital beds, for a bit less than half of the beds in surgical services and for 65 percent of beds in medium and long term stay facilities.

1.4. Financing and payments

France spent 9.8% of its GNP on health care in 1993, which is close to Canada (10.2%) or Germany (8.6%), but about 4% less than the USA (14.1%). In comparison, figures for the UK (7.1%) and Japan (7.3%) are low. As concerns expenditures, the value per capita was $1 835 (in purchasing power parities), compared with $3 299 (USA), $1 213 (UK), and $1 815 (Germany) - see table 1. Within the European countries, France has the highest health care expenditures.

Table 1:
% GNP, Expenses for OECD in 1993

	Total Health Expenditures	
Country	**Total Exp. on Health Care: % of GDP**	**Total Exp. on Health Care: Val./Capita PPP$**
United States	14.1	3299
Canada	10.2	1971
Switzerland	9.9	2283
France	9.8	1835
Austria	9.3	1777
Finland	8.8	1363
Netherlands	8.7	1531
Germany	8.6	1815
Australia	8.5	1493
Italy	8.5	1523
Belgium	8.3	1601
Iceland	8.3	1564
Norway	8.2	1592
New Zealand	7.7	1179
Sweden	7.5	1266
Japan	7.3	1495
Portugal	7.3	866
Spain	7.3	972
United Kingdom	7.1	1213
Luxemburg	6.9	1993
Denmark	6.7	1296
Ireland	6.7	922
Greece	5.7	500
Turkey	2.7	146

Source: Eco-Santé OECD, CREDES/OECD
PPP: Purchasing Power Parities: differences in price levels between countries are erased.

a) Financing and reimbursement

To finance benefits received under French national health insurance, employers contribute 12.8 percent of the wage bill and employees paid 6.9 percent of their full salary in 1993 to the State. The total payroll taxe (*cotisations salariales et patronales*) for health insurance represents 19.7 percent of all wages.

As a general rule, French patients pay the full fees directly to health care providers and obtain partial, or more rarely full reimbursement from the health insurance fund to which they are affiliated. The Social Security system pays 75.5% of health service expenditures through SIFs. The contribution of central and local governments diminished from 14% in 1950 to 1% now. Trends in sources of Health care financing are summarized in the following table.

Table 2
Sources of health care payments in France in %

Sources	1970	1975	1980	1985	1990	1994
Social Security	68.6	71.6	74.3	73.2	71.9	71.6
Out of Pocket	17.3	15.0	13.3	14.8	16.5	16.5
Supplemental Insurance	4.5	4.8	5.1	5.5	6.5	7.0
Local Government	7.8	7.2	5.9	5.2	3.9	3.6
Others	1.8	1.5	1.4	1.5	1.3	1.3
	100.0	100.0	100.0	100.0	100.0	100.0

Source: SESI

The very important trends over the past twenty years have been the decreasing part of the National Health System, and, as a correlary, the growth of the patients' copayment (*ticket modérateur*), particularly with supplementary insurance. In 1991, 83% of the population was covered by supplementary insurance (Bocognano, 1992) which can often lessen the burden of copayment for beneficiaries. The rate of copayment depends on the kind of service: about 7.4% for hospital care and 28.3% for physicians services. It is an essential fact of the French situation that the level of the copayment is very high compared with other developed countries: 20% in the USA, 19% in France, less than 10% for Canada, the UK, Netherlands, Germany [Moreau, 1994].

b) Provider payments

Since 1971, physician practice issues are subject to a formal national negociation process between the government, social security and medical union representatives. Issues covered include tariffs. This is one of the main characteristics of the French system: despite its *liberalism,* there is no competition based on prices. Nevertheless, with physician pressure, the government created in

1980 a « second tier » (*secteur II*). For physicians in the second tier, the SIFs reimburse the same amount based on the national fee, but the physicians are free to ask the patient for a higher price. There are, however, ceilings which physicians cannot exceed. Fewer than 25% of MDs are in second tier in 1995, the largest proportion being in the field of gynecology.

Concurrently, all public hospitals and some nonprofit private, (71% of short-stay beds) receive annual global budgets to cover all services. Private hospitals receive per diem payments for inpatient services.

To end this part, figures of health care resources and utilization are shown in the next table.

Table 3
Health care resources and utilization in France, 1989-1991

Resources	
Active physicians per thousand	2.67
Active physicians in private, office-based practice per thousand	1.89
General/family practice	52.9%
Obstetricians, pediatricians, and internists	8.5%
Other specialists	37.6%
Total inpatient hospital beds per thousand	9.1
Short-stay hospital beds per thousand	5.1
Public beds	62.7%
Private Beds	37.3%
Proprietary beds as percent of privated	68.3
Nonprofit beds as percent of private	31.7
Utilization	
Physician visits per capita	8.3
Specialists visits per capita	3.4
Hospital days per capita	2.8
Short-stay hospital days per capita	1.4
Admission rate for all inpatient hospital services	23.1%
Admission rate for short-stay hospital services	20.8%
Average length-of-stay for all inpatient hospital services (days)	12.3
Average length-of-stay in short-stay beds (days)	7.0

Source: French data are from Eco-Santé France (CREDES, 1996).

1.5. Performance indicators

In 1994, the average life expectancy at birth for French males was 73.3 years, and for French females, 81 [Duriez, Sandier, 1994.] These levels put France in seventh and second place respectively among all OECD countries. The difference between male and female life expectancy, i.e. 8.2 years, is the highest of all developed countries. Even given this current imperfect index, the figures illustrate the French specificity : very high male mortality, but indicators in the good mean of developed countries.

For infant mortality, in 1992, there were 6.8 deaths for every thousand live births, compared with 4.5 in Japan (U.K.: 6.6, U.S.A.: 8.5). It is difficult to make comparisons on other data than causes of death: France has high rates for road accidents and suicides. For ischaemic heart disease, the rates are lower than in other countries. Therefore the excess of French mortality can be explained by diseases related to alcohol and smoking (especially among males).

Table 4
Life expectancy, infant mortality in 1990

Country	Males at Birth Life Expect Years	Females at Birth Life Expect Years	Infant Mortality Death % Live Birth
Luxemburg	n/a	78.5	0.74
Japan	75.9	81.9	0.46
Iceland	75.7	80.3	0.59
Sweden	74.8	80.4	0.60
Switzerland	74.0	80.9	0.68
Australia	73.9	80.1	0.82
Canada	73.8	80.4	0.68
Netherlands	73.8	80.1	0.71
Italy	73.6	80.2	0.82
Norway	73.4	79.8	0.70
Spain	73.4	80.5	0.76
United Kingdom	72.9	78.6	0.79
France	72.7	80.9	0.73
Germany	72.7	79.1	0.71
Austria	72.5	79.0	0.78
Belgium	72.4	79.1	0.79
New Zealand	72.4	78.3	0.84
Denmark	72.0	77.7	0.75
Ireland	72.0	77.5	0.82
United States	71.8	78.8	0.92
Finland	70.9	78.9	0.56
Portugal	70.9	77.9	1.10
Mexico	67.9	73.9	2.40
Turkey	64.1	68.4	5.93

Source: Eco-Santé OECD, CREDES/OECD.

Most of the criticisms made in France about the health system are not about the outputs, but about the costs: the system is expensive and a large part of its cost (copayment) is not covered by the NHI. Moreover, there are problems in containing rising costs and the increase in out-of-pocket expenditures. According to polls, 15% of French people declare they have to give up some care (dentistry) because it is too expensive [Mizrahi, Mizrahi, 1994]. However, surveys show that French individuals are relatively satisfied with their health care system [Rodwin, Sandier, 1993].

To assess effectiveness in delivery of the French system, one must study data on inequalities, and more specifically, on geographical inequities.

Social inequalities

Social inequalities are obvious as concerns life expectancy based on professional status: the life expectancy of an engineer at age thirty five (45 years) was higher by nine years than that of a manual worker (35.8 years - see Desplanques). There are also inequalities in patterns of use: the higher class rely more on ambulatory office-based services, particularly for specialists. The more disadvantaged groups make greater use of GPs and public hospitals [Mizrahi, Mizrahi, 1994].

For this matter, it is difficult to compare with others countries because of the lack of international social indicators (social class or occupational status do not have the same meaning in different countries). For those reasons, it is difficult to assess if inequalities are higher or lower. For methological comparisons of social inequalities between the UK and France, [Aïach P., Carr-Hill R., Curtis S., Illsley R, 1987].

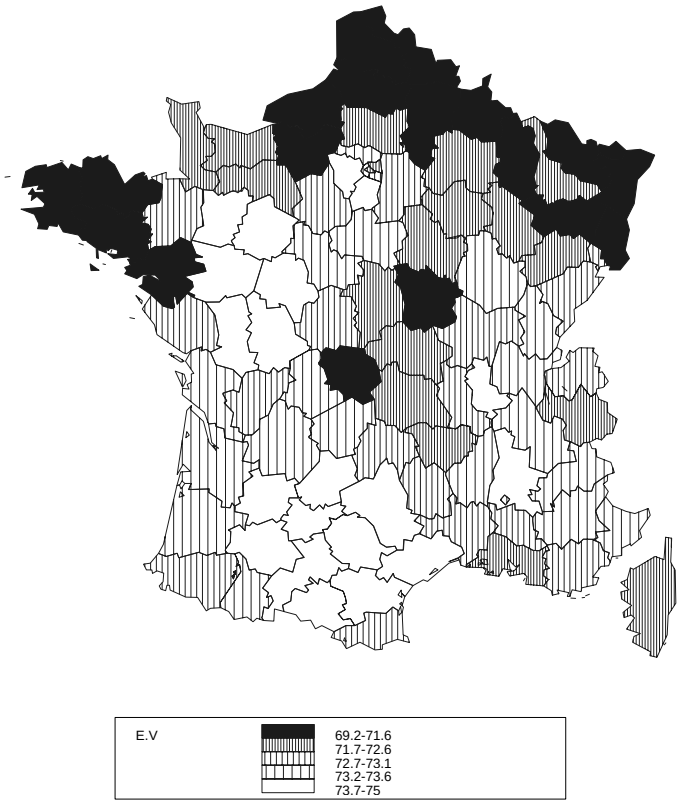
Geographical inequalities: the inverse care law

In France, there are considerable North/South differences in access to general practitioners (and specialists). This is clearly seen from the 1990 figures (map n°1) comparing physician density in French departments (« *départements »,* a French administrative district similar to the UK county).There are 95 « *départements »* in France with a mean population of 500 000 inhabitants, and 22 regions, which is an upper level for administration. The distribution of medical pratictioners among French departments does not differ fundamentally from that of a hundred years ago, though the number of practitioners has increased ten fold.

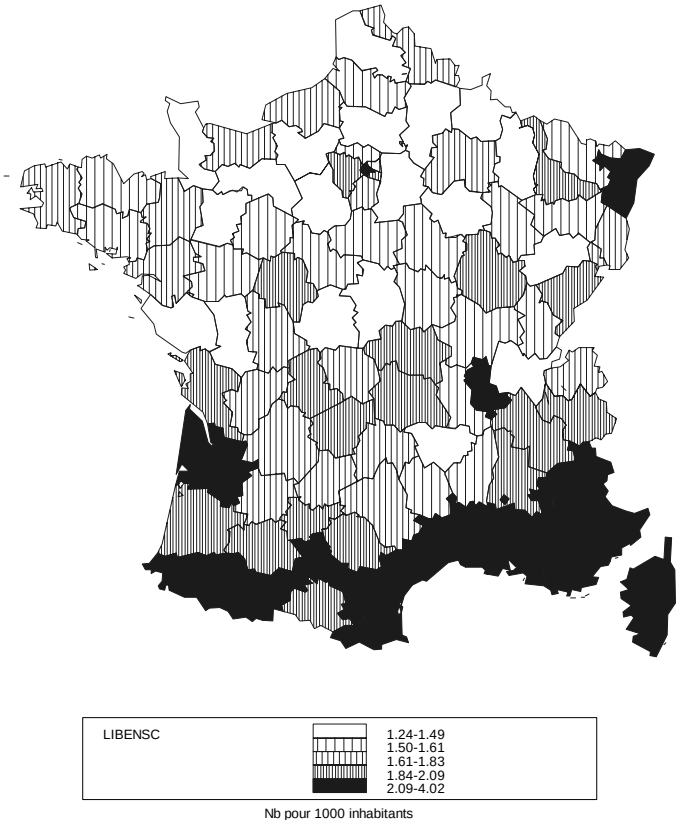
Inequalities in the past are, in fact, the source of today's inequalities. Today, as a century ago, high densities of physicians are found in regions offering the most opportunities for medical training. For regions with a comparative shortage of physicians, the opportunity to reduce inequalities was missed twenty years ago when the number of GPs doubled. At this time, it would have been sufficient to increase the number of students in medical schools in these regions [Tonnellier, 1992].

The mortality map (life expectancy) for France in 1990 reveals quite distinct characteristics (map n°2). All the North of France, including Britanny and the East, has a high level of mortality (SMR) with respect to the rest of the country.

Map 1: LIFE EXPECTANCY in 1990 (Males)



Map 2: PHYSICIAN DENSITY in 1994



The inequalities in life expectancy can be explained by a combination of factors: behaviour (an important part of excess mortality is due to alcoholism), environment, and social structure [Noin, Chauviré, 1991, Desplanques in « *Histoire de la population française* », 1988]. Attitudes toward health care and health can explain spatial differences: the level of education is higher in the south of France. This probably contributes to a greater demand for care and a different behaviour towards health. In the same time, it also explains the higher physician density: with a higher level of education, there have constantly been much more students in medecine schools in the South than in the North since the beginning of our century [Tonnellier, 1992].

For mortality, the situation in France has been stable for the last twenty years or so (1968-1990). The hierarchy of « departements » with respect to life expectancy has not changed a lot since 1962. Obviously, the level of mortality has decreased over the period, but similarly in all regions.

Comparing the maps 1 & 2 leads us to suppose that the « inverse care law » applies [Jones, Moon]: there is a lack of territorial equity in France. This is not exactly self-evident, because life expectancy is not only the result of physician activity: for many causes of death such as road accidents or smoking or alcohol, health care is not very effective. It is assumed that health care utilization most often pertains to conditions that entail a low case fatality ratio.

For medical care consumption, the same contrast between the North and the South remains for utilization of specialist care and technical procedures [Faure, Lucas, Tonnellier, 1993]. Home visits and pharmaceutical consumption reveal a very specific pattern, which suggests regionally defined behaviours, both for the patients and the prescribers.

Over a period of thirty years (1962-1990), evolution reflects the inertia of geographical distributions. The hierarchy of departments has remained constant with regards to supply, consumption and mortality, but a reduction of geographical inequalities has been observed over the period [Faure, Lucas, Tonnellier, 1993].

Inequalities in urban areas

There are disparities between inner city areas and deprived suburbs. (In France, inner cities are wealthy areas which makes a great difference with the USA or the UK). Even for primary care, physicians aren't equally distributed spatially. GP's are more frequently located in town centers (map 3). This is not sufficient to conclude that there is inequality in the provision of care. This could be functional inequality: many people commute and the location of physicians is almost the same as that of big stores or other services. But the next map shows an inverse relationship between the supply of GPs and their level of activity (map 4), which is more important in the city belts than in the city center. Moreover, the level of activity of GPs is high in industrial areas (as in the North/East part of greater Paris), suggesting a lack of primary care provision in the periphery of big towns [Lucas, Tonnellier, 1996]. At this scale, the Inverse Care Law also applies.

These inequalities (access to health care, mortality) are equally pronounced in the major conurbations. Within Greater Paris, inequalities are of the same magnitude as within the entire country.

Inequalities in rural areas

For rural areas, particulary for remote rural areas, the classical problems resulting from depopulation, great distances of access to facilities, and even of access to primary care remain. In France, each physician is free to practice where he wants. Despite project initiatives, there are no incentives for young physicians to practice in deprived areas (urban or rural). There are some rural « *départements* » with a low population density, (the minimum value is 14 inhabitants/km^2), but distances are not as high as in North America.

There is an acute problem, as in many others countries, with hospitals because health authorities would like to shut small hospitals, and particulary maternity wards which have insufficient numbers of births. This is essentially a planning problem, as the impact of hospitals closures may make the affected areas even more isolated (Lucas, Tonnellier, 1995).

Part 2

HEALTH CARE REFORMS & GEOGRAPHICAL PERSPECTIVES

2.1. Reforms in the past

The consumption of health care represents an important part of the goods and services produced in France, about 9% of the gross domestic product. This consumption is growing faster than the national wealth so that health care consumption as a percentage of G.D.P. is constantly growing. Because social security is financed through contributions based on workers' incomes, social security reserves evolve at the same pace as the G.D.P, that is to say, more slowly than expenses. As a result, the financial equilibrium of the social security system has been a constant problem for several years in France.

During the last twenty years, several plans have tried to control spending. But these actions were typically more restrictive measures on supply and demand neither than full-scale or comprehensive reforms.

Many measures have been taken to limit the volume of health care services. In 1971, a medical school quota system was instored limiting the number of medical students accepted. At the same time, a law on hospitalization established controls on hospital capacity and on heavy technology using population-based service standards. Recently, a new law on hospitalization (1991) has reinforced regional planning in order to reduce persistent regional disparities in equipment and technology levels. Over the course of twenty years, the rate of increase in the volume of care has slowed down (as we already said, volume means value in constant prices). However, this rate still remains higher than in other countries in Europe.

Others measures were taken with regard to costs and expenditures. For example, a global budget process imposing a total expenditure ceiling for all public hospitals since 1983 has significantly slowed the growth of hospital expenditures. The rate of increase per year for public hospital expenditures has decreased from 9.5 percent in 1970-75 to 2 percent in 1994 in volume. In the same way, negociations on prices between national health insurance and representatives from the health care professions has limited the increase of medical charges.

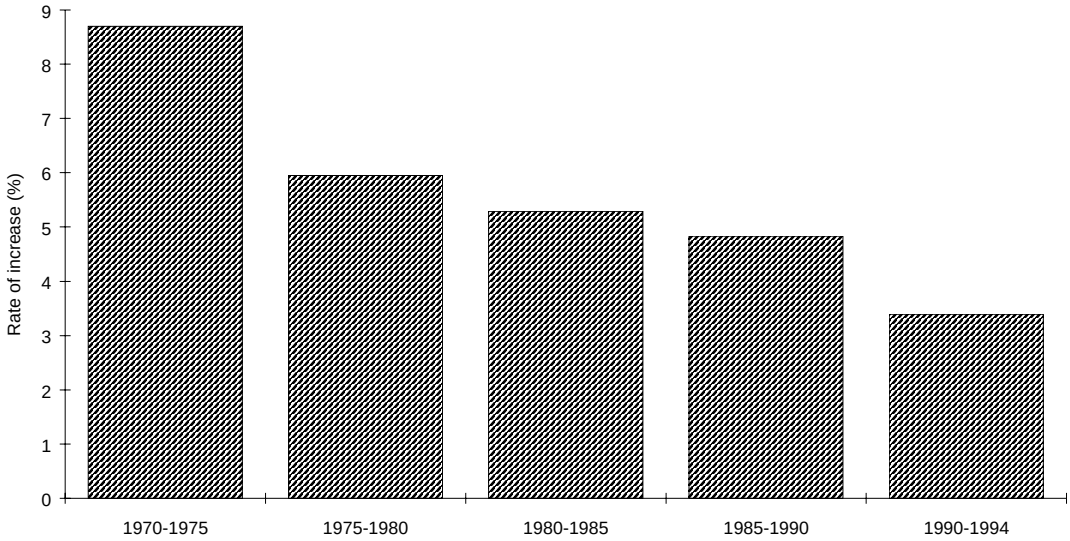
Concurrently, information systems similar to the DRGs in the United States called *Programme de Médicalisation du Système d'Information* (PMSI) are being tried out in France. This system should replace the present system of hospital financing (global budget) and enable to have a better understanding of the structure of costs according to the nature of illness. The creation of adequate information systems for the collection and processing of data related to costs and utilization is a very crucial question. For this matter, France has poor levels of computerization.

In the same period, measures on demand were taken by increasing the financial participation of patients, for example, by limiting the number of illnesses for which social security offers 100% coverage of costs, by increasing the co-payments for certain pharmaceutical products or physical therapy or by instituting a flat daily hospital rate. The impact of such measures on health care

expenditures is not exactly quantifiable, but what is certain is that the percentage of out-of-pocket costs for patients is now one of the highest in Europe (cf financing and payments).

Since 1975, severals plans for reform have been introduced to constain costs. Although « most of the control efforts of the plans are effective for only brief periods » [Fielding, Lancry, 1993], there has undoubtely been a certain deceleration in the overall volume of health care expenditure since 1970 [Rodwin, Sandier, 1993] - please refer to the next figure.

Evolution of health care consumption per capita (constant prices)



In 1993, new provisions were introduced, namely the application of clinical guidelines (*Références médicales opposables*), and the implementation of a permanent patient medical record (*carnet médical*) to avoid contradictory or redundant prescriptions. Surveys are made to assess the effectiveness of these reforms (but results are still unpublished).

2.2. Reforms in the future

In November 1995, Prime Minister Juppé made an announcement for a vast plan of reforms of the National Health Insurance, which was the cause of nation-wide, full-scale strikes for 21 days. These reforms planned to affect the entire social security system. The main measures proposed were the following (in terms of health care):

- One of the most important changes was to give the responsibility to the Parliament to vote each year for set a rate of increase for health care expenditures (i.e. a closed health care budget). Before that, this role was carried out by « *la Sécurité sociale »,* i.e. employers and trade unions who had, since 1945, the responsability to manage National Health Insurance (without parity of representation). The setting of a preliminary annual targets for the growth of private practice medical fees and prescriptions is a further change, and this contradicts physicians' traditional freedom to choose the treatment. This concept can be ambiguous with regard to physicians' services: « will the target apply to all health spending, or will it apply to spending reimbursed, with the risk of increasing inequalities in access to medical care ?» [see Rodwin, Sandier, 1993].

In addition, little information is presently collected allowing SIFs to identify physicians who provide inappropriate services, and no reliable data is issued on applied diagnoses and precise procedures performed [Rodwin, Sandier, 1993].

– To increase the financing of the system, taxes are to be increased, and payroll taxes (on wages) will decrease. This means a growing role for the State and less leverage for the National Health Insurance in the financing of health care.

The new system would provide universal coverage to all residents in France. Coverage is actually quasi universal at the present time (with only 1% of population not being covered), but for the administration, it could be a significant modification if it implies that each Sickness Insurance Fund must disappear.

2.3. Geographical perspectives

Up to now, the role of regional insurance funds was to make reimbursements and not to have control over regional expenditures. One of the projected reforms (and it will trigger off a great debate if it goes forward), is to create a local power to control costs with parity of employers and trade unions in decision making (joint management in decentralization). The role (and even the institution) of local authorities remains to be discussed. May be, it would be a manner to try to solve locally the problem on who decides: state or employers and trade unions. Will it be more effective with decentralization than with centralization ?

The debate focuses mainly on local authorities and on their role. But the policies and the reform underscruting aim mostly at cost control and hardly on inequity reduction at all, whether social or geographical. Moreover, there is no connection between Public Health and policy of cost containment, at a national level nor at a local level.

In their principles, many policies aim to reduce geographical disparities. But except for hospitalization recently, local measures are few. A project of resource allocation for ambulatory care was inspired by the British RAWP (Resource Allocation Working Party) [Bournot, Lucas, Tonnellier, 1995]. But the question remains: how can physicians be controlled on a fee-for-service basis ?

Allocating resources according to needs is a completely new procedure for French administration which had previously been envisaged theoretically only. It must be noted that its goal is to reduce discrepancies between levels of expenses and consumption, but not to reduce inequalities of access to health care, nor of health status. Furthermore, there are very few local action plans focused on public health or community health.

CONCLUSIONS

It is important to discuss the strengths and the weaknesses of the French system. Universal coverage, rather good health indicators, good consumer satisfaction are the positive points. On the other hand, high levels of copayment, difficulties in containing rising health care costs and an inefficient financing, high levels of expenditures (compared with European countries), social and geographical disparities, no or little quality control or regulation measures in place, poor data collection have prompted the many reforms over the past twenty years.

Just as the reforms strive to balance *solidarity and liberalism,* the present debates evaluate the proper mix between *centralization and decentralization*. The fact that local authorities do not play a clear role yet adds another difficulty. What is the ideal geographical unit for which local authorities will be responsible (regions, départments, or smaller) ? There are numerous administration bodies which share (and sometimes compete for) responsibility for health care administration: local representatives of state, elected officials, joint local governing bodies.

From a geographical perspective, it is impossible to conclude today what the impact of the reforms will be, since the reforms are still in progress, and a lot of projects involving changes (ex: the power of local authorities) are being studied. We can finally distinguish two kinds of problems:

How can affect geographical inequities ? In France, inequities are often accepted as a given fact, and the focus is on medical care [Aïach, Carr-Hill, Curtis, Illsley]. But inequities in the field of health care are of a different nature whether they are linked to health determinants (socio-economic variables, behaviors), health care organization, health status (morbidity, mortality), health care consumption. The distinction between these variables leads to differentiating between various needs and action taking.

During the set-up of reforms, the reduction of regional discrepancies is not always an explicit nor a priority goal. New local institutions focus primarily on cost management and control according to public health objectives. This last objective is completely new in France. Finally, the most recent legislation plans for different authorities and management for hospitalisation and for ambulatory care, which perpetuates one of the defaults of the previous system.

The search for territorial equity can take place only if the collection of indicators on health status improve and if an evaluation of the practices exists. The current system has to improve in collecting data on diagnosis and morbidity. This improvement of knowledge could then enable to judge the correspondence between health services and needs.

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