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Decentralization of Health Policy Making in France

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Abstract

It is pivotal how to advance health promotion activities into the health care system, in order to make the social insurance scheme sustainable in the coming aged society. In this article the author focuses the French health promotion program, Regional Public Health Plan (Plan Régional de la Santé Publique; PRSP). The PRSP project has been implemented under the principle of decentralization and new public health movement. Although there have been few evidences on effectiveness of PRSP, it seems that the French PRSP programs has been succeeding on the whole as a decentralization policy and new public health movement. One of the key success factors is its feature of decentralization. The French decentralization can be categorized into "deconcentaration". The central government always keeps its power of control over the territory thorough their local branches; DRASS and DDASS. The hypothesis of "steering at a distance" fits very well to the French decentralization process. The PRSP is implemented under the concept of new public health movement. The local health authorities are responsible for assessing the health needs of their population, deciding priorities for meeting those needs, placing contracts accordingly, evaluating the performance of those contracts and taking other action to promote health and prevent diseases. The French experiences will be suggestive for other developed countries with similar socio-political climates.

Key words: health promotion, public health policy, decentralization, new public health movement, France

❖ Introduction

Along with the ageing of the society and changes in the socio-economic environment, health policy has increased its importance both in national and local governments. The health policy debate often focuses largely on questions associated with the supply sides, such as measures to organize, finance and deliver health care in the cost-effective way. Less attention has been paid to key aspects of the demand side, in particular how the need for medical services might be rationalized by improving the health status of population. In most of the countries, public health services have been organized quite separately from the clinical sector, although it is widely recognized that the two sectors must work together for better health of population. In order to make the social insurance scheme sustainable in the coming aged society, it is pivotal how to integrate preventive and health promotion activities into the health care system. Furthermore, as most of the current health problems are closely related with lifestyle, health policy must be coordinated with other policy issues, such as education, labor, housing, sport, etc.

In this sentence, many countries have launched the national health promotion programs during the last decades; Healthy people 2010 in USA, Healthy Japan 21, National and Regional Public Health Plan in France.

In this article the author focuses the French health promotion program, Regional Public Health Plan (Plan Régional de la Santé Publique; PRSP). The aim of this article is to analyze the validity of its two background princples; new public health movement and decentralization.

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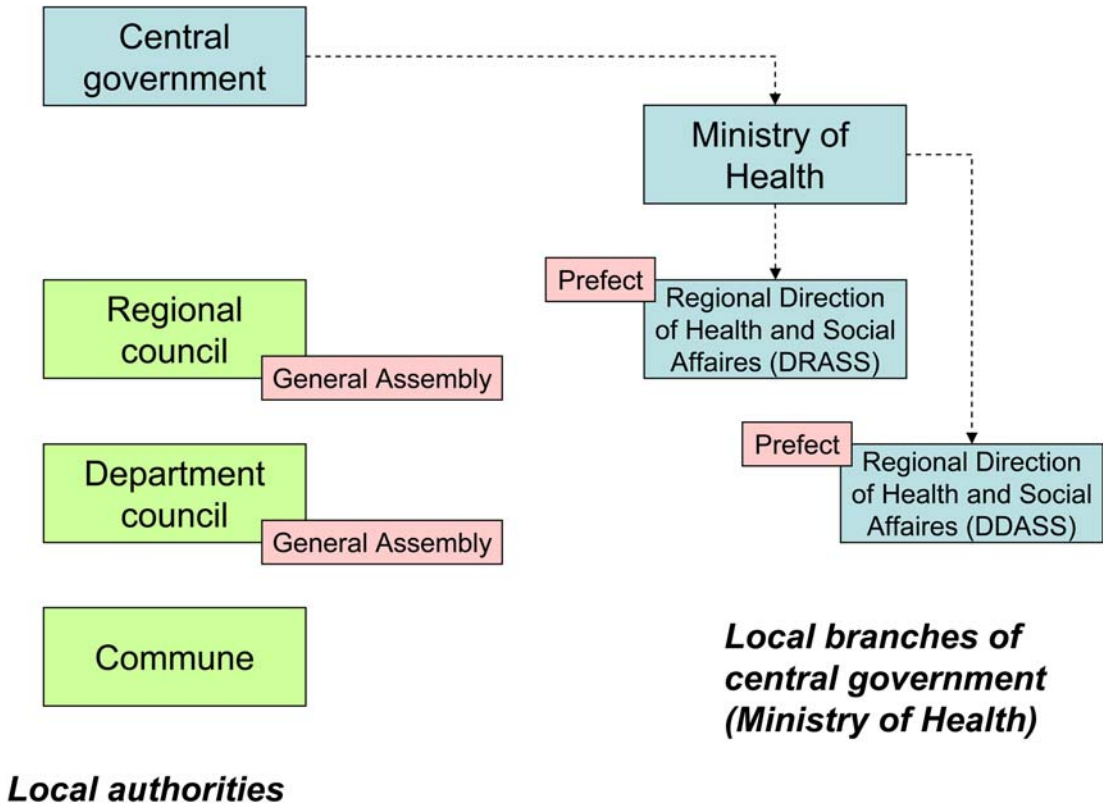

Figure 1 Administrative structures of France

❖ Health Policy Making Process in France

The French health policy making has two contrasting characteristics; that is centralization and regionalization. There are four levels of governing bodies (Figure 1); state, region, department and communes. The central government (states) is the dominating level of government equipped with the majority of competencies in many policy areas. The 1789 French revolution wiped out autonomy of local government and created a centralized administrative infrastructure throughout the French territory. The hierarchical mode of top-down organization was implemented in localities by state field agencies and local authorities, and was coordinated by the prefects, the representative of the French State in the region and department.

In the national French policy, traditionally, the administration (ministries and cabinet) has relatively stronger position than the legislature. Reflecting this situation, the bill by administration is dominant compared with that by the House members. As a result, most of the important frameworks of health policy are formulated by the bureaucrats and a few cabinet members. The mainstream of the bureaucrats and cabinet members are graduates from National School of Administration (Ecole Nationale de l'Administration: ENA). The graduates of ENA (Enarque) keep a strong tie beyond the differences of supporting political party. This is the most important reason why the French health policy can keep its baseline concept and continuity regardless the frequent changes in the ruling parties. Another important feature of French health policy is the coalition between the right and left wing parties. As the middle-of-the-road policy has been a mainstream in the French political scene since 1990s, there are no definitive differences in the health policy between the left and right wing parties. Under this political climate, the health policy making led by the bureaucrats has become a basic style of Health policy making in France.

The second feature of French health policy making is decentralization. According to the Law for decentralization in 1982, the central government has been transferring its administrative authority to the local government. In order to strengthen the authority

of region, France has recently, on 17 March 2003, adopted a constitutional reform which permits it to introduce a reference to a "decentralized organization (article 1)" in the Constitution of this traditionally centralized country. According to this modification, the regional governments have been transferred their autonomy of taxation, political decision making (including adoption of direct democracy), practice of social experimentation. However, the degree of autonomy is relatively weak compared with those of other European countries.

The region has responsibilities for economic development, transport, infrastructure, state-region plan, secondary education (high school), job training, and health planning. The department also has responsibilities for social services (i.e., handicapped, aged, maternal and child health), road building and maintenance, and secondary education (junior high school). Both regions and departments have their own councils which members are elected by the inhabitants. On the other hand, the central government controls the two decentralized bodies by state branches that are governed by prefect. In the case of health administration, those are the Departmental Direction of Health and Social Affaires (DDASS) and Regional Direction of Health and Social Affaires (DRASS). Based on this hierarchical mode of top-down organization, the public health policy programs originated within the central government are implemented in localities by state field agencies such as DRASS and DDASS.

❖ General Features of the French Health System

The basis of the French health system is the national health insurance fund that was modeled after the German sickness funds. Originally the French health insurance system was managed by representatives of labor union and employers, independent of government. All expenditures were to be financed by premium from the salaries of employees and contribution of employers. However, as the growth of health expenditures exceeded persistently the growth of general economy, the independency of administration has been gradually broken. Since 1991 a supplemental income tax, so called "general social contribution (CSG)", has been compensating the finance of funds. In 2005, CSG is set at 7.5% of salaries of which 5.29% are used for medical insurances[1]. This situation has gradually strengthened the position of government in administration of insurance funds.

All French were required to belong to some public insurance scheme according to their working place. Among the insurance funds, the National Health Insurance Fund for Salaried Workers (CNAMTS) is the biggest one, covering 86% of the total population. The administration of insurance fund is very centralized and computerized. Because of this structural feature, the CNAMTS's administration is relatively efficient. Its administration overhead was around 5%[2], while this figure is 1.3% for Canadian NHS[3], 2.3% for the Japanese Society-managed Health Insurance[4], 3.6% for US Medicare, and 11.7% for US private insurers[3].

The details of coverage and reimbursement are determined by the negotiation between the funds and the labor unions of health professionals. Most of the physicians outside the hospitals are private and paid by fee-for-services basis. Traditionally, Physicians have little constrains for ordering laboratory tests and prescribing drugs (Liberté de prescription). Since 1995, the insurance fund published a list of practices considered inappropriate (RMO) and detailed evidence-based recommendations (RPC) for practitioners. The objective of RMO and RPC is to realize the quality medical services and to rationalize the medical expenditures. However, effectiveness of these tools is not evident up to now.

In the case of hospital care, the function of each hospital is contracted with Regional Hospital Agency (ARH) under the Regional Health Plan. Each acute care hospital is reimbursed by DRG based per case payment. Middle-term care hospitals and long-term facilities are reimbursed by per-diem basis[1].

Patients are relatively free to receive medical services whatever generalist and specialist (Liberté de choix de médecin). They have to pay for a part of medical costs as co-payment at the end of consultation. The average levels of coverage were 70% for physician's services, 60% for paramedical services, 60% for laboratory tests, 35 to 100% for medications and 80% for hospitalization.

In order to rationalize the medical expenditures, the Alan Juppé's government introduced the expenditures target in 1996. The target is set by the vote in the National Assembly for public hospital services, private hospital services, private out-patient care, sociomedical care and coordinated care, respectively. As

Table 1 International comparison of Major causes of death (Mortality rate: number of deaths per 100,000 populations)

	USA (2000)		France (2000)		Germany (2001)		Sweden (2001)		UK (2002)		Japan (2005)	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Malignancy	207.2	186.2	303.2	187.9	269.5	235.6	252.9	233.2	279.2	246.6	319.1	200.3
Ischemic Heart Diseases	188.7	177.6	88.6	66.0	193.6	207.0	244.0	204.3	223.0	144.9	68.1	53.5
Cerebro-vascular Diseases	46.9	71.8	55.7	74.2	71.2	118.8	92.5	131.6	88.3	138.0	103.3	107.1
Traffic accidents	23.0	10.1	19.8	6.6	12.9	4.7	10.8	3.6	8.9	2.9	11.4	4.7
Suicide	17.1	4.0	27.9	9.5	20.4	7.0	18.9	8.1	10.8	3.1	36.1	12.9

Source: WHO

these targets have not been obligatory, however, expenditures have exceeded for most of the previous years.

In 2004, the High Council for the Future of Health Insurance published the final report[5]. In this report they proposed to make the French health care system more evidence based, cost-effective, efficient and quality oriented, and to create a governing council of the health insurance funds with more authority and responsibility. According to this recommendation, the president is given an authority to take some immediate countermeasures if there is a possibility for medical expenditures to exceed the year's target.

Another important reform is the introduction of gate-keeping system that the French government had long been wishing to introduce. In 2004, Minister of Health, Mr. Douste-Blazy introduced a new primary care system. All French more than 16 years old are required to choose their primary physician. If a patient directly go to other physician without referral from his/her primary care physician, he/she must pay extra money more than official tariff.

❖ Health Promotion Activities in France

France is evaluated as one of the healthiest countries around the world. Various health indicators support this evaluation. In addition to the longer life expectancy (76.8 years old for men, 83.8 for women, in 2005), lower infant mortality (4.4 deaths per 1000 live births, in 2005)[6], the French people shows a lower mortality by ischemic heart diseases among the European countries (Table 1), although they consume 30% more fats and cigarettes compared with the Americans. This phenomenon is known as "French Paradox"[7].

In 1994, the High Council of Public Health (HCSP) indicated that there were considerable differences in the health status among the French people[5]. Their 1998 report clarified the existence of large geographical differences in standardized mortality ratio (SMR) of premature deaths[8]. The Nord-Pas-de-Calais Region (the northernmost region of France) showed the highest mortality indices both for males and females (125 and 117, respectively[Note 1]) and Midi-Pyrénées Region showed the lowest indices (77 and 85, respectively). The socio-economic situation was closely related to the health condition. According to the 2006 governmental report on prevention strategy, the mortality of cardio-vascular diseases had decreased in 32% between 1970 and 1990. However, this reduction was three times larger among the high social class people (–42%) than among low social class people (–14%)[9]. From the geographical viewpoint, the rates of preventable death before 65 years old were the highest in Bretagne and the north regions of France (87.7 to 108.0 per 100,000) and the lowest in Ile-de-France and the Mediterranean regions (58.3 to 68.9 per 100,000). The factors associated with this geographical difference are smoking, alcohol consumption, nutritional factors, suicides and traffic accidents. Unequal accessibility to medical facilities is also another important contributing factor. All these factors are associated with socio-economic status of regions.

Considering the variability of health problems among the regions, it was perceived very insufficient that the central government decides a unique prevention program and implements it for the entire territory by top-down way. In order to solve this problem, the national government has promoted the decentralization of health policy making. There are two important

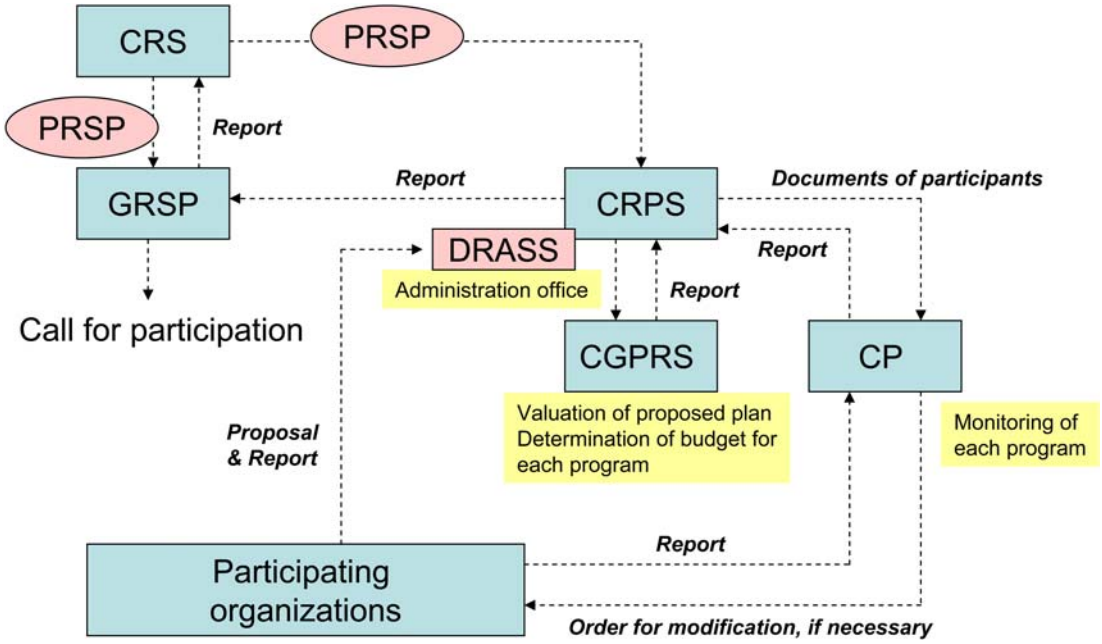

Figure 2 PRSP and related organizations

Abbreviations are explained in the text.

laws; the 24 April 1994 Ordnance and Act 2004-806 of 9 August 2004. The 1994 Ordnance requires each region to organize the Regional Health Conference (CRS), and the 2004 Act obligates for each region to establish multi-annual Regional Public Health Program (PRSP). In the following session, the author explains this interesting but complex framework in referring to the case of Nord-Pas-de-Calais region (Figure 2)[10].

❖ PRSP of Nord-Pas-de-Calais Region

The Nord-Pas-de-Calais region is located at the northernmost of France. It consists of the two departments; Nord and Pas-de-Calais. The region has an area of about 12,414 square kilometers with 4 million populations. This area was a major center of heavy industry in the 19th century with coal mines, steel mills and traditional textile manufacture. After the energy revolution in 1960s, it has experienced economic recession as the coal mines closed, the steel industry declined and the textile industry was defeated in the international competition. The unemployment rate rose to 16.5% in 1996 (France total: 12.1%)[11]. Meanwhile, the opening of the Channel Tunnel in 1994 has caused a positive effect on the regional economy. In 2006 the unemployment rate has declined to 12.5%. This figure was, however, still 3.4 point higher than France total (9.1%). The persons more than 65 years old occupy 14.2% of total population[10]. The three main causes of death are cancer, disease of circulatory system and disease of respiratory system. Another two important causes of death in this region are suicide and traffic accident (Table 2)[10].

Considering the relatively unfavorable health situation compared with other regions, DRASS of Nord-Pas-de-Calais has been actively engaged in the development of regional health programs (PRS; former PRSP). The Nord-Pas-de-Calais was the first region that established the PRS in 1996. They established the PRS for cancer in 1997, cardio-vascular diseases and high risk behavior in 1998.

The present CRS of this region composes of 120 members from six categories: administration, health professionals, inhabitants and patients, persons in economic sectors, health facilities, intelligent persons such as scholars and researchers. The participation of represents of patients and inhabitants is regarded indispensable for the implementation of public health policy. The 4 March 2002 Law for patient's right and quality of health care system requires the participation of patients for clinical decision. This principle is applied to the public health policy making. This is the notion so called "Democracy for health (démocratie

Table 2 Major causes of deaths in Nord-Pas-de-Calais region (2003)

	Male	Female
Infectious diseases	299	305
of which AIDS	18	2
Noplasm	6413	4251
Endocrine, Nutritional and metabolic diseases	560	890
Mental trouble and psychiatric diseases	515	652
of which alcohol	234	76
Disease of nervous system, eye and ear	625	924
Diseases of circulatory system	4723	5663
Disease of respiratory system	1690	1140
Disease of digestive system	1217	1068
Disease of genito-urinary system	275	351
External causes	1611	1048
of which suicide	646	196
of which trafic accidents	250	62
Others	1077	1560
Total	19005	17852

Source: INSEE

sanitaire)".

The conference has a mission to evaluate the actual situation of health and to formulate the opinion and proposal for PRSP. The members set priorities referring to the regional data and the national priorities of public health that were set by the National Conference of Health (CNS)[Note 2]. In the case of Nord-Pas-de-Calais region, the following six priorities are set for 2000–2006 periods; cancer, cardio-vascular diseases, high-risk behavior (unsafe sex, drunk driving, drug abuse, suicide, etc), health of youth and children, environmental health, and access for health and prevention facilities. These priorities were set based on the epidemiological and demographic data offered by Regional Observatory of Health (health information agency), DRASS, DDASS, INSEE and other resources such as "Baromètre Santé"[Note 3].

For each priority target, several sub-objectives are formulated. For example, in the case of cardio-vascular diseases, the following 6 sub-objectives are listed up; to facilitate regular physical activities, to facilitate balanced alimentation, to facilitate awareness of person with at least one risk factor, to ameliorate follow-up of person with risk factors (esp. Diabetes mellitus), to ameliorate the emergency medical services, and to facilitate rehabilitation care and services.

The PRSP is transferred to the Regional Committee of Health Policy (CRPS) and the Regional Public Health Group (GRSP). The CRPS composes of the members from local branches of state government (DDASS, DRASS), insurance funds, Regional Hospital Agency (ARH), local governments, regional union of private section doctors (URMEL) and other participants for programs. The missions of CRPS are monitoring, coordination and evaluation. Under the CRPS, there are two organizations; the Committee of Regional Health Program Management (CGPRS) and Committee for follow-up (CS). The former has missions to validate the program and to propose the budget for CRPS, and the latter has a mission to monitor the process and performance of individual projects in the field. The GRSP composes of the members from local branches of state government (DDASS, DRASS), insurance funds, Regional Hospital Agency (ARH), Institute of Health Surveillance (INVS), National Institute of Health Education and Promotion (INPES), and local governments. The GRSP evaluates each priority and to decide the amount of budget. The regional prefect acts as the president of both organizations.

For each year, the GRSP publishes the list of programs and invites the candidates for implementing each program in the field. The candidate organizations submit their proposal plan to CRPS. The CGPRS evaluates each submitted plan according the pre-fixed criteria and if a plan is evaluated as "suitable

for realization of PRSP" and "feasible and effective", the GRSP contracts with the candidate. The process and performance of PRSP is continuously monitored by the Committee for Follow-up. If a particular program is evaluated as inadequate for performance and/or violating the contract, CRPS can order the modification of program and/or suspend the program.

One of the characteristics of this program is that a variety of organizations are participating to PRSP. The most important participating organization is the NPO so called "association"[Note 4]. In the case of PRSP of Nord-Pas-de-Calais, sixty-two percent of the participating organizations are associations in 2007. They are playing an important role to promote health education and sportive activities in schools and communities.

The budget for PRSP was 15,351,798 euros for 2007, of which 52% came from central government, 20% from the health insurance funds and 18% from the general councils[10].

❖ Discussion

Is the French PRSP useful for solving the health problems that France faces? Although each CRPS has conducted a series of evaluation for each program of PRSP and presented relatively positive results, most of these results still remain qualitative, not quantitative. Up to now there are few evidences whether RPSPs have ameliorated the general health status of the French. For example, "Baromètre Santé" clarified that inequality of health is still large among the regions and social classes[12]. Compared with clinical settings, it is rather difficult to correctly measure the impact of health promotion and prevention programs on monetary basis. However, until there are convincing ways of evaluating health promotion interventions that satisfy the needs of managers, clinicians, health promoters and citizens, the full potential of health promotion will not be recognized.

In fact, the reduction of budget for public health programs has been under discussion within the French assembly. As the new President Mr. Sarközy is a big supporter for market-oriented economy and small administration, it is very possible that the current government will reduce the finance for public health. This situation is more or less similar in other developed countries under the current world economic situation. Even though a set of practical indicators to measure the effect of public health policy are established, it will require a relatively long time span before being able to obtain any results confirming the usefulness of health promotion. Thus, we, public health researchers are required to establish a clear philosophy and concept in order to integrate the health promotion into a community movement.

In this section, the author would like to analyze the meaning and validity of PRSP from the two concepts; new public health movement and decentralization.

PRSP and decentralization

Today, decentralization is a central tenet of health sector reform in many developed countries[13]. There is widespread disillusion with large, centralized and bureaucratic policy implementation as it is often inefficient and does not meet to local needs. Decentralization is expected to stimulate improvements in service delivery, to secure better allocation of resources according to needs, to involve the community in decision about priorities, and facilitate the reduction of inequalities in health. Rapid advances in information systems, such as internet, have helped to increase the technical feasibility of decentralization. As shown in the previous sections, the PRSP program has been developed under the decentralization policy.

Decentralization can be defined as the transfer of authority in public planning, management and decision making from national level to sub-national level. Borgenhammer explained four main types of decentralization; deconcentration (administrative decentralization), devolution (political decentralization), delegation and privatization[14]. Deconcentration is the redistribution of administrative responsibilities within the existing structure of central government. A typical form is to hand over administrative responsibilities to local offices of central government ministries. In the case of devolution, central governments transfer certain functions to new independent administrative organizations outside their direct control. The Swedish county council is a typical example of devolution. In delegation, a local authority is transferred the ability to plan and implement decisions without direct supervision by central government. Privatization is the ultimate form of decentralization. In this case, it is intended to replace direct public authority over decision making with privately capitalized organizations.

Apparently, the PRPS project is categorized into deconcentration. Even though most of the service providers are local organizations and the inter-hierarchical organizations such as CRS, CRPS and GRSP, are responsible for the program, the core parts of planning and management are handled by the State organization, especially by DRASS. This explains why France could advance a decentralized program; PRSP, even though they have a very complex center-local administration relationship.

As explained earlier, in France there are three basic localities; region, department and commune. There is no formal hierarchy among them. The largest local authorities, regions do not exercise leadership over other local authorities. That is, the French public health policy is managed by plural actors with overlapping responsibilities at several levels. Complex actor systems often produce the ambiguity of responsibilities. Sometimes this situation causes a severe opposition between region, departments and communes in the same territory. In order to avoid such rivalry, DRASS plays a pivotal role for coordination among the different actors.

The author evaluates that the French PRSP programs has been succeeding on the whole as a decentralization policy. Successful decentralization needs a specific social and cultural environment. As key success factors, Borgenhammer has identified the following requirements: sufficient local administrative and managerial capacity; ideological certainty in implementation of tasks; and readiness to accept several interpretations of one problem[14]. Especially the author thinks that sufficient local administrative and managerial capacity is important. In DRASS and DDASS, there are Public Health Inspectors (MISP) and Social and Health Affaires Inspectors (IASS) working. They received a series of intensive and integrated training of public health policy at the French National School of Public Health at Rennes. In the case of PRSP, these health professionals are playing a very important role for planning, implementation and especially coordination.

Decentralization can have negative effects, including fragmented services, weakening of central health departments, inequity and political manipulation in favor of particular interests and stakeholders of local territories. This situation might weaken the status and position of the public sector as its needs are often under-evaluated compared with other public sectors. In order to avoid these negative effects, the following areas are recommended to be kept by the authority of central governments for decision making[13];

- the basic framework for health policy
- strategic decisions on the development of health resources
- regulations concerning public safety
- monitoring, assessment and analysis of the health of the population and health care provision

In France, these points have been carefully integrated into the decentralization process. As mentioned earlier, the French decentralization is not devolution nor delegation, it is deconcentration. The central government always keeps its power of control over the territory thorough their local branches; DRASS and DDASS. Cole described that the hypothesis of steering at a distance explains well the motivations of key central state actors for the recent development of decentralization in France[15]. The French government keeps its top-down administrative traditions, whereby the state relies on local authorities and other partners to finance and implement policy programs. Furthermore, administrative decentralization can produce beneficial fiscal and functional effects, and improve public policies. And more interestingly, the central government can shift blame for their local health policy to local authorities. In this way, it seems that the French government has been implementing the decentralization process by carefully avoiding its negative effects.

PRSP as a new public health movement

Increasing awareness of the complexity of the determinants of health has led to a new approach to health promotion, based on a multifactorial concept of health. The Lalonde report introduced the "health field" concept, in which health is viewed as a product of lifestyle, environment, human biology and health care[16]. This approach became the basis of the European health for all strategy. This set out five action areas:

- building healthy public policy
- creating supportive environments
- strengthen community action
- developing personal skills
- reorientating health services

These principles reinforce the role of public health in enabling individuals and communities to

increase control over the determinants of health. The need for intersectoral action is a central theme of this approach. As factors such as poverty, nutrition, and tobacco consumption are some of the major determinants of diseases, a wide range of agencies must be involved in order to ameliorate the health status of target populations. These include central and local government, nongovernmental organizations and community groups, as well as private organizations.

One of the best known examples of this intersectoral approach is the WHO Healthy cities project, which includes more than 1300 cities and towns from 30 European countries, today[17]. Areas of action include health promotion, ecological management, social support for vulnerable groups, and program addressing equity, community empowerment and integrated planning for health.

Another important mile stone health program was the North Karelia Project, which addressed the high level heart disease in Finland, have been shown to be effective in bringing about change in behavior and thereby improving health[18]. Apparently, the French PRSP program is following to these health policies in the European countries.

All these activities can be interpreted by the concept of new public health movement. Frenk explained the new public movement as follows; "The new public health addresses the systematic efforts to identify health needs and to organize comprehensive health services with a well-defined population base. It thus includes the process of information required for characterizing the conditions of the population and the mobilization of resources necessary for responding to such conditions. In this regard, the essence of public health is the health of the public. Therefore it includes the organization of personnel and facilities for providing all the health services required for health promotion, disease prevention, diagnosis and treatment of illnesses, and physical, social, and vocational rehabilitation"[19].

The French PRSP program is constructed on this concept. In PRSP, local health authorities, such as CRS, CRPS and GRSP, are responsible for assessing the health needs of their population, deciding priorities for meeting those needs, placing contracts accordingly, evaluating the performance of those contracts and taking other action to promote health and prevent diseases. Along with the process of decentralization, local networks have become broader to develop voluntary associations and public-private partnerships (mixed economy societies)[20]. As mixed economy societies are subject to civil, rather than to administrative law, they are much more flexible than local authorities themselves. Therefore they can respond to local needs in a more fine-tuned way. Furthermore, mixed economy societies have facilitated the introduction of private sector management techniques, such as process management, value engineering and PDCA cycle approaches. The new public health movement is giving a dynamics into the French local health policy.

Although there have been few literatures that quantitatively clarified the effectiveness of PRSP, it is sure that PRSP will offer an important basis for the development of evidence based health policy in France. It has improved the transparency and accountability of health authorities. The French experiences will be suggestive for other developed countries with similar socio-political climates.

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❖ Notes

1. SMR

The reference is the value of all France (=100). The indices were calculated based on data from 1988 to 1990.

2. National priorities of public health policy for the 2004–2008 period in France

The five strategic priorities for the 2004–2008 period set by CNS are "Cancer", "Health and the environment", "Rare diseases (including the Alzheimer diseases)", "Violence, abuse, risk behavior and addictive behavior" and "Chronic illnesses and quality of life".

3. Baromètre Santé (Health Barometer)

Since 1992 the French Committee for Health Education (CFES) has been conducting a series of health survey, so called "Baromètre Santé". This survey gathers the information about the French people's attitudes, behavior, knowledge and opinions in the field of health. The survey covers four populations; adults (18–75 years old), youth (12–19 years old), general practitioners and pharmacists. The survey is organized closely linked with public health programs, such as health education and promotion campaign: drinking, smoking, drug taking, vaccination, use of medicines, accidents, cancer screening, nutrition, physical exercise, etc. The results of these surveys give the public health policy makers information on trends in the population's health behavior and make it possible for them to refine the objectives of national prevention programs, to direct specific quantitative and qualitative studies and to target grass-roots health education and preventive activities more appropriate for specific groups and regions.

4. Association

The association is a group for the same purpose of with at least two persons. The association can sell their products and services but must be not for profit. The origin of French association is very old. This type of group was permitted by the 16 August 1901 Law for association and the Declaration of Human Right in 1948 clarified the freedom of association in its article 20.

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