Cour des comptes

# PREVENTIVE HEALTHCARE POLICY

## Lessons learned from the analysis of three major pathologies

Communication to the National Assembly Public Policy Evaluation and Audit Committee

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# Abstract


❖ **The evaluation of the preventive healthcare policy first led the Court to measure its effectiveness and efficiency** by presenting the results of preventive action on the three major pathologies covered in this report (cancers, neuro-cardio-vascular diseases (NCVD) and diabetes) overall and in terms of social and regional inequality.

The Court addressed preventive healthcare for these three major types of pathologies, which are eligible for potentially concerned by a preventive approach that addresses common and known risk factors, unlike other pathologies. This choice was also guided by the number of people affected by these pathologies and the associated public health consequences such as the effect on public finances. Although this choice addresses most aspects of preventive healthcare policies, other decisive factors for public health (environment, working conditions, nutrition, housing, education, etc.) were also considered indirectly.

The Court's main finding is that the prevention of these three pathologies in France generally obtains poor results even though its financial efforts compare with those of neighbouring countries.

**1 -** The three diseases considered are continuously on the rise, in particular diabetes and cancer, while France has a lower mortality rate for NCVD. As a result, their impact on health and the resulting financial costs are very significant:

- the number of people with these diseases is high: 3.9 million people with diabetes, 5.1 million with cardiovascular disease, and 3.3 million with cancer. Infection with SARS-CoV-2 has shown that these people have a significantly higher risk of complications and death;
- these pathologies account for a quarter of annual health expenditure, totalling nearly € 50 billion. In addition, the rise in healthcare expenditure related to these three pathologies between 2015 and 2019 (+16 %) was stronger than the increase in the national healthcare expenditure target (Ondam) over the same period (+10 %).

These findings are worsened by the strong social and regional inequalities that characterise patients with these three pathologies. Indeed, there is a clear social gradient[1], with people from low-income disadvantaged communities being more affected than others. Similarly, some regions such as the north-eastern quarter of France, overseas regions, and several mainland *départements* located in low-density areas are much more affected than others.

**2 -** The total cost of prevention is estimated at approximately €15 billion. This figure represents the sum of two very different components: institutional prevention programmes (€6 billion until 2019) and prevention actions reimbursed to social security beneficiaries, estimated at €9 billion in 2016 by the the Directorate of Research, Studies, Evaluation and Statistics (Drees).The measurement of this expenditure is inaccurate and incomplete. For this reason, in 2011 and 2017, the Court of Accounts called for the definition of a method for measuring preventive healthcare expenditure and to set a separate Ondam target for this expenditure.


[1] The social gradient shows how social inequalities in health are distributed across society.

Based on this estimate, the percentage of GDP spent on prevention totals 0.63 % in France, which is close to figures for the United States, the United Kingdom and Germany.

**3-** Overall, the results obtained in France are well below their targets and the performance of other comparable countries.

Thus, medical prevention programmes (vaccination and screening) and healthcare promotion initiatives have insufficient take-up or are inadequately deployed to have a significant effect on major pathologies, even though their effectiveness has been proven. This is the case with screening for the three cancers concerned: cervical cancer, bowel cancer and breast cancer, which have much lower participation rates than our European neighbours (only breast cancer screening reaches 50 %, the others being closer to 30 %).

A similar finding can be made with regard to HPV vaccination (against human papillomavirus), the only existing vaccination for cancer, where France is well behind with a participation rate of 25 %, while most other countries have rates of between 30 % and 90 %.

Other shortcomings are noted:

- nearly 700,000 people unknowingly have type 2 diabetes due to insufficient screening offered to patients. Late detection of this disease significantly increases the risk of complications (heart attack, stroke, amputation, blindness, etc.), or even death;
- almost 13 million adults smoke daily but fewer than one million a year (6.6 %) receive nicotine replacement therapy, though this number has been multiplied by five in recent years;
- almost 10 % of French people (6.7 million) are responsible for 58 % of the country's total alcohol consumption, without being identified by their family doctor, treated and accompanied.

Existing tertiary prevention programmes[2] (implemented after the disease has been diagnosed) also fall short of needs, both in terms of the Prado programme to support patients returning home, which covers only 18,000 patients with cardiovascular disease out of a target population of at least 1.5 million people, and support for diabetics through the Sophia programme, which only reaches 30 % of patients.

❖ **The Court then assessed the relevance and usefulness of the prevention policy.** It noted that the French prevention strategy and governance have recently been reviewed, but they face persistent obstacles in applying the strategy both nationally and locally and in the organisation of primary care.

France redefined its prevention strategy and reorganised its governance in the law modernising the healthcare system (LMSS) of 26 January 2016.

**1 -** A national health strategy was drawn up at the end of 2017 to renew the national strategy launched in 2014. The number of targets was reduced to around fifty, compared with a hundred in 2011 (for adult healthcare covered in this report), and the targets are to be assessed using around twenty indicators produced by the Drees. The adoption of the national health strategy is a real step forward in demonstrating the government's willingness to act with

[2] Tertiary prevention aims to alleviate chronic or repeated illness and to reduce complications, disabilities or relapse caused by the disease. A diagram in the introduction to the report describes the concepts of primary, secondary and tertiary prevention.

an inter-ministerial and cross-departmental approach targeting relevant strategic priorities approved by the High Council on Public Health (HCSP).

Following the adoption of the national health strategy, the government announced the first national prevention plan, the National Public Health Plan - Priority on Prevention (PNSP), at the inter-ministerial health committee on 26 March 2018. This plan addresses all factors that influence health: environmental and behavioural factors and their impact at different ages in life. A specific focus was placed on 25 flagship measures covering smoking, alcohol and nutrition, screening for certain cancers and influenza vaccinations.

However, the PNSP does not set coordinated multi-annual national targets with a clear timetable for all major pathologies. It simply refers to other existing plans which have their own multi-annual timetable (for example, the ten-year cancer control strategy), without establishing any link or complementarity in terms of objectives and planning. As a result, this plan cannot be really assessed, unlike in the United Kingdom, Germany and Italy, which, while opting for a largely decentralised multi-annual timetable, have included indicators with quantified results.

In addition, the PNSP does not clearly interact with other existing focused prevention plans such as the housing plan, the national anti-smoking plan, the action plan for plant protection products, the national environmental health plan, the occupational health plan, the national nutrition and health plan, the national food plan, the chlordecone plan in the French Antilles, the national strategy on endocrine disruptors, the national addiction action plan, the national sports & health strategy, the 2014-2019 cancer plan, etc.

Finally, the PNSP does not specify how responsibility for its implementation is to be distributed between the different national and regional stakeholders and does not provide for a precise implementation at the regional level, even though the regional health authorities (ARS) play a key role in prevention.

In parallel, a reorganisation of the national stakeholders was carried out with the creation of the national public health agency (ANSP) called Santé Publique France by merging the Health Monitoring Institute (InVS), the National Institute for Preventive Healthcare and Education (Inpes) and the Health Emergency Preparation and Response Organisation (Eprus). The Technical Committee on Vaccination has been transferred from the High Council on Public Health to the High Authority for Health (HAS), in accordance with an audit recommendation made by the Court of Accounts.

**2 -** At the regional level, the prevention strategy is poorly implemented.

The definition of regional preventive healthcare objectives should result from a synthesis of national plans and epidemiological realities, which vary widely between regions. An approach by *département* or even within *départements* is a necessary step in targeting prevention policies. However, data rarely exist at this level and their collection should be organised on a larger scale in the information systems of the National Health Insurance Fund (Cnam) and healthcare professionals.

Furthermore, the regional health authorities struggle to ensure the regional coordination of prevention organisations, which are often tasked with implementing national programmes. The recent creation of larger regions makes this coordination even more complex. Conventional regulation of community medicine and healthcare professionals more generally, which is almost exclusively organised at the national level, also deprives them of essential levers and confines them to cumbersome, fragile experiments with no guarantee of success over time.

In addition, healthcare promotion initiatives are in fact delegated to quasi-institutional non-profit organisations such as regional healthcare education and promotion institutions (Ireps) and a few major national associations, which, in turn, requires that the ARS systematically assess the results achieved and their relevance to local priorities.

Finally, the complexity of screening initiatives, which are now organised at regional level, the poor results in terms of participation, and the challenges of improving professionalism that lie ahead call for a complete overhaul of the system. In this sense, the ongoing assessment by the Cnam and the National Cancer Institute (Inca) needs to be extended and reinforced in order to rapidly improve the effectiveness of screening.

**3 -** The organisation of primary care in France and its remuneration method are major obstacles to the deployment of prevention

The way in which community medicine is organised in France, with mostly isolated practices and payment per consultation, also has a negative impact on prevention, compared to other countries, in particular due to the segmentation of practitioners.

Remuneration based on public health objectives may, in principle, help to effectively implement the national health strategy. However, this tool remains too marginal and the weighting of public health indicators is too small in doctors' overall remuneration.

New methods that are more favourable to prevention have recently been implemented, for example local professional healthcare communities, local healthcare contracts, and occupational healthcare centres. Tests have also been carried out with pharmacists to measure risk factors, with the support of the ARS. It is, however, too early to draw any conclusions from these tests. Other experiments propose appropriate flat-rate remuneration arrangements to encourage prevention. As such, multi-disciplinary teams working in a collective healthcare structure (occupational or traditional healthcare centres), can opt for forward-looking flat-rate remuneration (payment as a team of community healthcare professionals), for all or some of their patients (diabetics, those over 65 years of age). However, the scope of this innovation remains very limited.

The combination of these collective exercises with flat-rate compensation schemes and the targeting of the most vulnerable populations would be an interesting solution aimed at offering preventive healthcare actions to the entire population, while adjusting them for disadvantaged communities in order to reduce the social gradient, which measures the distribution of social inequalities in terms of healthcare according to income or level of education.

Occupational healthcare services would also benefit from extending their activities to preventive healthcare.

While occupational health represents an annual expense of €1.7 billion and 30 % of so-called institutional prevention expenses, it barely performs a global, systematic prevention mission. Allowing occupational health professionals to access patients' personal health datas and shared medical records, with their consent, would help better target public health prevention actions. The advantages of preventing chronic disease among employees, and the reduction in absenteeism, as well as the economic cost of a potential confinement needed to avoid saturation in the healthcare system, are all arguments in favour of occupational medicine also being involved in addressing risk factors in the future.

Finally, the interaction between primary care teams and healthcare facilities should be consolidated.

Prevention in healthcare facilities is carried out mainly through some of their duties as primary care providers (e.g. emergency treatment not requiring hospitalisation, prison healthcare, management of health centres), as well as in external consultations (vaccinations and highly specialised screening, patient-centred education), and more intermittently through longer rehabilitation such as for complex addiction treatment. They provide primary care teams with information, support, research and training in prevention. The financing of these activities is often poorly defined, insecure, disparate and inappropriate.

❖ **Finally, the Court focused on defining the conditions for strengthening the impact of the prevention policy.** It considers that an overhaul is needed to achieve a real change of scale which would reduce the effects of major pathologies.

***First recommendation: strengthen the overall effectiveness of the prevention policy and its operational implementation.***

Action must cover both the content of the prevention plans, their regional implementation and improvements in medical prevention (screening, vaccination) and the quality of health promotion initiatives. To measure the efficiency of preventive healthcare policies, an exhaustive annual measurement of the various expenditures must be carried out, based on a clear method which has yet to be defined.

Prevention plans must now set coherent targets with quantified indicators to monitor their implementation over time and allow for a clear division of roles between the different national and regional actors. At a regional level, *the département* seems to be the most relevant level to coordinate prevention, under the auspices of the ARS through their departmental delegations. They should also have a repository, approved by the health authorities, of health promotion initiatives so they can direct their choices towards those that are the most effective or promising.

Finally, improving the rate of participation in screening will require simplifying funding channels and bringing them up to standard, under the aegis of Inca.

***Second recommendation: resolutely address risk factors.***

Since 2011, the Court of Accounts has issued a number of recommendations on the three main risk factors (smoking, alcohol, obesity). These recommendations have been unequally implemented, particularly concerning alcoholism.

**1** As regards anti-smoking campaigns, even though the number of smokers has fallen sharply, by almost 1.6 million people between 2016 and 2018, due to anti-smoking measures taken within the framework of the LMSS (plain cigarette packaging, increase in taxes, etc.), this improvement could stop due to the successive lockdowns and their impact on French people's smoking habits, while the sharp rise in tobacco prices has also come to an end.

Action on prices must be continued, in particular for rolling tobacco, as first incentive for giving up smoking, which needs to be increased significantly. In addition, the ban on cigarette sales to minors is neither applied nor controlled, and even less penalised. France is aiming for a non-smoking generation by 2030 among young people born after 2010 – a deadline that is

well behind those in other countries, such as the United Kingdom – without having specified how it will achieve this objective.

**2-** In As far as alcohol is concerned, our country is among the top OECD Member States for average annual consumption per person, and alcohol use is also increasing worryingly among young people and women. Public action struggles to change behaviour in this area and does not make effective use of existing levers that have demonstrated their usefulness in other countries, such as prevention based on targeted messages, the use of taxation to reduce harmful consumption, and regulations on advertising or access to products containing alcohol.

Of the eleven audit recommendations made by the Court in its report on harmful alcohol use in 2016[3], the four most stringent recommendations met with a formal refusal from the authorities: increasing taxation, setting a minimum price, prohibiting consumption in the workplace and banning advertising on the internet and social networks.

In the absence of an appropriate renewal of actions recognised as being the most effective in reducing harmful alcohol consumption, our country is at risk of suffering lasting impacts of alcohol in terms of chronic diseases. In May 2021, Inserm also called for a national roadmap requiring "political will and minimum resources," including action on prices (taxes and/or a minimum price), appropriate prevention messages, limits on marketing (tightening of the Evin law and restrictions on the sale of alcohol) as well as the detection of persons at risk by primary care professionals (the Early Identification and Brief Intervention approach). All these measures are in full compliance with the Court's audit recommendations of 2016.

**3-** In terms of obesity, while France is among the average of OECD countries, a series of measures already recommended by the Court in 2019[4] remain to be implemented. These include the adoption, in consultation with manufacturers, of maximum amounts of salt, sugar and fat in the nutritional composition of foods, the prohibition of advertising of certain foods in the audiovisual and digital sectors, and the use of the Nutri-Score nutritional ranking system as a mandatory reference for manufactured food.

### *Third recommendation: Increase and systematically include prevention in professional practice*

Each contact between users and the healthcare system must be seen as an opportunity to propose preventive actions. This involves increasing the number of persons involved in prevention and systematic prevention at every opportunity.

**1 -** This change of scale in the implementation of this policy must first be applied at the level of general practitioners

GPs are currently insufficiently informed of preventive healthcare issues by the public authorities, but are also infrequently asked about prevention by patients, who consult them almost exclusively when symptoms occur. Moreover, medical demographics does not always allow access to preventive healthcare: at least 5.4 million people (8.6 % of the population) do not have a family doctor, not always through choice.

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[3] Court of Accounts, Thematic Public Report - Evaluation of a Public Policy, "*Policies to tackle harmful alcohol use*", June 2016, available *at* *www.ccomptes.fr*.

[4] Court of Auditors, Evaluation Report for the National Assembly Committee on Social Affairs, "*The prevention and handling of obesity*" , November 2019, available *at* *www.ccomptes.fr*.

**2 -** This change will also require an increase in the number of professionals fully invested in preventive healthcare, by moving away from experimental schemes towards widespread implementation.

To be successful, this change of scale will mean involving other doctors, such as occupational physicians and other healthcare professionals, given the weak population coverage of family doctors. It will also require strengthening initial and ongoing training in public health and prevention.

Biologists, pharmacists, nurses and podologists are still very little involved aside from a few experiments that are difficult to maintain for the long term and roll out on a large scale. Almost twenty experimental cooperation protocols are in place for preventive actions, but they have not been definitively approved, with the notable and successful exception of diabetic retinopathy screening.

The recent creation of medical assistants should ultimately make it possible to relieve doctors of the tasks of monitoring or reminding patients eligible for prevention programmes, which are decisive for the efficiency of these policies. Their generalisation must therefore be considered in order to refocus doctors' activity on preventive acts with high medical value.

Finally, connected devices will put patients at the centre of their own preventive healthcare by allowing self-assessment, provided that this is well organised and supported.

**3 -** It is also important to create targeted opportunities for prevention throughout life.

The principle of preventive consultations with a doctor proposed periodically to the general population is not cost-effective, as the HCSP noted in 2009.

However, family doctors do not have a set of approved guidelines on prevention to be proposed throughout patients' lives, as is the case in many other countries. For example, in Switzerland, the five university hospitals produce an annual summary document for family doctors summarising all the concrete actions to be proposed during contact with patients. There is no equivalent in France.

### *Fourth recommendation: Use healthcare data to advance prevention practices and facilitate their assessment*

In terms of prevention, digital solutions can facilitate progress in three major areas:

**1-** The definition of health strategies at the regional level, in order to identify social and regional inequalities as accurately as possible. Other countries, such as the United Kingdom, produce epidemiological data on their populations at a community level. Without going as far as this level of detail, made possible by feedback from family doctors, it would be useful if data could also be collected within départements, so as to be able to determine the most appropriate actions in the areas concerned.

**2 -** Targeting priority populations that do not currently have access to prevention.

Today, the collection of useful and relevant data and their compilation and matching are insufficient, whereas this could allow for the targeting of patients based on an assessment of their risk, in order to provide them with appropriate individual prevention actions.

In this regard, it would be useful to draw on lessons learned from managing the Covid-19 pandemic in terms of information systems on screening and vaccination, as well as the opening of data to the public (Open Data), to address the matter of better targeting certain

individuals in the prevention of chronic diseases. With the multiplication of useful data for prevention, if family doctors have access to these data, they could share the benefits with their patients and implement targeted prevention actions.

**3-** Finally, there is no real structured strategy for defining and collecting data relevant to the evaluation of prevention policies. There is no clearly identified governance. Existing tools (registries, cohorts, large-scale health surveys) are poorly coordinated, leading to redundancies or gaps. As such, France does not have a diabetes register and practically no data are escalated by community doctors.

At the end of this evaluation of the preventive healthcare policy, the Court found that its impact on major pathologies is disappointing but that progress can be made without necessarily increasing the resources required.

This situation, which frequently puts us in an unenviable position with regard to comparable countries, and which is accompanied by significant social and regional inequalities, is not due to inadequate funding for prevention but to other more profound reasons. These include persistent political hesitation in tackling risk factors, the organisation of primary care and professional practice and remuneration methods that are not conducive to an effective ongoing prevention policy (we treat diseases, we do not accompany a person in their lifestyle and healthcare), and the historical weakness of the public health culture in our country (reluctance to impose approaches perceived as infringing individuals' freedom or to differentiate or target public policies).

However, developments have begun to take shape more recently: action undertaken – but since curtailed – to prevent smoking has paid off, the structuring and formalisation of the prevention policy have progressed, new forms of medical practice are starting to emerge and expand, even if this remains marginal.

The crisis linked to the Covid-19 epidemic is likely to significantly change the current situation by providing the opportunity to accelerate the necessary changes: doctors have realised that healthcare is a collective exercise, the notion of '*reaching out to the patient*' is no longer merely a slogan but has been turned into concrete actions, including vaccination, and public health insurance has become a major player in the implementation of public health policies. In this regard, the crisis also appears to be an opportunity to speed up vital developments in our healthcare system

# Recommendations

## First recommendation: strengthen the effectiveness of the prevention policy and its operational implementation

1. Adopt a method to estimate the expenditure incurred for prevention in public healthcare reimbursements each year; break down this amount for each region and distribute the amounts between the three categories of prevention (primary, secondary, tertiary). Adapt the information provided to parliament in support of the proposed Social Security Finance Act accordingly. (M*inistry for Solidarity and Health [MSS], Cnam, Hospital Information Technology Agency [Atih*]).

2. Each year, establish a repository of proven and promising health promotion actions for the ARS, to inform their funding decisions in this area (*MSS, national public health agency [SPF], Cnam)*.

3. Set common, multi-annual objectives for all preventive healthcare plans and monitor their implementation with relevant indicators; clearly distribute responsibilities between the national and regional level for both the government and public health insurance (*MSS*).

4. Set up a departmental conference on prevention policies under the aegis of the ARS, bringing together the primary healthcare offices (Cpam), the academy inspection department, municipal authorities, health professionals and healthcare facilities, occupational medicine and the non-profit organisations concerned, in order to share local epidemiological findings and to coordinate the implementation of prevention actions (MSS-SGMAS [*General Secretariat of Social Affairs], Cnam*).

5. Improve participation in screening (bowel cancer, breast cancer, cervical cancer), by entrusting the organisational deployment and funding of screening to the Cnam and the steering of regional cancer screening coordination centres to Inca (*MSS, Cnam, National Cancer Institute [Inca]*).

## Second recommendation: resolutely address risk factors

8. Harmonise taxation of all types of tobacco at a European level by levelling up. Tighten penalties for violations of the ban on the sale of tobacco to minors and ensure effective controls. Continue to raise tobacco prices, particularly with a sharp increase in rolling tobacco prices (*Ministry of Finance [Minefi], MSS)*.

9. Relaunch efforts to tackle harmful alcohol use: develop a national alcohol plan, act on prices (raise taxes differentially and prepare the conditions for setting a minimum price) and restrict access to products containing alcohol, better regulate advertising, develop early identification (*General Directorate for Health [DGS], Minefi*).

10. Establish in law the maximum levels of sugar, salt and fat in the composition of industrial foods, ban advertising for certain foods in the audiovisual and digital sectors, make the Nutri-Score a mandatory reference for manufactured food (*MSS, Minefi*).

(N.B. a full list of the Court's previous audit recommendations on risk factors is provided in Appendix No. 4)

### Third recommendation: transform prevention in professional practice

6. Increase the share of remuneration based on public health objectives in doctors' compensation and increase the weighting of prevention indicators in this remuneration; in the event of a favourable outcome of ongoing experiments, rapidly adopt flat-rate remuneration based on the 'payment as a team of community healthcare professionals' model (*MSS, Cnam*).

7. Expand occupational healthcare services' missions to include early identification of risk factors and the fight against addictions (*MSS, General Directorate for Labour [DGT]*).

11. Establish a recommendation, to be updated annually, on the prevention actions (screening, vaccination, monitoring of risk factors) that family doctors must offer patients throughout their lives and organise their promotion among professionals and the public (*MSS, HAS*).

### Fourth recommendation: make full use of the potential of digital technologies in terms of prevention

12. Integrate objectives for the development of digital uses and practices into the "Accelerating the transition to digital healthcare" roadmap so as to better prevent chronic diseases (*MSS, Cnam*).

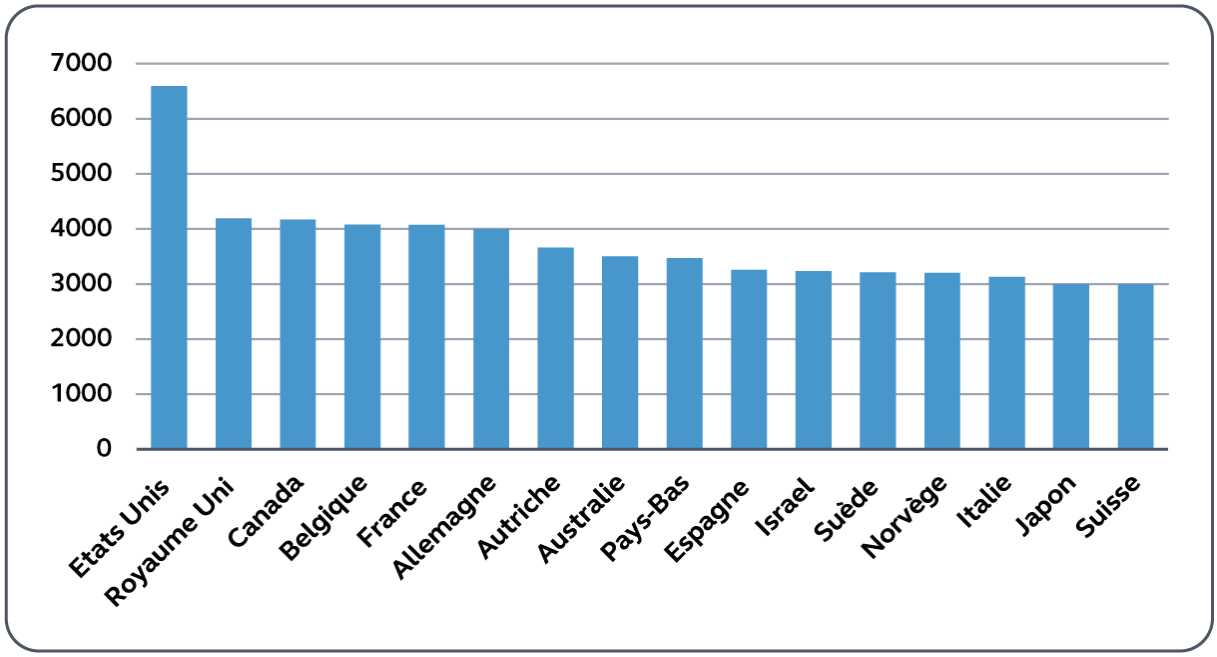
13. Engage in public reflection and debate 1) on social and medical data relevant to the targeting of preventive actions 2) on the usefulness and technical and legal feasibility of the transmission by the Cnam of patient information on prevention to family doctors, including geographical and social criteria (*MSS, Cnam*).

14. Develop, as part of the inter-ministerial health committee (CIS), a strategy for the definition and collection of health data necessary for public health research and for the evaluation of preventive healthcare public policy. Specify in this strategy the methods of governance and consistency in the various tools useful to collect these data, and the way in which they are financed. This strategy must set out the need for the sharing of health data, in compliance with regulations and citizens' rights, by making public funding conditional on this sharing (*MSS, Ministry of Higher Education and Research [MESRI], Cnam*).

## Appendix No. 1: Premature mortality data

France is in a poor position with regard to premature mortality for all causes, according to the indicator of potential years of life lost before the age of 69 per 100,000 inhabitants, i.e. the sum of the difference between age at the time of death and that which could have been reached according to the population's average life expectancy, for all individuals in the same population. In 2018, this indicator stood at 4,067 in France. Switzerland has the best performance with 2,990 (26.5 % lower than France).

**Potential years of life lost before the age of 69 per 100,000 inhabitants**




*Source: OECD*

According to OECD data for 2017, 60 % of premature deaths in the OECD (1.8 million out of 3 million deaths) could have been avoided, including 32 % related to cancer and 19 % to cardiovascular diseases. The OECD has calculated a mortality index on preventable causes, which puts France in an intermediate position with a result of 106 deaths per 100,000 inhabitants, compared with the OECD average of 133 (36 countries). France is ahead of the United Kingdom (120) and Germany (119) but behind Sweden and Spain (93), Italy (88), Japan (87), Australia and Israel (72).

The following table uses a slightly different definition that considers deaths before the age of 65 as being premature.