OVERVIEW
Population: 65 million (31.5 million men, 33.5 million women)
> 20 years: 16 million
< 65 years: 11 million
827,000 births in 2011
555,000 deaths in 2011
Life expectancy: 78 years (men), 84 years (women)
GDP: estimated at 0.6 per cent in 2012 versus 1.7 per cent in 2011, (+1.4 per cent in 2010; -2.7 per cent in 2009)
GNI per capita: $44,000
Health expenses per capita: $4,629
Health expenses as per cent of total GDP: 11.2 per cent
• €2,717 ($3,449): is the average consumption of healthcare per person per year (2009); it is increasing
• €665 ($820): is the average consumption of drugs per person per year (2011); it is increasing
Capital: Paris
Head of State: President François Hollande
Health Minister: Marisol Touraine
Language: French
Currency: Euro (€)

EXECUTIVE SUMMARY
• France, with the second largest population in Europe (behind Germany), has a unique social protection system that covers the majority of healthcare expenses (75.5 per cent), which represent 35 per cent of French social expenses, after retirement/survival expenses

• The pharmaceutical industry business model in France is mainly based on developing and marketing drugs that are reimbursed by social security (72 per cent of their income), and are distributed by 22,000 pharmacies or sold to 3,000 hospitals and clinics

• For the past four years the global economic downturn, patent expiration, the euro crisis, the Médiator drug scandal, the PIP (breast implant) crisis and the recent generic drugs crisis has profoundly impacted this model in France. This environment is increasing the rigidity of the French pharmaceutical regulatory system, which is already among the strictest in the world

• The pharmaceutical industry is therefore seeking other areas of significant growth, such as exports, emerging markets, partnerships in research, biotechnology and life sciences and personalised medicine, in order to maintain its high value to the French economy.
INTRODUCTION
As the European debt crisis unfolds, France, like Spain and Italy, is being pressed to balance its finances and help cut the deficit back to 3 per cent in 2013.

Deficit spending amounted to €90.72bn, or 4.55 per cent of GDP for 2011, (a €14bn improvement over 2010) and is expected to drop to 4.4 per cent this year. France has been hard hit by a trade imbalance, a loss of competitiveness and rising unemployment. France’s share of the global export market fell by 19.4 per cent between 2005 and 2010, contributing to an unemployment rate of 10 per cent, with the young French being the hardest hit – 1 out of 4 young people are without a job.

French economic growth in the first quarter of 2012 was flat according to the National Institute of Statistics and Economic Studies (INSEE), while the European Commission has estimated a growth rate of 0.5 per cent for the year.

Meanwhile, France is the world’s biggest spender on social programmes: 30.8 per cent of GDP versus 26 per cent for the rest of Europe and 17 per cent for the member states of the Organisation of Economic Co-Operation and Development (OECD). Social expenses are divided between retirement/survival at 45.6 per cent of the total budget, health care/social security at 35 per cent, maternity/family payments at 9 per cent and employment at 6 per cent. In 2010, social security funded 75.8 per cent of the Consumption of Medical Care and Goods, 13.5 per cent was covered by supplementary programmes such as mutual insurance firms and pension funds, while the balance was covered by individuals and households.

“France is the world’s biggest spender on social programmes:
30.8 per cent of GDP versus 26 per cent in the rest of Europe and 17 per cent among OECD nations”

With expenses of €455.8bn, the social security budget is higher than the State budget which is about €365bn. Of this total, the general social security scheme (private employees) amounts to €330bn, with a deficit projected by the government of €13.8bn in 2012.

Marisol Touraine, the new Minister of Social and Health Affairs, has been charged with improving France’s social accounts while preserving the national model of social protection. The focus is expected to be on health and pensions, with current expenses paid through additional borrowing.

French President François Hollande supports limiting the rise in health spending to 3 per cent per year, compared to 2.5 per cent advocated by the former President Nicolas Sarkozy.

HEALTHCARE IN FRANCE
France’s healthcare system has long been seen as the gold standard in Europe. Over the past 30 years, French women have added 6.5 years to their life expectancy and men have added 8.

French women now enjoy one of the highest life expectancies in Europe and out of a total French population of 65 million, more than 11 million are over the age of 65.

But good health costs money and the weight of health expenses in GDP is the highest in Europe, 11.2 per cent in 2008, followed by Germany and Austria at 10.5 per cent and Belgium at 10.2 per cent. However, it ranks sixth for health expenses per capita because the consumer is not the payer and the majority of health expenses are covered by social security which sets reimbursement rates and keeps costs down.

Medication consumption has not been ‘consistent with the country’s performance in terms of morbidity and mortality’. That is, consumption of drugs has not kept pace with life expectancy. Since 1975 there has been an irregular increase in pharmaceutical consumption: +4.3 per cent/year on average between 1980 and 1985; + 2.4 per cent/year between 1985 and 1990, but only +1.7 per cent between 1990 and 1995. In 2006, medication consumption fell 3 per cent.

Nevertheless, France still holds the record in both quantity of drugs purchased and costs per capita. The result is high prices, a lower (even declining) proportion of generic drug prescriptions compared to other countries, and a high number of people with long-term illnesses who need expensive and innovative treatments and extended treatment periods.

Reimbursable medicines represent the largest share of total consumption. Non-prescription and, therefore, non-reimbursable drugs are rather less developed in France than in other European countries, as explained by French pharmacists and politician Catherine Lemorton in her 2008 report La prescription, la consommation et la fiscalité de médicaments.

Spending control plans
In addition to controlling drug prices, the government continues to draft plans to control health spending, especially on drugs, by using different levers that include:

Demand management of drugs
This is used to curb consumption by placing a heavier burden of costs on the consumer or private insurance to reduce demand. There are also continuing efforts to delist drugs.

Since the 1970s, the government has implemented various plans to rescue social security by delisting classes of drugs, such as homeopathic medicines or antihistamines, as well as those drugs with an insufficient medical benefit (IMB). The government is now trying to encourage self-medication which may in some cases replace reimbursable drugs.

Supply management
The policy implemented in the 1990s between the government and the pharmaceutical industry aimed to involve professionals in managing their spending. Since a framework agreement was signed in 1999, a target rate of increase in pharma revenues has been set each year as part of the social security financing law. If this agreed-upon rate is exceeded, the industry is liable for the payment of rebates to the health insurance system.

Generic drugs were introduced in France in the mid-1990s to promote price competition. In 1997–98, GPs were encouraged for the first time to prescribe generics, although still given the option to prescribe branded products.

Doctors agreed to prescribe less expensive drugs for at least 15 per cent of their total drug prescriptions, including 5 per cent in generic drugs. Community pharmacists were allowed to substitute specialty generics for specialty reference drugs prescribed by the doctor. There were financial incentives for the pharmacists making such substitutions since profit margins on generics are greater than margins on branded drugs.

Following the 2002 Finance Act, doctors could write prescriptions using the name of the molecule, also known as the international non-proprietary prescription name (INN). Despite steady growth in this market – from 4.1 per cent in 2002 to 12 per cent in 2009 – the French still consume fewer generics than their European neighbours, according to a health insurance study in May 2011.
Good medical practice
Medical control of health spending is intended to promote best practice by preventing doctors prescribing, or patients demanding, high-cost drugs when lower cost equivalents are available.

Originally put into effect in 1993, the good medical practice established to prevent unnecessary prescriptions was extended in 2000 under the Social Security Financing Act and companion agreements on the appropriate use of care (AAUC). Individual physicians are expected to adhere to a best practices agreement.

In France advertising prescription drugs to the general public is illegal. Advertising is authorised subject to the issuance of an a priori General Public Visa for some OTC medicines.

CRISES & REFORM IN 2011
In 2011, France lost confidence in the pharma industry following the Mediator scandal at Servier Laboratories. In that case, the privately held pharmaceutical company found itself at the centre of France’s largest public health scandal in a decade, with health officials saying as many as 2,000 people died and others were hospitalised with cardiac valve damage and hypertension linked to the diabetes drug that had been used off-label for weight loss.

The French regulatory authorities also were the subject of public and media criticism.

Then, at the beginning of 2012, the PIP (breast implants) scandal again shook the confidence of the French public in both industry and government regulation.

Law no. 2011-2012
As a direct result of the Mediator scandal, Law no.2011-2012 of December 29, 2011 was published in the Official Journal to balance health safety and therapeutic advances, while ensuring that the decisions and interests of health authorities are transparent (source: www.irdes.fr, April 2012). The strengthened Safety of Medicines and Health Products Act provided greater clarity to off-label use which was not previously subject to rigorous legal restrictions.

The key measures of the Act include:
Redefinition of the Temporary Use Authorisation (ATU) plan
The ATU provides an exception to the law to allow early access to new treatments when there is a real public health need and the treatment has not yet received market entry authorisation in France (MEA). ATUs, in effect since 1994, cover cancer and neurological and infectious diseases, including AIDS.

• ATUs are granted as an exceptional and temporary measure when certain conditions are met: serious or rare illness; no therapeutic alternative; drug benefit/risk ratio is presumed positive
• Prescribing using an ATU is supervised by a doctor on a named patient basis
• The Act specifies the conditions a laboratory must adhere to in order to be granted nominative ATUs by the National Agency for the Safety of Medicinal and Healthcare Products (ANSM) previously known as the French Agency for the Safety of Health Products (AFSSAPS). It stipulates that clinical trials should not be delayed if an ATU is awarded. The Act is also related to an MEA or cohort ATU, which concerns medicinal products strongly presumed to be effective and to have an acceptable safety profile and having reached an advanced stage of development, for example with a marketing authorisation dossier being compiled or registered, and protocols created for monitoring patients.

Supervision of outside MEA (off-label) prescriptions
Off-label prescribing is a widespread practice in France. It must be carried out by a prescribing doctor and be documented in the patient’s medical records to ensure traceability. The strengthened Safety of Medicines and Health Products Act has given clear guidance on off-label prescribing. In the absence of a suitable alternative medication, the Act stipulates that:

• the indication or conditions of use are subject to a temporary recommendation of use established by the ANSM
• the prescriber believes use of this specialty medicine is essential
• the doctor is obliged to tell the patient that prescribing the specialty medication does not comply with its MEA and that there is no suitable alternative medication. The prescription must be marked as ‘prescription outside market entry authorisation’.

The Act also includes the support or reimbursement conditions for medications prescribed off-label.

Prescription in international non-proprietary name (INN)
Prescribers are required to prescribe using INN but few do because they still have the option of using the brand name. According to French mutual insurers, La Fédération nationale de la mutualité française (FNMF), in mid-2010, just 12.4 per cent of drugs prescribed in France were prescribed using the INN. Widespread use of prescription assistance software, due to come into effect no later than January 1, 2015, is expected to boost current low levels of INN prescribing.

“The strengthened Safety of Medicines and Health Products Act has given greater clarity to off-label prescribing, which was not previously subject to rigorous legal restrictions”

Strengthening pharmacovigilance
The Act also implements the recent European directive designed to strengthen pharmacovigilance and clarify the roles of stakeholders. It includes patients and patient associations and strengthens reporting obligations for healthcare professionals. Moreover, pharmacists are now required to report all suspected adverse reactions of which they become aware.

The launch of the national pharmacovigilance system introduced as part of the Hospitals, Patients, Health and Territories (HPHT) Act follows several pilots conducted by ANSM over the past 10 years, in collaboration with associations.

The sanctioning powers of the ANSM have been considerably strengthened in case of breach of obligations. ANSM will be able to require the MEA holder to conduct post-authorisation studies on the safety and efficacy of the product.

Following a breach of MEA, the regulator can demand justifications and corrective measures from the MEA holder. The holder has the right to defend itself through a written appeals procedure. If the holder does not remedy the breach and the regulator still believes it is not complying, ANSM has the power to suspend the MEA for up to a year or withdraw authorisation altogether.

Tighter control of advertising and user information
Before the Act, advertising to HCPs was controlled a posteriori (after it was distributed) by AFSSAPS. In accordance with the Code of Public Health (CPH), pharmaceutical companies had to file any promotional material with the agency within eight days after it was distributed. Now, under the new Act, this material must be distributed beforehand, a priori.
In France, the head pharmacist within a pharma company is responsible for advertising. He ensures that the CPH is followed within the company and he decides who validates all the promotional elements and allows or disallows their use with HCPs. Very few advertisements were banned by AFSSAPS (less than 10 annually).

The law on advertising of medical devices – defined as ‘any form of information, including canvassing, prospecting, or inducement designed to promote the prescription, supply, sale or use of these devices, with the exception of information provided by pharmacists as part of their duties in managing a pharmacy for internal use [...]’ – is the same as that governing advertising of prescription medicines.

Previously, medical device advertising had not been subject to review. The new law introduces an priori review of advertising for products posing a significant risk to human health. The advertising of certain in vitro diagnostic medical devices ‘whose failure would cause a serious risk to health’, is also subject to draft authorisation by the ANSM. Medical devices that are either totally or partially supported by health insurance cannot be advertised to the general public.

“A pilot scheme is currently underway (and will last at least two years) in which reps promoting certain new products to HCPs working in secondary care must do so in a group setting. The group medical visit, which applies only to health facilities, does not include drugs used only in hospital, those initially prescribed in hospital or devices.

The government plans to present a report on January 1, 2013, on the findings of the pilot programme and discuss developments with Parliament, including expanding the law to become general practice.

The Safety of Medicines and Health Products Act introduced draft authorisation, known as an ‘advertising visa’, similar to the regulations that govern advertisements to the public. The French market is now transitioning from posteriori to priori verification.

The Act also includes provision for an outright ban on advertising following a negative re-evaluation of a medicine’s risk/benefit ratio and as a resulting pharmacovigilance alert.

Non-institutional advertising campaigns to the public for vaccines are allowed only if their content is consistent with the opinion of the High Council of Public Health. Such campaigns must also include clearly identified references defined by this authority.

Anti-gift provisions: greater transparency

Since the introduction in 1993 of Act No. 93-121 of January 27, giving financial or in-kind benefits to HCPs, such as trips, tickets, invitations, have been subject to sanctions.

These sanctions, which applied previously only to HCPs, were extended through Act No. 2002-303 of March 4, 2002, to apply also to businesses offering prohibited benefits and gifts. It prevents benefits from being given to institutional health policy players, such as experts and scientific or technical collaborators with agencies.

The new Act expands the list of people who should not be given or receive gifts and introduces new measures to increase transparency among healthcare stakeholders, including students.

It also requires that health sector businesses be transparent about relationships with HCPs, students, professional associations, patient associations, foundations, health institutions, as well as media editors, publishers of prescribing and dispensing assistance software, and legal personnel who provide or are involved in the initial training of healthcare professionals. These companies are required to disclose the benefits they provide to professional stakeholders.

Prevention and transparency to deter conflicts of interest

One of the major objectives of the Act is to reassure the public that HCPs, experts performing assessments and health authorities are operating in a transparent and objective manner. Hence, the Act contains the following:

1. The requirement for a public statement of interest

Those subject to this portion of the Act may only take part in the proceedings relevant to them. People with a vested interest, direct or indirect, in the case being considered may not participate in deciding outcomes.

The public statement of interest, submitted to the relevant authority, discloses interests of any nature – either directly or through intermediaries – that exist or have existed with companies in the health sector during the five years prior to someone taking office.

2. Parliamentary hearings for presidents, managers and general managers of health agencies prior to appointment

This measure is particularly relevant to managers of the ANSM, National Agency for the Health Safety of Food, the Environment, and Labour (NAHSEF) agency, the National Health Monitoring Institute (NHMI), the National Cancer Institute (NCI) or the National Institute for Prevention and Education for Health (NIPEH).
3. Specific rules for publishing proceedings from expert panels
Proceedings from debates and expert panels are recorded and stored, and the minutes are published online for public view. The Act also sets out how to define the principles of medical expertise and the establishment of a charter.

New governance of health products: ANSM
The French Agency for the Safety of Health Products (AFSSAPS) has been replaced by the National Agency for the Safety of Medicinal and Healthcare Products (ANSM). The responsibilities and powers of the new agency are notably more far reaching than its predecessor.

With new administrative and financial sanctioning powers, the ANSM will assess the benefits and risks of health products, monitor these risks throughout the product life cycle, and conduct regular reassessments. It also may request that clinical trials be carried out against active comparators rather than against a placebo.

The Act gives the ANSM two new missions:
1. Scientific and technical support for the development and implementation of public health plans.
2. The ability to coordinate and, where appropriate, carry out, in particular through agreements, follow-up patient studies and data collection on efficacy and tolerance.

For public health reasons, ANSM can access the data held within the Pharmaceutical Record (PR). Similarly, it may demand, from a legal representative or entity, access to information necessary to perform its duties without the need to invoke professional, medical, industrial or commercial confidentiality.

The ANSM can halt the prescribing and dispensing of a specialty medication, and withdraw it from the market.

PHARMACEUTICAL MARKET
France is the second largest drug market in Europe after Germany with annual sales topping €36bn.

Pharma remains a crucial sector for the economy and the fourth most important contributor to the nation’s trade surplus. It is second in R&D investment, with a combined budget of around €3bn per year. According to the industry association, Les Entreprises du Médicament (LEEM), the market lost momentum in 2010, achieving growth of just +0.7 per cent over 2009, or €27.3bn in revenue. Domestic growth was a slim 1 per cent. Almost €20bn came from reimbursable medicines.

After enjoying 5 per cent growth for a decade, drug revenues fell 1 per cent in 2011, and revenue is forecast to stay flat in the short term. The stunted growth of the domestic market is explained by measures to control healthcare expenditure, such as a drop in prices, policies to promote generics, changes in the evaluation criteria by the Transparency Commission and changes in hospital prescriptions management.

Analysis from IHS Global Insight shows that growth was driven by ‘a very healthy hospital market’, where drug spending was up by 4.2 per cent. This part of the market has been much more dynamic, but tighter regulation and efficiency-driven restructuring are expected to impact this market as well. French pharma companies went abroad to find growth, with exports, primarily to Europe, rising to €24.1bn in 2010, a growth rate of 4.5 per cent.

The reimbursable drug market grew a mere 0.3 per cent in 2010. Price cuts of about €670m are planned for 2012, while reimbursement cuts will affect 64 drugs, IHS Global Insight said.

LEEM described the budget cuts and added levies on the industry as ‘unfair, incomprehensible and short-term measures’.

Market dominance
The majority of drug research, development and production in France is carried out by the top five French players: Sanofi, Servier, Ipsen, Pierre Fabre and LFB. Collectively, they represent more than 45 per cent of employment in the sector, almost 60 per cent of R&D investment and more than half of those employees engaged in research.

Outside of the top five, France has a network of innovative companies operating across the drug value chain, in research, development, production and marketing.

Sanofi continues to dominate the French market, accounting for 13 per cent of pharmaceutical sales in 2009. Other big firms, such as Novartis, Roche, GlaxoSmithKline and Pfizer each had market share below 6 per cent.

The French pharma giant remains in fourth place worldwide, with revenue of €30.4bn in 2010. Vaccines, generics and consumer health are its strongest units and make up a crucial part of its diversification strategy. According to the company’s projections, about 40 per cent of its profits by 2015 could come from ‘pharmerging’ markets as conditions worsen in Europe and the US.

In 2010, for the third consecutive year, the pharma sector saw work-force levels drop. Employment fell an estimated 1.8 per cent, a loss of 1,959 jobs, attributed to restructuring in the sector and a difficult economic climate. By comparison, according to Unédic, employment in all French industrial sectors fell by 5.16 per cent during 2009.

**BREAKDOWN OF SALES IN FRANCE + EXPORTS IN 2010**

**MEDICAL AND PHARMACEUTICAL RESEARCH EXPENDITURES**

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<th>2009</th>
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<th>2010/2009 (in %)</th>
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<td>Civil research and development budget</td>
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<td>Total expenditures</td>
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Source: Drees
### EVOLUTION OF THE GENERICS MARKET

<table>
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<th>Year</th>
<th>Generics Directory in % of the reimbursable market</th>
<th>% Generics in Generics Directory</th>
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<tr>
<td></td>
<td>In value</td>
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<td>2010</td>
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Source: IMS Health, LMPSO

### PRICING AND REIMBURSEMENT

The French pricing system, controlled by CEPS, the pricing committee, aims to be fair and reward R&D. European reference pricing is in place, so negotiations between the committee and the industry focus on volumes and conditions.

Pricing is mainly determined by clinical benefit or added value of a medicine, prices of similar products, European prices, sales forecasts and size of the target market. Over-the-counter (OTC) products and some hospital drugs face no restrictions on pricing.

There is also a system of industry paybacks, where companies are ‘taxed’ on sales growth that exceeds a set target. Some exemptions are allowed for generics, orphan drugs and medicines with high clinical benefit. But even in these cases, the exemptions are for agreed-upon periods of time period.

Prices have remained low in France compared to other European nations (14 per cent lower than the EU average) due to state control. For example, the VAT for prescribed medicines is only 2.1 per cent, compared to 19 per cent in Germany, according to EU and European Federation of Pharmaceutical Industries and Association figures.

The Transparency Committee of the High Authority for Health (HAH) decides if a drug is eligible for reimbursement based upon medical benefit rendered (MBR). It evaluates the improvement in the medical benefit rendered (IMBR) by comparing it to available treatments.

Prices are set by the Economic Committee of Health Products (ECHP). Before 2007, hospital drug prices were set independently. With the introduction in 2007 of the Hospital Plan, prices were regulated for innovative and expensive drugs, as well as for drugs dispensed in hospitals for outpatients.

After two years of zero growth, the French market for reimbursable drugs is expected to decline in 2012 for the first time when savings measures taken by the government begin to be felt, according to IMS Health, which is predicting a 2 per cent decrease in value. The impact of efforts to reduce health spending will be felt until 2015.

Market access is still slow, even though ATU allows for the launch of innovative, life-saving drugs in hospitals before registration and at no cost to the drug developer. This applies to oncology drugs under France’s national cancer care plan that includes fast access to new therapies.

The therapeutic benefits of all medicines are subject to evaluation (Service Médical Rendu) by the Transparency Committee, after which reimbursement status can be applied so that patients can access innovative medicines. To keep costs down, products considered of low or moderate value may see their reimbursement rate cut or may even be removed from the list.

Approved medicines remain listed for five years before they are once again evaluated, including a price review.

Drugs are covered at an average rate of 65 per cent, although expensive, innovative and unique drugs may be covered at up to 100 per cent while those considered of limited medical benefit may only be covered at 15 per cent. An IRDES study found that 24 per cent of drugs remained reimbursable at the 15 per cent level between 2005 and 2010. Nevertheless, the study reported pharmaceutical expenditure grew 12.3 per cent over the same five years.

In 2010, the reimbursement rate for 150 medicines fell to 15 per cent; in 2011 hundreds of drugs considered of lesser value were delisted and price cuts on drugs amounted to €500m, while reimbursement levels dropped to align France with other EU countries.

### GENERICS IN 2010

In 2010, generics accounted for €4.5bn in sales, or 23 per cent
of the reimbursable market (£1.9bn for originator medicines and £2.6bn for generics: up 3 per cent).

In 2008, the rules for managing generic drug prices changed: the price of new generics was set at -55 per cent of the price of the originator medicine (compared to -50 per cent previously) while at the same time, prices for originator medicines were lowered.

Pay-for-performance contracts, set up by the government in 2009, have been changing the generics market. Physicians have the option of committing to quantified targets for prescribing drugs that have lost their patent (these are substituted by the pharmacist) and the doctors receive compensation in return.

Generic drugs have resulted in significant savings over the last decade, €1.8bn in 2010 alone, according to the European Association of Magistrates for Mediation. Today, nearly one in four medicines dispensed is a generic. More savings are on the horizon with the expansion of pay-for-performance contracts and the entry into the public domain of many more molecules. These two forces, and others, are expected to support the generics market through 2016–2017.

IMPROVING THE RESEARCH SYSTEM

With the exception of universities, life sciences research in France is being reorganised, the culmination of a policy shift made in 2004. At that time, the government established ‘competitiveness clusters’ to better position France against global competition. The research and higher education clusters (RHEC) were launched in 2006. The National Strategy for Research and Innovation (NSRI) in strategic thinking was established in 2008–2009. And three global clusters were created in health. Project funding and public-private partnerships were integrated into some parts of the reorganisation.

To support the competitiveness clusters, the government-backed OSEO created a strategic investment fund as part of its mandate to support innovation for projects with real market potential. OSEO guarantees funding provided by banks and equity markets and co-invests alongside banks in projects.

In 2010, OSEO announced the distribution of €330m to support six projects in the pharmaceutical/biotech sector, and pledged an additional €58m. The funding comes at a time when the old R&D model is being profoundly transformed by the emergence of biotech and the traditional business model is in major transition. France has an interest in protecting and encouraging this high-value sector that employs more than 22,000 researchers and provides a major competitive industry for the nation.

France wants to remain a key global player as medicine undergoes the revolution of personalisation in wealthy, industrialised nation as patient care evolves and as the health industry professions converge to provide comprehensive management of diseases.

New diagnostic and treatment approaches are already available to patients, such as cell therapies and functional imaging, and the application of new technologies is revolutionising medical practice and patient care. All these forces have far-reaching implications in disease prevention, regenerative medicine, point-of-care diagnostics and much more.

Many of the most recent reforms (LRU Act, HPST Act, reform of public research) are encouraging. France has the scientific, industrial and medical assets that, if it can adapt, could make it a leading global centre of therapeutic innovation.

The decision to make life sciences a first priority could be a watershed if it is acted upon and followed through. Both the focus on the biopharma sector and the high level of government support are positive trends that bode well for healthcare companies in France.

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