Eu Recovery Plan and National Health Systems: the French case[*]

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Summary: 1. Introduction. – 2. The PNRR in the framework of the reform of the French health system. – 3. The fight against sanitary desertification. – 4. Attempts at territorial "*déconcentration*" and criticism of the ARS model. – 5. Population aging and prevention policies. – 6. Conclusion.

1. Introduction

Together with Italy, France is one of the countries that can boast a high life expectancy rate at birth. Although it has undergone a slight decrease from an average of 83 years (combining data for both sexes) in 2019 to 82 years and 3 months in 2020, the figure went back up again in 2021 to 82 years and 5 months, also thanks to a positive vaccination campaign against Covid-19. This affirmative trend was also confirmed for 2022 despite the long period of extreme heat, which according to INSEE caused at least 10,000 excess

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deaths[1] and which placed France among the EU countries with the highest life expectancy at birth. These figures are particularly signifcant when compared to some Central-Eastern European countries whose life expectancy, already not especially high (circa 75 to 76 years), dropped, sometimes drastically, due to the pandemic and has had notable difficulty recovering.[2]

Despite these somewhat comforting data, the French health service has seen numerous reforms since the 1990s. Still recently, reform was at the center of the Borne Government's commitment and the personal commitment of the President of the Republic, E. Macron, who made it a key point of his electoral campaigns in 2017 and 2022. The *Plan national de relance et de résilience* (PNRR), presented at the end of April 2021 to the European Commission and currently in an advanced stage of implementation, which required the EU to provide funding of around €40 bn was included in a broader national plan called *France Relance* worth €100 bn distributed over 2 years, presented by the Government on September 3, 2020, approved by Parliament and supported by the State budget with the Social Security Financial Acts (SSFA) for 2021 and 2022.[3]

In summary, according to the PNRR, an additional €6 bn will be allocated to healthcare. Resources that are to be distributed to hospitals, établissements *médico-sociaux* (EMS) (as identified by Article L. 312-1 of the *Code de l'action sociale et des familles* last modified by Act no. 2023-1196 of 12/18/2023), to the restructuring and the creation of places in accommodation facilities for non self-sufficient elderly people, the EHPADs (établissement*s d'hébergement pour personnes* âgées *dépendantes*), as well as their modernisation, equipment upgrade and digitalisation. Furthermore, these resources will also be allocated to projects that see collaboration among clinics, établissements, and public and private health personnel with local hospitals in the area (*ville-h*ô*pital* project) in order to counteract healthcare desertification and respond to the actual needs of the community.[4]

Despite not receiving as conspicuous financial support as had been hoped for by the WHO, this complex and demanding plan for the State should have been foreseen, if one considers that the EU has set among the objectives to be pursued through the PNRR the strengthening of the healthcare system to such an extent that it would be capable of managing future pandemics. Though this criteria was established by EU Regulation 2021/241 of the European Parliament and of the Council of February 12, 2021 (Article 3, letter e) it was still part of the French health system's tormented path toward reform. If the plan

[1] The data is available on the website of Institut national de la statistique et des études économiques at: insee.fr/fr/ statistiques/6206305?sommaire=4487854.

[2] Eurostat, *Life expectancy continued to decrease in 2021 in the EU*, 5/6/2022.

[3] See *Rapport du Gouvernement au Parlement sur France relance*, 2022; *Rapport final*, 1/16/2024; and Cour des Comptes, *La préparation et la mise en oeuvre du plan de relance,* 2022.

[4] See *Plan national de relance et de résilience* 2021, 25 available on the website of Ministry of Economy: economie.gouv.fr/plan-national-de-relance-et-de-resilience-pnrr#. The PNRR was updated on 4/21/2023 in order to join the *REPowerEU* plan to receive an additional €2.8 bn to deal with the energy crisis.

is successfully implemented, it will contribute to the realization of the vast program conceived by President Macron.

2. The PNRR in the framework of the reform of the French health system

The French health system is a mixed insurance type system, which[5], on the basis of universalistic and egalitarian principles, is founded on cooperation between the public and private sectors. The French constitutional order places the protection of health among the primary objectives of the Republic as established by the 11th paragraph of the Preamble of the 1946 Constitution with particular regard to minors, mothers and the elderly.
The *Conseil constitutionnel* (CC), in its now consolidated jurisprudence, has always placed emphasis on the importance of health protection as an objective that both the legislator and the Government must pursue in direct connection with the principle of equality, specifying the obligation on the part of the health authorities "to guarantee the equal access of every person to the treatment necessary for his state of health"[6] albeit through the balancing of various instances including the availability of resources.[7] Furthermore, and more recently and extensively, the right to health has also been connected to environmental protection as established by Article 1 of the Charter of the environment placed at a constitutional rank.[8]
Finally, the *Code de la santé publique* (CSP) (Article L. 1110-1 last modified by Act no. 2022-217 of 2/21/2022) reaffirms how the right to health protection is one of the legal system's fundamental rights, which must be implemented "with all means available and for

[5] There are three main insurance schemes: the *Régime général d'assurance maladie* (*Caisse nationale d'assurance maladie* which is aimed at approximately 87% of the population, i.e. public workers and, from 1/1/2020, private workers, the self-employed and freelancers; and the *Régime agricole* (*Mutualité sociale agricole*) which concerns workers in the agricultural sector and their families. From 1/1/2000 with Act no. 1999-641 of 7/27/1999 the *Couverture maladie universelle* was established and replaced starting in 2016 by the *Protection universelle maladie* (PUMA) which extends health care to all those who work or reside in France on a stable and regular basis for life both in the event of job loss, separation, divorce or change of residence and by the *Aide médicale de l'État* (AME) which also offers access to medical care to foreigners in an irregular situation under a certain income. Finally with Act no. 2004-626 of 6/30/2004 the *Caisse nationale de solidarité pour l'autonomie* was established to which the SSFA for 2021 has entrusted the newly established 5th branch of social security dedicated to the loss of autonomy for both elderly people and people with disabilities. The insurance scheme, compulsory for all residents, usually provides for direct payment by patients for non-hospital healthcare services, with the exception of emergency services, and their partial or total reimbursement, depending on the case. Persons covered by PUMA and AME are exempt from paying for health services.

[6] CC dec. no. 93-325 DC of 8/13/1993, paragraph 125; but also dec. no. 89-269 DC of 1/22/1990, paragraph 26.

[7] CC dec. no. 97-393 of 12/18/1997 paragraph 30, 31, 32, 33 e 34; but also dec. no. 2004-504 DC of 8/12/2004; and dec. no. 2010-620 DC of 12/16/2010. See L. Gay, *La protection de la santé dans l'alinéa 11 du préambule de la Constitution de 1946. Un principe, des droits*, in *Politeia*, 37, 2020, 167-187; and F. Jacquelot, *La protection de la santé par le Conseil constitutionnel: un parfum français aux notes d'Italie*, in *Rev. fr. dr. const.*, 115, 2018, 513-532.

[8] CC dec. no. 2000-436 DC of 12/7/2000 and X. Bioy, A. Laude, D. Tabuteau, *Droit de la santé*, Paris, 4e éd., 2020, 3-6.

the benefit of every person" ensuring "the continuity of care and the best possible health security". This concept determines that there is a close correlation between health protection and the social security system established with Ordinances no. 45-2250 of 10/4/1945 and no. 45-2454 of 10/19/1945.

Within this constitutional framework, numerous reforms of the health system have taken place over a short period of time in recent decades. To just cite some of the most recent ones, there was Act no. 2002-2 of 1/2/2002, which reformed the social and medical-social activity and Act no. 2002-303 of 3/4/2002 on patients' rights, which reaffirmed the principle of fairness in access to care and the quality of that care, also through constant updating of the professionals working in the sector, as well as the provision of compensation methods in the event of harm to patients. While as far as the organization of the health system is concerned, there was Act no. 2009-879 of 7/21/2009 which created the Regional Health Agencies (ARS) by merging and rationalizing the healthcare bodies and institutes in each of the original 26 regions, which in 2016 were reduced to 18, pursuant to Act no. 2016-41 of 1/26/2016 on the modernization of the health system. This law established the National Public Health Agency with the task of supervising the epidemiological state of the population in order not only to guide health policies but also to identify as many health risks as possible as quickly as possible and to deal with them by promoting prevention first of all from childhood. Then Act no. 2019-774 of 7/24/2019 was passed relating to the reorganization and transformation of the health system on the basis of the broad *Ma santé 2022* program presented by President Macron on September 18, 2018, which aimed at addressing issues such as population aging, the sharp increase in chronic diseases,[9] and the lack of professionals in the sector, which was making access to treatment difficult. These reforms were also supposed to deal with the advent of technological advances that make it necessary to modernize diagnostic tools and therapies as well as the transition to digitalisation. Many new laws, therefore were introduced.

Starting in 2019, financial resources were allocated to hospitals for the management of chronic pathologies, for the creation of new professional figures of *assistants médicaux* established by the Act to provide support to doctors (both generalist and specialist) and for the creation of the *Communauté*s *professionnelles territoriales de santé* (CPTS) already provided for by Act no. 2016-41 to encourage collaboration between the various public and private professional figures who operate at an outpatient level, hospitals and EMSs who wish to coordinate in order to respond to the health needs of the population of a given territory. Furthermore, the Government undertook to recognize, starting in 2020, both public and private *hôpitaux de proximité* with the task of carrying out a coordination

[9] European Commission-OECD, *State of Health in the EU. France*, 2021, 3, highlighted that France has the lowest avoidable mortality rate in the EU thanks to adequate healthcare, however preventable mortality determined by lifestyles, socio-economic status and environmental conditions is among the highest of the high in the EU in particular compared to Italy, Sweden and Spain.

function between public and private healthcare professionals, the EHPADs and the EMSs of a given territory, constituting a first level of hospital care closest to the patient's home.[10] This appeared to be an overly ambitious program, as President Macron himself noted in a meeting with the staff of the Parisian hospital of La Pitié-Salpêtrière on May 25, 2020, and then it proved to be a "strategic error" in light of the dramatic experience of Covid-19[11]. After the strikes and violent street demonstrations, in order to seek the maximum possible consensus on some primary objectives, the Castex Government launched a broad consultation, called *Ségur de la santé,* with all interested parties which ended on July 10, 2020.[12] The data provided by the Ministry of Solidarity and Health (MSS) in July 2021[13] presented the picture of the financial commitment of €19 bn that the Government allocated above all toward improving the economic conditions of all personnel working in the sector, including EHPADs and EMSs, the modernization of hospitals and EHPADs, the creation of new EHPADs, the creation with Institutional Act no. 2020-991 and Act no. 2020-992 both of 8/7/2020 of a Fifth branch of the *Sécurité sociale* dedicated to the prevention and care of non-self-sufficiency of the elderly and people with disabilities,[14] and to the enhancement of the digitization of the health sector and telemedicine. These first measures were aimed at tackling the great challenges of the French health system already identified by the *Ma santé 2022* program and taken up by the *Ségur de la santé*, however they placed greater attention on prevention.

3. The fight against sanitary desertification

Despite the fact that the SSFA for 2023, approved to make intensive use of Article 49, paragraph 3 of the Constitution, scaled down the healthcare system reform projects, brought the deficit in the social security sector down to €7.1 bn, a clear improvement compared to 2022 (€18.9 bn) and above all to 2020 which had reached around €39 bn, the Act was able to ensure, thanks to the resources of the PNRR, the expenditure forecasts for hospitals, while reductions in expenditure were envisaged for medicines and laboratories. By limit-

[10] C. Calvez, *"Ma Santé 2022" et la loi relative à l'organisation et à la transformation du système de santé n. 2019-774 du 24 juillet 2019*, Dossier documentaire, EHESP, 2022.

[11] See F. Béguin, «On a sans doute fait une erreur dans la stratégie»: le mea culpa d'Emmanuel Macron sur l'hôpital public, in *Le Monde online*, 15.5.2020.

[12] At the end of the consultations, four objectives were identified: the transformation and enhancement of the professionalism of the sector; the definition of a new investment and financing policy for the health service; the simplification of the professional activity; the involvement of all health professionals to ensure effective access to treatment throughout the country. See N. Notat, *Ségur de la santé. Recommandations*, Rapport, 2020.

[13] MSS, *Ségur de la santé. Un an de transformations pour le système de santé*, 2021.

[14] B. Ferras, *La cinquième branche: mythe, réalité, objectif? Une analyse, deux ans après…*, in *Les tribunes de la santé*, 2, 2022, 47-58, but also Cour des Comptes, *La prévention de la perte d'autonomie des personnes âgées. Construire une priorité patagée*, Rapport public, 2021.

ing the analysis to the main objectives pursued by the PNRR, which do not differ from the conclusions of the *Ségur de la santé*, the French Government's awareness of the need to face the challenges posed by the profound economic, social, territorial, demographic and environmental transformations of the country emerged.[15]
First of all, there was the fight against sanitary desertification, which is an objective that fits into the framework of the fight against inequality in access to health services for economic and social but also territorial reasons connected to the depopulation or impoverishment of some areas of the country aggravated by the shortage of doctors and health personnel.[16] France, like many other EU countries, has had to face a serious shortage not only of doctors (generalists and specialists), aggravated in some areas by their aging, and by the choice of the free or mixed profession, which has become prevalent,[17] but also of other healthcare professionals. These shortages have made it increasingly difficult for patients, especially the elderly and the chronically ill, to access quality and continuous care and treatment throughout the national territory. This phenomenon, which has worsened over the last ten years, no longer concerns only some depopulated agricultural areas, but also some of the poorer neighborhoods of large cities or towns in deindustrialized areas, generating strong inequalities between the various departments[18] and in the conditions of health and life expectancy between the highest-income and lowest-income populations.[19]
Despite the fact that Act no. 2019-774, mentioned above, starting from the a.y. 2020/21 suppressed the number cap for access to university studies for the health and pharmaceutical professions, for the next decade the shortage of personnel will however remain serious. For this reason, a part of the resources of the PNRR was destined above all to develop the attractiveness of jobs in the healthcare professions, not only thanks to an improvement in economic conditions long considered inadequate, but also through the creation of new

[15] Part I, Ch. 5. del PNRR *Santé, et résilience économique, sociale et institutionnelle, notamment en vue d'accroître la* réaction et la préparation aux crises.

[16] See Fabrique territoires santé, *Discriminations et santé. Lutter contre les discriminations pour réduire les inégalités de santé*, 2022; the no. 3, 2021 of *Revue française des affaires sociales* dedicated to *La fabrique des inégalités sociales de santé*; the no. 35-36, 2020 of Émulations – Revue de sciences sociales, dedicated to *Santé, inégalités et discriminations*; and T. Lang, V. Ulrich, *Les inégalités sociales de santé*, Acte du Séminaire de recherche de la DREES 2015-2016, 2017.

[17] As of 1/1/2022, 51.8% of doctors practiced in private or mixed professions. See Conseil national de l'ordre des médecins, *Atlas de la démographie médicale*, 2022; and M. Anguis, M. Bergeat, J. Pisarik, N. Vergier, H. Chaput, *Quelle démographie récente et à venir pour les professions médicales et pharmaceutique? Constat et projections démographiques*, DREES, 2021.

[18] Académie nationale de médecine, *Les zones sous-denses, dites «déserts médicaux», en France. États des lieux et propositions concrètes*, 2023; and G. Lafortune, G. Balestat, *Médecins et infirmiers: leur nombre et leur rémunération en France et dans les autres Pays de l'OCDE avant la pandémie*, in *Les tribunes de la santé*, 72, 2022.

[19] The Haut Conseil de santé publique in 2009 noted that France was one of the European countries with the highest levels of inequality in mortality rates. This situation has gotten worse: in 2022 the life expectancy of the richest male population was about 13 years higher than among the poorest. HCSP, *Les inégalités sociales de santé: sortir de la fatalité*, 2009; but also Commission nationale consultative des droits de l'homme, *Avis sur les inégalités sociales de santé,* 2022; N. Duvoux, N. Vezinat (dir.), *La santé sociale*, Paris, 2022; D. Fassin, *De l'inégalité des vies*, Paris, 2020; and *Inégalité et santé*, Paris, 2009.

paramedical professional figures with the opportunity for career advancement and professional growth. These figures support the doctor in numerous outpatient and home care activities with a dual purpose. On the one hand, they will make the doctor's work less burdensome, especially in areas not adequately covered by the health service, by improving the quality of professional life and, on the other hand, these reforms will allow patients continuous access to treatment.
The passing of Act no. 2021-502 of 4/26/2021 perfected the status and tasks assigned to the new paramedical professionals such as the *auxiliaires médicaux*, the *auxiliaires médicaux en pratique avancée* (AMPA), and the *infirmiers en pratique avancée* (IPA) who collaborate with doctors in the management of stabilized chronic pathologies, which nonetheless require constant monitoring and complex care situations.[20] To this end, on May 26, 2023 the Ministry of Health and Prevention launched a national consultation, which involved citizens, students and health professionals and which was aimed at redefining the nursing profession and the training paths to access it. The conclusions, scheduled for September 2024 will cover three aspects: skills, training and careers.
The same Act also established access to treatment service (SAS), under construction, which should allow access health care free of charge 24 hours a day, 7 days a week and 365 days a year, to anyone who requests it, through the collaboration between the emergency medical assistance service (SAMU) and the local public and private health operators who carry out the activity in the clinics and in the établissements.[21] This program should provide more timely and appropriate access to treatment by reducing the need for emergency room access, which has become increasingly frequent and unsustainable.[22]
Finally, thanks to the resources of the PNRR, Act no. 2021-502 has rethought the internal organization of hospitals in light of the *ville/hôpital* project, introduced by Act no. 2016-41,[23] which encourages territorial cooperation among hospitals, public and private health operators, CPTSs and *maisons de santé pluriprofessionnels* (MSP).[24] From this point of view, the resources of the PNRR will also be allocated toward overcoming the condition of precariousness in such an essential sector such as healthcare, where women currently represent the majority of those employed.[25] Hence, France will be able to combine health

[20] Act no. 2023-379 of 5/19/2023 allows access to IPAs without a doctor's request. The IPAs are also authorized to prescribe medical tests and certain types of drugs.

[21] See the Article L. 6311-3 CSP introduced by Article 28 of Act no. 2021-502 of 4/26/2021.

[22] See the Rapport flash *Sur les urgences et soins non programmés* of 2022 coordinated by F. Braun on behalf of the President of the Republic who also hopes that first response structures for emergencies will be maintained in the EHPADs and EMSs.

[23] Baromètre santé, *Nouveaux usages en santé*, March 26, 2018 according to which in 2018, 65% of doctors and 90% of directors of établissements declared themselves dissatisfied with the results achieved in the implementation of the *ville-hôpital* project.

[24] The legal and financial framework of CTPSs and MSPs was defined by Ordinance no. 2021-584 of 5/12/2021.

[25] See Académie nationale de médecine, cit., which highlights how on 1/1/2022 the majority of doctors in regular practice were women (50.5%); and the PNRR which on p. 40 reports the data provided by the 2020 Report of the Ministry in

objectives with the pursuit of other targets set by the *Next Generation EU* such as gender equality.[26]

4. Attempts at territorial "*déconcentration*" and criticism of the ARS model

The French health system, being essentially a centralized health service, starting in 1996, with the reform introduced by the Juppé Government, began a process of "*déconcentration*". The expansive constitutional revision of 2003 then broadened and consolidated this process by constitutionalising the regions which, however, still do not have legislative autonomy. The legislative discipline in healthcare is, nevertheless the responsibility of the State, while its administration is still headed by the MSS, which has been divided into two ministries in 2022-2023: the Ministry of Health and Prevention and the Ministry of Solidarity, Autonomy and Persons with Disabilities, and since January 11, 2024 in the Atal Government merged into a "super" Ministry of Work, Health and Solidarity. The process of drawing up health policies is entrusted to these ministries which, together with the economy and finance ministries, have the task of defining healthcare expenditure commitments for the annual SSFA budget.

As was pointed out, starting in 2010 with Act no. 2009-879 the ARS responsible for regional healthcare planning were created, which included financing, and provision and coordination of public service activities at regional and departmental levels, the evaluation and promotion of the quality of health personnel training, the granting of authorizations for the creation of établiss*ements* and *services de soins* and *médico-sociaux* in the region, and finally, in collaboration with the prefect, monitoring, prevention, preparation and management of health and environmental crises.[27] The regulation by the ARS of the healthcare services provision for the region was then called upon to achieve a double objective: respond in the best possible way to the territorial healthcare needs and ensure the effectiveness of the healthcare system in the three sectors: outpatient (*médecine de ville*), *médico-social* (help and accompaniment of elderly and disabled people and children) and hospitals, contributing to the achievement of the national expenditure target for health insurance.

The Covid-19 crash test highlighted the limitations of the ARS model, which had long been subject to criticism. It was widely believed that the ARS, viewed as prisoners of their bureaucratic organization, were not able on the one hand to adopt autonomous decisions

charge of Equality between Women and Men, according to which women represent 77.3% of doctors and non-medical staff in hospitals, and 87.4% of staff of the EHPADs.

[26] See Act no. 2021-1774 of 12/24/2021 *visant à accélérer l'égalités économique et professionnelle entre femmes et hommes*.

[27] See the Article L. 1431-2 CSP as amended by Act no. 2022-140 of 2/7/2022. The ARS is *an administrative public body of the State* in charge of implementing health policy in its region.

in the sectors of their competence nor fully carry out their health system supervisory function.[28] On the other hand, they were contemporaneously unable to develop coordination networks with public and private subjects present in the area, especially after the 2016 reform, which created macro-regions called upon to manage territories that were too vast and diversified.[29] Indeed, during the health emergency it was, once again, the regional and departmental prefects who carried out the fundamental function of coordinating the territorial public and private health systems and of transmitting the decisions taken at the state level.[30]

The PNRR, recalling paragraph 4 of the Article 72 of the Constitution, underlined the importance that Institutional Act no. 2021-467 of 2/21/2021 may have had, according to the intentions of the legislator, in the development of the process of decentralization and territorial differentiation also in the context of the health system.[31] The Act simplified those procedures that would allow territorial entities to access and abjure, even on an experimental basis and under precise conditions, to the regulation and implement matters of competence, derogating from what had been established by statutes and regulations of the State, in order to better respond to the specific needs of the local area. However, The Act did not introduce any substantial innovation in the relations between the State and local authorities. In effect, the initiative, organization and control of the process of experimenting with territorial differentiation remained firmly in the hands of the State while the territorial communities were excluded from any possibility of influencing them. In essence, this reform did not expand local decision-making power and consequently administrative autonomy, particularly in the health sector.

Rather, Act no. 2022-217 of 2/21/2022 (Act 3Ds "*différenciation, décentralisation, déconcentration*"), despite having amended Article L. 1110-1 of the CSP, which introduced the territorial authorities and their groupings among the subjects who were to be called upon to ensure equal and universal access to care, limited itself to transforming the Supervisory Board of the ARS into a Board of Directors whose chairmanship would be attributed to the prefect of the Region and vice-chairmanship to three representatives of the local authorities.[32]

[28] E.g. the scandal over the condition of elderly people hospitalized in the EHPADs. See Défenseur des droits, *Les droits fondamentaux des personnes* âgées *accueillies en EHPAD*, Rapport, 2021; and *Suivi des recommandations du report 2021*, 2023.

[29] D. Pittet, L. Boone, A.-M. Moulin, R. Briet, P. Parneix, *Mission indépendante nationale sur l'évaluation de la gestion de la crise Covid-19 et sur l'anticipation des risques pandémiques*, Rapport final, 2021.

[30] Sénat, *La coordination collectivités territoriales-Agences régionales de santé, un premier bilan*, Round Table, May 28, 2020.

[31] PNRR, 25 and 38.

[32] J.-C. Zarka, *Que retenir de la loi 3DS du 21 février 2022?*, in *Les petites affiches*, may 2022, 5-11.

5. Population aging and prevention policies

Last, the PNRR has paid particular attention to the issue of the ageing population. As mentioned, France, together with other countries such as Italy, boasts one of the highest life expectancies at birth in the EU. This is an aspect which, according to forecasts, is destined to consolidate and grow over time, generating numerous problems especially in the health and social welfare fields both for the overall growth in the number of people over 65 and for the growth in the number of people suffering from chronic pathologies as well as those who are not self-sufficient.

As already mentioned, in 2021, the fifth branch of the social security administration dedicated to the loss of autonomy was established. This PNRR also aimed to improve the care of the elderly and their autonomy by allowing equal and universal access to the EHPADs and its services.[33] In this context, the PNRR not only provided for investments in the medical-social sector, especially in the EHPADs, both to modernize buildings in terms of energy and architecture, enhancing smaller facilities in order to improve the quality of life of the residents, and optimizing performance and services, it also sought to increase specialized personnel and increase the availability of beds, while also supporting the choice of the elderly to stay at home, by rethinking the health service to guarantee them adequate assistance at home or at the EMSs. According to what has been stated, there is in fact a commitment to transform the EHPADs "into real centers specialized in the elderly, projecting part of their services and skills into home assistance".[34]

From this point of view, as has already been observed, also in consideration of the progression of health desertification, the PNRR envisaged the creation of new professional figures. For example, the IPAs, while also allocating important resources to the digitization of the health system (including telemedicine), to its strengthening and its diffusion throughout the national territory. In fact, among the long-term objectives of the PNRR there a radical change of perspective of the health system has taken root, aimed at accompanying the elderly towards remaining as active and healthy as possible and, if they wish, while living at home.[35]

As highlighted in the 2021 Chauvin Report, the crisis in the French health service, considered one of the best performing systems in the world, is to be found in the poor development of the primary care and prevention sectors. This has resulted in the progressive increase in health inequalities in recent decades, including lowered life expectancy, growth

[33] PNRR, 25. C. Pirès-Beaune in his Report to the Prime Minister of June 2023 *Garantir la prise en charge des personnes* âgées *en* établissement proposes the creation of a single universal state contribution paid to all EHPAD residents in a degressive manner based on income. This would also allow people with low incomes to access EHPAD and its services without burdening family members.

[34] PNRR, 643 and 700-706; and Cour des comptes, *La prévention* …, op cit., 47-54.

[35] Gouvernement, *Grand âge: le Gouvernement engagé en faveur du bien vieillir à domicile et en établissement*, 2022 available at the address: sante.gouv.fr/IMG/pdf/dp_ehpad_2022_accessible.pdf.

in the incidence and prevalence of chronic diseases, stagnation of life expectancy in good health and without disability, while, regardless of these issues, life expectancy at birth continues to rise.[36] Furthermore, according to OECD data, France is among the countries in which the indicators of life expectancy, avoidable mortality and premature mortality show great disparities between social groups and territories.[37]

For these reasons, at the end of a broad national consultation promoted by the MSS and concluded in February 2019,[38] the French Government adopted the *Stratégie globale pour prévenir la perte d'autonomie* document for the years 2020-2022 in the framework of the first *Plan national de santé publique* which placed among the priority objectives the implementation of systemic prevention policies and the coordination of the health system and of the territorial communities at various levels.[39] The document allocates financial resources to the healthcare system for the implementation of specific tasks both in the field of prevention and patient care. For example, it establishes the prescriptions for different age groups of specific routine tests, aimed at preventing the onset of loss of self-sufficiency or at diagnosing it promptly. Though the Plan also encourages vaccination against disabling infectious diseases while, in the context of outpatient and hospital care for the non-self-sufficient elderly, it requires adequate home and outpatient assistance in order to avoid hospitalization, it also provides for the establishment of dedicated priority pathways and suitable professional reception should hospitalization become necessary.

Furthermore, among the prevention measures, the document includes research on environmental factors with an impact on health. This last theme is taken up and detailed by the fourth *Plan national santé environnement* of 2021 and by the Report of the *Haut Conseil de la santé publique* from which emerges on the basis of national data, confirmed by the WHO figures, the awareness that prolonged exposure over time to certain pollutants can contribute to the onset of chronic diseases, certain types of cancer as well as neurodegenerative diseases.[40] In particular, the onset of chronic diseases is a phenomenon that has progressively worsened in recent decades and is today the leading cause of death in France, affecting all ages. Social, territorial and gender inequalities then represent a factor that increases the risk of the onset of these diseases which also constitute an important

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[36] See F. Chauvin, *Dessiner la santé publique de demain*, Rapport 2021, 2-3, which highlights how less than 1 in 2 French people reach the age of 65 in good health according to the WHO definition.

[37] OCDE, *France: Profils de santé par pays*, 2019; and G. Menvielle, T. Lang (coord.), *Les inégalités sociales de santé: vingt ans d'évolution*, in *ADSP*, no. 113, 2021.

[38] See the Report D. Libaut, *Concertation Grand âge et autonomie*, 2019.

[39] MSS, *Vieillir en bonne santé*, 2020 elaborated on the basis of the first Plan national de santé publique, *Priorité prévenir. Rester en bonne santé tout au long sa vie*, 2018.

[40] Gouvernement, *Un environnement, une santé. 4e Plan national santé environnement 2021-2025*, 2021, 6-8; HCSP, Évaluation globale des PNSE (2009-2014), 2022; and Santé publique France, *Imprégnation de la population française par les pesticides organophosphorés. Programme national de biosurveillance, Esteban 2014-2016*, 2021.

financial burden for the health system.[41] A worrying picture, to which we must add the growth in infant mortality within one year of birth which is today among the highest in the EU.[42]

6. Conclusion

There is no doubt that the serious health crisis caused by the Covid-19 pandemic in France as in other EU countries accelerated the process of rethinking the organization of the healthcare service.[43] Though the French health system is certainly viewed among the best performing in the EU, it is essentially devoted to responding to requests for assistance and patient care. Despite having passed this test, however, the great effort made by all professionals in the sector to meet, in a short time, a massive request for assistance, especially from the most fragile people: the elderly, the non- self-sufficient and those with disabilities or with chronic diseases, has highlighted the system's shortcomings.
The PNRR included in the broader *France Relance* investment program has made it possible to initiate some of the reforms promised by the Government and hoped for during the *Ségur de la santé*. However, much remains to be achieved and the SSFA for 2024 no. 2023-1250 of 12/26/2023 constituted a severe test for the Government[44].
What emerges from this first analysis is the increasingly widespread awareness among French institutions of the complexity of the task entrusted to them by the Constitution. The commitment made in recent years in favor of a transition from a healthcare system devoted essentially to patient care towards a system more attentive to the prevention of the onset of diseases has also led to the consideration of the plurality of factors that can affect health and the need to involve and coordinate different sectors of the public administration to achieve this goal efficiently and sustainably.[45]

[41] Conseil économique, social et environnemental, *Les maladies chroniques*, Avis voted in plenary on 6/11/2019, *https://www.lecese.fr/sites/default/files/pdf/Avis/2019/2019_14_maladies_chroniques.pdf* According to the data reported in the document, 35% of French policyholders suffer from chronic diseases and commit 60% of the health costs.

[42] Eurostat, *Mortality and life expectancy statistics*, March 2023; and Vie publique, *Mortalité infantile en France: pourquoi le taux ne baisse plus?,* 6/23/2023 in vie-publique.fr/en-bref/289948-mortalite-infantile-en-france-pourquoi-le-taux-ne-baisse-plus. Among the main causes are the increase in advanced age, smoking and the social precariousness of mothers.

[43] See the conclusions of R. Balduzzi, *Diritto alla salute e sistemi sanitari alla prova della pandemia. Le "lezioni" di alcuni Piani nazionali di ripresa e resilienza*, in *DPCEonline*, 1, 2023, 429-432.

[44] Approved making extensive use of the of Article 49, paragraph 3 of the Constitution, the SSFA for 2024 raised the national spending target for health insurance to 8.7% of GDP compared to 8.2% of GDP before the health crisis. Among the measures adopted there is, for example, the increase in the frequency of routine exams scheduled for different age groups (18-25 years, 45-50 years, 60-65 years and 70-75 years); and free vaccination against papillomavirus for children aged 11 and over.

[45] HCSP, *Contribution à la Stratégie nationale de santé 2023-2033*, 2023, 26-27 and 62-67, recalls two principles already established at an international and European level: *Health in all policies* for an effective fight against health inequalities

The methodological choice of consultation and active involvement of the representatives of all stakeholders in the institutional sphere (State and territorial communities), of associations, trade union organisations, businesses, professionals and citizens in the elaboration of public policies also falls within this perspective in the field,[46] while the proposals in favor of the creation of a territorial governance of the health system will clearly require collaboration among the prefects, the territorial communities, the ARS (rethought and strengthened) and the subjects mentioned above.[47] Measures which, together with the commitment to create biomedical research centers of excellence,[48] are aimed, over the long-term, at making the public health service more attractive and present in the territory[49]. From an institutional perspective, there has emerged the need to strengthen the role of the *Comité interministériel pour la santé* and the *Groupe santé-environnement* called upon to carry out a more incisive function of orientation and coordination of the activities of the ministries concerned, which unfortunately are still considered "compartments that are too watertight". Moreover, from the point of view of regulatory sources, if the Statutes (Institutional Acts and ordinary Acts) and the ordinances are the primary sources of implementation of the PNRR, the recent transformation of the *Stratégie nationale de santé* into a medium- and long-term planning tool endowed with binding, operational and unifying force for public health policies has been advocated.[50]

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and *One Health* which emphasizes the interactions between human, animal and environmental health. See aso the Conclusions of the ECHR, Grand Chamber, case Verein KlimaSeniorinnen Schweiz and Others v. Switzerland, no. 53600/20, april 9, 2024.

[46] E. Rusch, F. Denis, *Conseil national de la refondation en santé: une opportunité pour renforcer la démocratie en santé et initier une nouvelle gouvernance du système de santé?*, in *Santé publique*, 6, 2022, 757-760.

[47] HCSP, *Contribution*…., 122 and 166-169; and F. Chauvin, *Dessiner…*, 6-7.

[48] Gouvernement, *Innovation santé 2030*, 2021.

[49] Among the first measures in this sense are, on the one hand, the salary increases that the LFSS for 2024 assigns to medical and paramedical staff who work at night and on holidays, equalizing the public sector (which, in fact, takes care of this service) to the private one and on the other side the Valletoux loi no. 2023-1268 of 27.12.2023 which prohibits the practice of the temporary profession in hospitals, EHPADs, EMS and biology laboratories in the first years of a career, and establishes the figure of the public and private *infirmier référent* (reference nurse) which upon medical advice provides assistance to chronically ill patients.

[50] HCSP, *Contribution*…., 134-136.