

Child Health Care Policy and Delivery in France

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ABSTRACT. Medical and social protection of mothers, infants, and children began in France more than a century ago. A number of laws and regulations have improved the system, which is discussed in detail. The discussion includes an overview of health policy, service delivery, and the financing of care. Is the current French system of Maternal and Child Health responsible for the good health of today's children? This question is addressed through selected examples. Finally, failures and shortcomings of the system are described, including the persistence of underserved groups, unequal access to care, and other problems. Solutions are feasible, and some are now being implemented.

Wherever we look, children's fate is at stake: we must define the lines along which we have to work in order to improve it.—Robert Debre, 1978.

No sentence could be more appropriate to introduce a paper in the setting of a conference aimed at finding ways and means to improve the fate of millions of American children. On the other hand, no time could be more propitious to speak about the status of child health and the delivery of care in the French context, because two important acts have been passed in 1989 in France to improve and reorient relevant policy and programs.^{1,2} In this paper we first consider the current status of child health, as reflected by selected indicators. We then describe child health policy and delivery of care. Finally, we discuss the relationships between health care and child health, underscoring a few failures and shortcomings that call for further improvement.

CHILD HEALTH STATUS³⁻⁶

Figure 1 shows the decrease of infant mortality from 1950 to 1987. The reduction is striking, from 50 to 8 per thousand. Similarly, the rate of perinatal mortality has decreased from 32 to 10 per thousand. The decline in

postneonatal mortality has been smaller, however; and after a plateau in 1983 to 1984, a slight increase was noted, up to a rate of 3.8 per thousand in 1986 to 1987. This may be the result of postponement of deaths from the perinatal period.⁷

Figure 2A illustrates the relative importance of the main causes of infant death. Sudden infant death syndrome is now the leading cause, followed by deaths of perinatal origin and congenital anomalies. Accidental deaths also account for a substantial portion of infant mortality and will be discussed in a separate paper.

Death rates among older children are also declining, although the amount of improvement is smaller for older age groups (Table 1). The situation is most worrisome for adolescents because of high injury mortality. Figure 2, B and C, shows the important causes of child mortality in different age groups.

In summary, a dramatic reduction of mortality among French children documents improving health over the past several decades. More refined indicators of child health (immunization rates, postneonatal infectious dis-

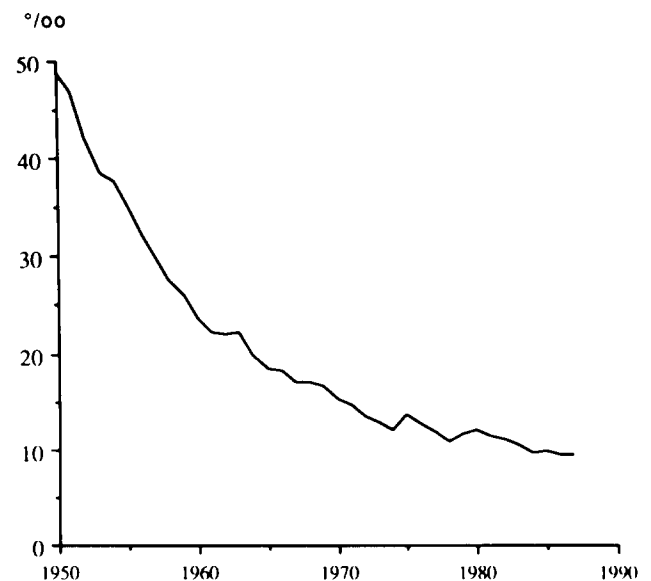


Fig 1. Infant mortality in France, 1950 to 1987 (deaths per 1000 live births).

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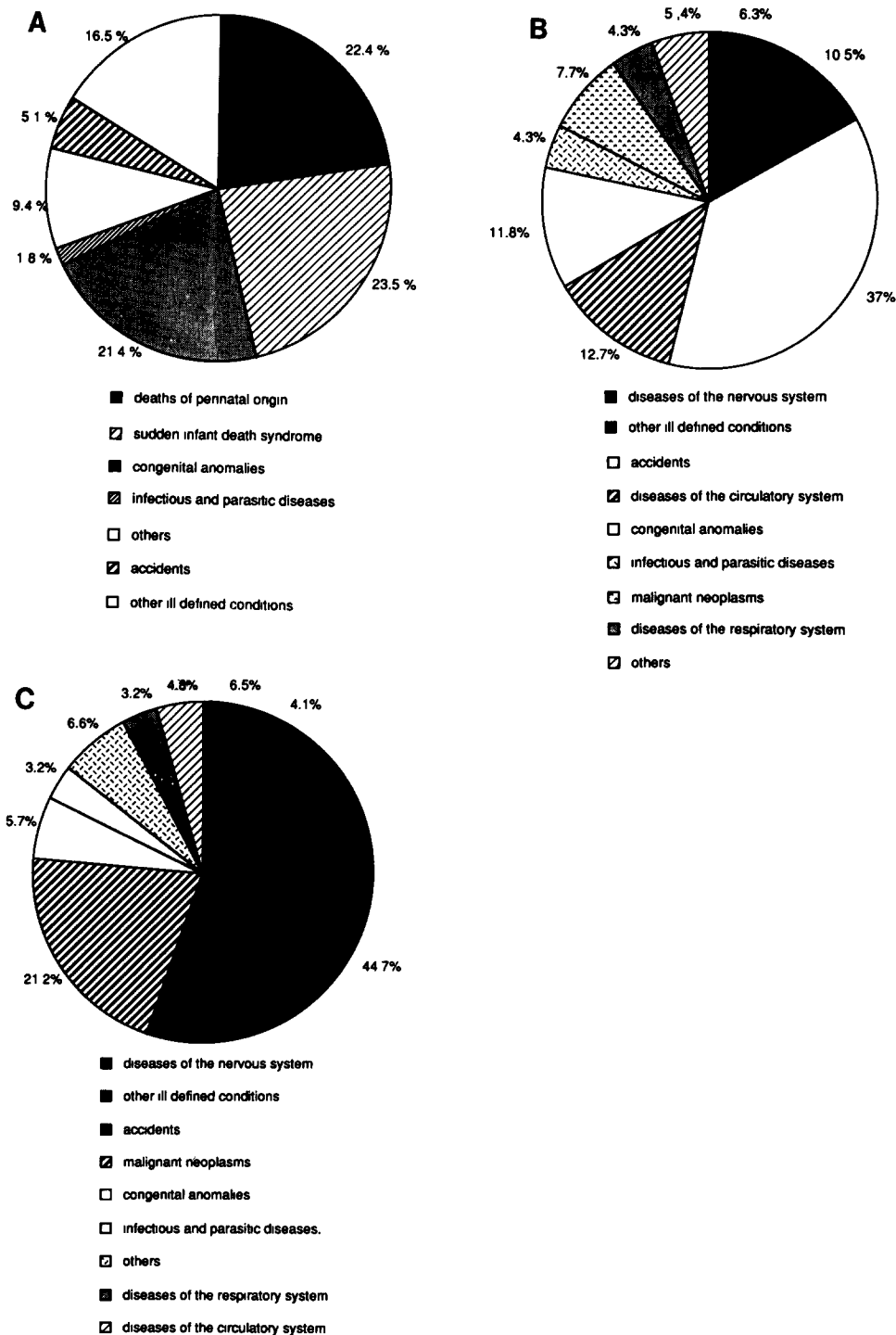


Fig 2. A, Infant mortality in France by main causes, 1987.⁵ B, mortality of children aged 1 to 4 years in France by main causes, 1987.⁵ C, mortality of children aged 5 to 14 years in France by main causes, 1987.⁵

ease mortality, and injury mortality) will be addressed in other papers of this conference.

CHILD HEALTH POLICY AND SERVICES

The overall structure and functioning of health services in France were presented in some detail by Lacro-

nique in 1983.⁸ Since then, the Decentralization Act has somewhat altered the picture, giving greater responsibilities to the local authorities and to those at the departmental level (the French regional administrative division: about 100 departments). The recent act on protection and promotion of child and family health² determines the

framework within which the national policy is applied and care is provided.

The current situation is the result of a long-lasting process going back to the second World War and summarized in Table 2. French health policy combines measures of health and of social protection, both for mothers and children. Because children benefit from programs directed to the health and well-being of their mothers, maternal and child health issues are inseparable. In this discussion, however, the maternal component is not discussed.

Health Measures and Services

Since 1945, preventive consultations have been available free of charge to children from birth to 6 years of age. The scope of preventive care includes monitoring of growth and development; prescribing vitamins and routine immunizations; and giving parents advice and guidance on feeding, care, and education. Visits are recommended once a month from birth to 6 months of age, every 3 months from 6 to 12 months of age, every 4 months from 1 to 2 years of age, and then every 6 months until 6 years of age.

TABLE 1. Mortality Rates of Children (per 100 000), France, 1950 to 1985.

	Children		
	1-4 y	5-9 y	10-14 y
1950	234	69	61
1955	181	44	38
1960	119	41	34
1965	92	40	33
1970	80	41	34
1975	67	36	31
1980	64	39	35
1985	45.4	24.8	24.2
Decrease 1960-1985	62%	40%	30%

Since 1970, three of these examinations have served a dual purpose. At selected, key ages—8 days, 9 months, and 24 months—physicians provide routine preventive care but also record specific information on all children, completing a certificate for each. These certificates contain full information on the medical history, measures of development, and immunization status. Special note is also made of any medical and/or social risk requiring follow-up. Certificates are included in each child's health record (*carnet de santé*), and a copy is sent to the appropriate maternal and child health (MCH) center to ensure necessary follow-up. Epidemiologic information is collected in anonymous form and computerized at the national level.

Parents or caretakers may choose to have children examined either free of charge in a MCH center or by a physician, often a pediatrician in private practice; in the latter case, they must pay initially but are reimbursed totally. Precise data are available from the MCH centers. In 1987, 735 child health doctors, 3 023 pediatric nurses, and 1 023 nurses working in 5 932 centers organized 253 300 child health sessions and performed a total of 2 656 800 health examinations.⁵

In addition to private physicians and the MCH centers, several other important sources of child health care exist. If needed, home visits are available to complement the MCH program. Children with developmental abnormalities receive free care in specialized outpatient clinics called Centers for Early Medico-social Action. By 4 years of age, children of most families attend nursery school, systematically visited by MCH teams. The school health service takes over preventive care for older children, with screening routinely performed at 6, 10, and 14 years of age. Unfortunately, in many areas, the school health service suffers from chronic shortage of human and financial resources and is unable to perform optimally; this constitutes a weak point in the French child health system.

The French ministry in charge of health is no longer

TABLE 2. Maternal and Child Health in France: Legal Provisions

1939	Act on family allowances
1945	Order on MCH
1962	Decree on MCH
1964	Strengthening of MCH services
1967	Act on birth control
1970	Compulsory health examinations. Health certificates at 8 d, 9 mo, 24 mo
1974	New act on birth control
1975	Abortion act Orientation act on prevention and care of handicapped persons
1976	Decree on centers for early medicosocial action
1978	Lengthening of the legal maternity leave: 16 wk
1980	Lengthening of the legal maternity leave: 6 months for the third child
1981	Instruction on premarital examination
1982	Decentralization act Order on regionalization of preventive activities
1985	Re-form of family allowances Instructions on the use of the health record (<i>carnet de santé</i>)
1988	Act on minimal income and social integration
1989	Act on child abuse and child protection New act on MCH and promotion of family health

responsible for the MCH system, a result of the Decentralization Act of 1982. However, in addition to its role in preparing bills and regulations (cf references 1 and 2), this authority still issues guidelines to peripheral services and even to physicians, including private practitioners. Periodically, the Ministry issues and distributes information on various topics pertaining to health of mothers and children.

Social Protection

Family allowances are cash payments designed to assist families in bringing up their children. These payments are provided under some conditions of age, number of children, and family resources. They are given systematically to one-parent families from pregnancy until the child reaches 3 years of age. The last national census enumerated roughly 268 000 one-parent families with children younger than 16 years of age, accounting for 9.4% of all families with children and 9.6% of all French children younger than 16 years of age. Four of five of these single parents were women.⁹ This phenomenon has likely increased since 1982.

Other social supports available in France include home auxiliaries for families in trouble, day care centers (either collective or in caring families (see Fig 3), day nurseries for a few hours per day or per week, and nursery schools, which admit children from 2 years of age. Provision of these services is not sufficient to meet the need for them, and availability is uneven.¹⁰

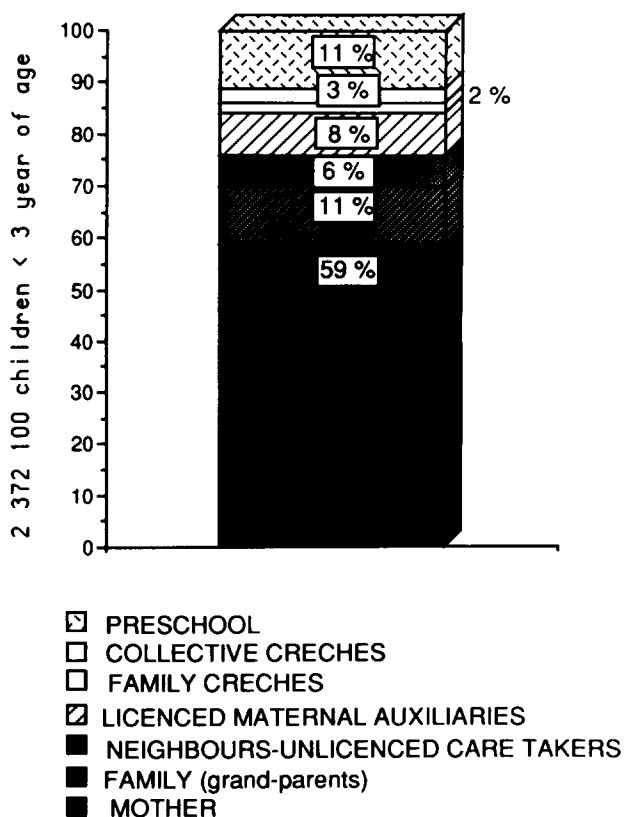


Fig 3. Day care of children younger than 3 years of age, 1982.¹⁰

A special service in each department is in charge of children who need parental supervision, including orphans, abandoned children, and those endangered in their families. Called Social Assistance for Childhood (Aide sociale à l'enfance), this service in 1987 had responsibility for 114 441 children in institutions or foster homes, and another 105 262 kept in their families under administrative or juridical mandate and/or with financial assistance.⁵

Administrative and Financial Provisions

Since 1984, MCH programs and services have been under the authority of each Department and financed by its budget. Recent law² mandates a minimum level of services and benefits that each department must ensure, and also provides for reimbursement from Social Security for all mandatory examinations of mothers and children. The Social Security system directly reimburses the expenses of private physician care, special care at home, and care rendered by hospital outpatient clinics and other institutional providers.

Social assistance for children is also the responsibility of the departments, and the estimated financial burden amounted to more than 16 billion francs in 1987.⁵ In some departments, the social expenditure (all age groups, all allowances) accounts for about half of their total budget. At the national level, the Social Security system distributed more than 90 billion francs to families in 1987 related to the various categories summarized in Table 3.¹¹ The gross national product for the same year was 5300 billion francs; the overall social budget amounted to 1570 billion francs, about half allocated to the elderly.

That the French Social Security system is experiencing financial difficulties is not surprising. Nonetheless, in spite of some cutbacks in reimbursement of medical procedures and pharmaceuticals, the overall system is still working, and French people are so attached to it that changes in the near future are unlikely.

HEALTH OUTCOMES OF THE CHILD HEALTH SYSTEM

The mandatory MCH program started almost half a century ago. At this point, evaluation is a key issue. In spite of the difficulty in doing so, several questions must

TABLE 3. Family and Various Allowances Distributed by Social Security, France, 1987 (in Millions of Francs).¹¹

Family allowances	46 200
Family supplement	11 800
Allowance for young child	10 700
Pre- and postnatal allowances	300
Delivery leave	100
Housing allowances	10 900
Allowance for special education	900
Family assistance	2 800
Schooling allowance	1 300
One-parent allowance	3 200
Supplement to family income	100
Paid leave for parental education	2 600
Total	90 900

be answered. Are French child health policy and programs at least partly responsible for the current health status of French children? Are the existent programs reasonably efficient? And most important of all, is the care utilized by the eligible population?

The very structure of the health system makes it difficult to evaluate the French system; both public service and private practice contribute to the delivery of care. Statistics are scarce, and their private component is often either weak or lacking. A survey by the French Institute of Statistics and Economic Studies (INSEE), based on observation of a national sample for 12 weeks, indicates the average number of yearly consultations by a physician for children from birth to 19 years of age (Fig 4).⁷ When all ages are considered, only 8% of these visits were for preventive care, but 40% of visits by children younger than 2 years of age and 15% of visits by children aged 2 to 4 years were preventive. Most of these preventive consultations take place in the official child health system.

Examination of infants and children is compulsory at 8 days, 9 months, and 2 years of age; the number of health certificates filled out and sent to the health authorities is determined, and compliance is calculated annually. In spite of the absence of financial incentive, in 1988, 93.6% of the 8th day certificates were sent back, 72.2% at 9 months of age, and 68% at 24 months of age. The percentage of children examined is probably still greater, because all certificates are not completed and collected. Also of interest is that pediatricians are the examiners for 89.6% of the children at 8 days of age, 43% at 9 months of age, and 37% at 24 months of age, general practitioners progressively taking over.

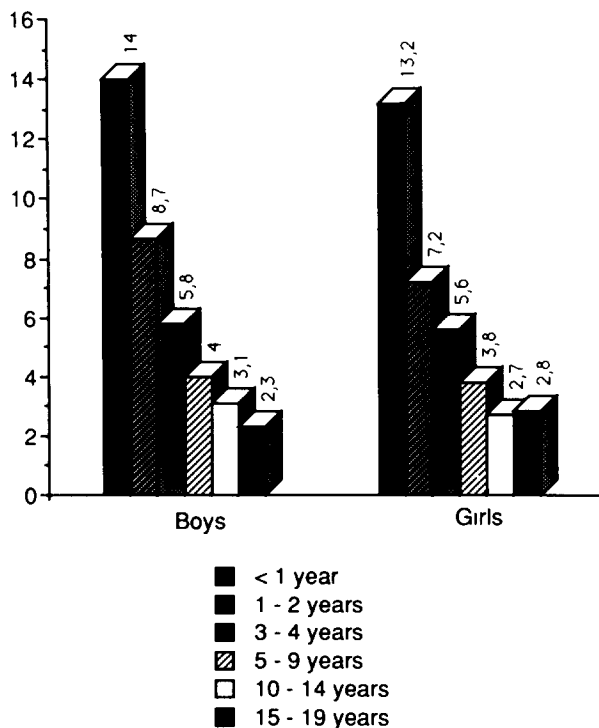


Fig 4. Average yearly number of consultations by a physician from birth to age 19 years, 1984.⁷

The impact of making certain visits mandatory has been studied with respect to prenatal care. One survey, conducted on a representative sample of births in 1976, demonstrated that “the great majority of women receive at least the minimum antenatal care laid down by law.”¹² A smaller study in two hospitals showed that in one hospital, 96% of the pregnant women had more than the four mandatory antenatal visits, even though half of them did not know the required number; whereas in the other hospital, “where the mean number of visits was nearer to the statutory minimum, about half of the women who said that 4 visits were required made exactly that number of visits and about half of those who gave 3 as the number made 3 visits.”¹² Many women comply with requirements when they have correct information, but information alone is not enough.

The French MCH system is often said to be well utilized by the eligible population because of financial allowances linked to utilization. Evidence to confirm or refute this assertion is lacking. At first, financial incentives probably attracted mothers and families to the health services, and they still may attract certain population groups, especially the middle class. The relationship between monetary incentive and attendance is complex, however; the value of financial allowances decreases markedly as family income rises, but the diminution of attendance is limited. Moreover, the poorest mothers and families, who should be the most interested in the financial aspects, are very often those who do not take benefit from the health care provisions. In view of this fact, and partly due to the concern of social workers, there is a movement to no longer link financial assistance to health attendance. Nevertheless, there will be no financial disincentives to utilize services, as MCH clinic services are free of charge and private sector services are reimbursed.

From these results, it can be concluded that, globally speaking, the child health policy is adhered to by the French population and the legal provision of care largely used. But is this efficient?

Evaluation of the French perinatal program is encouraging. Conducted from 1970 to 1980, with some regional extensions until 1985, this study shows acceleration of the expected “natural” decrease in perinatal mortality.⁶ This change was associated with a number of interventions, including increased attention to information and research, allocation of human and material resources to lower mortality, and special attention to groups at risk for poor birth outcomes.

At a later stage of the child’s development, the checkup performed at 4 years of age by the MCH personnel in nursery schools is certainly beneficial and cost-effective. Two evaluations at the Department level^{13,14} demonstrate early detection of hearing and vision deficiencies by the MCH team. Following confirmation by more refined procedures, this screening allows early treatment, before school performance is affected. In other conditions as well, early diagnosis and referral to specialized care may increase the chances of recovery.

The value of child health care remains open to discussion. Fender and colleagues, in trying to explain the differences in perinatal mortality rates among European countries, state that economic factors have more weight

than the nature of the care system.¹⁵ Others emphasize the importance of social policies designed to reduce inequalities,¹⁶ in spite of the possible negative side effects of doing so.

Analyzing the influence of health and social policies on the evolution of mortality, Bouvier-Colle concludes that health care workers "cannot solve by themselves all the health problems. They must be supported or reinforced by some interventions of economic and social nature."¹⁷ Child health policies and programs are necessary but not sufficient; to be efficient they must be part of a comprehensive welfare policy, of "the social effort of the nation."

FAILURES AND SHORTCOMINGS

Underserved Groups and Unsolved Problems

Economic and social progress does not benefit everyone at the same rate; on the contrary, the gap between the well to do and the poor tends to increase, in spite of the social policies aimed at reducing inequalities.¹⁶ The social penetration of technologic progress is a slow process, and the use of health facilities also retains a social gradient. The underserved are not only migrant or ethnic minorities, but also French people of low social attainment, one-parent families, the unemployed, and teenage mothers; special approaches will be necessary to reach these groups.¹⁸

Some health and social problems remain incompletely solved, either by lack of means and resources, as with school health services, or because of their complexity. The sudden infant death syndrome and child abuse and neglect are but two examples. Such problems call for specific programs which are now developing in France, some of them by law.¹

Health and Social Inequities

According to the World Health Organization, "the existing gross inequalities in the health status of the people, particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable."¹⁹

It is well known that the incidence of accidental injuries and of handicapping conditions is higher in the lower

social groups.^{20,21} More striking is the differential mortality in various groups of the population in the same country. Table 4 shows the infant mortality rate by socioeconomic classes, defined by the father's profession. In spite of continued progress, recent mortality among children of unskilled workers is about equal to that of the upper middle class 12 years earlier; it is still 1.7 times higher than the current rate in the managerial group.³

Figure 5 illustrates this by showing the projection, on the decreasing curve of the average infant mortality rate, of the figures of the extreme socioeconomic groups for the 1976 to 1983 period. The mortality rate of infants of the highest social group appears to be 10 years ahead of that of infants belonging to the lowest group. There are encouraging trends; progress has benefitted all groups, even if not equally, and the differential between the most extreme groups is narrowing. There is still much work to be done.

The same applies, at least partly, to children of migrant workers and mixed families. From 1976 through 1983, the average infant mortality rate for the nation as a whole was 9.3 deaths per 1000 live births. For children of Algerian parents the rate was 12.4, whereas the rate among children with French mothers and Algerian fathers was an intermediate 11.2. Among Turks and Yu-

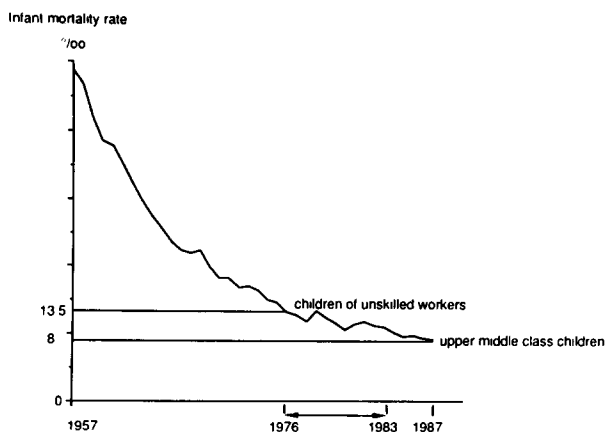


Fig 5. Infant mortality by father's profession, unskilled workers vs upper middle class, 1976 to 1983. Rates are presented on the curve of decreasing infant mortality for the total population.³

TABLE 4. Infant Mortality Rates for 1000 Live Births, in Three Periods, According to the Socioprofessional Status of the Head of the Family.³

Father's Profession	Generations		
	1956 to 1960	1966 to 1970	1976 to 1983
Farmers	31.2	18.7	9.6
Farm workers	35.3	23.9	10.7
Employers in industry and trade	25.4	17.7	9.2
Managers	17.0	12.2	8.0
Middle class managers	19.7	14.1	7.9
Employees (white collar)	24.9	17.2	8.7
Workers (blue collar)	32.8	20.8	10.4
Skilled	28.1	18.9	9.7
Partly skilled	32.9	21.7	10.9
Unskilled	44.8	30.4	13.3

goslavs, infant mortality was even higher, with 13.1 deaths for every thousand live births.⁹ Death certificates no longer include parents' citizenship; additional data by national origin are not available.

The Side Effects of Decentralization

The Decentralization Act has placed MCH and social services under the authority of each Department, ending almost two centuries of central control over these services. It is too early to evaluate the effects of such a revolutionary change, but it is already clear that some Departments do more and better than others. Concern about regional variation in care led to passage of the new MCH Act,² which established minimum standards for MCH services. Recent reports indicate that the rate of premature deliveries has increased in some areas; a survey is being conducted to assess the situation. Such matters will require continuous observation in the years ahead, for nothing is irreversibly achieved in the field of health.

FIT FOR THE FUTURE?

A "Family Plan" is being prepared by the State Secretariat of Family Affairs and will be instituted in the months to come.²² This proposal, which will cost the State about 1.5 billion francs annually, will help families with children and alleviate many burdens of families in difficult situations. It will also simplify a redistributive system that has become increasingly complex through the years. This approach promises to correct some of the inequalities referred to in this paper. Will it further improve the health and well being of French children? This is the challenge presented to us by Robert Debre.

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