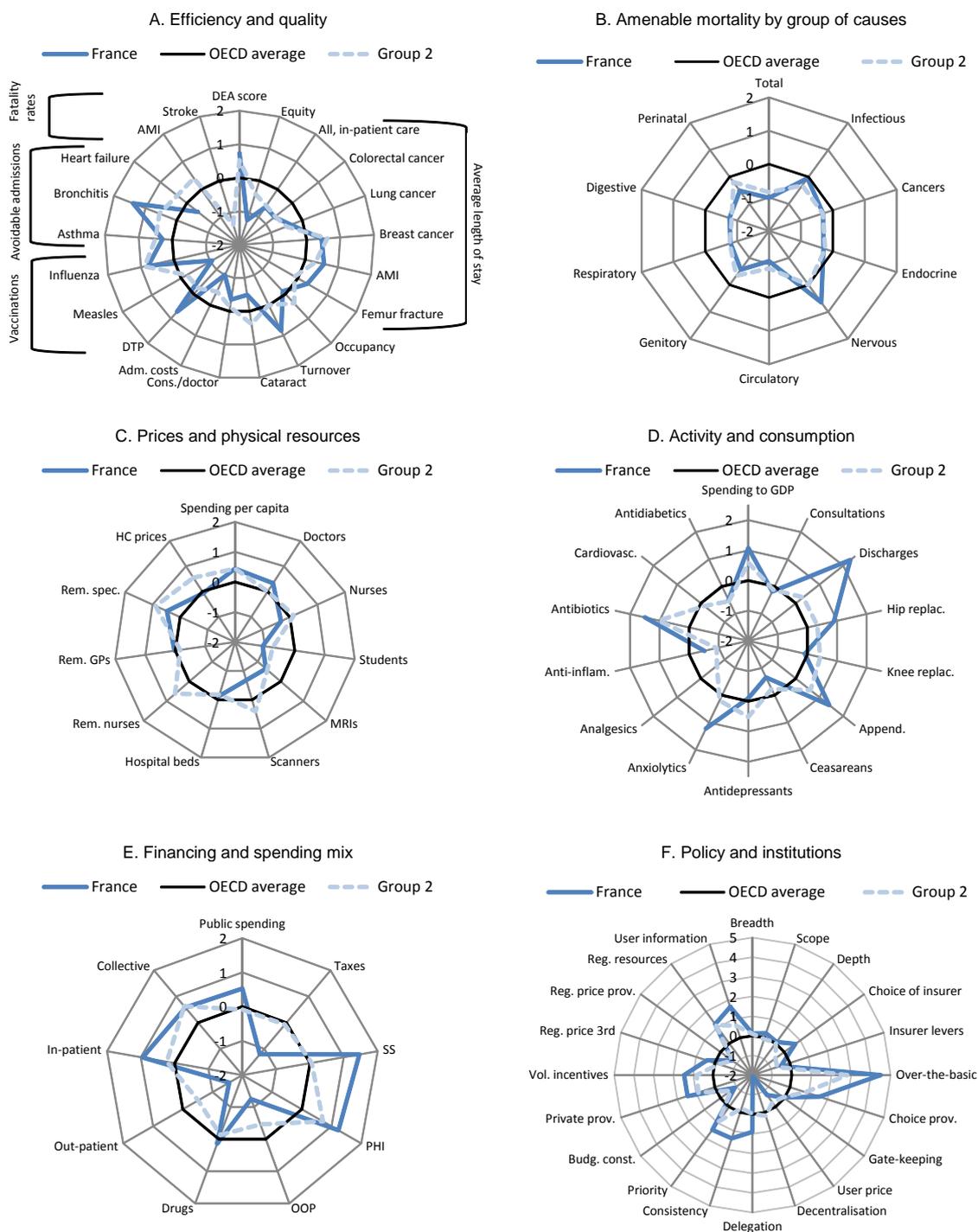


France: health care indicators

Group 2: Australia, Belgium, Canada, France



Note: Country groups have been determined by a cluster analysis performed on policy and institutional indicators. In all panels except Panel A, data points outside the average circle indicate that the level of the variable for the group or the country under scrutiny is higher than for the average OECD country (e.g. Australia has more scanners than the average OECD country). In Panel A, data points outside the average circle indicate that the group or the country under scrutiny performs better than the OECD average (e.g. administrative costs as a share of total health care spending are lower in Australia than on average in the OECD area). In all panels except Panel F, data represent the deviation from the OECD average and are expressed in number of standard deviations. In Panel F, data shown are simple deviations from the OECD average.

Source: OECD Health Data 2009; OECD Survey on Health Systems Characteristics 2008-2009; OECD estimates based on Nolte and Mc Kee (2008).

FRANCE

GROUP 2: Public basic insurance coverage combined with private insurance beyond the basic coverage. Heavy reliance on market mechanisms at the provider level, with wide patient choice among providers and fairly large incentives to produce high volumes of services contained by gate-keeping arrangements.

Efficiency and quality	Prices and physical resources	Activity and consumption	Financing and spending mix	Policies and institutions	Weaknesses and policy inconsistencies emerging from the set of indicators
High DEA score and OECD best performer on amenable mortality but high inequities in health status	Higher health care spending as a share of GDP		Higher public, social security and PHI shares; less out-of-pocket payments	More reliance on market forces in the insurance sector	Explore the main causes for high inequities in health status, and in particular the role of over-the-basic coverage (complementary insurance)
Mixed scores on output/hospital efficiency	Less nurses and high-tech equipment	More hospital discharges	Higher in-patient share	More choice among providers, less price signals	
Rather high quality of (out-patient) care	Less medical students		Lower out-patient share	More private provision and incentives to increase volumes. More regulation of workforce and equipment, in particular in the hospital sector, and of prices paid by third-party payers.	Reconsider government controls on labour and equipment in the in-patient care sector (the reform of the hospital payment system may require more flexibility on labour and equipment for hospitals to adjust to the new set of incentives)
Very high administrative costs				Less decentralisation	Explore options to reduce administrative costs, including the consolidation of social security funds