

The French Health Care System, 2009

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Who is covered?

Coverage is universal; all residents are entitled to publicly financed health care. Following the introduction of *Couverture Maladie Universelle* (CMU) in 2000, the state finances coverage for residents not eligible for coverage by the general public health insurance scheme (0.4% of the population). The state also finances health services for illegal residents (*L'Aide Médicale d'Etat* [AME]).

What is covered?

Services: The public health insurance scheme covers hospital care, ambulatory care, and prescription drugs. It provides minimal coverage of outpatient eye and dental care. Preventive services (immunizations) are covered to a certain extent, usually for defined target populations.

Cost-sharing: Cost-sharing is widely applied to publicly financed health services and drugs, and takes three forms: coinsurance, copayments, and extra billing.

Coinsurance rates are applied to all health services and drugs listed in the publicly financed benefits package. Coinsurance rates vary depending on:

- the type of care—hospital care (20% plus a daily copayment of €16–€20 [US\$24–US\$29]), doctor visits (30%), dental care (30%)
- the type of patient—patients suffering from chronic conditions and poorer patients are exempt from cost-sharing, though only if they are treated with services and supplies listed in the benefit package, which is published and updated by the HAS
- the effectiveness of the prescription drug—0 percent for highly effective drugs, 35 percent, 65 percent, and 100 percent for drugs of limited therapeutic value
- whether or not patients comply with the recently implemented gatekeeping system (*médecin traitant*)—visits to the gatekeeping GP are subject to a 30 percent coinsurance rate, while visits to other GPs are subject to a coinsurance rate up to 50 percent; the difference between the two rates cannot be reimbursed by complementary private health insurance (see below)

In addition to cost-sharing through coinsurance, which can be fully reimbursed by complementary private health insurance, the following non-reimbursable copayments apply, up to an annual ceiling of €50 (US\$74): €1.00 per doctor visit (US\$1.49), €0.50 (US\$0.74) per prescription drug, €2.00 (US\$2.98) per ambulance and €18.00 (US\$27.00) for expensive hospital treatment.

Reimbursement by the publicly financed health insurance scheme is based on a reference price. Doctors and dentists may charge above this reference price (extra billing) based on their level of professional experience. The difference between the reference price and the extra billed amount must be paid by the patient and may or may not be covered by complementary

private health insurance, depending on the contract. Out-of-pocket payments, including both cost-sharing and expenditure paid directly by private households, accounted for 7 percent of total national health expenditures in 2007.

Safety nets: Exemptions from coinsurance apply to people with any of 30 chronic illnesses, people with low income, and people receiving invalidity and work-injury benefits. Hospital coinsurance applies only for the first 31 days in hospital, and some surgical interventions are exempt. Children and people with low income are exempt from paying non-reimbursable copayments. Complementary private health insurance covers statutory cost-sharing (the share of health care costs not reimbursed by the health insurance scheme). It applies only to health services and prescription drugs listed in the publicly financed benefit package. Most people obtain complementary private coverage through their employers. Since 2000, people with low income are entitled to free or subsidized complementary private coverage (CMU-C) and free eye and dental care; in addition, they cannot be extra-billed by doctors. Complementary private health insurance covers over 92 percent of the population. In 2007, out-of-pocket payments and private health insurance accounted for 8.5 percent and 13.6 percent of total health expenditure, respectively (comptes nationaux de la santé en 2007).

How is the health system financed?

Publicly financed health care: The public health insurance scheme accounted for 76.6% of total health expenditure in 2008. The public health insurance scheme is financed by employer and employee payroll taxes (43%); a national income tax (*contribution sociale généralisée*, 33%), created in 1990 to broaden the revenue base for social security; revenue from taxes levied on tobacco and alcohol (8%); state subsidies (2%); and transfers from other branches of social security (8%). There is no ceiling on employer (12.8%) and employee (0.75%) contributions, which are collected by a national social security agency. Coverage for those not eligible for the public scheme or complementary private coverage is mainly financed by the state through an earmarked tax on tobacco and alcohol and a 5.9 percent tax on the revenue of complementary private health insurers.

Government: The public health insurance funds are managed by a board of representatives, with equal representation from employers and employees (trade unions). Every year parliament sets a (soft) ceiling for the rate of expenditure growth in the public health insurance scheme for the following year (ONDAM^a). In 2004, a new law created two associations, the National Union of Health Insurance Funds (UNCAM^b) and the National Union of Voluntary Health Insurers (UNOCAM^c), incorporating all public health insurance funds and private health insurers, respectively. The law also gave the public health insurance funds responsibility for defining the benefits package and setting price and cost-sharing levels.

Private health insurance: Complementary private health insurance reimburses statutory cost-sharing. It is provided mainly by not-for-profit, employment-based mutual associations (*mutuelles*), which cover 87 percent to 90 percent of the population. It covers only those services that are also covered by the public health insurance scheme. There is some evidence to show that the quality of coverage purchased (in other words, the extent of reimbursement) varies by income group. Since 2000, people with low income (including unemployed people and people receiving single-parent subsidies) and their dependents have been entitled to complementary private coverage at little to no cost (CMU-C). CMU-C covers about 5 million people with vouchers that can be used to obtain coverage from a variety of insurers, although most choose to obtain it from the public health insurance scheme. More recently, for-profit commercial insurers have begun offering coverage for services not included in the public benefits package, such as psychotherapy or acupuncture.

^a Objectif National de Dépenses d'Assurance Maladie.

^b Union Nationale des Caisses d'Assurance Maladie.

^c Union Nationale des Organismes Complémentaires d'Assurance Maladie.

How is the delivery system organized?

Health insurance funds: Public health insurance funds are statutory entities with membership based on occupation, so there is no competition between them. There is limited competition among mutual benefit societies providing complementary private health insurance, but as they are employment-based, employees for the most part have a choice of only one or two *mutuelles*. There is no system of risk adjustment among *mutuelles*, even though there is inadvertent risk selection based on occupation.

Physicians: The 2004 health financing reform law introduced a voluntary gatekeeping system for adults (aged 16 years and over) known as *médecin traitant*. There are strong financial incentives for patients to encourage gatekeeping, with higher copayments for visits and prescriptions without a referral from the gatekeeper. Physicians are self-employed and paid on a fee-for-service basis. The cost per visit is slightly higher for specialists (€23 [US\$34]) than for GPs (€22 [US\$33]) and is based on negotiation between the government, the public insurance scheme, and the medical unions. Depending on the duration of their medical training, physicians may charge above this level. There is no limit to what physicians may charge, but medical associations recommend restrained fee levels. Hospital physicians in public or not-for-profit facilities are salaried.

The 2009 Hospital, Patients, Health, Territories Reform Act attempted to improve access to care in deprived areas by creating negative incentives for physicians who set up practice in areas with current oversupply. Opposition from the physician unions has led to the withdrawal of the measure; however, nurses' unions have agreed to a similar arrangement with the MoH.

Hospitals: Two-thirds of hospital beds are in government-owned or not-for-profit hospitals. The remainder are in private for-profit clinics. All university hospitals are public. Since 1968, hospital physicians have been permitted to see private patients in public hospitals, an anachronism originally intended to attract the most prestigious doctors to public hospitals, and one that has survived countless attempts to abolish it. As of 2008, all hospitals and clinics are reimbursed via the DRG-like prospective payment system (the original DRG scheme was not to be fully implemented until 2012). Public and not-for-profit hospitals benefit from additional non-activity-based grants to compensate them for research and teaching (up to an additional 13% of the budget) and for providing emergency services and organ harvesting and transplantation (on average, an additional 10%–11% of a hospital's budget).

What is being done to ensure quality of care?

An accreditation system is used to monitor the quality of care in hospitals and clinics. The quality of ambulatory care rests on a system of professional practice appraisal. Both systems are mandatory and are overseen by the national health authority (Haute Autorité de Santé, or HAS), created in 2004. Hospitals must be accredited every four years by a team of experts. The accreditation criteria and reports are publicly available on the HAS Web site (www.has-sante.fr). Every fifth year, physicians are required by law to undergo an external assessment of their practice in the form of an audit. For hospital physicians, the practice audit can be performed as part of the accreditation process. For physicians in ambulatory practice, the audit is organized by an independent body approved by HAS (usually a medical society representing a particular specialty). Dentists and midwives will soon have to undergo a similar process. In addition, HAS undertakes comparative effectiveness review of all new drugs, devices, and medical procedures before their inclusion in the public benefit package. It also publishes guidelines on care and defines best-care standards.

What is being done to improve efficiency?

Improving efficiency is the major challenge facing the public health insurance funds, which are currently working on structural and procedural changes. Structural changes involve the creation of a national computerized system of medical records to limit duplication of tests, overprescribing, and adverse drug side effects, and to facilitate the implementation of

prospective payment for all hospitals and clinics from 2008. Procedural changes on the supply side focus mainly on two issues: the reorganization of inputs (for example, by transferring some physician tasks to nurses or other professionals) and improved coordination of care (particularly for patients with chronic illnesses). On the demand side, the main health insurance scheme is experimenting with patient education and hotlines. As of 2008, it also transfers some drugs to over-the-counter status. The Hospital, Patients, Health, Territories Reform Act voted on in July 2009 reformed the governance of public and not-for-profit hospitals by increasing the role of the hospital director in defining the strategies and deciding on a hospital's operations. At the regional level, one single authority (regional health agency) combines the roles of purchaser of hospital and ambulatory care, planner, and regulator. Notably for a Bismarckian health system, the 2009 reform merged the administrations of the public health insurance scheme with other public services at the regional level.

How are costs controlled?

Cost control is a key issue in the French health system, as the health insurance scheme has faced large deficits for the last 20 years. More recently the deficit has fallen, from €10 billion–€12 billion per year in 2003 (US\$15 billion–US\$18 billion) to €5 billion (US\$7.4 billion) in 2009. This may be partly attributable to the following changes, which have taken place in the last three years:

- a reduction in the number of acute-care hospital beds
- new limits on the number of drugs reimbursed; around 600 drugs have been removed from public reimbursement in the last few years
- increases in generic prescribing and in the use of over-the-counter drugs
- a requirement to deliver a generic drug unless otherwise specified on the prescription
- the introduction of a voluntary gatekeeping system in primary care
- a basic benefit package for the management of chronic conditions
- since 2008, reclassification of copayments for prescription drugs, doctor visits, and ambulance transport as non-reimbursable by complementary private health insurance

At the same time, there has been an increase in the number of medical students admitted to university due to an expected shortage of doctors in the coming decade. Public funding has also had to increase to accommodate a rise in the fee schedule, since GPs are now considered as specialists and their cost per visit has risen from €20 (US\$30) to €23 (US\$34).

The economic downturn constitutes a threat for the state budget in general (the public deficit for 2009 was 7.5 percent of GDP) and the health insurance scheme as the revenue base shrinks.

What recent system innovations and reforms have been introduced?

The major innovations concern the governance of public and not-for-profit hospitals and the creation of regional health agencies that merge public health insurance and other public administrations at the regional level. More than simply creating administrative economies of scale, the merger creates one department responsible for health care and public health policies, managed care, and social services (previously overseen by seven departments). It is intended to be a major step toward a more consistent system.

In April 2009, the public health insurance scheme launched a series of individual contracts with office-based physicians (Contrats d'Amélioration des Pratiques Individuelles, or CAPI). These contracts link monetary rewards up to €5,000 (US\$7,357) per year to the achievement of targets in the process of care for asthma, diabetes, hypertension, immunization, and breast cancer screening. The contracts also stipulate the prescription of generic drugs, particularly for cardiovascular conditions. The physicians' unions, the national physicians' regulation authority and the union of pharmaceutical industry opposed these contracts in court, on the grounds that 1) individual contracts (as opposed to contracts negotiated between the SHI and the unions) undermine the basis of a Bismarckian health system; 2) the physician-patient relationship should not be polluted by the suspicion that physicians may not prescribe in the best interest of the patients; and 3) by setting targets for generic prescribing, the contracts might limit patients' access to innovative medicines. Three months after implementation, however, the contracts had been accepted by more than 5,000 GPs (or 10% of the total GP population)—far more than initial forecasts had estimated. Some incentives to coordinate care are available; GPs who manage patients with chronic conditions receive an additional €40 (US\$59) per patient per year. Social health insurance also finances a number of providers' networks that coordinate hospital and out-of-hospital care for diabetes, cancer, chronic renal failure, and multiple sclerosis.

References

OECD Health Data, 2009