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HRC [Hillary Rodham Clinton]/Paris Breakfast 6/7/94

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FIRST LADY HILLARY RODHAM CLINTON
BREAKFAST WITH LEADING FRENCH WOMEN
PARIS, FRANCE
JUNE 7, 1994

TALKING POINTS

INTRODUCTION

Thank you, Madam Minister. It is wonderful to be back in Paris, although I always feel cheated here because I never have enough time to see all of this city's vast cultural treasures. But at least this week I'll visit L'Opera [Lo-pair-ah] and the Musee [Mew-zay] Rodin.

And hopefully on my next trip I'll be able to sample one of Chef Arabian's [Ah-rah-bee-yahn] dinners at Le Doyen.

COMMON BONDS AMONG WOMEN

* No matter what continent we live on, women are almost assuredly the primary caregivers in our societies. And we often juggle the responsibilities of caring for small children and aging parents along with the duties of demanding professions.

* These unique experiences give women a unique perspective on social policy.

* It's no coincidence that legislation involving children, families, health, nutrition, and education progressed further and faster once more women were elected to state and federal offices.

And here in France the leadership of women in all walks of life has helped produce an Equal Rights Amendment, a pay equity law, and even a Cabinet-level office that concentrates on women's issues.

THE COMMON CHALLENGES OF FRENCH AND AMERICAN WOMEN IN THE 1990S

* On both sides of the Atlantic, we are witnessing a dislocation of family life, an increase in violence and alienation among our youth, and a general fraying of the social fabric. In both the France and the United States, there is a temptation to blame working women for the escalating divorce rate, for the breakdown of families, and for many other social ills.

* But the fact is that while women continue to be the primary caregivers, we also enrich our nations economically, socially, culturally, intellectually, and politically through our careers.

* It would be nice if solving all of our problems was simply a matter of women staying at home OR working. But as Simone Veil has said: "We must give women the possibilities to respond to both aspirations" -- work and motherhood. "We must give them choice."

* I know that Parliament has debated a government proposal to offer financial assistance to women wishing to leave the work place to raise children. [checking the status of this bill]

WOMEN AND HEALTH CARE

* My interest in health care stems in part from my role as a mother, as a wife, as a daughter -- in short, as a caregiver. And it also reflects a belief that individual good health is essential to the collective health of society.

* In working on health care reform at home, I've been interested to learn about the experiences in other countries, and I'm particularly struck by the emphasis "la Secu" [Say-coo] places on the health needs of children and women. As you know, universal coverage and a philosophy of preventive care are cornerstones of President Clinton's approach to reform.

WOMEN HAVE A HUGE STAKE IN THE GREAT ISSUES OF THE DAY

* Women must continue to participate, to speak out, to offer their unique perspectives, particularly at a time when our nations face new and complicated challenges.

* The positive contributions you have made in the vast array of professions you represent is an inspiration to women everywhere who share your hopes and goals.

###

TO: Lissa

FROM: Erin

RE: GENERAL FAMILY SUPPORT BILL

The bill was submitted to the National Assembly (lower house) last week. It has already been debated in the Council of Ministers. It may go to vote in the National Assembly as soon as tomorrow, but that's not definite. I spoke with Craig Kelly(ey?) of the Western Europe division of the State Department. His comment was that this bill should not be seen as a groundbreaking one for women. It has been criticized by women's groups in France for not going far enough to encourage working women. The bill's increase in payments extends benefits for two children instead of one. Because of this, women's groups are concerned that this bill encourages women to stay in the home as opposed to the workplace.

Let me if you have any further questions —

Erin

FRANCE / WOMEN

Mat. Insurance

100% reimb. f care + tests during pregnancy
lower inf. mortality rate
exams for kids up to 6 yrs. old
16 wks leave; 26 for 3rd child

Protection Maternelle et Infantile

preventive + curative public consultations
preg women, mothers + young children
- day care
- Elem + secon + univ. health serv.

In Fr. system — patients still choose their doctors

Securité Sociale — la Sécu

health, retirement, family

More generalists 3 out of 5

Both societies ↗ marriages ending in divorce
Wkg women ↗

Inter Press Service

March 5, 1994, Saturday

LENGTH: 738 words

HEADLINE: FRANCE-WOMEN: GETTING THE RIGHT MIX OF CAREERS AND CHILDREN

BYLINE: By Angeline Oyog

DATELINE: PARIS, Mar. 5

BODY:

Defending their right to work and their freedom to choose, French working women are weighing their options on how to reconcile careers and children.

Some 200 women gathered this weekend in Paris in a national debate on employment warned against imposing simplistic solutions to the worsening unemployment crisis and to the upbringing of children in socially troubled times.

"Reconciling careers and work and children is a major stake of society," said Marie-Therese Hermange, deputy mayor of Paris in-charge of social affairs and vice-president of the Regional Council of the Paris region.

"But the remedies to such problems as the dislocation of family life, and the rending of the social fabric, cannot be found in past," stressed Hermange.

"In these times of crisis, people search for scapegoats," said Simone Veil, state minister of health, urban and social affairs, speaking before the women.

"Women are accused of taking jobs away from men, and mothers are told that children will be better educated with the women at home," she added.

"We must give the working woman the possibilities to respond to the two aspirations. We must give them the choice," Veil said, promising that the government will not impose on women one way or the other.

Veil regretted that past government policies had oscillated between the "all-maternity" and "all-work." "If certain women see themselves in either of these policies, the majority wish to reconcile the two, or hope to adapt to the priorities of the moment."

Organized by the National Council of French Women (CNFF), the debate comes at a time

of profound mutations of society, said Paulette Laubie, CNFF president.

The debate, which ends March 12, also comes a few weeks before the male-dominated Parliament debates a law proposed by the government offering financial assistance to women wishing to leave the work place to raise children.

The government-sponsored bill was preceded by more rigid propositions by male legislators, who offered working women salaries in exchange for giving up their jobs, and who thought they found an answer to both the unemployment crisis and the education of children.

Aside from the unprecedented unemployment rate of 3.3 million jobless, leaving a trail of social upheavals, France is also panicking over lower birth rates, and a greying population.

"The choices of women must not proceed from an illusion. The future of our children raises questions, but women are also factors in the economy," stressed Paulette Laubie, president of the National Council of French Women (CNFF).

According to official statistics assembled by CNFF, the number of working women in France grew from 6.6 million in 1962 to 11.1 million in 1992, or a growth of some 60 percent in 30 years.

More than three-quarters of women between 25 and 49 years of age are working and activity is the most intense between the ages 25 and 39.

More and more jobs are being held by women, growing from 38.2 in 1975 to 42.7 percent in 1992. Women comprise one-third of self-employing professions like doctors and lawyers; more than 50 percent of the professors and scientists; and almost 30 percent of business managers.

There are more divorcees working, than married women, and single mothers are more likely to work.

Some jobs, including secretaries or social assistants are almost all held by women. In 1992, women represent 30 percent of the industrial manpower and 51 percent in the service sector.

On the other hand, the unemployment rate in 1992 was higher among women (12.8 percent) than men (7.9 percent). Moreover, it is the youngest women, between 15-24, who are the worst hit by unemployment.

If financial assistance is being offered to working women choosing to tend their children, Veil cautioned against permanently closing the doors to them.

Women pausing in their careers or work to bring up their children must be able to return to their former jobs, stressed Veil.

According to the minister, where possible, women and employers are also being encouraged to resort to the various innovative options being opened up to reconcile professions and family: part-time work, shorter work hours, working from home, job-sharing, etc.

"We need to be imaginative today, more than ever. We are in effect confronted with two legitimate but contradictory demands of more protection in a rapidly changing world and more individual liberty," said Veil.

LANGUAGE: ENGLISH

LOAD-DATE-MDC: March 08, 1994

FACTS ON
FRANCE

92.19 *April 1992*

Women in France

France has a population of 56.6 million, approximately 51 percent of whom are women, 4.5 million are over the age of 65 (compared with 2.8 million men) life expectancy for French women is 80.7 years and 72.5 years for men.

French Women and Equal Rights

By law, French women enjoy equal rights with men. The women's emancipation movement, sparked by the industrial revolution, has accelerated in this century, especially during the past 15 years.

The following are the principal stages:

1881: Women are allowed to open bank accounts and make withdrawals;

1892: Banning of night work;

1907: Married women who work are authorized to keep their wages;

1908: Married women cease to be under their husband's guardianship;

1909: Women obtain the right to have maternity leave;

1945: Women obtain the right to vote and stand for election;

1946: The Constitution grants women equal rights with men;

1965: The Civil Code is amended to provide for greater equality between spouses;

1970: Husband and wife share parental authority;

1972: Equal work for equal pay;

1975: Adoption of law allowing voluntary termination of pregnancy; Discrimination against hiring on grounds of gender is prohibited;

1980: Women may not be dismissed on the basis of pregnancy;

1983: Law on equal employment opportunities for men and women is passed; The concept of "head of family" in fiscal law is abolished;

1985: Legislation strengthens the equal rights of spouses in managing the couple's assets; Children are allowed to take the mother's family name in addition to the father's;

1988: Revision of social statute for mothers;

1991: Penal Code is amended calling for individuals found guilty of sexual harrassement in the workplace to face one year in prison and a $16,000 fine.

French Women and Marriage

Fewer marriages are taking place in France-281,000 in 1989 as compared with 417,000 in 1972-and the number of women marrying before the age of 20 has dropped by 75 percent over the past 10 years. Many women opt to live with a man before marriage and 24 percent of the children are born outside of marriage (as compared with 9.7 percent in Germany and 22 percent in Great Britain). There are roughly 13.5 million couples in France, of which 7.7 have children, 3.3 million widows and 1.3 million divorced women. The divorce rate has tripled between 1970 and 1985 with one out of every three marriages ending in divorce.

French Women in the Work Force

More and more women are working in France than ever before now, making up 44 percent of the working population. One out of four women works part-time. Between 1962 and 1990, the number of working women rose from 6.7 million to 11.1 million, or an increase of 4.4 million whereas the working male population rose only 1.4 million. Women are, however, more affected by unemployment than men-13 percent are unemployed as compared with 7 percent of the male working population.

Females seem to do better than males in school (they account for 57.5 percent of candidates for the *Baccalauréat*, the national high-school exit examinations, and for 52 percent of students in universities). However, girls tend to choose humanities over technical or scientific studies and are therefore significantly under-represented in some fields.

The situation is changing more and more and women are increasingly entering fields such as medicine and scientific research. Nowadays, fewer than one woman in twenty chooses not to work after leaving school. Compared to other EC Countries, the proportion of women in the French working population is high (42.5percent against an EC average of 39.4 percent in 1988) but noticeably lower in the USA. At present, woman account for 73 percent of those employed in medicine and social fields, 83 percent in the service sector and 61 percent in education; however, they are a minority in supervisory roles in industry (6 percent), engineering (6 percent) and in the police and military forces (5 percent).

French Women and Politics

Women won the right to vote and to run for elected office in 1945. But as early as 1936, three women (one of whom was Irene Juliot-Curie) were in the cabinet of Leon Blum as Under Secretaries of State for Scientific Research, Education and Child

The actual ministery contains six female ministers : (1992, former socialist government)

- Minister of Cooperation and Development:	Edwige AVICE
- Minister of Sports and Youth:	Frederique BREDIN
- Minister for European Affairs:	Elisabeth GUIGOU
- Minister of Labor:	Martine AUBRY
- Minister for Housing:	Marie-Noelle LIENEMANN
- Minister of the Environment:	Segolene ROYALE

As well as two female Undersecretaries:

- Undersecretary for Women's Rights:	Véronique NEIERTZ
- Undersecretary for Francophony:	Catherine TASCA

Although politically active, French women tend to run in fewer elections than men; at this time there are only 33 women deputies in the National Assembly (out of a total of 577), 31 in the Senate (out of 319 senators), 157 on general councils (out of 3,810 councillors) and 1,451 mayors in more than 36,000 townships. However, women account for 53 percent of the electorate.

More than half of all French women belong to one or more socially oriented associations (often having considerable political influence). Some examples are: the social advancement of low-income families, consumer protection and environmental protection.

not patients. The physician-population ratio is about 10% higher in France, but about three in five French physicians are generalists compared with only one in three in the United States. Per capita physician visits are about 35% higher in France. Broader coverage, high rates of supplemental insurance, and lower prices may contribute to this differential.

Hospital care is mixed, with about three fifths of short-stay beds in public facilities. The period 1960 through 1980 saw a transformation of hospitals with tremendous growth, particularly of centrally financed regional hospital centers, and rapid improvement in technological sophistication. The hospital sector during this period grew at an annual rate of 4% greater than the ambulatory sector, producing a more hospital-centered health care system. Public hospitals, once known as the place where the poor went to die, became regional centers with the most technologically advanced services and with highly trained physicians often linked to universities. Part of the improvement in hospital care is due to the establishment of 26 000 prestigious, full-time hospital-salaried positions for physician specialists. Of these, 8000 are university affiliated, carry academic titles, and provide income comparable to non–hospital-based practice.

Office-based practitioners cannot care for their patients as inpatients in public hospitals. However, the estimated 20% of office-based physicians who are *attachés* can admit patients for outpatient procedures. Inpatient care in public hospitals is supervised by salaried hospital-based physicians of the appropriate specialty. Patients cannot generally choose their physician in public hospitals, except by seeing the physician during his or her limited private practice time there at substantially increased out-of-pocket cost. Private patients cannot occupy more than 8% of beds in public hospitals.[10]

Private hospital care now accounts for 24.2% of total hospital expenses but over two fifths of patient days in short-stay hospitals. These facilities, smaller on average than public hospitals, mostly evolved from the *cliniques*, for-profit doctor's hospitals. Many believe that these facilities provide the most attentive patient care, and they are often used for routine operations, maternity care, and care for particular categories of problems, such as cancer. Physician arrangements with private hospitals range from full-time salaried positions to agreements permitting office-based practitioners to admit and care for patients. In private hospitals, which represent 35% of all beds, 7100 physicians are salaried and 36 000 are in private practice, of which 10 000 are full time.[11]

Table 1.—Comparative Figures on Health Care Systems in the United States and France

	United States	France
Population (1990)	248 709 873*	56 735 109
% of uninsured	14.4*	<1
% of population aged ≥65 y (1989)	12.6	13.6
Infant mortality rate per 1000 births (1990)	9.2	7.2
Total physicians per 1000 population (1990)	2.37	2.6
Total registered nurses per 1000 population (1989)	6.7‡	5.3
Primary care physicians (family practice, general practice, internal medicine, pediatrics) as % of total physicians (1990)	34.1†	67.7
Hospital personnel per short-stay bed, in full-time equivalents (1990)	3.7‡	1.2
Short-stay hospitals‡		
Beds per 1000 population (1989)	3.7	5.2
Occupancy rates, all short stays (%, 1989)	66.5	77.4
Occupancy rates, nonfederal, nonprofit (%, 1989)	68.8	...
Occupancy rates, for profit (%, 1989)	51.7	91.5
Discharges per 1000 population (1990)	91.0	204.7
Days of care per 1000 population (1990)	607.1	1483.1
Average length of stay (days, 1990)	6.7	7.2
Ambulatory physician visits per capita (1989)	5.3	7.2

	United States, %		France, %
Hospital care payments (1990)‡			
Out of pocket	5.0	Out of pocket	6.8
Government	54.7	Social security	89.9
Private health insurance	34.9	Private health insurance	3.3
Other private funds	5.4	Other public sources	1.5
Physicians services payments (1990)‡			
Out of pocket	18.7	Out of pocket	28.3
Government	35.0	Social security	62.0
Private health insurance	46.3	Private health insurance	8.6
Other private funds	0.0	Other public sources	1.1
Total personal health care expenditures (1990)‡			
Out of pocket	23.3	Out of pocket	18.8
Government	41.3	Social security	74.0
Private health insurance	31.8	Private health insurance	6.1
Other private funds	3.6	Other public sources	1.1

*US Bureau of the Census. *1990 Census of Population and Housing (CPH-1)*. Suitland, Md: Dept of Commerce; 1991.
†*Physicians' Characteristics and Distribution in the US, 1992 Edition*. Chicago, Ill: Dept of Physicians' Data Services, Division of Survey and Data Resources, American Medical Association; 1992.
‡National Center for Health Statistics. *Health, United States, 1991*. Hyattsville, Md: Public Health Service; 1992.

French physicians appear less hassled than US physicians. This undocumented difference derives from a less complicated professional life. Office-based practitioners usually do not have to divide time between office and hospital, have utilization monitored by only one agency, are rarely subject to malpractice claims (and even then awards are infrequent and paltry by US standards), and receive payment directly from patients on a fee-for-service basis. Hospital-based physicians, almost all specialists, are subject to minimal utilization review or systematic quality assurance and, like their office-based confreres, rarely have to counterbalance patient advocacy with cost-containment goals.

HEALTH CARE COVERAGE

The French social protection umbrella includes protection related to health, family, and old age under a social security system, and protection against adverse economic effects of unemployment managed through a separate system. Protection against the costs of illness is accomplished primarily through the Sickness Insurance Funds (SIFs) (Caisses d'Assurance Maladie). Unlike Canada, health care coverage through the SIFs is not automatic by virtue of residency. Yet, almost every citizen and permanent resident are covered. Three major funds provide coverage, with type of employment determining to which fund contributions are made. The general fund is for all employees in industry, commerce, and government and covers, including dependents, 81% of the population.[12] The agricultural fund covers 9%, and the third major fund, comprising professionals and other self-employed persons and their dependents, covers about 6%. A large number of minor funds serve other specific working groups.

Since 1978, individuals not obtaining obligatory coverage through employ-

Table 2.—Sources of Health Care Payments in France, %

Year	Social Security	Local Government	Supplemental Insurance	Out of Pocket
1970	68.6	5.4	4.4	20.6
1980	76.5	2.9	5.0	15.6
1990	73.6	1.1	6.2	19.1

ment have had access to the SIFs through individual contributions. Social security covers payments for the unemployed during a period determined through a complex formula incorporating age and prior work activity.[12] Thereafter the unemployed have access to the SIFs via payment of premiums individually. However, since 1988, local governments have been required to pay the premiums for those without a defined minimum income level on request. The 1988 law provides that all persons older than 25 years and those with one or more children receive a subsidy to bring them to a defined minimum monthly income, currently $440 for one person and $660 for a couple, with supplements for each child. There remain an estimated 350 000 to 500 000 uncovered French citizens and other residents; at maximum, these constitute about 1% of the population of 56 million.[13]

Coverage was established by stages. The first social insurance law, enacted in 1928, covered about 45% of the population.[15] This percentage remained unchanged, despite the creation of a social security system and the general fund in 1945, until 1950, when further growth began. Key events included the creation of health insurance for agricultural workers in 1961, for professionals and other self-employed individuals in 1966, and for others through individual insurance in 1978. Coverage under the general fund increased to 81% of the population by 1991. From 1945 to 1991 the contribution of social security payments to total health care expenditures increased from 44% to 75%.

FINANCING AND PAYMENT

In France, as in the United States, a system established to finance insurance against high individual health care costs has evolved to one that finances all costs, even those amenable to individual or family budgeting. Thus, despite good financial protection provided by SIFs, supplemental insurance has a well-entrenched role as the reimburser of some or all of the copayments required by the basic system, particularly for ambulatory services.

The main SIF, which operates as an independent quasi-public entity (Caisse Nationale d'Assurance Maladie des Travailleurs Salariés [CNAMTS]), is self-supporting through payroll contributions of employers and employees. The CNAMTS director is appointed by the Council of Ministers (equivalent to the President's Cabinet). Seats on the CNAMTS governing board were equally split between unions representing workers and employer groups until 1982, when union representation was increased to 16 and employers decreased to seven. These totals include two voting Ministry of Social Security–designated representatives. In addition, mutual insurance companies designate two seats. Nonvoting governmental representatives also attend.[16] The governing board has the authority to propose an increase in payroll taxes to keep pace with expenditures but usually leaves specific proposals to the Ministries of Finance and Social Security. The two other SIFs of significant size each operate in a similar manner. Even though each sickness fund is self-supporting, including cross subsidies, it experiences deficits in some years that must be made up through increased sources of revenue, ie, payroll tax increases or actions that reduce expenses below revenue in subsequent years.

Contribution levels differ by fund.[17] Employers contributing to the general fund pay 12.8% on gross salary while employees pay 6.8% as of early 1993. However, about four percentage points of this 19.6% total go for SIF-paid salary continuation benefits,[8] leaving about 16% as the cost for health care services, related administration, and, in the case of the general fund, cross-subsidization of other funds. For government workers, the payroll taxes are commensurately less because the state provides salary continuation separately. By comparison, the employer cost of employee health benefits represented 7.81% of wages in the United States in early 1992.[18]

Self-employed individuals are required to enroll for coverage and must pay the employer payroll tax rate of 12.85%. However, this rate is about one-third lower than the combined rate of employer and employee payroll taxes. Associated with this lower aggregate payroll tax rate is a lower rate of reimbursement. In addition, this payroll tax does not cover salary continuation for the self-employed. Applying the principle of intergenerational solidarity, retired people pay 1.4% on social security payments and 2.4% on other pensions.

Trends in sources of health care financing are summarized in Table 2. In 1991 the social security system, through SIFs, paid 75.5% of health service expenditures. The contribution of central and local governments diminished from 14% in 1950 to about 1% currently due to coverage of more people through the SIFs, growth of supplemental insurance, and the transfer of mental health costs from the central government to the social security system.

Employer opposition to frequent increases in payroll taxes over the last 20 years has not prevented their growth from 10.25% on salary up to a low ceiling plus 2% on the entire salary to the current rate of 12.8% on total salary. Public opposition to the augmentation of the payroll tax rate has been muted but becomes adamant when any benefit reductions, however minor, are proposed. The French support the concept of universal coverage and the current mechanisms of payment but have limited understanding of how much they contribute. In an October 1992 poll,[19] only 29% of a representative sample of French adults correctly identified that 5% to 10% of their salary went for health insurance, while 56% thought that the correct figure was between 10% and 50% of salary. The French appear to believe that the system of supplemental insurance is necessary and that this system, for which expenses are borne by the individual, his or her employer, or both on a shared basis, is well managed.

Supplemental insurance has benefited from consistent support of the government, which wishes to reduce pressure on it to increase employer and employee contributions to keep up with health care cost increases. In 1991, 83% of the population[14] was covered by supplemental health coverage. In general, those without supplemental coverage have limited resources, are covered 100% by their sickness fund, or are the young and others who believe their risk of serious illness is too low to justify the expense. About 60% of those with such insurance obtain it from mutual insurance funds, primarily through employment.[20] Alternatively, supplemental insurance may be purchased from private insurers, who primarily insure self-employed individuals and those not working. Private insurers pay a 9% tax on their revenues, placing them at an economic disadvantage.

Supplemental insurance, in principle voluntary, is required by many employers to obtain an attractive rate from the mutual insurance fund. Lack of employee deductibility from income for payroll and income taxes, coupled with deductibility of employer contributions, generates a strong incentive for the employer to pay most or all of the cost. Payments to the mutual fund are a fixed percentage of salary. Therefore, higher-paid employees subsidize lower-paid employees for these voluntary insurance services. The same cross-subsidization

14

I.2.

Universal access to health care is a reality in France thanks to a compulsory and generalized system: the health insurance plan known as *Sécurité Sociale*. This system finances or largely reimburses the health care available to 56 million inhabitants - both French nationals and legal aliens - living in France (which covers an area of 212,918 square miles).

The French health insurance system differs from national health services of some other nations in that it protects the freedom for patients to choose, based on their preferences, between a public hospital or dispensary, a private hospital, or a doctor in a private practice.

National Health Insurance is financed mainly through mandatory contributions by both employers and workers. For this reason, National Health Insurance Funds, which are responsible for managing these contributions, are administered by Boards composed primarily of labor union delegates and employer representatives.

The State therefore has no direct responsibility for the health insurance system; the National Health Insurance budget does not figure into the overall State budget and is not subject to parliamentary vote. However, the State does play a very important role insofar as National Health Insurance rules and regulations are determined by law, rate agreements must be approved by the Government, resources are allocated in accordance with an overall plan, and public funding finances both health care training and research to a large degree. Moreover, the rapidly increasing costs of health care represent a major problem in France as in most other industrialized countries, even if France spends "only" 9% of its Gross Domestic Product on health care, compared to 12.4% in the United States.

Although its most important feature, National Health Insurance represents but one component of *Sécurité Sociale*, an instrument designed to foster what is commonly referred to as "national solidarity" by providing concrete assistance whenever any individual needs help with the cost of raising children, undergoing a medical procedure or retirement. As a result, the French are very attached to their system, and it is no exaggeration to say that *Sécurité Sociale* (often referred to as *la Sécu*) has become a cornerstone of the French national identity.

15

Brief Background

1898: Complete recognition of Mutual Aid Societies. Employers become responsible for workplace accidents.

1910: Law establishing paid retirement for workers and farmers; old age pensions extended to salaried employees below a limited amount of income.

1930: Law establishing obligatory national insurance for all salaried employees in industry and trade.

1945: Creation of *Sécurité Sociale*.

1961: Creation of health, maternity and disability insurance for farmers.

1966: Creation of insurance for non-salaried, non farm-related professions (i.e., the self-employed).

A General View of Sécurité Sociale

First established in 1945 and then progressively extended (in different forms) to virtually the entire population, *Sécurité Sociale* is divided into three distinct branches:

* National Health Insurance for the coverage of risks relating to illness, maternity, disability and death. This Insurance also includes coverage against work-related illness and accidents.

* Family benefits designed to assist families and in so doing, having a positive effect on the birth rate.

* Old Age Pension Fund, which manages the obligatory retirement system.

Guiding Principles

Sécurité Sociale is founded on the principle of national solidarity: every French citizen, as well as every foreign national who is a legal resident of France, must

* have access to health care;
* be able to deal with the consequences of illness, accidents or disablement;
* benefit from sufficient means during retirement;
* be able to raise children if so desired.

National Health Insurance naturally embodies this fundamental principle as well as several other specific assumptions:

Universal access to health care: every individual, regardless of means, must be able to take care of himself/herself, whether he or she is employed or unemployed, working or retired, a salaried worker or a housewife, and whether he or she has always enjoyed good health or is suffering from any preexisting conditions;

Freedom of choice for all patients to consult any doctor at any time;

Freedom for doctors to prescribe treatment;

A mixed health care system in which a strong public sector of primarily hospitals and preventive services co-exists alongside a private sector which is equally strong, especially in ambulatory care, but with numerous hospitals as well (Tables A and B).

The mixed character of the French health care system is illustrated by the fact that professors in the faculty of medicine, who are at the same time doctors in university hospitals, can receive patients in private practice.

Health care is abundant in France, with more than one doctor for every 400 inhabitants and 1,010 (public and private) hospital beds for every 100,000 inhabitants (Tables A and B).

Virtually all doctors (99.5%) have signed onto the doctors' agreement with *Sécurité Sociale*, which sets the rates that they may then charge. Some doctors, however, do have the right to charge higher fees. Similarly, all not-for-profit hospitals, and most for-profit hospitals, have also signed agreements with *Sécurité Sociale*.

France's overall health picture is satisfactory: infant mortality stands at 7.2 per 1,000, and life expectancy at birth is 72.7 years for men and 80.9 years for women. However, an analysis of both mortality and disease rates also reveals the existence of certain troubling problems, notably alcoholism, nicotinism, accidents, etc. (Table C).

Of course, France's demographic structure exhibits the same evolution observed in all industrialized nations, with a decrease in the number of births (13.5 per thousand) and an increase among the elderly members of the population (over 60 years old: 19.4%; over 65 years old: 14.2%). The way in which health care is consumed reflects these trends, as does the evolution of health care expenses and the appearance of new problems stemming, in particular, from the loss of autonomy among the elderly (Tables D and E).

Prevention & Public Health

There are many programs for prevention and public health in France today involving all partners in the health care process. Among these initiatives, some of the most important are:

* The MCH program, known as PMI (*Protection Maternelle et Infantile*) provides a network of preventive and curative public consultations for pregnant women, mothers and their young children. PMI teams plays an important role with respect to contraception, and in both day-care centers and pre-schools. PMI, which is present in every Department, is free and open to all.

* Elementary School, Secondary School and University Health Services, a program under the auspices of the Ministry of National Education, provide medical check-ups for both school age and university students, as educational activities relating to health, social and vocational guidance, and ergonomics.

* The Occupational Medical Service helps workers adapt to their job responsibilities, provides periodic check-ups, and promotes environmentally sound working conditions.

* The National Health Insurance Service of Preventive Medicine enables each individual and members of his/her family to receive a free, complete medical check-up every five years.

* The Public Psychiatry Service operates by geographic sector and includes specialized hospitals, dispensaries, and mobile units.

Required vaccinations are obtainable, either free of charge at specialized centers, or from family physicians, in which case the cost is completely reimbursed. As a result, around 80% of all 2 years olds have received their systematic vaccinations (Diphtheria, Tetanus, Polio, BCG).

Finally, each National Health Insurance fund maintains a budget for sanitary and social intervention designed to fund various prevention initiatives, one example of which would be flu shots for persons over 60.

There are also specific health services for certain groups, including the military health service for members of the armed forces and their families, or the penitentiary medical service for prisoners.

The quality and availability of health care explains why there is a growing number of foreigners, including those from Western European countries, coming for health care treatment in France.

National Health Insurance, one of the three branches of *Sécurité Sociale*, covers the following "risks" : illness, maternity, disability, death and work-related illnesses and accidents. However, the way in which National Health Insurance works varies from one area to another.

Illness

National Health Insurance intervenes in two ways in case of illness. First, it reimburses (completely or partially, depending on the circumstances) such health care costs as medical consultations, hospitalization, medication, paramedical care, etc. Secondly, it pays "daily indemnities" to workers who are temporarily unable to work because of illness, thereby limiting the financial impact that illness can have on the income of a wage earner and his/her family.

Maternity Insurance

In order to guarantee each future child the best chances for good health, *Sécurité Sociale* offers 100% reimbursement of all medical care and tests which a woman undergoes during pregnancy, as well as the costs of delivery, post-natal examinations for both newborn and young children up to six years of age. *Sécurité Sociale* also pays the working mother a "daily indemnity" so that she may enjoy a "maternity leave" of 16 weeks (26 weeks beginning with the third child).

Disability Insurance

This insurance covers against lost income in case of partial or total disablement due to non-professional illnesses or accidents. Under these conditions, the victim collects a "disability pension".

Death Benefits

Death Benefits ensure that the dependent family of every deceased individual will receive "emergency assistance" equivalent to approximately three months' salary.

Work-Place Accident & Professional Illness Insurance

This insurance, which functions according to specific rules, covers 100% of the corresponding medical costs and provides for the payment of daily indemnities equal to at least 50% of real wages if an individual is forced to stop working temporarily, and for a disability pension if the victim remains unable to resume normal work.

FACTS ON FRANCE

Vol. 93.30 *October 1993*

Simone Veil

Minister of State, Minister of Social, Health and Urban Affairs

Born in Nice in 1922
Married with three sons.

Deported to Auschwitz and Bergen Belsen from March 1944 to May 1945.

EDUCATION

- Secondary education at the Nice lycée.

DIPLOMAS

- Law degree and diploma from the Institut d'Etudes Politiques in Paris
- Accredited as a judge in 1956.

CAREER

- Entered the Ministry of Justice in February 1957 with an appointment to the Prisons Division. In 1964, was appointed to the Division of Civil Affairs and Seals and served as Secretary of the Committee to Reform the 1838 Act on the Confinement of the Mentally Ill and Secretary of the Committee to study the problems related to adoption,
- In 1959, served as National Delegate to the International Society for Criminology,
- In 1969, served as counselor in the office of Mr. René Pleven, Keeper of the Seals,
- In 1970, was appointed by the President of the Republic as Secretary of the Higher Council of Judges,
- In 1972, served as member of the governing board of the *O.R.T.F.* (French Radio and Television Broadcasting Organization) and member of the board of the *Fondation de France*,

- From 1974 to 1976, served as Minister of Health,
- From 1976 to 1979, served as Minister of Health and Social Security,
- In 1977, served as Chairman of the Nuclear Power Information Council,
- In 1979, elected to the European Parliament and subsequently re-elected in 1984 and 1989,
- From 1979 to 1982, served as President of the European Parliament,
- From 1982 to 1984, served as Chairman of the Legal Affairs Committee of the European Parliament,
- From 1984 to 1989, served as President of the Liberal and Democratic Reformist Group of the European Parliament,
- In 1987, served as Chairman of the French Committee for the European Year of the Environment,
- In 1988, served as Chairman of the European Committee for the Year of European Cinema and Television,
- On March 30, 1993, appointed Minister of State, Minister of Social, Health and Urban Affairs in the cabinet of Prime Minister Edouard Balladur.

AWARDS AND DECORATIONS

French decorations:

- *Chevalier de l'Ordre National du Mérite.*

Foreign decorations:

- Doctor Honoris Causa from the Universities of: *Princeton* (USA - 1975), Yale (USA - 1980), Cambridge (Great Britain - 1980), *Edinburgh* (Scotland - 1980), *Georgetown* (USA - 1981), *Yeshiva* University (USA - 1982), the *University of Sussex* (Great Britain - 1984), *Brandeis* (USA - 1989).

Awards:

- Louise Weiss Foundation Prize (Strasbourg - 1981),
- Louise Michel Prize (Paris - 1983),
- Jabotinsky Prize (USA - 1983),
- Prize for Everyday Courage (Paris -1984),
- Special Freedom Prize, Eleanor and Franklin Roosevelt Foundation (Middleburg - 1984),
- Living Legacy Award (San Diego - 1980),
- Klein Foundation Prize (Phildelphia, 1991).

PUBLICATIONS

- *"Les données psycho-sociologiques de l'adoption,"* with Professor Launay and Dr. Soulé.

***

Feminist movements became significant in 1970 with the founding of the MLF (Women's Liberation Movement), followed shortly thereafter by the "Choisir" movement. The League of Women's Rights, founded in 1973, runs the Editions des Femmes publishing house. Several other feminist movements have publications as well.

France has a cabinet-level office dealing with women's issues and the protection of women. The Delegation for Women's Rights, created in 1986, is responsible for promoting measures that ensure women's rights in society as well as monitoring compliance with existing legislation.

The present Secretary of State for Women's Rights is aided by 29 regional delegates. There is also a National Center for Information on Women's Rights which maintains offices throughout France where women can seek general advice, counseling as well as specialized advice regarding assistance for single mothers, battered women, legal counsel, and so on.

French Women and the Future

We are currently in a "post-feminist" period and while women have learned how to defend their interests, they do not intend to stop there. Many have looked beyond their immediate gains in an attempt to define new social models.Their current situation still leaves room for improvement.

The different associations, movements, offices and the Delegation for Women's Rights are working on this improvement. Their program comprises three principal aims:

- to further women's professional integration and their access to all levels of responsibility.
- to promote the importance of the mother in society.
- to eliminate discrimination towards women and protect their dignity.

They Broke the "Glass Ceiling"

1924: Ms. FRADIS, the first woman to graduate from the High School of Aeronautics.

1930: Janee EVRARD, first woman Orchestra Conductor.

1947: Germaine POINSON CHAPUIS, first woman minister.

1949: Jacqueline JOUBERT and Arlette ACCART, first women announcers on TV. Ms. GAYET, first woman notary.

1962: Marguerite PERET, first woman to enter the Academy of Sciences.

1967: Marcelle CAMPANA, first woman Consul General.
Dagnelle DECURE, first woman airline pilot.

1972: Marcelle CAMPANA, first woman ambassador.

1976: Valérie ANDREE, first female General of the Airforce.

1980: Michele COLIN, first woman fire captain. Marguerite YOURCENAR, first woman elected to the French Academy.

1985: Sylvie GIRARDET, first woman stock broker.

1991: Edith CRESSON, first woman prime minister.

Marion VANIER, head of the French branch of the firm AMSTRAD, Armelle ROUX, president of BENETEAU's building site, and Odile JACOB, president of her own publishing house, can also be considered women who broke the glass ceiling.

Source:

French Embassy Press and Information Service
4101 Reservoir Rd., NW
Washington, DC 20007

Tel (202)944-6060
Fax (202) 944-6085

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TAMING THE BEAST

U.S. and French analysts discuss the challenge of controlling health-care spending

BY KAREN TAYLOR

What can be done to tame health-care costs? FRANCE Magazine invited Janet Shikles, director of Health Financing and Policy Issues at the U.S. General Accounting Office, and Dr. Pascal Chevit, Counselor for Social Affairs at the French Embassy in Washington, D.C., to give their views.

FRANCE Magazine: The GAO recently studied health-care spending controls in France, Germany and Japan. Why did you choose these countries?

Janet Shikles: Senators Heinz, Glenn, Cohen and Pryor asked us to look at these countries because they have multipayer systems, combining private and public insurance. They believe that politically, a multipayer system may be more acceptable to Americans than a single-payer system, such as the one in Canada. The senators were interested in seeing how these systems—which also offer patients a choice of doctors, including private doctors paid on a fee-for-service basis—manage to insure the entire population yet control costs better than we do.

FM: Like many Western European countries, France has a national health-insurance system. How did this system evolve?

Pascal Chevit: It was during the Industrial Revolution that the notion of health insurance took root in Great Britain, France and Germany. Workers began to demand access to health care and to workers' compensation, and employers needed a healthy work force to keep the factories running.

Germany was the first to set up a large coherent system, prior to WWI. After the war, Alsace and Lorraine were returned to France, and they brought with them the German health insurance experience. Little by little, French industries (mining, railways, etc.) organized their own health insurance systems, and in 1946, Sécurité Sociale was created.

Sécurité Sociale is now three "mega funds" made up of smaller funds. The largest (it covers 80 percent of the population) is for salaried workers; another is for farmers and agriculture-related businesses; the third is for the self-employed.

FM: Isn't this history quite different from the American experience?

J. Shikles: Very much so. Hospitals and doctors encouraged the development of our health insurance industry, starting in earnest during the Great Depression, when many people could no longer afford to pay their medical bills. The Blue Cross and Blue Shield plans, our dominant health insurers and administrators, were initiated by hospitals and doctors, respectively. During and after World War II, labor unions made a big push for health insurance, and nonunionized businesses had to go along to compete for labor. One of the attractions of this benefit was that it was tax-free income.

Thus, in the U.S., insurance evolved at the employer level. Initially, it was accessible only to those who were actively working for companies offering coverage as a benefit. This left out a lot of people, so in 1965, Congress created Medicare, which covers the elderly, and Medicaid, which covers the poor.

Although millions of people still fell through the cracks, the overall system worked reasonably well through the early '70s. Most companies purchased insurance for their employees and premiums were based on community rating; that is, on the overall health risk of the entire community. In the '70s, and more so in the '80s, large employers began to negotiate with insurers to cut their own deals. A big firm with a young, white-collar and mostly male staff would ask for a lower rating based on the health "experience" of its employees. It would essentially say, "We don't want to pay for sick people, pregnant

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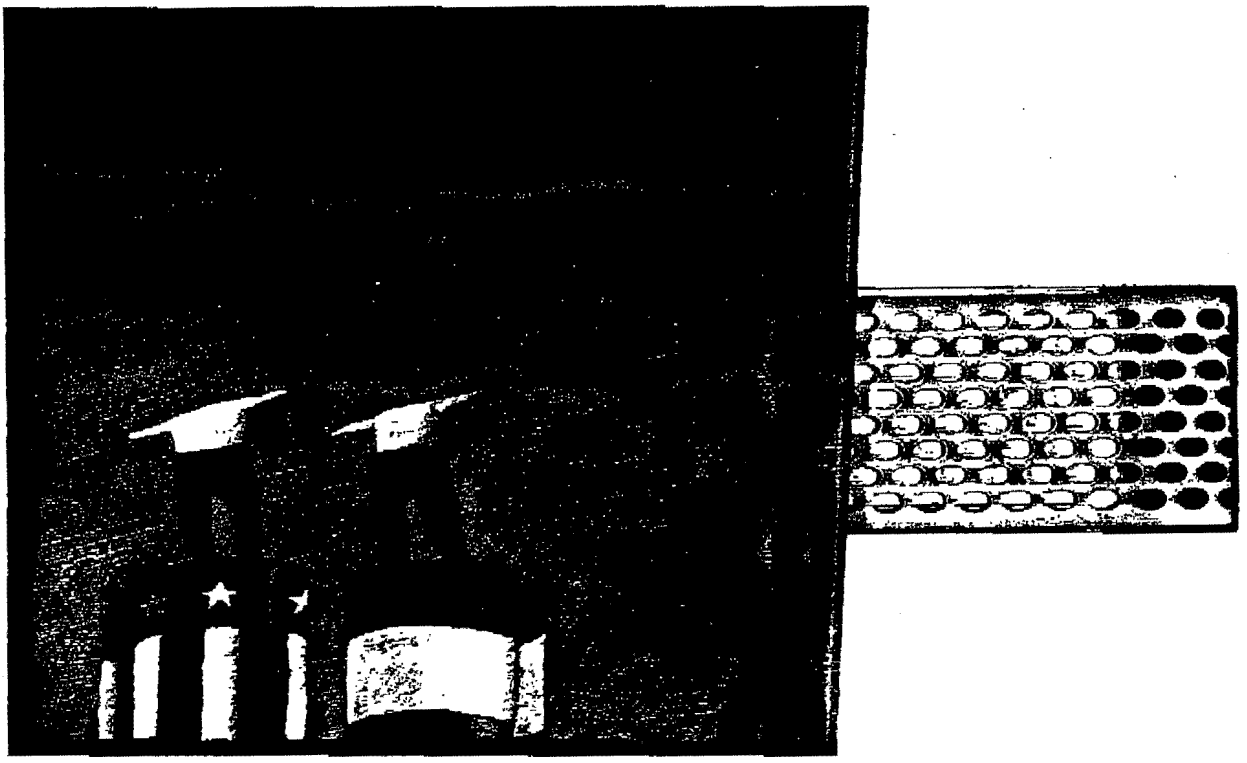
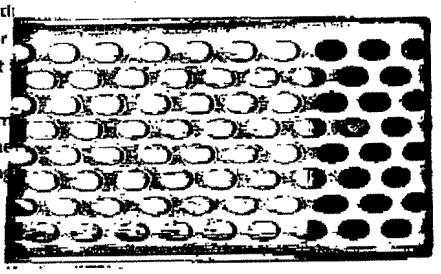


Today a firm that has been paying $3,000 a year per employee can see
based rate jump to $11,000 if one employee gets cancer and needs
transplant. The company has a choice: Either go out of business or drop h
This is where we are now—which is why some people think we're facir
a meltdown in our system. This is what is pressuring Congress to act.

FM: These very different histories would suggest that France a
States value health care very differently.

P. Chevit: Clearly, the health-care system in every country is related t
history, culture and set of values. In France, health care is not considered
it's a basic right, one that's written into the preamble of our Consti
European systems are based on a sense of national solidarity. For
involvement is a good thing. But for many Americans, government
imply loss of privacy, inefficiency.

These different values must be kept in mind when considering reform
In France, the government would be considered responsible if the he
failed. I don't think that would be the case here. There is not yet a strong
appeal for the U.S. government to take leadership on this issue.



"In France, health care is not a fringe benefit; it's a basic right."

FM: In spite of these differences, the French and American syst
things in common—one being rising costs. Has your study of th
suggested any solutions to American problems?

J. Shikles: We were very impressed by the way the countries we studi
care costs. While the French are very different from us culturally and i
government, we think that their use of budget controls on health-care s
We're especially interested in the budget controls they've put on hosp
price controls on its Medicare program, and they do appear to be holdi
if you don't cap overall spending, there is no stopping the growth of he

France's system, with its universal coverage and coordinated p
prevents the cost-shifting that is driving our system crazy. In France,
come in for the same procedure, you can't charge one $20 and the othe

this happens all the time, simply because the doctor knows one insurer will pay more than another. Insurers are played off against one another—a situation made even worse by the fact that many people aren't covered at all. The result is that doctors and hospitals shift costs around to make up on some patients what's being lost on others.

As much as Americans like their freewheeling system, we have concluded that if we are ever to get a better handle on spending *and* have good health care, as France and other countries do, we will have to consider coordinated payment rates, budget caps on the rate of spending growth and universal coverage. We've been testifying before Congress on this issue, and these ideas are coming up in legislative proposals.

FM: In France, a visit to a general practitioner runs $20—only about a fourth of what it costs in the U.S. How do you explain such a big difference?

P. Chevin: There are several explanations. First of all, French doctors don't set their own fees; they are determined through negotiations between doctors associations and Sécurité Sociale. But there are other factors. One is that medical education, like almost all education in France, is free. Physicians don't start their professional life with a huge debt to pay off. This also means that the government can control the number of admissions to medical school. As part of our efforts to control costs, we have decreased the number of admissions from 8,000 per year to 3,800. This assures each doctor a certain volume of patients, which means that he can afford to charge lower rates.

Administrative costs are also *much* lower in France than in the U.S. This is because our doctors fill out only one form: the Sécurité Sociale form. American doctors have to deal with paperwork from some 1,500 insurance companies, which means they need much more accounting and secretarial support.

Another big factor is that malpractice suits are rare in France: In the U.S., 13 percent of all doctors are sued every year! This is another cultural difference.

FM: Some U.S. policymakers say that universal coverage would mean an end to the kind of medical advances the U.S. is so proud of. Do you agree?

J. Shikles: No. I think we could provide universal coverage without sacrificing creativity and scientific advances. We spend $800 billion on health care—more than any other country in the world. We'll be up to a trillion dollars in a few years. Much of the money goes to innovation, but a lot is waste, abuse. Southern California has so many MRIs that people wonder why it hasn't sunk! We have hospitals operating at 60 percent occupancy. MRIs operating at inefficient levels, yet people still make money off the system. We're also doing too many unnecessary medical procedures.

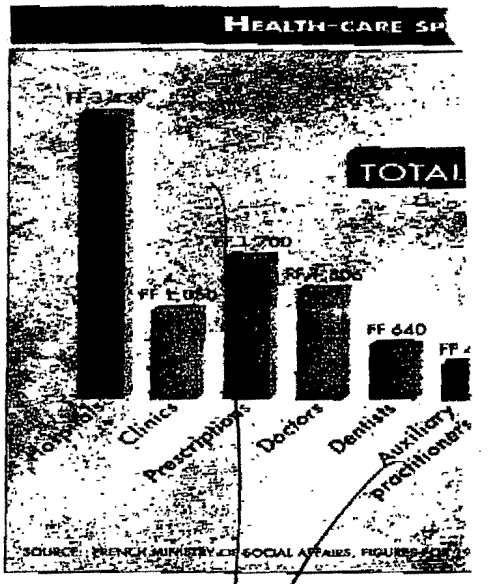
Most people think we can slow the rate of spending increases without stifling innovation. Current proposals don't envisage reducing the share of GDP devoted to health care but rather stabilizing it. At the current level, it is the highest in the world. Incentives should still exist for technological innovation. Moreover, NIH will continue to receive strong financial support.

FM: Dr. Chevit, part of your job here in Washington is to observe what is going on and report any good ideas back to France. What have you observed that could be of interest to your country?

P. Chevin: France's Sécurité Sociale is a centralized system, so we don't have a great variety of experiences to draw upon. In the U.S., however, there are dozens of initiatives in every state. We wouldn't want to import the U.S. system as a whole, but there are certainly many interesting ideas here.

The U.S. prides itself on private medicine, so it is somewhat ironic to see that it has an outstanding public-health system. The Centers for Disease Control, the Food and Drug Administration, the National Institutes of Health are very powerful, knowledgeable institutions. We are currently setting up a national center for public health in France, and we have learned a lot from the CDC. We're also setting up a national drug agency, and we are looking to the FDA for many ideas.

The motivation in creating these new centers in France is not primarily to control costs, although better preventive policies can improve public health and therefore can help control health costs. One of the most difficult tasks facing France and the U.S. is to coordinate research findings, experimental outcomes and policy making. No country in the world knows how to deal with contagious diseases better than



the United States, yet there are still outbreaks of
policy, or funding, for immunizations.

Another area where the U.S. is far more
evaluation process for hospitals and care prov
hospital accreditation process, for example, is

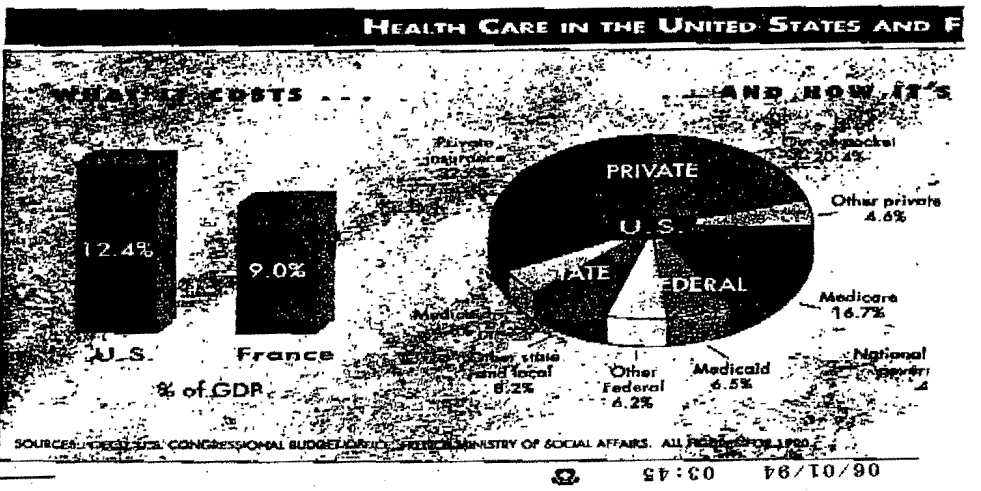
"I think the U.S. c coverage without sacrificing advances."

and we would do well to have a similar syster
physician recertification requirements. Agai
entirely effective and is sometimes bureaucrat
incentives for doctors to improve their skills anc
That's important, but it is not enough.

I've also been impressed by the role of nurse
to see French nurses modeled on American nu
delegate to nurses much more of the responsit

FM: Do you think there will be significant
time soon?

J. Shikles: Yes, but I think these changes are m
a national consensus on this question develops



Nouchi recognizes that government planning is not always foolproof; political pressures sometimes mean that one region or city is favored over another.

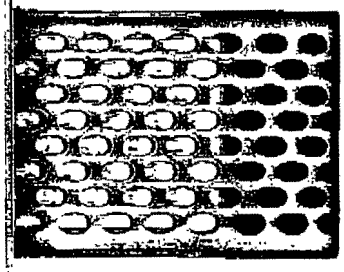
Another problem is that France has too many physicians—perhaps 20,000 too many—the result being that many doctors don't have enough patients to generate sufficient income. To compensate, they tend to drive up the number of visits per patient, for example, by recommending diagnostic tests and requiring the patient to return to learn the results. Such practices obviously bloat health-care costs, and the Health Ministry is responding by limiting the number of admissions to medical school and encouraging physicians to move into related careers.

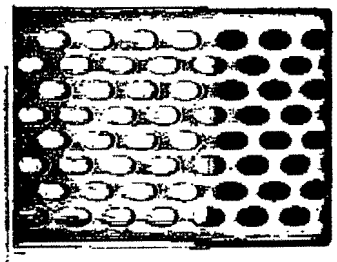
And what about the patients? Do they have any incentives to keep costs down? Dr. Pascal Chevit, representative of the Ministries of Health and Social Services at the French Embassy in Washington, D.C., explains that patient incentives were built into the system. "In most cases, consumers pay part of the bill; for example, they are responsible for 25 percent of regular office visits. This contribution is called a *'ticket modérateur.'* As the name implies, it was designed to 'moderate' consumption of medical services. But there are many cases where 100 percent of the costs are reimbursed, and three-fourths of those insured by Sécurité Sociale now have additional insurance. These factors cancel out the intended effect of the *ticket modérateur*, severely reducing the efficiency of the system."

Finally, Sécurité Sociale employs 3,000 doctors who act as watchdogs, granting prior authorization when required (reimbursements for spa treatments, cosmetic surgery), assessing the quality and efficiency of health care and trying to spot abuses in the system. Still, many observers seem to think that there are not enough of these doctors to do a proper job.

Like other nations, France is trying to find the right combination of policies that will both limit spending growth and promote high quality care. But whatever changes are made, they will not replace the basic principles that guide the system, as expressed in the dedication of people like Annick Sachet, who has been caring for forgotten old people for 20 years.

"It is true that it is a bit depressing to work with old sick people," she says. "But I look at the long term, at the way things have improved, and in that sense it is positive. That's why I stay."





Benefits provided by "la Sécu"

Virtually all French citizens are covered by the national health insurance system, which entitles them to the following benefits:

Outpatient services/ inpatient care	Most treatment and diagnostic services covered.
Maternity care	Prenatal, maternity and well-baby care services are covered. Cash benefit—about $150 a month paid for nine months (five months before birth, the birth month and three months after birth). Additional 16-week maternity leave paid to mother; rate is based on previous income and is limited to a maximum of about $50 a day.
Preventive care	Covered care includes a free preventive exam every five years. Immunizations also provided; funding comes from government.
Dental and optical care	Covered items include basic dental care, dentures and eyeglasses.
Long-term care	Home care services, day care and some inpatient chronic care services are covered.
Prescription drugs	Covered, subject to some restrictions.
Income maintenance	Generally, workers are entitled to 50 percent of wages, up to about $33 a day, for up to 360 days in any 3-year period (for certain diseases, such as cancer, benefits may be granted for an unlimited number of days, for up to 3 years).
Cost-sharing	Physician visits: 25 percent; hospital services up to the 30th day of care: 20 percent; hospital services after the 30th day: 0 percent; daily room charges at hospitals: $6; laboratory tests and dental services: 30 percent; covered prescription drugs, depending on the necessity of the medication: 30 to 70 percent; other (uncovered) prescription drugs: 100 percent. Cost-sharing for poor people is paid for by the social welfare system. Cost-sharing for hospital costs is waived for maternity care and for certain high-cost illnesses.

Source: U.S. Government Accounting Office.

Sécurité Sociale: They Don't Leave Home Without It!

France's national health-insurance system provides cradle-to-grave coverage for virtually the entire population, but what happens when French citizens move abroad? They have a number of options: foregoing coverage altogether; accepting the type of coverage offered in the host country; taking out insurance with a private company. Or they can join the Caisse des Français de l'étranger (CFE)—an insurance fund affiliated with Sécurité Sociale. The CFE provides its 36,000 members the same benefits they would receive in France, including coverage for illness, maternity, disability and work-related accidents. And when expats return home, they are assured a smooth switch back to Sécurité Sociale.

Unlike membership in the "Sécu," which is mandatory in France, joining the CFE is optional. And while both employers and employees in France contribute a fixed percentage of wages to Sécurité Sociale, French companies abroad can decide how much, if anything, they wish to contribute.

Benefits are based on French rates—general practitioners charge about $20 for office visits while specialists charge about $25—so CFE coverage should be supplemented by additional insurance in countries such as the United States, where health care is more expensive.

CFE's latest project: a new package offering better coverage to French students abroad.

For additional information, contact Claire Boijot at the Social Services Department of the French Consulate, 972 Fifth Avenue, New York, NY 10021; Tel.(212) 439-1493; fax (212) 439-1488.

—M.O.

times as sick. The system seems to foster the hypochondriac in everyone: If one doctor pronounces all is well, the patient may consult another physician, knowing he or she will be reimbursed for most of the cost.

"French people like to go to the doctor and leave with 30 different prescriptions. If they don't, they think the doctor is strange," said Zalmanski. "We really have to effect a change in mentality."

Sécurité Sociale, in conjunction with the Ministry of Health and the Committee on Health Education, has launched a media campaign to do just that. In one new television commercial, an announcer stands beside a five-foot-high bottle of pills and urges people to think twice before popping any more. In another move to discourage overmedication, the state now reimburses 60 percent rather than 100 percent of the cost of some medicines.

Weaning French doctors from their prescription-writing habits was one of the objectives of negotiations recently concluded between Sécurité Sociale administrators and doctors associations. This year, Sécurité Sociale has set a 7:1 percent cap on the increase in reimbursements to patients for costs generated by physicians—office visits, prescriptions, lab tests and so on. It is hoped that this cap will serve as an incentive for doctors to curb unnecessary treatments. In exchange, the Minister of Health finally approved a 1990 agreement raising the standard fees for office visits. Similar cost-containment agreements have been reached between Sécurité Sociale and nurses, pharmacists, physical therapists and other private-practice health-care providers.

More and more, the French are resorting to budget controls rather than price controls to reduce health costs. In 1984, a decision was made to place budget controls on hospitals—the biggest component of health-care spending. Global spending targets were set for the fiscal year, and then budgets for each public hospital were negotiated. Formerly, Sécurité Sociale had paid hospitals a per diem rate—a system that led to unnecessarily long hospitalizations for some patients. The effect of these hospital budget controls, as recently reported in a study by the U.S. General Accounting Office, has been that spending increases are 9 percent lower than they would have been without the controls.

Will these budget controls affect the quality of care? "No, I really don't think so," says Le Monde's Franck Nouchi. "Things had gone too far; these measures were absolutely necessary. The runaway costs of health care aren't as bad here as in the United States, but they are still very high and we had to do something. It's now up to each hospital to plan its development and submit its budget proposal. Hospitals receive a lump sum and can use it as they see fit. The more efficient they are, the more they will get for their money."

Yet another attempt to control spending is regional planning. The Health Ministry approves all hospital construction, and any addition of hospital beds must be offset by reductions elsewhere. Similarly, high-cost medical equipment must be authorized by the Government. Do these controls mean that the French do not have access to the services they need? "The problem in France isn't one of scarcity: We have too many hospital beds and too much high-tech equipment—too many scanners, MRIs and so on," says Nouchi. "The problem is that you don't always find hospitals and equipment where they're needed. You can't run hospitals like grocery stores, letting each one act

Nouchi recognizes that government plann
sometimes mean that one region or city is

Another problem is that France has to
many—the result being that many doctors
sufficient income. To compensate, they tend
for example, by recommending diagnostic
learn the results. Such practices obvious
Ministry is responding by limiting the num
encouraging physicians to move into relate

And what about the patients? Do they h
Pascal Chevit, representative of the Ministrie
Embassy in Washington, D.C., explains that p
"In most cases, consumers pay part of the b
percent of regular office visits. This contributi
implies, it was designed to 'moderate' cons
many cases where 100 percent of the costs
insured by Sécurité Sociale now have additi
intended effect of the *ticket modérateur*, seve

Finally, Sécurité Sociale employs 3,000 d
authorization when required (reimburseme
assessing the quality and efficiency of health
Still, many observers seem to think that the
proper job.

Like other nations, France is trying to fin
both limit spending growth and promote h
made, they will not replace the basic princi
the dedication of people like Annick Sach
people for 20 years.

"It is true that it is a bit depressing to worl
at the long term, at the way things have imp
why I stay."

Benefits Provide

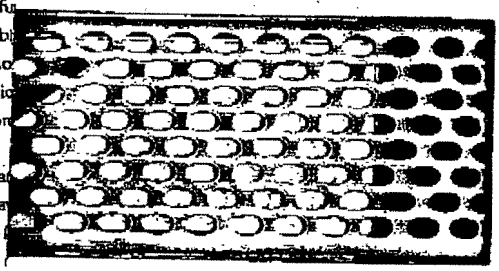
Virtually all French citizens are covered by the nc
them to the following benefits:

Outpatient services/ inpatient care	Most treatment and diagnostic s
Maternity care	Prenatal, maternity and well-bal Cash benefit—about $150 a m birth, the birth month and three Additional 16-week maternity le income and is limited to a maxi
Preventive care	Covered care includes a free pr Immunizations also provided; fun
Dental and optical care	Covered items include basic de
Long-term care	Home care services, day care c covered.
Prescription drugs	Covered, subject to some restri
Income maintenance	Generally, workers are entitled for up to 360 days in any 3-ye benefits may be granted for ar
Cost-sharing	Physician visits: 25 percent, percent; hospital services at hospitals: $6; laboratory te: prescription drugs, dependi percent; other (uncovered) p Cost-sharing for poor peopl Cost-sharing for hospital co: cost illnesses.

Source: U.S. Government Accounting Office.

not exceed its fee schedule. (Public hospital standard rates, so all the costs of delivery and he tion at Port Royal are covered.)

If, however, the expectant mother decides to in a private maternity clinic, her pregnancy will be by her own obstetrician. Again Sécurité Social 100 percent of the costs, up to the standard f doctor charges more, the patient will either pay th out-of-pocket or cover it through private i "Women who choose private clinics either want doctor or want to receive more amenities—priv better food, things like that," explains Frédéric C spokesman for the national health-insurance fu complications are likely, a woman will probabl public hospital. That is where you find the mo cated equipment and technology." The situatio ing, however, as private clinics purchase mor gear.

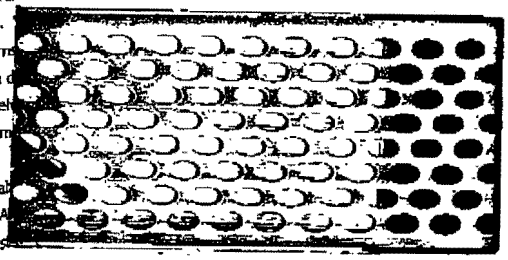


Patients have yet another option: privat hospitals that are approved by, but do not ha agreements with, Sécurité Sociale. There are in France (less than 1 percent of all hospitals), being the American Hospital in Paris. The adva choice is excellent amenities and the immediat of certain treatments. Explains hospital sp Isabel Mathieu, "If you need a magnetic scan may have to wait two days at a public hospital. work extra hours, weekends, sometimes alm a day to get the tests done." But of course, s patient may have to pay for part of the test, public hospital it might be free. Moreover, at Hospital, Sécurité Sociale reimburses patients

blood pressure to AIDS—that is not covered and a

percent of hospitalization costs, which are at least 80 percent covered in pu

Most health officials complain that France's health insurance syste bureaucratic and far too costly, but they all seem to agree that it works. social protection has many faults, but it's the least bad of all system Nouchi, the newspaper Le Monde's medical reporter for more than a d easily, when we see what happens in the United States, we say to ourse very happy to have this system. The architecture of the system must be m is fundamental."



The debate today in France—and throughout Western Europe—is ab not replacing, a system that has functioned for more than 40 years. A spends less than the United States on health care per capita, costs are s of control. With health spending doubling every eight or nine years, the fund cannot cover its expenditures—the $100 billion fund now has ab deficit—and it continues to take more and more from workers' payc

"The principles of the system are not being called into question. W do now is to control it better," said Richard Zalmanski, a spokesma Ministry. "When social protection reaches a certain high level, when its c ceiling, it suffers from dysfunction, and that's where we are now. Inde European countries are trying to control their systems better."

The reasons for skyrocketing costs are similar in all Western coun technology, an aging population, increasing patient expectations. But the major contributing factors is far more basic. That problem, health an the French tend to run to the doctor for every ache and pain, and p overprescribe medicine and treatment. The French, experts point ou times as much medicine as their German neighbors, and it's not bec

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There is no illness—from high blood pressure to

partially reimbursed by Sécurité Sociale.

where 37.4 million people have no insurance at all.

That's the financial bottom line; the health balance sheet shows that the French enjoy a level of health care that is among the best in the industrialized world. According to the Organization for Economic Cooperation and Development, France's infant mortality rate—a key indicator—is 7.2 per 1,000 births, compared with 9.7 per 1,000 in the United States.

The principles underlying France's health system are to provide care to all—regardless of income, health risk or other factors—and to allow each patient the choice of doctor, hospital or other facility. There is no illness—from high blood pressure to AIDS—that is not covered and at least partially reimbursed by Sécurité Sociale.

Thus unlike the system in the United States, where doctors set their own prices, or in Great Britain, where patients are assigned doctors at local clinics, the French system is a combination of uniform availability and free choice.

In France, fees charged by health-care providers are negotiated between national health-insurance administrators and the various associations representing doctors, nurses and other care-givers. The agreed-upon fees are then approved by the Ministry of Health. Visits to a general practitioner currently run about $20; to a specialist $25; to a psychiatrist $38. In every case, Sécurité Sociale reimburses 75 percent of the cost. Private doctors may charge more, but reimbursement is based on the Sécurité Sociale fee schedule.

Care facilities in France include large public hospitals, many of which are university hospitals or research centers, and private institutions called *cliniques*. The latter may be either non-profit or for-profit, and virtually all (99 percent) have contracts with Sécurité Sociale providing for reimbursement to patients.

Again, the patient chooses. For example, a pregnant woman may choose to have her baby at a public hospital like Port Royal. Sécurité Sociale reimburses 100 percent of maternity costs—hospitalization, doctors' fees and so on—as long as these charges do

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NAL HEALTH INSURANCE

e pulse of the French system

BY SHARON WAXMAN

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id drinking orange juice, and that's

. they smile, they act differently,"
al's 11 units for the aged ill. "Here
d offer something like this to every

example, Paris's Port Royal, a public hospital. Headed by Emile Papiernik, a leading specialist on premature babies and a pioneer of France's in-vitro fertilization program, Port Royal is one of Paris's most respected maternity hospitals—public or private.

At Port Royal, a pregnant woman may register to be cared for by a doctor or a midwife throughout her entire pregnancy. Most often, a midwife delivers the baby; should problems arise in the delivery room, doctors are on duty. Mothers keep their newborns with them 24 hours a day under the surveillance of nurses, nutritionists, obstetricians and nurses' assistants. "Any woman who wishes to may have her baby

-care utopia. All the developed nations are reexamining
oed by a unique combination of values, culture and history.
improve its policies, striving to reconcile social responsibility,
ffordability.

es Foix Hospital has become the
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regional fund.
e U.S. health-care system, but
every woman. Consider, for

here," explains Sylvie Beck, a midwife who has been delivering babies for 15 years. How can they afford it? "Maternity care is always paid for by Sécurité Sociale," says Beck.

From infancy to old age: the French cradle-to-grave health system provides comprehensive care to 99.8 percent of the population. Most of the costs are reimbursed to patients by the national health-insurance fund that is administered by the Sécurité Sociale—or the "Sécu," as the French call it. (The $184 billion Sécu budget also includes funds for pensions, workers' compensation and family benefits.)

The health insurance fund is financed by monthly contributions by employers (12.6 percent of total wage bill) and employees (6.8 percent of wages, with no ceiling). More than three-fourths of those insured take out additional coverage, either with non-profit mutual insurance companies or through for-profit insurance companies.

Thus in 1990, 72 percent of health costs in France were paid by Sécurité Sociale, 6 percent by private insurance, 4 percent by state and local government and 17 percent by patients. In all, health care expenditures account for 9 percent of France's Gross Domestic Product, as compared with 12.4 percent of GDP spent in the United States—

NATIONAL HEA

Taking the pulse of

French Influence upon America and American Culture
Prepared for Alison Muscatine by Claire Wofford
May 31,1994

Historical Impact

The French were some of the earliest settlers in the United States, arriving in the Southeast as early as 1562. Although the immigrants fled their native France to seek religious, political and economic freedom, their development of various occupations and trades greatly enhanced both their existence and the strength of American colonial life. As fur traders, soldiers, journalists (the first French newspaper was printed in the U.S. in 1784) and priests, the French immigrants had a profound impact in early America (Ethnic Almanac, 1981).

Modern Influence

The French culture, although now more thoroughly blended with the American culture, is still an integral and valuable part of the U.S. society. Those colonial immigrants are now dispersed throughout the United States, and now form a substantial portion of communities in NY, MA, PN, MI, OH, IN, IL, CA, TX, LA, which contribute both unique histories and perspectives to the diversity of American towns (We the People, 1981). As the early fur traders are now professors, architects, draftsmen, musicians and painters, descendants of French immigrants are responsible for a great deal of the dissemination of French culture and its integration into our own. Indeed, "Frenchness" has always and continues to be the favorite culture of Americans. With its distinctive cooking, mannerisms, fashions, music, books, and plays, French society continues to provide Americans with fascinating cultural endeavors (Encyclopedia of American Ethnic Groups, 1980). In particular, American heroes such as George Washington (whose dentist was trained by the major contributors to American dentistry, Joseph LeMayeur and James Gardette), John Jay, Paul Revere, and Theodore and Franklin Roosevelt all have roots in France (Ethnic Almanac, 1981; Encyclopedia of American Ethnic Groups, 1980). Even several of our states, including Louisiana, Maine and Vermont were named for Frenchmen or derived from the French language (Ethnic Almanac, 1981). Finally, several great symbols of American ideology and history have French ties, including the White House, which was designed after a French chateau, the bald eagle, which was a gift to America from Major L'Efant, and, of course, the Statue of Liberty. In short, despite the history of friction and animosity which occurs during such a combination, the French and American cultures have achieved a peaceful, valuable and mutually beneficial blend. (Despite some difficulties in French-American relations, "common interests, traditions, and good sense" have allowed for peace- Dictionary of American History, 1976).

Quotes

"We will not cede either an inch or our territory or a stone or our fortresses" (Jules Favre, Minister of Foreign Affairs- September 8, 1870)- perhaps resembles spirit of Americans during the Revolution.

"Half artist and half anchorite,
Part siren and part Socrates"
(Percy MacKaye on France, no date given)

"France is . . . Athenian in beauty and Roman in grandeur. Moreover, she is generous. She gives herself. More often than other peoples, she knows the mood of devotion and sacrifice" (Victor Hugo, 1862- rest of quote is very critical, however).

"Everything ends this way in France. Weddings, christenings, duels, burials, swindlings, affairs of state- everything is a pretext for a good dinner" (Jean Anouilh-no date given)

(Quotes 1 and 2 are from The Home Book of Quotations, 1967. Quotes 3 and 4 are from The Columbia Dictionary of Quotations, 1975).

BY SHARON

The Charles Foix Hospital outside Paris is having a tea dance. Even if nobody's dancing, the guests are sitting, some swaying to "Que Sera Sera" on the stereo. Many are smiling and drinking orange juice, and that's already something.

"When people come here, they talk, they smile, they act differently," explains Annick Sachet, who heads one of the hospital's 11 units for the aged ill. "Here we do their make-up, their hair, their nails. If we could offer something like this to every unit, it would be wonderful."

No country is a health-care utopia. All th
their systems, each shaped by a unique cor
France too is working to improve its policies,
individual choice and affordability.

Once a hospice and a home for the elderly, Charles Foix Hospital has become the repository for the most wretched among France's old—and aging—population: the homeless, the alcoholic, the abandoned, people with advanced Alzheimers Disease.

"Many of our patients have no family or are cut off from their relatives," she says. "Either they are just abandoned—sometimes they are left on our doorstep—or they are brought in by a neighbor."

Cases of abandoned elderly have become increasingly common in the United States as well, where families that cannot afford health insurance or full-time nursing care crack under the strain of having to care for the elderly themselves. While the abandoned elderly in the United States may have nowhere to go, in France they come to places like Charles Foix. Their care is paid partly by France's national health-insurance fund; the rest comes from pensions, private insurance funds and, in some cases, contributions from the patient's family. And those who cannot pay—like the homeless—do not pay; their care is underwritten by a regional fund.

Poor pregnant women pose another problem for the U.S. health-care system, but in France, comprehensive maternity care is available to every woman. Consider, for

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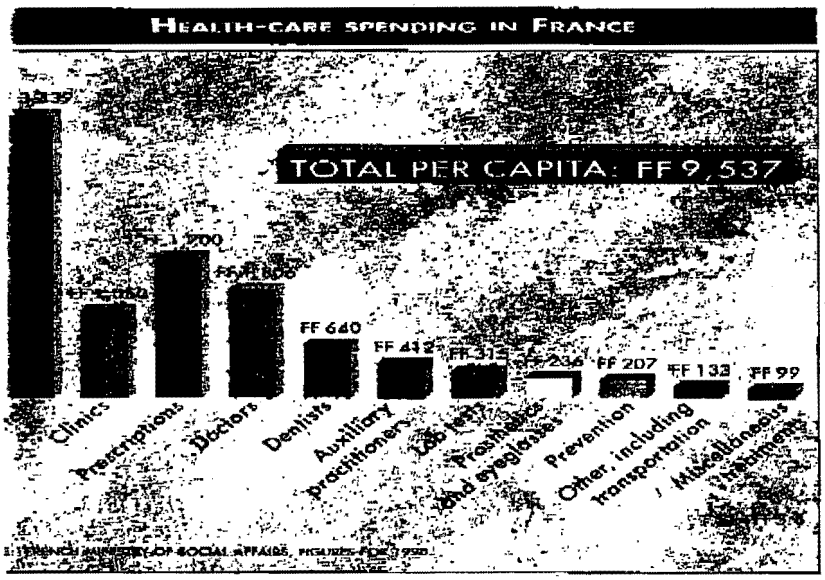


lted States, yet there are still outbreaks of measles here. Why? Because there is no or funding for immunizations.

other area where the U.S. is far more advanced than we are is the quality-tion process for hospitals and care providers. Some people complain that the al accreditation process, for example, is a bit bureaucratic, but it's a good thing

think the U.S. could provide universal erage without sacrificing creativity and scientific ances."

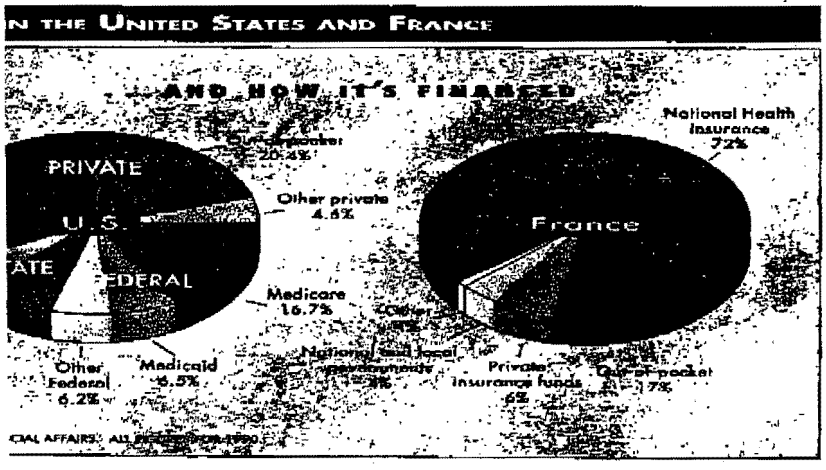
—Janet Shikles

e would do well to have a similar system in France. We could also benefit from ian recertification requirements. Again, the U.S. system may not always be y effective and is sometimes bureaucratic. But in France, all we have are moral ives for doctors to improve their skills and to keep up to date on medical advances. important, but it is not enough.

also been impressed by the role of nurses in this country. I don't think I would like French nurses modeled on American nurses, but I think French physicians should ite to nurses much more of the responsibility for patients' medical care.

o you think there will be significant changes in U.S. health insurance any oon?

les: Yes, but I think these changes are more likely to occur at the state level. Until nal consensus on this question develops, action is not likely at the federal level. ◆



Lessons From France—'Vive la Différence'

The French Health Care System and US Health System Reform

Jonathan E. Fielding, MD, MPH, Pierre-Jean Lancry, PhD

GERMANY, and Canada, maybe England. These countries are where US policy makers look for lessons applicable to reform of the US health care system. Why not France? France provides almost universal coverage with a uniform comprehensive benefit plan that, unlike those in the United States, includes pharmaceuticals, physical therapy, and even medically prescribed spa treatments. Consumers have coverage that follows them from job to job, including any intervening periods of unemployment. Out-of-pocket costs are capped below the level where they could cause financial hardship. There is free choice of office-based physicians and ancillary service providers for ambulatory care.

France spent 9.1% of its gross domestic product (GDP) on health care in 1991, similar to Canada (10.0%) and Germany (8.5%) but over 4 GDP percentage points less than the United States at 13.4%.[1] Yet life expectancy in France at 81.1 years for women and 73.0 years for men in 1991 was better than for their US counterparts, and French infant mortality was 8.3 per 1000 live births compared with 8.9 in the United States. (Statistics not otherwise referenced come from ECO-SANTE France and ECO-SANTE OECD. Paris, France: CREDES; 1992.) And the French appear more satisfied with their system than Americans. In a 1990 survey,[2] about 10% of French respondents advocated complete system rebuilding vs 30% of Americans, with French respondents less likely by one half than Americans (40% vs 60%) to indicate that fundamental changes were needed. Yet few analyses of the French health care system have appeared in English-language journals.[3-7]

The objective of this article is to explain the French system and highlight strengths and weaknesses that can inform the debate about alternative health system reforms in the United States. France has already faced, with varying levels of decisiveness, many challenges currently confronting the United States. Sufficient time has elapsed to judge the intended and unintended impacts of some of these decisions.

PRINCIPLES

In contrast to the United States, explicit principles undergird the French health insurance system. One is the shared perception that government has the prime responsibility to protect all citizens and permanent residents against having to pay a large out-of-pocket sum for health care. A second is intergenerational solidarity, which acknowledges that the younger, working generation will subsidize the older generation. A third principle is intergroup cross-subsidization. For example, as the number of agricultural workers has declined while the number of agricultural pensioners has increased, the agricultural health insurance fund has received significant subsidies from the general insurance fund to which most of the population contributes. In 1991, 4.6% of the payments of the general fund went for subsidies to the other systems.[8]

Additional key principles incorporated in the Medical Charter of 1927, and then again in the 1979 Code of Ethics, were free choice of physician and freedom for physicians to treat patients as they see fit. Physicians can establish ambulatory practice wherever they choose.

SYSTEM ARCHITECTURE

The French system has a complexity born of the many compromises required to achieve incremental changes in a country where a virtually inviolate principle is to never revoke a right previously granted. Complexity and lack of Cartesian rationality may make the French system a more attractive model to those who favor an incremental and distinctly American solution to existing problems of access, costs, and coordination.

Comparative figures on the two health care systems are displayed in Table 1.[9] The provider system is a mixture of public and private. Ambulatory care is primarily private, with physicians free to establish office practices anywhere. French physicians are like the fabled French shopkeepers, proud of their independence and wont to practice alone. When French physicians practice "together," space, secretarial assistance, and equipment are usually shared but

In alphabetical order, from the Department of Health Services, UCLA School of Public Health, and Department of Pediatrics, UCLA School of Medicine, Los Angeles, Calif (Dr Fielding), and the University of Paris XII and CREDES (Centre de Recherche, d'Etude et de Documentation en Economie de la Santé), Paris, France (Dr Lancry).

Reprint requests to UCLA School of Public Health, Department of Health Services, 31-236 CHS, 10833 Le Conte Ave, Los Angeles, CA 90024 (Dr Fielding).

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August 11, 1993 Volume 270

May 30, 1994

BREAKFAST WITH FRENCH WOMEN

DATE:	Tuesday, June 7
TIME:	9:15 am
LOCATION:	Le Doyen Restaurant Paris, France
FROM:	Liz Bowyer

I. PURPOSE

To attend a breakfast with French women held in your honor by French Minister Simone Veil.

II. BACKGROUND

Breakfast

Minister Veil has invited approximately 25 French women prominent in academia, business, the arts and literature, government, politics and labor. The women are very interested in discussing politics, social issues, and your role in reforming America's health care system. According to the NSC, the French (particularly French women) greatly admire you and you get very positive press coverage.

The breakfast will be held on the terrace of Le Doyen, a small restaurant located in the Champs-Elysees across the street from the Grand Palais. The two-story stone/masonry building that houses Le Doyen was built in 1792. Le Doyen is one of Paris' two-star restaurants (there are approximately ten two-star restaurants in Paris. As you know, three stars is the highest ranking a restaurant can receive in France). The chef at Le Doyen, Gisele Arabian, is one of the top five chefs in the world and the only woman in that category.

Simone Veil

Simone Veil, a Holocaust survivor, is perhaps the best known and well-respected woman in France. She is the Minister of Social Affairs and one of the four Ministers who also hold the title of Minister of State. Most recently, she has been identified with the fight against AIDS and has strongly pushed the French proposal for an AIDS Summit in December. She discussed this at length with Secretary Shalala during their May 3rd meeting in Geneva, and she will probably raise it with you (see attached talking points on AIDS and the U.S. Government.)

III. PARTICIPANTS

HRC
Simone Veil
Approximately 25 women (see attached list)

IV. SEQUENCE OF EVENTS

* See attached scenario

V. PRESS

Pool spray.

VI. REMARKS

No remarks needed (*subject to change)

Breakfast - Tuesday June 7, 1994

9:15 am to 10:15 am

Hosted by Minister Simone Veil

In honor of Hillary Rodham Clinton

at Le Doyen

(The Chef at Le Doyen is a woman called Madame Ghislaine ARABIAN who belongs to the prestigious Club of the five best cooks in the world. She is the only woman of this club)

* * * * * * * * * * * * * * * * * * * *

GUEST LIST

Mme Michele ALLIOT-MARIE	Minister of Youth and Sports
Mme Helene AHRWEILER	University Professor - Byzantinist
Mme ANDRE-CORRET	President of the National Bar Association
Mme Gilberte BEAUX	Administrator, Company Director
Mme Marianne BERNHEIM	Chairman of French Association of Women College Graduates
Mme Francoise CACHIN	Director - Orsay Museum
Mme Helene CARRERE d'ENCAUSSE	Delegate for the European Parliament
Mme Nicole CATALA	Vice-President of the National Assembly
Mme CHOFFEL	Director-General of the French-American Foundation
Mme Michele COTTA	Journalist - TV producer

Mme Anne d'ORNANO	Mayor of Deauville
Mme Jacqueline de ROMILLY	Member of the French Academy
Mme Myriam EZRATTY	President of the Paris Court of Appeals
Mme FEKETE	University Professor of medecine
Mme Michèle GENDRAU-MASSALOUX	President of all Paris Universities
Mme Francoise GIROUD	Journalist - Former Minister
Mme Helene GISSEROT	Magistrate with the Cour des Comptes
Mme Odile JACOB	Publisher
Mme Colette KREDER	Director of the Polytechnic School for Women
Mme Paulette LAUBIE	President of the National Council of French Women
Mme Noëlle LENOIR-FREAUD	Member of the State Council and of the Constitutional Council
Mme Lucette MICHAUX-CHEVRY	Minister for Humanitarian Action and Human Rights
Mme Christine MORIN-POSTEL	Business Woman
Mme Nicole NOTAT	Chairman of Socialist-led Labor Union "CFDT"
Mme Christine OCKRENT	Journalist
Mme Hélène PLOIX	Deputy CEO of Caisse des Depots et Consignations
Mme Francoise SAMPERMANS	CEO of the magazine l'Express
Mme Anne SINCLAIR	Journalist - TV producer
Mme Rose-Marie VAN LERBERGHE	Managing Director - BSN

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b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
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Michèle ALLIOT-MARIE

[002a]

(pronounce ALEEO-MAREE)

Minister of Youth and Sports

Personal Data:	P6/b(6) Single; no children
Education:	Sorbonne Graduate in: Doctorate in Law and Political Science; CAPA (French Bar Exam)
Political Party:	RPR (conservative)
Previous Position:	Junior Minister of Education (1986-1988)
Currently:	Also Parliamentary Deputy for Pyrénées Atlantiques at the National Assembly.

June 1994

Hélène AHRWEILER

(pronounce ARVAYLER)

University Professor - Byzantinist

Personal Data	P6/b(6) married; 1 child
Education:	Doctorate in history and humanities from the University of Athens
Previous Position:	President of the Sorbonne (1976-1981); President of the Pompidou Center (1989-1991); President of the University of Europe (1983-1989)
Currently:	University Professor and Byzantinist

June 1994

Madame ANDRE-CORRET

(pronounce ANDREY-CORAY)

President of the National Bar Association

Personal Data:	Married; 1 child
Education:	Law Graduate
Previous Position:	Former President of a local French Bar
Currently:	Lawyer

June 1994

Gilberte BEAUX

(pronounce BOE)

Administrator, Company Director

Personal Data:	P6/b(6) Married; 1 daughter
Education:	Graduate from the prestigious Technical Institute of Banking (first in her class)
Previous Position:	Since 1963 President of various banking institutions
Currently:	Member of the Economic and Social Council (since 1989) Administrator of Fiat-France (since 1989) CEO of the financial group "Efficacité Finance Conseil"
Awards:	Business Woman of the Year (1987)

June 1994

Marianne BERNHEIM

(pronounce BAIRNEM)

President - French Association of Women College Graduates

Personal Data: Born in 1922; Married; Three children

Education: Degree in English Litterature

Currently: Associate Professor at the Political Science Institute

June 1994

Françoise CACHIN

(pronounce CASHEN)

Director - Orsay Museum

Education:	A Graduate of the Art Institute at the Sorbonne; Internships at the Louvre Museum and at the Impressionists' Museum of the "Jeu de Paume"
Previous Position:	General inspector of National Museums (1988) General Curator / French Heritage (1989)
Currently:	Director of the Orsay Museum (since March 1986)

June 1994

Hélène CARRERE d'ENCAUSSE

(pronounce CARARE DONKOS)

Delegate for the European Parliament

Personal Data:	P6/b(6) Married; Three children
Education:	Doctorate in History and Human Sciences
Political Party:	RPR (conservative)
Currently:	History Professor Member of the East-West Institute for Security Studies in New York Member of the French Academy Author - Specialist on Russia

June 1994

Nicole CATALA

(pronounce CATALA)

Vice President of the National Assembly

Personal Data:	P6/b(6) Single; one child
Education:	Holds a doctorate in Law
Political Party:	RPR (conservative)
Previous Position:	Junior Minister in charge of Professional training for the Minister of Education (1986 - 1988)
Currently:	Also: Judge at the High Court of Justice (since 1993) which hears of impeachment cases of Government of France officials; Deputy for Paris at the National Assembly and Advisor to the Mayor of Paris

June 1994

Nicole CATALA

Vice-President of the National Assembly
Deputy (RPR) Paris

Phonetic Pronunciation: Ka-ta-la

Nicole Catala, 58, is a Vice-President of the National Assembly and Deputy representing Paris. Launching her career with a focus on academia, Catala initially spent two years, 1962-1964, as a lecturer at the University of Law in Dakar, Senegal. Moving back to France in 1964, she became Professor of Law at the University of Dijon until 1969 when she taught at Paris' University of Law, Economics and Social Sciences. In 1970, Catala became the Founder and Director of a practical work-related training center for University students called The Inter-University Center for Personnel Formation, where she remained 15 years. Her appointment, in 1986 in the government of then - Prime Minister Jacques Chirac, as Junior Secretary of State in the Department of Education in charge of professional training, along side with her simultaneous position as Regional Council for the Ile de France region, marked her entry into the political sphere. She was first elected to her current position as Deputy to the National Assembly in 1988. In 1989, she was also elected as Councilor of Paris and assistant to Mayor Chirac.

Catala holds both a degree in Letters and Social Science from the University of Montpellier as well as a law degree from the University of Law in Paris. She also spent a year studying at Tulane University. As an extension of her academic and political focus on labor issues, Catala has also written several books on the issue and is considered to be an expert in the field.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002b. paper	DOB; Birthplace (Partial) (11 pages)	ca. 06/1994	P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Speechwriting
OA/Box Number: 8168

FOLDER TITLE:
HRC [Hillary Rodham Clinton]/Paris Breakfast 6/7/94

2012-1004-S
ms491

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
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C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
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Madame CHOFFEL

(pronounce SHOFELL)

Director-General of the French-American Foundation

Personal Data:	Born 1932; Married; Two sons
Education:	Graduate of the Paris Political Studies Institute (Doctorate in Management)
Previous Position:	Former economic journalist
Currently:	Director-General of the French-American Foundation

June 1994

Michèle COTTA

(pronounce COTTA)

[0026]

Journalist - TV producer

Personal Data: P6/b(6) Married; Two children (from previous marriage)

Education: Graduate of the prestigious Paris Institute of Political Studies;
Holds a doctorate in Political Science

Previous Position: Chairman of Radio France (1981 - 1982)
CEO of the Audiovisual Broadcasting Council (1982 - 1986)

Currently: Author
Producer of political shows on French public TV channel "France 2"

June 1994

Anne d'ORNANO

(pronounce DOOR NANO)

Mayor of Deauville

Personal Data:	[redacted] P6/b(6) Widow, Two children
Education:	Glen Coves Friends Academy in Long Island Medical College in New York
Political Party:	Conservative
Currently:	President of the Normandy tourism office President of the Regional Council of Calvados (since 1991)

June 1994

Jacqueline de ROMILLY

(pronouce DE ROMEYEE)

Member of the French Academy

Personal Data:	P6/b(6) Divorced; no children
Education:	Doctorate in Humanities
Previous Position:	Professor of Hellenic studies
Currently:	Author Member of Several Academies in Europe Member of the American Philosophical Society

June 1994

Myriam EZRATTY-BADER

(pronounce EZRATTY-BADER)

President of the Paris Court of Appeals

Personal Data:	P6/b(6) Married; No children
Education:	A Law Graduate from the University of Aix-en-Provence
Previous Position:	Advisor to the Minister of Health, Simone Veil (1974 - 1979) Section President at the Paris Court of Appeals "Cour de Cassation" (1975 - 1981) Public Prosecutor at the Supreme Court of Appeal (1986 - 1988)
Currently:	First women president of the Paris Court of Appeals (since 1988)

June 1994

Madame FEKETE

(pronounce FAYKAYTAY)

University Professor of medicine

Personal Data: P6/b(6) Married; Two sons

Education: Medical studies Professor

Currently: Also Head of pediatric surgery at the Necker children's Hospital

June 1994

Michèle GENDRAU-MASSALOUX

(pronounce JOHNDROE-MASALOO)

President of all Paris Universities

Personal Data:	P6/b(6) Married; No children
Education:	A Graduate of the Paris Political Studies Institute; Holds a doctorate in Spanish
Political Party:	Socialist
Previous Position:	Vice-President of the University of Limoges Director of the Academy of Orléans-Tours Spokesperson for President Mitterrand (1986 - 1988)
Currently:	Director of the Academy of Paris (since 1989) Vice President of the High Council of National Education (since 1989) Member of the High Council of the French Language (since 1989) Member of the Orientation Council of the "Ecole du Louvre" (since 1991) Member of the French University College of Moscow (since 1991)

June 1994

Françoise GIROUD

(pronounce JEEROO)

Journalist - Former Minister

Personal Data: [redacted] P6/b(6) - Two children (one dead)

Previous Position:
Script-writer (1932)
Editorial Director for the magazine ELLE (1945-1953)
Co-fonder of the magazine L'EXPRESS (1953)
President of the press group "Express-Union" (1970-1974)
Minister for The Conditions of Women (1974-1976)
Culture. Minister (1976 -1977)
Honorary President of the International Action against Hunger (1988)

Currently: Author

Awards:
Literary prize from the Medici International Academy in Florence for her book "An Honorable woman" (1984)
Doctor honoris causa from Michigan University

June 1994

Hélène GISSEROT

(pronounce JEESAROE)

Magistrate with the Cour des comptes (French equivalent of GAO)

Personal Data:	P6/b(6) married; four children
Education:	Graduate of the Paris Institute Political studies and of the National School of Administration "ENA" (1958- 1959)
Previous Position:	Assistant Public Prosecutor (1979-1984) Chief prosecutor at the "cour des comptes" (1985-1986) Government official in charge of Women's Rights (1986-1988)
Currently:	Also President of the Federation of hospitals and non-profit making establishments (since 1989) Magistrate at the "cour des comptes" (since 1993)

June 1994

Odile JACOB

(pronounce JACOB)

Publisher

Education:	Harvard Graduate
Previous Position:	Founder of publishing House "Editions Odile Jacob" which specializes in science, anthropology and economic books
Currently:	Publisher
	Was named best publisher of the year (1988)

June 1994

Colette KREDER

(pronounce KRADER)

Director of the Polytechnic School for Women

Personal Data:	P6/b(6) Widow; Four children (one dead)
Education:	Graduated as an Engineer from the Polytechnic School for Women
Previous Position:	Engineer at the technical and telecommunications department of the Ministry of Air (1957-1964) CEO of the company SOREDI (1971-1980)
Currently:	Director of the Polytechnic School for Women (since 1980) Vice-President of the Association "Presence and Promotion of French Women" (since 1991) Treasurer of the National Council for French Women

June 1994

Paulette LAUBIE

(pronounce LOBEE)

President of the National Council of French Women

Personal Data: Born 1929; Married; Two Children

Currently: Also President of the French exportation Firm, " Partenariat Trans-Frontières"

June 1994

Noël LENOIR-FREAUD

(pronounce LENOOAR-FRAYÜ)

Member of the State Council and of the Constitutional Council

Personal Data:	P6/b(6) Married
Education:	Graduate of Public Law and of he Paris Political Science Institute
Political Party:	Socialist
Previous Position:	Senate Administrator (1972 - 1982) Member of the State Council, France's highest Administrative Court (since 1984) Cabinet Director for Minister of Justice, Mr. Arpaillange (1988-1990) Member of Prime Minister Michel Rocard's private staff (1990)
Currently:	Only woman Member of the Constitutional Council (since 1992) Mayor of Valmondois (since 1989)

June 1994

Lucette MICHAUX-CHEVRY

(pronounce MEESHOW-SHAVREE)

Minister for Humanitarian Action and Human Rights

Personal Data:	[redacted] Widow; Two children
Education:	Graduate of Law
Political Party:	RPR (conservative)
Previous Position:	Lawyer
Currently:	President of the General Council of Guadeloupe Mayor of Gourbeyre Deputy for Guadeloupe at the National Assembly Junior Minister for Humanitarian Action and Human Rights

June 1994

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002c. paper	Birthplace (Partial) (1 page)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Speechwriting
OA/Box Number: 8168

FOLDER TITLE:
HRC [Hillary Rodham Clinton]/Paris Breakfast 6/7/94

2012-1004-S
ms491

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

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[002c]

Lucette MICHAUX-CHEVRY

Minister of Human Rights and Humanitarian Aid

Phonetic pronunciation: Meshow-shayvry

Lucette Michaux-Chevry, 65, was appointed Minister of Humanitarian Aid and Human Rights in the Spring of 1993. She began her career as a lawyer in 1955. Shortly after, in 1957, Michaux-Chevry became a Municipal Councilor in the region of Sainte-Claude, Guadeloupe. By 1976, she had climbed to the position of Attorney General of Sainte-Claude. In 1983, she accumed the title of Attorney General of all of Guadeloupe, a position which she held until her election as RPR Deputy to the National Assembly in 1986. From March 1986 - 1988 Michaux Chevry moved from the National Assembly to the Prime Minister's Office due to her appointment as Junior Secretary for Francophone Affairs. Simultaneously, beginning in 1987, she was also the Mayor of Gourbeyre. Once again in June 1988, Michaux-Chevry was re-elected RPR deputy to the National Assembly.

Michaux-Chevry, P6/b(6) has a law degree from Paris' Law University. Since her appointment as Minister of Humanitarian Aid and Human Rights, she has tried to distinguish herself from her predecessor. Her conception of Humanitarian Aid, according to the media, will focus less on charitable and ostentatious action, and more on the treatment of real issues. Michaux-Chevry is a widow and has two children.

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002d. paper	DOB (Partial) (7 pages)	ca. 06/1994	P6/b(6)

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First Lady's Office
Speechwriting
OA/Box Number: 8168

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2012-1004-S
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[0028]

Christine MORIN-POSTEL

(pronounce MOREN-POSTEL)

Business Woman

Personal Data	P6/b(6) Divorced; Two children
Education:	Graduate of the Management Institute
Previous Position:	Administrative and Economic Director of the Normandy Chamber of Commerce (1968-1973) International Affairs Director of the French water company "Lyonnaise des Eaux" (1982-1984) CEO of the utility company "CGCD" (1984-1986)
Currently:	President and Administrator of subsidiaries "Lyonnaise UK" and "Lyonnaise American Holding" (since 1993) Associate-Manager of French banking group subsidiary "Financière Indosuez" (since 1993)

June 1994

Nicole NOTAT

(pronounce NOTA)

President of Socialist-led Labor Union "CFDT"

Personal Data:	P6/b(6) Single
Education:	Certified School Teacher
Political Party:	Socialist
Previous Position:	School Teacher
Currently:	President of the Socialist-led Labor Union, "CFDT"

June 1994

Christine OCKRENT

(pronounce OAK KRENT)

Journalist

Personal Data:	P6/b(6) one son (father is former Minister Bernard Kouchner)
Education:	Graduate of the Paris Political Studies Institute
Previous Position:	Journalist at the European Community Information Bureau (1965-1966) Researcher at NBC news in the U.S. (1967-1968) Reporter for CBS News in the U.S. (1968-1977) Evening news Presenter on various French TV networks
Currently:	TV Producer for the Public TV station "France 2" Presenter of late evening news on public TV station "France 3" News Editor for National TV channels "France 2" and "France 3" Author

June 1994

Hélène PLOIX

(pronounce PLOOA)

Deputy CEO
State-owned Financial Institution "Caisse des Depots et Consignations"

Personal Data: [redacted] P6/b(6)

Education: Holds a Masters of Arts and a Public Administration diploma from Berkeley University

Political Party: Socialist

Previous Position: CEO of the BIMP (private bank) (1982-1984)
Economic and Financial Counselor to Prime-Minister Laurent Fabius (1984-1986)

Currently: Deputy CEO of the "Caisse des Depots et Consignations"

June 1994

Françoise SAMPERMANS

(pronounce SEMPERMONTZ)

CEO of the magazine l'Express

Personal Data: P6/b(6) mother of two children

Education: Master's of Arts Degree

Previous Position: Communications Director of French Telecommunications Giant "Alcatel-CIT" (1984-1987)

Currently: Managing Director of the "Generale Occidentale" (a subsidiary of engineering and transport group "Alcatel Alshthom") (since 1991)
Vice-President of the Baroque Music Center in Versailles

June 1994

Anne SINCLAIR

(pronounced SINCLAIR)

Journalist - TV producer

Personal Data:	P6/b(6) Married to former socialist Trade and Industry Minister Dominique Strauss-Kahn; 2 children from previous marriage
Education:	Graduate of Law.
Previous Position:	Journalist for various Radio and TV stations
Currently:	Journalist and Producer of Political programs on French private TV channel TF1 Author

June 1994

Rose-Marie VAN LERBERGHE

(pronounce VAN LAIRBERG)

Managing Director

Personal Data: P6/b(6)

Education: A Graduate from the Paris Institute of Political Studies and of the National School of Administration "ENA", she also holds a degree in history

Previous Position: Head of the National Employment Fund (1976 to 1981)
Deputy Director for the defense and promotion of employment at the Ministry of Employment (1983-1986)
Director for social development at Food group BSN (1986-1988)

Currently: Director General of BSN subsidiay "l'Alsacienne"
Member of the "Cosmetic Executive Women"
Author

June 1994

Gisèle ARABIAN

(pronounced ARABIAN)

Chef - Restaurant LeDoyen

Personal Data: Born in 1950; Married; Four children

Education: Self-Educated

Currently: Also belongs to the Club of the five best cooks in the world (she is the only woman of the club)

Chef at the restaurant "Le Doyen" since 1992

June 1994