The French Health Care System

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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 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.

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

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

- the type of care: hospital care (20% plus a daily co-payment of €16/$23), doctor visits (30%), dental care (30%)
- the type of patient: patients suffering from chronic conditions and poorer patients are exempt from cost sharing
- the effectiveness of the prescription drug: 0% for highly effective drugs, 35%, 65% and 100% for drugs of limited therapeutic value
- whether or not patients comply with the recently-implemented gatekeeping system (*médecin referent*): visits to the gatekeeping general practitioner (GP) are subject to a 30% co-insurance rate, while visits to other GPs are subject to a 50% co-insurance rate; the difference between the two rates cannot be reimbursed by complementary private health insurance (see below).

In addition to cost-sharing through co-insurance, which can be fully reimbursed by complementary private health insurance, the following non-reimbursable co-payments will apply from 2008, up to an annual ceiling of €50 ($72): €1 per doctor visit ($1.50), €0.50 ($0.75) per prescription drug, €2 ($3) per ambulance journey and €18 ($26) for expensive 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.

Safety nets: Exemptions from co-insurance apply to people receiving invalidity and work injury benefits, people with specific chronic illnesses and people with low income. Hospital co-insurance only applies 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 co-payments. Complementary private health insurance covers statutory cost-sharing (the share of health care costs not reimbursed by the health insurance scheme). It only applies to health services and prescription drugs listed in the publicly-financed benefits package. Most people obtain complementary private coverage through their employer. Since 2000, people with low income are entitled to free complementary private cover (CMU-C) and free eye and dental care; in addition, they cannot be extra billed by doctors. Complementary private health insurance covers over 92% of the population. In 2005 out-of-pocket payments and private health insurance accounted for 7.4% and 12.8% of total health expenditure respectively (World Health Organization 2007).

How is the health system financed?

Publicly-financed health care: The public health insurance scheme is financed by employer and employee payroll taxes (43%); a national income tax (*contribution sociale generalisée*; 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%). CMU is mainly financed by the state through an earmarked tax on tobacco and through a 2.5% tax on the revenue of complementary private health insurers. There is no ceiling on employer (12.8%) and employee (0.75%) contributions, which are collected by a national social security agency. Public expenditure accounted for 79.1% of total expenditure on health in 2005 (World Health Organization 2007).

Government: The public health insurance funds are managed by a board of representatives, with equal representation from employers and employees (trades 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[1]). In 2004 a new law created two new associations, the National Union of Health Insurance Funds (UNCAM[2]) and the National Union of voluntary health insurers (UNOCAM[3]), 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 mainly provided by not-for-profit employment-based mutual associations (*mutuelles*), which cover 87% to 90% of the population. It only covers those services that are already 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 (unemployed people, people with low income and people receiving single parent subsidies) and their dependants have been entitled to obtain complementary private cover at little to no cost (CMU-C). CMU-C covers about two million people via a voucher which can be used to obtain cover from a variety of insurers, although most choose to obtain cover 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. For example, the company AXA offered a plan giving faster access to renowned specialists, but this was outlawed by the physicians' association and parliament.

How is the delivery system organized?

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

Physicians (non-hospital based 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 to encourage gatekeeping. Physicians are self-employed and paid on a fee-for-service basis. The cost per visit is slightly higher for specialists (€23; $33) than for GPs (€22; $32) and is based on negotiation between the government, the public insurance scheme and the medical unions. Depending on the total duration of their medical studies, physicians may charge above this level. There is no limit to what physicians may charge, but medical associations recommend tact in determining fee levels.

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. Hospital physicians in public or not-for-profit facilities are salaried. 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. From 2008, all hospitals and clinics will be reimbursed via the DRG-like prospective payment system (the original DRG scheme was only to be fully implemented by 2012). Public and not-for-profit hospitals benefit from

[1] Objectif National de Dépenses d'Assurance Maladie.
[2] Union Nationale des Caisses d'Assurance Maladie.
[3] Union Nationale des Organismes Complémentaires d'Assurance Maladie.

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, under the responsibility of the national health authority (HAS) created in 2004. Hospitals must be accredited every four years by a team of experts. The accreditation criteria and reports are publicly available via the HAS website (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.

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, over-prescribing 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 mainly focus 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. From 2008 it will also transfer some drugs to over-the-counter status.

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 €10-12 billion per year in 2003 ($14-17 billion) to an expected €6 billion in 2007 ($8.6 billion). This may be attributed to the following changes, which have taken place in the last two years:

- a reduction in the number of acute hospital beds
- limits on the number of drugs reimbursed; around 600 drugs have been removed from public reimbursement in the last few years
- an increase in generic prescribing and the use of over the counter drugs
- the introduction of a voluntary gatekeeping system in primary care
- protocols for the management of chronic conditions
- from 2008, new co-payments for prescription drugs, doctor visits and ambulance transport will not be 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 ($29) to €22 ($32).

References

World Health Organization (2007). World Health Statistics 2007. Geneva, World Health Organization.