Relative and Global Health: A Comparative Study between Healthcare Systems of Jordan and France

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Abstract

Objective: This relative study includes categorical exploration of the economics, demographic, political, social and financial data to realize the basic reasons of the present healthcare systems in these countries.

Methods: Descriptive and comparative methods were used. This study tries to relate the healthcare systems of Jordan with that of France to produce effective lessons that can be helpful for guiding future developments down the correct path.

Results: Depending on many factors such as life expectancy, the mortality rate in infants, universal medical coverage and availability of healthcare services to the masses, significant disparities between the two systems were found.

Conclusion: Through this study, it has been concluded that the healthcare system of Jordan has a lot to improve with regard to standards of services offered, and there are many aspects to be learned from the French healthcare system by the Jordanian one, including the healthcare coverage system and the cost-sharing strategies.

Introduction

The World Health Organization (WHO) defines health from a very broad perspective. According to the WHO, health indicates a condition of total well-being including physical, mental and social aspects (WHO 1993). Health, therefore, is not only about the healthcare system but also includes issues like housing, heredity and nutrition. At present, France is one of the most developed nations and is often considered a leader amongst the European countries. The healthcare system of France was ranked first by the WHO in 2000 mainly due to its global approach, promptness and liberties of the patients, as well as of the healthcare providers (WHO 2011).

Socio-Cultural, Economic And Political Circumstances

Lasting social and economic changes occurred in France from 1914, the period covering the second and third republics (Sciolino 2006). However, modernism in social systems that include healthcare took place in the fourth and fifth republics spanning from 1944 to date (Sciolino 2006). France made radical changes to the social and economic systems at the time of the fifth republic as a colonial master in both Asia and Africa, including healthcare as part of the foreign policy of assimilation of colonies annexed as "the other France" rather than as French territories (Sciolino 2006). Although France was amongst the winners in the World Wars I and II, the state suffered extreme damages regarding affluence and manpower reducing its positioning as a steady state both socially and economically (Segouin et al. 2007).

In 1993, France participated in the establishment of the European Union to become a resilient political authority (Stuckler et al. 2010). Table 1 shows the total population of France including a majority of Roman Catholics (63–66%) (Frenk 2010) and other religions such as Islam (7–9%), Protestants (2%), Jewish (0.5–0.75%) and unaffiliated (23–28%) (Frenk 2010). From 1992, French is the only official language of the country (Frenk 2010). Therefore, except the autonomous microstates, France is the only nation in Western Europe with one official language (Frenk 2010).

Table 1. Demographical features of Jordan and France (2014 est. except where indicated)

Demographical data	Jordan	France
Population	7,930,491	62,814,233
Age structure		
0–14 years of age	35.8%	18.7%
Male	1,457,174	6,337,877
Female	1,385,604	6,053,185
15–64 years of age	60.3%	63%
Male	2,408,340	20,881,936
Female	2,371,803	20,846,888
65 years of age and over	3.9%	18.3%
Male	145,515	5,197,519
Female	162,055	6,941,607
Median age	21.8 years	40.9 years
Male	21.5 years	39.3 years
Female	22.1 years	42.4 years
Population growth rate	3.86%	0.45%
Net migration rate (migrants/1,000 population)	17.22	1.09

Demographical data	Jordan	France
Sex ratio (male:female)		
Total population	1.03	0.96
At birth	1.06	1.05
Under 15 years of age	1.05	1.05
15–64 years of age	1.02	1
65 years of age and over	0.95	0.74
Ethnic groups	Arab 98%, Circassian 1% and Armenian 1%	Celtic and Latin, with Teutonic, Slavic, North African, Indochinese and Basque minorities
Religions	Islam, Christianity and other	Christianity, Islam, Judaism and unaffiliated
Languages	Arabic (official), English widely spread	French
Literacy rate*		
Total population	95.4% (2015 est.)	99% (2003 est.)
Male	97.7%	99%
Female	92.9%	99%
School life expectancy (primary to tertiary education)		
Total population	13 years (2011 est.)	16 years (2012 est.)
Male	13 years	16 years
Female	14 years	16 years
Education expenditures (% of GDP)	4.9% (1999 est.)	5.6% (2007 est.)
Health expenditures (% of GDP)	7.2% (2013 est.)	11.7% (2013 est.)

Est. = estimate; GDP = gross domestic product.
*Age 15 and over can read and write.

The Healthcare System of France

Structure, coverage, costs and reimbursements across in-patients and ambulatory care

The French health insurance system comprises both public and private insurers (Saltman and Dubois 2005). The health system of France is based on the Public Health Insurance (PHI) of the country. PHI is a vital part of the Social Security System privilege plan (Glied 2008). It has private and public sectors that contribute to the overall national health system (Glied 2008). In France, government hospitals own 65% of the hospital beds, with the rest held by a non-profit, profit-oriented and surgery-centred hospitals (Glied 2008). The offices usually cater for the optional charges for the health services rendered to patients covered under a health insurance plan (Glied 2008). Availability of healthcare meets accessibility through the parliamentary health insurance system. However, the patients also take part in meeting the costs of the healthcare in a cost-sharing program that encourages patient responsibility and accountability in the healthcare services being offered. Besides, the patient needs to be referred by a qualified and practicing medical specialist to lower the cost of medication. Otherwise, the cost of health services increases for the patient (Chevreul et al. 2015).

The French PHI allows the patients to pay at the point of service delivery and be reimbursed immediately by their health insurance providers to a given rate for the cost incurred. This system means that even the outpatient care in the country is not free for the patients at the time of health service delivery (Green and Irvine 2013). However, the immediate reimbursement by the insurers means no financial hitch is felt by the patient under the *carte vitale* reimbursement rates that also differ from various health needs of the patients (Green and Irvine 2013). For instance, those with human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS), diabetes and other chronic conditions are exempted from the cost-sharing system. Besides, the patients with special conditions such as pregnancy into the fifth month, pensioners of war and children with disability lack the opportunity for co-payments (Green and Irvine 2013).

In the ambulatory category, 80% of the total incurred medical cost is refunded to the patient (Green and Irvine 2013).

However, any stay as inpatient attracts a fixed charge pegged per day at €18 for every patient (Green and Irvine 2013). A visit to a general practitioner (GP) under the out-patient category also attracts between 50% and 75% cost reimbursement pegged on the level of compliance (Green and Irvine 2013). Other reimbursement rates for the ambulatory category include vaccinations at about 65–100%, seeing a dentist is reimbursed at 70%, other costs that encompass transport at 30% and drug prescriptions ranging from 35% to 100% based on the level of effectiveness and necessity (Green and Irvine 2013). Increased cost sharing towards medical costs is improved recently in France set at a maximum of €50 annually (Green and Irvine 2013). Besides, some excluded medical conditions by the National Health Insurance (NHI) also covered by special private insurers as based on the health policy agreement between the health consumer and the insurer. The NHI system recognizes and covers healthcare delivery for both private and public hospitals, diagnostic services, medical appliances and products and determined transport closely related to medical service visits (Green and Irvine 2013). Medical services derived from GPs, dentists, midwives and other health specialists are covered by the NHI (Green and Irvine 2013).

Insurance

Legislation of the health insurance coverage

Subscribing to a medical insurance policy is mandatory. This legislative provision enables France to reach nearly 100% health insurance coverage for its entire population (WHO 2011). A pillar in this achievement is the program called Assurance Maladie that ensures people of low socio-economical class also enjoy the health insurance (Chevreul et al. 2015). Assurance Maladie works to include independent citizens such the self-employed, the unemployed and their eligible dependants (Chevreul et al. 2015).

Corresponding Coverage by Health Insurance

Complete coverage for the costs of healthcare is provided in cases of severe ailments, industrial injury or maternity (Awad et al. 2009). The only refunded part of the healthcare cost is pegged on the extent of services offered (Awad et al. 2009). Still, other services are funded by the patient exclusively (Awad et al. 2009).

Some other similar health insurance plans are available to provide coverage for the expenses allowed by the patient (Saltman and Dubois 2005). One of these plans is mutuelles or the mutual benefits funds that cover more than 40 million people as of today. Moreover, private insurance organizations and sound foundations are jointly run by the councils of companies and workers (Saltman and Dubois 2005).

Universal Medical Coverage Scheme

Under Couverture Maladie Universelle (CMU), social security and health insurance coverage is extended to people with lower incomes depending on their legitimate residential status (Rough 2013).

Finance and Health Expenses

France has a total healthcare expense of 11.7% of the gross domestic production (GDP) which is the maximum amongst the European countries. The projected expense of the nation on healthcare is $42,513.3 per capita (Table 2) (OECD 2013; CIA 2014a).

The great financing of the PHI is accomplished through the offerings of companies and workforce. Up to 12.8% of the monthly wage of each employee is paid to the fund by the employer and the employees give 0.75% of their salary to the fund (Green and Irvine 2013). Also, 5.5% of the income collected as a personal income tax is added to the PHI fund (Green and Irvine 2013). The detailed specifications of the PHI of a person depend on own profession and the total money earned.

Table 2. Economical features of Jordan and France

Economical data	Jordan	France
GDP – real growth rate (2011 est.)	2.5%	1.7%
GDP – per capita (PPP) (2013 est.)	US $5,214.20	US $42,513.30
GDP – composition by sector (2014 est.)		
Agriculture	3.2%	1.7%
Industry	29.3%	19.4%
Services	67.4%	78.9%
Labour force (2013 est.)		
Total population	1,772,636	30,143,373
Agriculture	2.0%	3.0%
Industry	20.0%	21.3%
Services	78.0%	75.7%
Unemployment rate		
Total population	13.0% (2015 est.)* 11.9% (2014 est.)*	9.9% (2015 est.)[§] 9.9% (2014 est.)[§]
World ranking	142	114
Youth aged 15–24 (2012 est.)		
Total	29.3%	23.9%
Male	25.2%	23.7%
Female	48.8%	24.2%
World ranking	27	39
Budget (2014 est.)		
Revenues	US $9.845 billion	US $1.507 trillion
Expenditures	US $11.42 billion	US $1.631 trillion
Inflation rate	3.0% (2014 est.)	0.6% (2014 est.)
Consumer prices	5.6% (2013 est.)	1.0% (2013 est.)

Est = estimate; GDP = gross domestic product; PPP = purchasing power parity.
*Official rate; unofficial rate is approximately 30%.
[§]Includes overseas territories.

Approximately, 75% of the total expenses of healthcare are covered by PHI (Green and Irvine 2013). Services like outpatient care, hospital admission, nursing home care, recommended medications, visual and dental care are covered by PHI, while the remaining costs will be shared between the patient and additional private insurances (Chevreul et al. 2015).

Health System of Jordan

Political, socio-cultural and economic backdrop

Jordan is a small nation with incomes in the lower-to-middle range. The nation has a total of 89,300 km^2 area with only 7.8% of arable land (CIA 2014b). The nation's natural resources are limited. Jordan is a statutory kingdom where the prime right is bestowed on the king and the ministers of his assembly. Jordan has a population of 7.93 million with an average growth rate of 3.86% per annum (CIA 2014b). Only 30% of the population is above the age of 30 years (CIA 2014b). Jordan has the best performance amongst all the Arab nations in the aspects of life expectancy, the rate of school admission, adult literacy and literacy of female and other direct pointers (Awad et al. 2009).

Health System Institutions

Jordan enjoys much-modernized healthcare arrangements compared to other countries in the Middle East (Ajlouni 2010; Kronfol 2012; Mainil et al. 2011). According to Ajlouni (2010), there are three main divisions in the healthcare system of Jordan consisting of the public sector, the private organizations and the non-profit organizations. Two key public plans make the public health sector, namely, the Royal Medical Services (RMS) and the Ministry of Health (MOH). There are other minor public plans contributing to the national public healthcare system. These programs include different those run by the universities like the Jordan University Hospital, the special program of the Royal Cabinet of Jordan (RCJ) that caters to the full expenses of medical cost of the lowest socio-economic class with no apparent medical cover, and the King Abdullah Hospital in the cities of Amman and Irbid (Hasna et al. 2010).

In 2013, the total cost of healthcare was estimated to be 7.2% of the total GDP, which made the per capita expenditure on health reach US$5,214.2 (CIA 2014b). Official health

insurances cover around 87% of the population of the country (CIA 2014b). At 27%, the RMS is the highest insurer in the health sector (CIA 2014b). The MOH insures 19.5% of the population, and 11% of the population is insured by the United Nations Relief and Works Agency (UNRWA) (CIA 2014b). Private firms and the university hospitals account for 8.8% and 2% of the population insured (Al-Qudah 2011).

Relative Study

Comparison of Significant National Demographics

The elderly population is much higher in France than in Jordan. This situation naturally explains the higher rate of mortality in France. However, the rate of infiltration is much greater in Jordan compared to France mainly because of the volatility of the surrounding nations (Zineldin 2006). This scenario naturally contributes to a higher rate of population growth in Jordan. In addition, a greater rate of fertility can also be a reason for high population growth in the country compared to France (Zineldin 2006).

Comparison of health systems

Structure

A characteristic feature of the healthcare system of both countries is observable. In France, as well as in Jordan, both public and private institutions strongly exist forming the healthcare sector. Besides, both the services offered and the initiatives also enter into play for providing coverage. However, in 2000, WHO ranked the French healthcare system at the first position with the Jordanian at the 83rd overall (WHO 2011). Therefore, significant disparity between the two healthcare systems is expectable (WHO 2011).

Public sectors

Eligibility

As mentioned, all the citizens of France are entitled to a free-of-cost health services. Immigrants working as missionaries for an institution, even outside the territory of France, have the right to get the same facilities.

Healthcare Charges

Services in the healthcare system of France are provided without any fees except for some pre-determined charges applied to adults for medicaments, dentistry and optical care. However, for people in the low-income range comprising kids of less than 16 years of age and pensioners, there are no charges for these services either (Fund 2010).

In case the patient willingly opts for treatment as a private candidate, in the public healthcare systems of France and Jordan, no refund will be provided by the public sector and the total expense of the healthcare will be shouldered by the patient. The Ministry of Health and Solidarity became the MOH in France after 2007 (Chevreul et al. 2015). The French MOH is also known as the Administration Sanitaire et Sociale (Administration of Health and Social Affairs). It comprises four directorates including the General Directorate of Healthcare Supplies (Direction Générale de l'Offre de Soins; DGOS) and General Directorate of Health (Direction Générale de la Santé; DGS) (Chevreul et al. 2015: 24). The other dockets within the MOH are the General Directorate for Social Security (Direction de la Sécurité Sociale; DSS) and the General Directorate of Social Policy (Direction Générale de la Cohésion Sociale, DGCS) (Chevreul et al. 2015: 24). This MOH in France is concerned with healthcare cover charges patients, who access private services, 10% and 20% more than the rest when treated in health centers and hospitals, respectively (Chevreul et al. 2015).

The medical practitioners

In France, the general practitioners (GPs) working in private practice need to be in a contract with the national health agency to offer medical services. These GPs are paid a different fee negotiated and determined by the concerned national health agency.

Every French citizen needs to register with the GPs in their area because they cannot

directly see a specialist unless referred by their own GP (Green and Irvine 2013). On the other hand, the doctors, including the GPs and the specialists working with the hospitals, work on a direct payroll of the public healthcare sector while getting regular wages from the hospital (Green and Irvine 2013).

In the case of Jordan, the scenario is quite different. In Jordan, every medical staff in the public sector, including the doctors working in the hospitals and the GPs, are on the direct payroll of the public healthcare sector and paid wages by their respective healthcare facilities for which they work (Green and Irvine 2013). In contrast to the healthcare system of France, in Jordan, it is not compulsory for a patient to be referred by own GP to see a specialist.

Private Sectors

About 85% of the French population is medically covered by the private insurers (Green and Irvine 2013). It should be highlighted that the private healthcare is never considered as superior to public healthcare in a matter of efficiency in France. This equal consideration of both healthcare sector players in France emanates from the fact that similar senior specialists perform the treatment in either public or private healthcare provision (Green and Irvine 2013).

The private healthcare sector of Jordan includes some hospitals and clinics. According to the latest data, there are a total of 58 private hospitals in the country (Ministry of Health 2014). However, all of these facilities are available only in the major cities. Private insurance covers around 8.8% of the population of Jordan (Ministry of Health 2014). This population mainly includes the employees of big companies who either are self-insured or are provided with private health insurance by their companies (Hasna et al. 2010). Also, a significant information gap exists concerning the contribution of private sector firms to the national strategy of providing comprehensive health insurance coverage to the population.

Health indicators

The next section provides the primary indicators in both the healthcare systems of France and Jordan. It details the major differences between the healthcare systems of the two countries.

Maternal mortality rate and infant mortality rate

It can be observed from Table 3 that the infant mortality rate is much higher in Jordan compared to France. However, according to 2001 Jordan Annual Fertility Survey, the infant mortality rate in Jordan has come down to 15.57 per 1,000 live births from 33 per 1,000 live births (CIA 2014b). This improvement in infant mortality rate is no doubt a remarkable development.

To reduce the rate of maternal mortality, the MOH is offering 27% of the health budget on basic healthcare (CIA 2014b). This plan includes, free-of-cost delivery and prenatal care in 385 health centres offering maternal and childcare (CIA 2014b).

The much higher birth rate in Jordan compared to that of France could be due to many reasons. Reduction in the infant mortality rate and expansion of life expectancy along with extensive infiltration, particularly from Iraq, can be pointed to like some of the primary causes of high population growth. Jordan uses mobile health service delivery such as those set up in the refugee camps to cater for the medication of the influx populations from the unstable neighbouring nations (Hasna et al. 2010; Young 2011). The cost of such medication to non-citizens is met mainly by the aid assistance such as the United Kingdom Aid (UKAID) supplementing the national official efforts (Hasna et al. 2010). The exact figures of the amounts of money going into the medication of the immigrant refugees into Jordan is, however, not available in the public domain as of now (Young 2011).

The government contribution is low compared to the foreign aid supporting the refugee influx, but it still creates a strain in the social health system of the country in terms of medical personnel and facilities (Young 2011).

The public sector healthcare system of Jordan, including the Jordanian Association for Family Planning and Protection, UNRWA and others, offers free-of-cost family planning services (CIA 2014b). Based on the reports of the WHO in 2012, 61.2% of the married women population was using contraceptives for birth control (Table 3) (CIA 2014b).

Table 3. Health indicators for Jordan and France (2014 est. except where indicated)

Health indicator	Jordan	France
Infant mortality per 1,000 live births		
Total population	15.73	3.31
Male	16.63	3.63
Female	14.79	2.97
Maternal mortality per 100,000 live births	50	9
Neonatal mortality per 1,000 live births	11 (est. 2014)	2 (est. 2013)
Births per 1,000 population	25.23	12.49
Deaths per 1,000 population	3.8	9.06
Life expectancy at birth (years)		
Total population	74.10	81.66
Male	72.79	78.55
Female	75.50	84.91
Healthy life expectancy total population (2002 est.)	61 years	75 years
Fertility rate (children born per woman)	3.16	2.08
Contraceptive prevalence	61.2% (2012 est.)	76.4% (2008 est.)
Adult obesity rate	28.1%	25.7%
Hospital beds per 1,000 population	1.8 beds (2012 est.)	6.4 beds (2011 est.)
Physicians per 1,000 population	2.56 (2010 est.)	3.19 (2013 est.)

Est = estimate.

According to this study, the cultural tendency towards having big families is one of the reasons for higher birth rate in the nation. However, with time, this concept has started to change, mainly due to the financial conditions of the parents and also the efforts by the MOH to educate people with the help of media (Hasna et al. 2010). Conversely, for the healthcare system of France, offering the best care to their senior population is a challenge. Integrating all the healthcare services, like welfare, primary, secondary and tertiary services, through proper planning is the other challenge to the system.

In Jordan, only 3.9% of the population is aged over 65 years (CIA 2014b). This group of people, however, needs lesser healthcare because the culture of the society in Jordan dictates that the other members of the family take care of their elders. In Jordanian society, it is a matter of great shame to leave an elderly member of the family alone in a retirement center (Hasna et al. 2010).

Main Causes of Death

In both countries, the dominant pattern of illness is not infectious diseases but chronic ones. This pattern can be attributed to the alteration in demographics and also the changing style of life as shown in Table 4. In France, as well as in Jordan, cancer in different forms and of different organs and cardiovascular diseases are the main reasons for death. This health situation can be directly attributed to the effects of smoking. According to the 2002 WHO reports, 30% of the population of Jordan is regular smokers (WHO 2011). There are no stern rules about smoking in either of the countries, but some initiatives to restrict smoking in and around public places have started to come into action in the last few years (WHO 2011).

In Jordan, cancer is the second highest cause of death (CIA 2014b). For detecting cancer at an earlier stage, proper treatment and prevention initiatives have been started in both countries. However, due to inadequate funds, medicines and dearth of specialty in the area, Jordan suffers from higher mortality rate attributed to cancer. In Amman of Jordan, the first cancer specialty center was established in 1997 (Hasna et al. 2010). Since then, the organization has been

providing cancer treatment to the Jordanian population. However, due to the quick growth of population, more specialty centers for treating cancer have become indispensable.

Table 4. Common causes of death in France and Jordan

Cause of death	France		Jordan	
	Rank	No. of deaths	Rank	No. of deaths
Coronary heart disease	1	4,261	1	4,688
Stroke	2	3,411	2	3,188
Alzheimer/ dementia	3	3,142	28	127
Lung cancer	4	3,083	17	307
Colon/rectum cancer	5	2,056	14	352
Influenza and pneumonia	6	1,429	7	1,160
Breast cancer	7	1,395	13	401
Other injuries	8	1,265	11	453
Diabetes mellitus	9	1,181	4	2,048
Prostate cancer	10	1,081	24	155

No. = number.

Evaluation of Jordanian healthcare system and French healthcare system

Although the healthcare system in Jordan is facing ample challenges, it also has some noteworthy high points compared with the other nations in the region. These strengths are:

- *Well-trained healthcare staff:* From the very beginning, Jordan has stressed creating highly trained personnel, and this is no doubt a major advantage of the healthcare system of the country.
- *Medical tourism:* Jordan has a better healthcare system compared to neighbouring countries, and hence some patients from different Arabian nations come to Jordan for treatment. Medical tourism has a strong, positive effect on the overall economy of the country, and can be a great assistance for offering better healthcare services.
- Jordan nurtures a well-coordinated relationship with different global health associations like United States of America Aid (USAID). The organization has started various programs for the betterment of the healthcare services in the county.

The following drawbacks can be observed in the healthcare system of Jordan:

- Lack of research initiatives and statistical studies.
- The paucity of resources, mainly finance, in developing the healthcare system.
- As much as 32% of the population is not covered by any health insurance (CIA 2014b).
- Huge gap in services offered by private and public sectors.
- Redundancy of some pattern of services due to an absence of proper coordination between different healthcare providers.

France works together with major international bodies like the WHO, Organisation for Economic Co-Operation and Development (OECD) and health ministries of other nations to achieve healthcare goals related to research on the ways to resist and check epidemics. These collaborations and partnerships enable France to establish higher healthcare standards than Jordan while encouraging preventive health actions. The healthcare system of France draws strength from this aspect, especially the interaction with other nations, because it also enables France to learn from the experiences of other nations, thereby employing best practices to various aspects of healthcare service delivery (Hyder 2007).

Jordan, therefore, needs to learn the comprehensive health cover system using a

strategy similar to the Assurance Maladie in France to increase its coverage from the current 87% to 100% (Green and Irvine 2013). In addition, Jordan needs to emulate the cost-sharing strategy but moderate the cost-burden to the patients. Lastly, Jordan needs to improve on the general quality of the healthcare system and services in competition with the Western European nations like France that are ahead of the game worldwide rather than against the peer Asian nations.

Conclusion

The measure of success of the healthcare system of France

1. Depending on some healthcare factors, the WHO ranked the healthcare system of France number one, in the year 2000.
2. The healthcare system in France was found to be well structured and planned according to the requirements and anticipations of the masses. The system offers sufficient coverage across different geographical areas, and all the players in the healthcare sector were well coordinated.
3. The healthcare system of France provided global coverage combining both private and public hospitals and care providers. After putting the best efforts forth for over half a century, finally, in the month of January 2000, France was able to insure the residual 1% of the population that was not covered.
4. Advances in the sector of medical sciences and pharmacology have brought wide enhancements into the French healthcare system.
5. According to the healthcare rules of France, the coverage is provided to the patient depending on the level of illness. For individuals, with any one or more of the 30 marked long-term conditions that have expensive treatments like mental illness, cancer and diabetes, 100% of the healthcare cost is assured.
6. It has been observed that the citizens of France enjoy a longer and healthier life, which can be attributed to the best healthcare provided right from the time of birth.

The Challenges Faced by the Healthcare System of France

Although there is a substantial and vigorous effort towards improvement, still the healthcare system of France has its challenges (Annual Report 2006). Some of these are discussed below.

Accessibility

Control of the excessive demand for the significant cost sharing in the French healthcare system is governed by capping of minimal fees to be paid by the patients depending on the extent of the coverage by the private or public sector insurers (Green and Irvine 2013). The reimbursement schedules outlined earlier provide the breakdown of the cost sharing per service or goods category in either the ambulatory and in-patient care delivery modes (Green and Irvine 2013). In the public healthcare sector of Jordan, the rules for gaining healthcare are different. As, the MOH and RMS serve only their staffs and wards of their personnel and other referred patients from public providers, the masses do not have any admittance to these services (Chevreul et al. 2015).

Financial shortage

The financial crunch is a major drawback for the healthcare systems of both the countries. In France, the GPs are given salaries, or receive a pre-set fee for the services offered, which, in either case, is considered as inadequate by medical professionals. This inadequacy results in long waiting lists for the patients.

In the same way, the doctors and staffs working in the Jordanian healthcare sector felt discouraged and discontented due to minimum pay and improper working environments (Hasna et al. 2010).

Continuous improvement and restructuring

The increasing rate of immigration, growing number of aged people and the alterations in the global financial scenario bring the healthcare system of France under the continuous requirement of re-assessment and active restructuring.

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