National Consistency: France

1. Class 1 - Demography and socio-economic situation

1.1. Population Status: Our National Institute of Statistics and Economic Studies (INSEE) provides population age groups for 5-year periods from 0 to 84. Number and rates is then a single category for 85 and upwards. This is also available by gender for the same period.

Deaths are available from the National Institute for Medical Research (INSERM) as total number and rates and by ICD code for principal causes of death. Total number of deaths and rates are also available from INSEE. Hospital admissions are recorded by the hospital inpatient enquiry system (OTALIA) and are available by ICD code, age, gender and with a certain amount of DRG data available as well as length of stay. The data are available for national, sub-national and county level from the INSEE and the Ministry of Health (OTALIA).

1.2. Socio-economic factors: There are recent surveys available on the level of education. Social class is routinely available from the census data into the categories required. Ethnicity however, is not well defined. The only information is on the number of people who come from different countries. Their ethnicity is not declared or collected in any systematic way. GDP is available and there is a poverty index available. Much debate about the criteria for definition of poverty (percent of population less than half median) and not good agreement between official and NGO sources.

2. Class 2 - Health Status

2.1. Mortality by cause specific: Deaths are available by ICD codes. Independent rates have been done but are not routinely published. Standardised death rates are available as are age-specific death rates, especially for asthma or COPD. PYLL are not routinely collected or available for any disease in this country.

2.2. Morbidity respiratory system: There are no national agreed prevalence data. Independent surveys by a number of people and organisations have looked at different groups. I coordinate the French ISAAC survey and therefore there is some knowledge of asthma in children. Other investigators have participated to the ECRHS. There are several other selective surveys particularly around asthma and to a less extent COPD. There are no good data available on the severity of asthma in France that I am aware of. Apart from ISAAC and ECRHS which I have mentioned, there are no real widespread surveys of asthma symptoms available, certainly on a national basis or indeed on any structured regional basis. However there is some data available on a regional basis, for example in the Paris area and in the Provence area. The surveys have been performed by "Social Security". They described the distribution of asthmatics according to severity grades and treatment prescribed (and followed) in each category.

As regards prevalence of treatment the French "Social Security" organization could provide national figures on anti-asthmatic drug consumption, because prescriptions are routinely computerized in each administrative area.

3. Class 3 - Determinants of health

3.1. Biological Risk Factors: Data identified on 3.1.1 are not available on a national basis. There is no doubt that obesity is a very serious concern. Genetic susceptibilities can be approached through family history and, in the near future, by ad hoc genetic epidemiology studies.

3.2. Health Behaviours: The importance of tobacco smoking in respiratory disease is such that it is probably necessary for all diseases. Reliable national smoking statistics are not available but many "representative" national pools have been performed over the last years. The importance of second hand smoke on children is undoubted and this information is necessary but is not routinely available. More precise information would be very important; obviously in COPD it is crucial.

3.3. Living and Working Conditions: The role of airways pollutants in asthma is known but its relative importance is unsure. Certainly there is great interest in it and information on this would be valuable but is probably not the main factor in asthma occurrence. The whole question of exposure to damp is an important one but needs a multi-disciplinary team to be fully understood. There are no nationwide data on this issue. Occupational asthma is of great importance and the identification of different occupations not already recognised is important and will only be achieved if there is good data on exposures. On a national basis, the "Observatoire National des Asthmes Professionnels" has been operating since 1995 but its representatives is doubtfull.

4. Class 4 – Health Systems

4.1. Health promotion: Health promotion and respiratory diseases are obviously crucial. Smoking cessation is just becoming organised on a local basis. A list of smoking cessation clinics and the number of smokers visiting them can be known but obviously they are involved in a minority of smoking cessations. There are some numbers available on successes in cessation but to the best of my knowledge, they have not been broken down into success in different respiratory diseases.

4.2. Health Protection: Health protection is obviously very important and important achievements have been experienced in France to protect from tobacco exposure both in terms of restriction of smoking and in particular recent workplace ban where there is no smoking allowed in any workplace. Occupational risk is covered by a compensation board but with the new agents, this is often late by the

time it can be effective. There is great public awareness of the possibility of an adverse effect from air pollution but only point studies have not been done to date and therefore no national data are available.

4.3. Health Care Resources: Few primary health care are available in primary health care centres. General health care system practitioners with an interest in child diseases and paediatricians increasingly form part of the Group Practice Centres but these are not well developed at present. The number of specialised asthma education nurses and indeed with a wider role in asthma is developing rapidly and is available in many of the hospital and some of the large private centres. The number of Respiratory units is a matter of record.

In France, there are University allergy units mostly dedicated to respiratory diseases. The manpower figures are known and mostly published. Hospital clinicians are governed the Ministry of Health which regulates the number and type of posts and they regularly publish the manpower statistics for each specialty including respiratory medicine. There are no good data on the use of management plans or peak flows at home although of course these are used by a number of practitioners. There are no data on the number who have access to allergy testing. Allergy testing is done in many of the Respiratory Units but there are no published data on this. Likewise, the pulmonary function testing activity in all of the individual respiratory labs in the hospitals are of course published internally and are available in reports from these hospitals but are not collected nationally.

The hospital activity statistics are collected by the Ministry of Health (OTALIA) and the number of admissions is known. There is very little known about their treatment or outcomes. Again, the Emergency Room visits are collected and outcome is known there, obviously in terms of whether they went home, what they were given going home and how they were admitted.

Length of stay is known for different diseases. Outpatient care at the primary care level can be known from the "Sécurité Sociale" data on a national or local level. Obviously the outpatient data for the Respiratory Units is known and internally published in each of the hospitals but nothing on a national or regional level or on any individual disease basis.

The use of medicines is collected on a national basis through the national insurance system ("Sécurité Sociale"). The repayment to hospitals is based on diagnostic related groupings (DRGs) Estimates of the total cost of medicines for asthma and COPD are nationally available through the " Sécurité Sociale". There is little information on subjective indicators of health in asthma or COPD. Again outcome measurement is very poor and apart from individual surveys, there are no national data available.