Cost Sharing in France

Working paper

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A brief overview of the French health insurance system[2]

Since its inception in 1946, the French national health insurance has been developed as an employment-based statutory system. Initially for salaried workers and their families, it has been progressively extended to agricultural workers (1961) and to self-employed workers (1966). In 2000, the Universal Health Coverage Act (CMU Act) introduced a right to statutory health insurance coverage on the basis on residency in France.

At present, three main health insurance funds cover more than 95% of the population:

- the general fund (*Régime général)* covers employees in commerce and industry and their families (about 84% of the population) and the beneficiaries of the CMU basic coverage (estimated to be 1.4 million people as of the end of 2002, around 2% of population)[3, 4];
- the agricultural fund (*Mutualité sociale agricole;* MSA) covers farmers, agricultural employees and their families (about 7.2% of the population);
- the fund for non-agricultural self-employed people (CANAM) covers craftsmen, and self-employed professionals (about 5.0% of the population).

Until recently, the levels of coverage (and of contributions) were lower in the agricultural and self-employed funds than in the general one, but in 2001, the coverage was harmonized to match that of the general fund.

Other small funds cover certain categories of the population, also on a work-related basis. Many of these are linked to the general fund, as is the case for local and national civil servants, students and military personnel. About 15 others funds (such as those for miners, employees of the national railway company, the clergy, seamen and the national bank) have their own particular form of organization and function autonomously. Usually, the level of coverage is more advantageous for beneficiaries of these special funds and in some cases, free ambulatory care is delivered through an integrated network of providers.

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[2] For more details see (Sandier, Paris, & Polton 2003).

[3] Source: Boisguérin (2003)

[4] The CMU Act also created a complementary health insurance policy for the poorest that will be presented later.

For historical reasons (Bocognano & Lecomte 1992), inhabitants of the Alsace-Moselle region, though affiliated to the main sickness fund, have always benefited from lower user charges than the rest of the population[5].

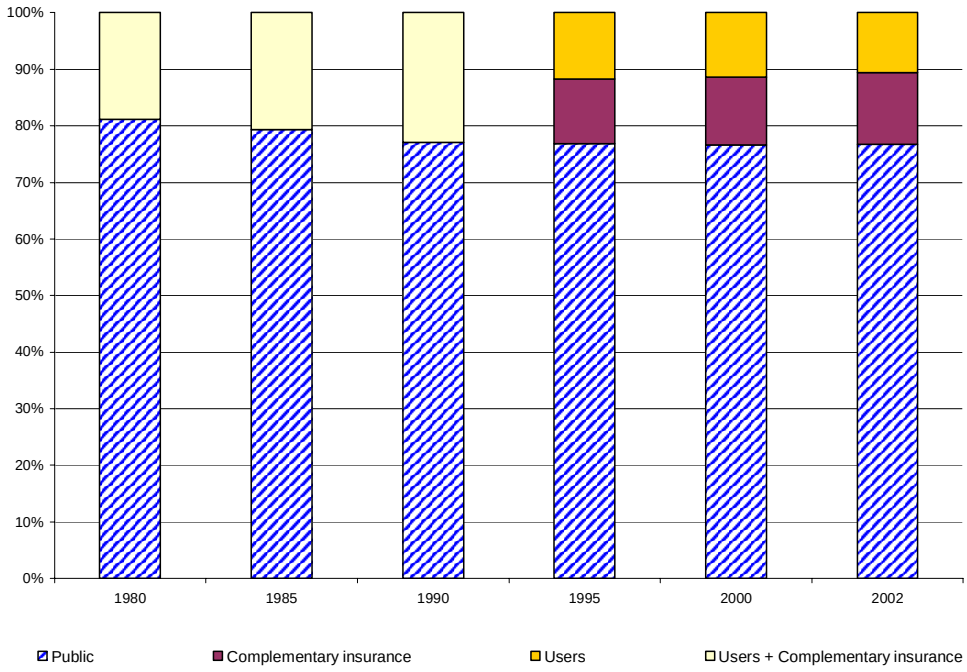
The remainder of this text will focus on the rules applicable to beneficiaries of the three main sickness funds.

To complete this overview, it should be noted that complementary health insurance is wide-spread in France (92% of the population is covered) and plays a key role in the financing of user charges.

1. Levels of private expenditure on health care

According to National Health Accounts, users and their complementary insurance policies finance roughly a quarter of overall expenditure on medical goods and services (23.3% in 2002). As Figure 1 shows, while this figure tended to increase during the 80's, it has stabilized since then.

Figure 1: Trends in user charges since 1980



Source: National Health Accounts Eco-Santé France 2003 2nd edition.
Note: Before the mid-90's, National Health Accounts did not clearly separate user charges and complementary insurance

In fact, the private participation estimated in the framework of the National Health Accounts contains components of differing natures:

[5] Co-insurance of 10% for all types of goods and ambulatory services and 0% for hospitalization and transportation to be compared with the co-insurance in Table 6.

- The consumption of medical goods and services that are not covered by statutory insurance (for instance: drugs purchased without prescription or drugs that are not reimbursed, non-prescribed auxiliary services, etc.).

- The co-insurance or co-payments (see below) that are built into the statutory health insurance as user charges. They vary with the type of care and numerous exemptions for these payments exist. Additionally, they would most often be covered by a person's complementary VHI.

- The extra-billing, which is permitted in some cases and is then neither regulated nor covered by the statutory health insurance. Complementary VHI contracts may cover (part) of these amounts.

There are no separate estimates for each of these components of the private contribution. However, we can provide general information on it:

- Extra-billing is very high for dental prosthesis and for "other medical goods" for which they are allowed (see Table 6 for more details on all these items). It is also relatively common for physicians' services though it represents a little more than 10% of their total fees (Cnamts 2003c).

- For drugs, as nearly all complementary insurance policies cover the co-insurance rate, we can assume that a large part of the 17% of expenditure on drugs paid by users corresponds to the purchase of non-prescription and/or medicines that are not reimbursable.

As a result, the level of participation varies with the type of care (Table 1).

Table 1. The financing of health expenditure in 2002

	Public [a]	Complementary insurance	Users	Total
In-patient care	92.0%	4.2%	3.7%	100%
Out-patient physician services	71.8%	20.2%	8.0%	100%
Out-patient auxiliaries services	81.6%	8.8%	9.6%	100%
Dental service	34.8%	35.2%	30.0%	100%
Laboratory exams	74.7%	21.1%	4.2%	100%
Transportation	94.9%	3.0%	2.1%	100%
Pharmaceuticals	65.3%	17.6%	17.1%	100%
Other medical goods	44.8%	25.4%	29.8%	100%
Total medical consumption	76.7%	12.7%	10.6%	100%

[a] Public = Sickness funds + State (which finances only 0.7% of total expenditure).
Source : DREES, in Eco-santé France 2003.

2. Current cost sharing arrangements: a mapping exercise

The decision-making framework to define the level of cost-sharing and protection mechanisms

The State is ultimately responsible for setting the general rules of cost-sharing and protection mechanisms.

The State also establishes positive lists of goods and services covered:

- Positive list of drugs and medical devices are established by ministerial order based on recommendations by the Commission of Transparency (for drugs) and the Commission for Evaluation of Medical Products. These commissions assess the medical service rendered by each product according to available scientific evidence. They are composed of representatives of the State, the sickness funds, health professionals and producers.

- For medical services, the positive list is the fee schedule used by health professionals in ambulatory care and by physicians in private hospitals. This schedule is prepared by a Commission composed of representatives of health professionals, representatives of sickness funds, representatives of the State, and experts. Then, it must be approved by ministerial order.

- *De facto*, goods and services delivered in public hospitals are always reimbursed, even if not included in positive list (bone mineral density tests for instance).

In a second phase, the State approves the “official” tariffs or prices which are negotiated between:

- health professionals unions and sickness funds for services;

- the Economic Committee of Medical Products, which includes representatives from the State and from sickness funds), and every pharmaceutical company.

This official tariff or price ultimately determines the co-insurance amount for each medical service or product. But as we will see below, user charges can exceed these official co-insurance amounts.

General rules for user charges

For most goods and services, a first type of user charge is defined as a proportion of the official tariff/price, which is not covered by statutory health insurance. This co-insurance rate (*Ticket modérateur*) ranges from 0% for drugs considered to be ‘not substitutable and particularly expensive’ to 65% for ‘minor’ drugs. A per diem co-payment also exists for in-patient stays (see Table 6).

But there are other forms of user charges:

- Some physicians are allowed to charge more than the “official” tariff. In this case, the patient (or his complementary insurance) has to pay extra-billing.

- For some medical products (prosthesis, medical devices), prices can be higher than the official tariff. In this case, the patient has to pay extra-billing, he/she is often partially reimbursed by his/her complementary insurance

- Reference prices have been recently introduced for some drugs. The difference between the retail and the reference price has to be paid by the patient and some complementary insurers have announced that they will not cover it.

Informal payments are uncommon in France. There is suspicion that such payments may exist in some hospitals in order to "jump the queue" to benefit from services of specific (prestigious) physicians. However, no data on this is available.

Finally, mention should be made of advance payments which have always been a rule for ambulatory care. As a general rule, patients are expected to pay the health care provider themselves and then receive (total or partial) reimbursement of their expenses from the health insurance fund. This rule does not apply in case of hospitalization (the hospital is paid directly by the sickness fund), and some sectors have developed third party payments in the past

decade (pharmacies and laboratories). While advanced payment can not be considered as a user charge, it has been shown to constitute a financial barrier for access to care (Dourgnon & Grignon 2000).

Protecting people from user charges

Under certain circumstances, the patient can be exempted from user charges (co-payment or/and co-insurance). Extra-billing is never covered by statutory insurance but some people are protected from extra-billing in the sense that the producer cannot charge them beyond the official tariff (see § CMU).

The first type of exemption aims at alleviating the cost of treatment for those whose health status requires costly treatments.

When patients suffer from one of 30 listed serious and chronic illnesses (diabetes, AIDS, cancer, psychiatric illness,…[6]), they are exempted from co-insurance for all medical goods or services used in the treatment of that illness. A similar rule applies if the patient suffers from a serious and disabling illness not included on the list, but requiring a medical treatment longer than 6 months or particularly expensive, or for the disabling combination of several pathologies.

Also exempted from user charges are: victims of workplace accidents or occupational disease, beneficiaries of occupational disability income, handicapped children, war veterans, people staying in nursing homes or residential homes for the handicapped, children victim of sexual abuse, persons treated for sterility, women more than 5 months pregnant and newborns in their first 30 days.

In Table 6, which describes user charges, the exemptions listed above will be referred to as "general rules of exemptions". About 8.5% of the population is exempted from co-insurance: 6.8% for serious illness and 1.7 for other reasons (Auvray, Dumesnil, & Le Fur 2001a).

Other types of exemptions exist for expensive treatments (e.g. for certain in-patient stays, also detailed in Table 6).

Additionally, some specific goods and services are also exempted from co-insurance for public health reasons: recommended examinations during pregnancy as well as some preventive care (influenza vaccines for people over 65, measles-mumps-rubella vaccines for children less than 13 years old, cancer screening in the framework of public health programs, dental examinations and subsequent normal dental procedures for children from 13 to 18, etc).

Given all these exemptions mechanisms, the actual participation of users (or of their complementary insurance) for health services is often far lower than the theoretical co-insurance rate. For instance, Table 2 shows that, in spite of a high theoretical *ticket modérateur* (40%), the actual co-insurance for ambulatory auxiliaries services only amounts to 15.7% because of a high concentration of these services among exempted users. Likewise, taking into account the respective weight of the different types of medicines in the total medical consumption eligible for reimbursement (i.e. prescribed by a health professional), and the proportion of exemptions, the average co-insurance rate for medicines can be estimated to 25.2%.

[6] For a complete listing of these illnesses (named "*Affections de longue durée*" or *ALD*), see http://www.ameli.fr/16/DOC/54/enquete.html.

Table 2: Private participation in the financing of "covered care" - 2002

	Theoretical *ticket modérateur* (%)	Actual co-insurance[a] (%)
• **Physician visits** • **GP Home visits**	30	25.3 16.8
Dental treatment	30	26.3
Medical Auxiliaries	40	15.7
Laboratories	40	23.7
Medicines	0, 35, 65	25.2
Hospital care	20	n.a.

[a] *The share of expenditure valued with the official tariffs which is paid by patients who belong to the main health insurance fund. These actual co-insurance rates are slightly overestimated for technical reasons: the exempted benefits for pregnancy beyond 6 months, for workplace accidents and occupational diseases are not included.*

Source : (Cnamts 2003d)

Finally, some specific mechanisms have long existed to protect the poorest people from the impact of user charges.

Until 2000, exemptions of co-insurance existed for very poor citizens. These programs of "medical assistance" (*Aide médicale Départementale*) were managed by local authorities or the State if the person was homeless. The extent of the coverage and the income thresholds below which people were entitled to be covered varied from *département* to *département*[7]. In 1998, roughly 2% of the population was covered by these programs[8].

These programs were replaced in January 2000 by a uniform means-tested public supplementary insurance program called CMU (*Couverture maladie universelle*). Its purpose is to decrease the existing financial barriers which limit access to care for those whose income is below a certain threshold (about 10% of the population is eligible)[9].

The CMU complementary insurance policy covers the co-insurance for all medical goods and services (including hospital services). Additionally, the CMU protects beneficiaries from extra-billing: those physicians who are in general allowed to balance bill may not charge CMU beneficiaries above the official tariff. Moreover, such services as dental prostheses and glasses are fully covered but the providers receive payments that are fixed above the official tariff. So in essence, the providers bear part of the cost of this coverage as their extra-billing, unlike for other patients, is limited. In other words, access to care is supposed to be completely free of charge for CMU beneficiaries. Additionally, they do not have to advance the cash at the point-of-service, and professionals are directly paid by health insurance.

Table 3, based on a survey conducted in 2000 shows, as expected, that vulnerable populations were the primary beneficiaries of the CMU.

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7 A *département* is a regions' geographic subdivision.

8 Source: Health and Health Insurance Survey (ESPS) 1998.

9 Eligibility thresholds in 2003: € 562 per month for a single person, € 843 Euros for two people, etc. (Cnamts 2003a)

Table 3: Coverage by the Couverture Maladie Universelle depending on employment status and household structure

Employment status	%
Working	2.2
Unemployed	20.3
Retired / widower	1.5
Housewife	9.1
Other inactive	12.8
Student, child	6.9
Household structure	**%**
Single	4.8
Single parent	17.1
Couple without child	1.6
Couple with children	4.6
Total	**5.0**

Source: Health and Health Insurance Survey (ESPS) 2000.

As of the end of December 2002, 4.5 million people benefited from the CMU (about 7% of the population)[10].

Two additional protection mechanisms were added in 2002 for those whose income increases above the threshold below which they can benefit from the complementary CMU: first, for a year after they have been excluded, they remain exempted from advancing the amount which will be later covered by social security at the point of care. Second, if their income does exceed the threshold by less than 10%, they can receive a lump-sum to help pay for a private supplemental coverage (€ 115 for a single person). While the insurers can decide on the price for that contract, it has to provide coverage that is equivalent to that of the CMU.

Finally, specific protection is available to individuals who do not fill the "stability of residence" criteria required for the CMU (essentially non-legal residents and some homeless people). They receive free care in a hospital setting and provided they can prove they have lived in France continuously for the past 3 years, they are also covered for ambulatory services.

Complementary insurance [11]

The purchase of complementary VHI coverage has burgeoned over the years in response to the slow but steady decline of the percentage of health costs reimbursed by the public insurance system. While a third of the population had private health insurance in 1960, and half in 1970, the figure stood at 86% in 2000.

Health insurance policies can be taken out by individuals or groups. 34% of the population purchase individual insurance[12]. Most often, policies are taken out in the context of employment, i.e. the employer buys group insurance for his staff.

As a consequence, the proportion of people covered varies with employment-related factors: the employed and pensioners are more often covered than the unemployed or other non-

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10 (Boisguérin 2003).

11 For a recent report on complementary VHI in France, see Sandier and Ulmann (2001)

12 Source: Health and Health Insurance Survey (ESPS) 2000.

working persons; unskilled workers are less often covered than managerial staff or office workers (Table 4).

Table 4: Private health insurance coverage depending on employment status and occupation (% of the population)

Employment status	%
Working	89.9
Unemployed	60.1
Retired / widower	88.7
Housewife	80.1
Other inactive	66.1
Student, child	84.6
Occupation	**%**
Farmers	89.3
Artisans, retailers	82.0
Executives, intellectual professions	93.5
Intermediary professions	94.4
Office clerks	85.2
Customer service clerks	69.2
Skilled workers	84.0
Unskilled workers	71.8
Total	**85.7**

Source: Health and Health Insurance Survey (ESPS) 2000.

Access to private health insurance, and therefore the reduction of out-of-pocket expenditures for households through mutualisation and sometimes cross-subsidization, is not identical for all groups. The disadvantaged plainly have less access to private health insurance.

Virtually all private insurance contracts cover (at least) the co-insurance (*ticket modérateurs*) and many of them the hospital daily co-payment[13]. Additionally, for physician services and medical goods, contracts may cover part of the difference between the official tariff and the price paid by the patient. The extent of that coverage varies greatly and until recently very little was known about the content of contracts. However, in general, private insurers' coverage only applies to goods and services which are listed as reimbursable by social security. In other words, they act as secondary payer but rarely cover excluded goods and services. A notable exception (in some cases) is contact lenses which are rarely covered by social security but are considered by insurers a substitute to glasses (covered, however insufficiently, by social security). Recently an insurer proposed a contract which covers osteodensitometry but the simple fact that this information became public knowledge confirms that it is an exception rather than the rule.

Lastly, some contracts cover supplements which are charged by private hospitals for single rooms, but this most likely represents a small percentage of their reimbursements.

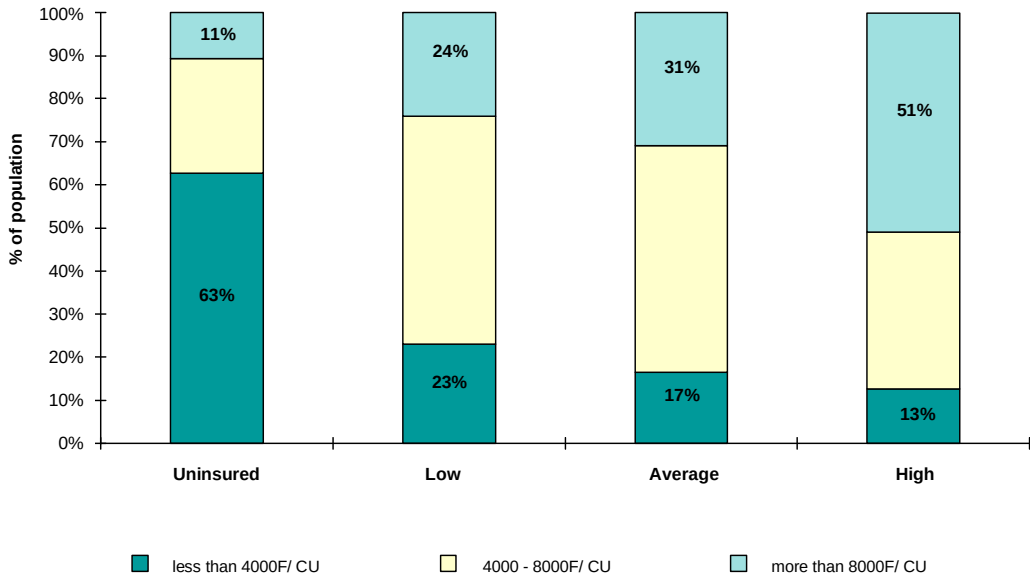
A legitimate question is whether all those who have access to VHI are equally well protected. Until recently in France, there was no reliable information on the content of health insurance contracts. In its 1998 Health and Health Insurance Survey (ESPS), CREDES introduced a set of detailed questions on heath insurance contracts. Based on this information, Bocognano et

[13] There is no official data to back this assertion, but survey results and experts' opinions concur on this.

al. (1999) distinguish groups of contracts which differ by their levels of coverage and show that the extent of the coverage varies among social groups.

Figure 2 represents the distribution across income groups of four categories of people: those not not covered by private health insurance, those whose private coverage is low, average, and high. It is obvious that the higher the coverage, the more likely it is that the insured are rich.

Figure 2: Distribution of the population with respect to income per consumption unit for various levels of insurance



Source: Health and Health Insurance Survey (ESPS) 1998.

Evolution of user charges from 1980 to 2003

The cost-containment of public health expenditure has been on the political agenda since the end of the seventies. In this context, user charges have been increased several times, as a short-term measure to cut sickness funds expenditure and as a long-term tool to reduce demand for goods and services, or, according to the official line, "to make patients consume in a more responsible fashion" (see Table 5 for a detailed list of reforms). However, as private insurance developed and increasingly covered co-insurance, any impact these measures could have had on moral hazard was canceled. In 1967, an attempt was made to forbid the re-insurance of co-insurance but the project was never completed. In the 80s it became clear that increases in co-insurance were essentially a way to decrease public payments. It also became clear that these increases of user charges over time deterred the poorest citizens (few of whom had private complementary insurance) from seeking care, and concerns grew over the system's inequity, leading to the creation of the CMU in 2000. The increase in the amount of user charges over time can also be explained by decisions not to reevaluate social security’s tariffs for some categories of goods and services, and to slow the addition of new products and procedures to the lists of reimbursable items. Inversely, until recently, very few decisions were made to drop items from the lists, with the exception of a few pharmaceutical products (1991 for instance).

Table 5 Major reforms of user charges since the early 80's

1977	The "Veil [a] reform": Prior to this reform, all medicines were covered up to 70%. Starting in 1977, drugs considered to be 'not substitutable and particularly expensive' became fully reimbursed; drugs 'mainly used for the treatment of disorders not usually of a serious nature' were reimbursed at the rate of 40%, and other drugs were reimbursed at 70%.
1982	Lowering of reimbursement rate for 1,300 products from 70% to 40% (cough suppressants, expectorants, phlebotonics, vitamins, stomatological preparations) and delisting of calcitonins.
1983	Creation of the per diem co-payment for in-patient stay (20 FF = € 3,05).
1985	Increase of co-insurance from 30% to 35% for laboratory exams and ambulatory nursing services. Lowering of reimbursement rate for 379 products from 70% to 40% (antidiarrheals, antispasmodics, urologicals, non-specific immunostimulants, peripheral vasodilatators).
1986	The "Séguin[a] reform": The list of "serious illnesses" justifying exemption from user charges is reviewed and expanded to include 30 pathologies. The existing exemption for sick leave from work longer than 3 months is cancelled. From now on, only goods and services directly linked to the pathology are free from user charge and co-insurance is always due for medicines reimbursed at 40%, even for exempted patients. Daily in-patient co-payment is increased to 25 FF (€ 3.81).
1987	115 products (vitamins, except D and B12) are deleted from the list and the reimbursement rate of 28 other products (antinauseants, vitamins D and B12) are reduced. Adjustments to the Séguin reform: reintroduction of reimbursement of "comfort medicines[b]" in certain cases (e.g. antinauseants for pregnant women and patients with cancer), and exemption from all co-payments for people suffering from one of the 30 serious illnesses, as well as an exemption for those whose income is inferior to a certain level.
1988	Partial cancellation of the Séguin reform: full reimbursement of all prescriptions linked to serious illnesses is restored and a new category is created as the 31st pathology ("polypathology").
1991	Daily in-patient co-payment is increased to 33 FF (€ 5,03). 141 antiasthenic products (including psychostimulants), 191 magnesium combinations and 91products with trace elements, and 124 other products (chosen by pharmaceutical companies) are struck from the list
1993	"The Veil [a] reform": increasing all co-insurance rate by 5 points. Daily in-patient co-payment is increased to 55 FF (€ 8,39).
1996	Daily in-patient co-payment is increased to 70 FF (€ 10,67).
1999	Publication of the decree modifying rules for inclusion in the positive list and re-assessment of an important part of the pharmacopoeia according to the new criteria.
2000	Implementation of the CMU reform offering supplementary insurance coverage to the poorest part of the population (see details in the text).
2001	Lowering of reimbursement from 65% to 35% for about 200 products with insufficient medical service rendered. Harmonization of reimbursement rates of the main sickness funds.
2003	In application of the decree of 1999, lowering of the reimbursement rate from 65% to 35% of 617 products with a moderate medical service rendered (certain forms of analgesics, NSAI and corticoids, anti-histamine drugs, antinauseants, etc.).
July 2003	84 products with an insufficient medical service rendered are struck from the list. Introduction of reference prices for about 30 active ingredients.

[a] Simone Veil and Philippe Séguin were Ministers of Health
[b] Medicines reimbursed at 35% (and at 40% before 1986) are often named "comfort medicines".

3. The impact of cost sharing on equity, efficiency and health outcomes: a review of the literature

The first type of evidence regarding the impact of cost sharing comes from the observation of those who forego care. Until 2000[14], about 15% of the population usually declared that they had foregone care for financial reasons in the past 12 months (Auvray, Dumesnil, & Le Fur 2001b). This rate was much lower for those who had complementary insurance then those who did not (14% vs. 26%) and decreased as income rose. The most frequent type of care patients declared having foregone was dental care, followed by eye-ware and specialists' services (higher user charges). Regarding dental care, an econometric analysis of a regional survey of dentists showed that those without complementary VHI had a 240% more chance of not following recommendations to undertake a treatment (URCAM des Pays de la Loire 2002). Even if this very large impact also reflects an income effect (that variable was not available at the individual level), it also points toward financial barriers to care.

Another group of studies that conveys information about the impact of user charges in France does so indirectly, as it's primary objective is to measure the impact of complementary VHI on consumption[15].

The first result gleaned from this literature is that all else being equal, individuals covered by complementary health insurance consume significantly more care in the ambulatory sector than those without.

Caussat and Glaude (1993), Genier (1997; 1998), who studies episodes of care, and Raynaud (2002a; 2002b) find similar results: the probability of consuming ambulatory care is higher for those covered. Moreover, all types of ambulatory care are concerned (additional evidence on drugs is provided by Dourgnon and Sermet (2002). Regarding ambulatory expenditure, all except for Genier find that the privately insured have significantly higher expenditure on ambulatory care than the uninsured.

Regarding hospital care, the evidence is mixed: while Reynaud (2002a; 2003) finds no impact of VHI on consumption, Caussat et Glaude (1993) find a significantly negative one.

Since insurance covers user charges, these results show that consumption (or access, depending on how we look at it) is price sensitive.

These studies also suggest that, to a certain extent, there might be a change in consumption patterns explained by insurance (hence indirectly by user charges). Individuals with insurance would be more prone to consume care that can lead to extra billing (specialists[16] , dental care and eye-ware), and that there might even be a substitution of hospital for ambulatory care. Whether the latter point is simply a direct consequence of user charges or is also an indirect one (delaying ambulatory care ultimately results in people going to the hospital when the condition is serious) can be argued. Based on cross-sectional data for various age groups, Polton and Grignon (2000) do find that, amongst those in relatively good health, the rich have higher ambulatory expenditure than the poor, when they are young, while the reverse becomes true at later stages of life. Testing this hypothesis requires longitudinal data over a long period which is currently unavailable.

Another major concern regarding user charges is whether or not they are equitably distributed in the population. Aligon and Grignon (1999) estimate the actual amount of user charges paid

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[14] Introduction of CMU.

[15] Most models control for adverse selection, which is only found to be significant but small by Genier (1998), though, her consumption equation does not control for it).

[16] Even though, looking specifically at conditions for which substitution between GP and specialist care is more likely, Buchmueller and al. (2002) find no clear evidence of that happening.

by a sample of individuals covered by the main health insurance fund. They show that 11% of the poor (monthly income below 458 € per consumption unit) spend more than 13% of their monthly budget on user charges. On average however, the out-of-pocket payments of the poor are slightly lower than those paid by the whole population. This indicates a lower spending on health care by the poor (- 8%), which in turns partly explained by a higher proportion of the poor that does not consume any health care during the year. They also compare the structure of user charges of the poor and non-poor and show that co-insurance (*ticket modérateurs*) represent a higher share of the poor's out-of-pocket payments. This confirms (as we said before) that they tend to seek care eligible for reimbursement and that the structure of their consumption differs from that of the overall population.

The only study which explicitly measures equity in the finance of the French health care system's financing was conducted in the early nineties. Based on survey data, Kakwani indices were computed by van Doorslaer et al. (1993) according to a uniform methodology. Results shows that both VHI and direct payments in France are regressive, in other words, those with lower income assume a bigger share of private expenditure, and contribute relatively more to the private financing of care than those with higher income. This study also shows that total private expenditure on care is more regressive in France than in every other country with the exception of the US and Switzerland, both countries in which private insurance is the main source of coverage.

The introduction of the CMU may have changed that. Indeed, examining the consumption of the poor who are protected from user charges by VHI (Aligon & Grignon 1999) or public funds, like the AMD (Raynaud 2002a) and later the CMU (Raynaud 2003) shows that protection mechanisms reach, to a certain extent, their objective. For instance, Grignon and Aligon complete their study of user charges by a multivariate analysis which compares the out-of-pocket payments of the poor to those of the rest of the population. They show that once coverage by private insurance is taken into account, the difference between the poorest and the rest of the population becomes insignificant. According to this study, access to private insurance restores a level of access to care which is comparable (all other factors being equal) to that of people with higher income.

4. Political feasibility: a discussion of policy debates concerning cost sharing

A series of reforms or policy debates have been spawned by growing dissatisfaction with the way public health insurance covers care and the need to limit public expenditure. The lists of reimbursable items have always been managed on a day-to-day basis by the State, sometimes based on advice by the health insurance funds and health professionals. The process is not always rational and is never transparent (at least to the public). Many experts (Haut Comité de la Santé Publique 2001) believe that it would be more efficient and equitable to clearly define a set of indispensable goods and services which should be available to everyone and which would be extensively or completely financed by public health insurance. The remaining goods and services would be available to those who desire and / or can afford them, with or without relying on private insurance. Rather than increasing user charges on a wide range of goods and services, it would be preferable to collectively decide where the public intervention should be concentrated, in other words, to elaborate a basic benefits package.

Priority setting based on economic evaluation is clearly one orientation of current reforms. Since 1999, the assessment of the medical service rendered by each drug is a prerequisite for inscription on the positive list and the rate of reimbursement is supposed to depend on its level. The same rules now apply for prosthesis and medical devices. Likewise, the fee schedule for physicians services has been currently completely reassessed and procedures without valuable service medical rendered are to be excluded from the new schedule.

However, these reforms are not so easy to implement and the case of medicines offers a good illustration of encountered political difficulties. Although the results of total re-assessment of the total pharmacopoeia have been published by the Transparency Commission since 2001, the first decisions for striking items from the list or lowering reimbursement rates of drugs only occurred in 2003. Moreover, pharmaceutical companies have initiated lawsuits at the highest French administrative court (*Conseil d'Etat*) to contest the Transparency Commissions' decisions. The new fee schedule for physicians services also encounters strong opposition (essentially because of its potential impact on physicians' revenue).

Another related change in the way social security might operate is the idea of making more room for the care provider to evaluate the medical need of the patient (or the context in which the service is delivered) and to change the amount paid by social security depending on this judgement. For the exemption of co-insurance for specific conditions physicians have long been asked to separate the care related, as opposed to unrelated to the disease. A more recent example is that of the home visits conducted by GPs. Since last year, medically justified visits have been reimbursed on the basis of 30€, while for other types of house calls social security's basis of reimbursement is 20€ (as for an office visit) and the GP is allowed to charge beyond that amount (the difference constituting a user charge).

Another major political issue is a pending reform of public health insurance. Though the government recently announced that the debates would not take place in the fall 2003 as initially planned, but much later, it had already commissioned a report that was published earlier this year. The core proposal of the Chadelat report (2003) is the creation of a "Generalized health insurance" (GHI) programme that covers the services all citizens should have access to. This GHI would consist of two separate tiers:

- mandatory health insurance (not essentially different from the existing one);

- "basic complementary health insurance" (BCHI) which would not be compulsory but would be made accessible to anyone, through a progressive subsidy for the poorest part of the population[17]. The CMU complementary policy (see above) would be maintained as a part of BCHI, along with its constraints on providers (no extra-billing), but only for the poorest insured. The other part of the BCHI would not impose such constraints on providers. In principle, BCHI policies would be provided by private insurers[18]. They would be under obligation to cover a defined set of services (co-insurance for goods and services covered by compulsory insurance). The premiums would be set freely but in accordance with "solidarity principles", i.e. no health questionnaire or differentiation of premiums according to health status[19].

The GHI positive lists and levels of cost-sharing would be drafted according to the above-mentioned principles and the split between the mandatory health insurance and the BCHI would be negotiated in order to improve their joint and separate capacity to "manage care".

Beyond the basic complementary coverage, private insurers would still be free to provide more advantageous contracts (for extra-billing and non-covered care).

The Chadelat report was heavily criticized by actors of various background (providers' unions, employer and employees unions, private insurers representatives, …). Whether the government follows these proposals or not, any reform of the health insurance will automatically have an impact on user charges.

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17 The non-compulsory characteristic is designed to avoid an increase in withheld taxes and contributions.

18 With a possible exception for the poor (as is currently the case for the CMU) in order to spare them excessive paperwork and cumbersome administrative procedures.

19 These solidarity principles are already part of the private health insurance regulatory framework. Institutions that respect them are exempted from a 7% tax on contracts.

Table 6. Current cost sharing arrangements in France

Good or Service	Type of cost sharing	Value in Euros	Protection mechanism
Out-patient GP visits	Co-insurance (30%)	€ 6.00	General rules of exemptions applicable Covered by complementary CMU
	Extra-billing (only for doctors in "sector 2")	€ 11.5 on average for visits with extra-billing (about 12% of GP visits)*	Not permitted for CMU beneficiaries
Out-patient specialists visits	Co-insurance (30%)	€ 6.90	General rules of exemptions applicable Covered by complementary CMU
	Extra-billing (only for doctors in "sector 2")	€ 17.3 on average for visits with extra-billing (about 35% of specialist visits)*.	Not permitted for CMU beneficiaries
Dental services	Co-insurance (30%)	€ 6 for a visit € 4.34 for a simple filling € 32.25 for a crown	
	Extra billing for prostheses	€ 309 on average per crown [b]	For CMU beneficiaries the extra billing is capped at € 90.7 and the dentist cannot charge more.
Prescription drugs	Co-insurance (0%, 35% or 65%, according to the type of drug)	Varying with the price	General rules of exemptions applicable Covered by complementary CMU
	+ difference frfom the reference price for drugs included in reference priced generic groups.	No estimates available	
Prescribed out-patient services of medical auxiliaries (nurses, physiotherapist, etc.)	Co-insurance (40%) With prior authorization for certain types of care.	€ 2.32 for an I.V. injection by a nurse	General rules of exemptions applicable Covered by complementary CMU
Laboratory exams	Co-insurance (40%)	€ 4.32 for complete blood count	General rules of exemptions applicable Covered by complementary CMU
Transportation	Co-insurance (35%) with prior authorization (except for emergency cases)	No estimates available	General rules of exemptions applicable Covered by complementary CMU

Good or Service	Type of cost sharing	Value in Euros	Protection mechanism
In-patient stays	The patient has to pay the highest of the following two amounts computed over the length of stay: (1) Co-insurance (20% of the total bill)	No estimate available but 85% of in-patient stays are exempted from co-insurance	Covered by complementary CMU General rules of exemptions applicable + Exemption: • starting on the 31st day of stay • for stays which are motivated by a surgical procedure exceeding about € 200 • for delivery and the 12 following days The amount of these exemptions is limited to what would be charged in the hospital closest to where the patient lives.
	(2) Daily co-payment	€ 10,67 per day	Exemptions for: • women more than 5 months pregnant stay for delivery • newborns < 30 days • beneficiaries of CMU or "State Medical Aid" • handicapped < 20 years • seriously disabled war veterans • victims of occupational disease or workplace accidents
	"Extra-billing" for: • more comfortable accommodation in the private sector (e.g. single room) • physician services in private hospitals	No estimates available	Exemption from extra-billing if the need for additional comfort is medically justified.
Lenses	Co-insurance (35%)	▪ for adults: € 0.8 to 8.59 ▪ for children: € 4.21 to 23.28 The more complex the lenses the higher the co-insurance.	General rules of exemptions applicable Covered by complementary CMU.
	Extra billing	▪ for adults on average € 97 [b] ▪ for children on average € 26 [b]	For CMU beneficiaries the extra billing is capped and the provider cannot charge beyond that amount.
Hearing aids	Co-insurance 35% Extra billing	No estimates available but known to be high	General rules of exemptions applicable For CMU beneficiaries the extra billing is capped and the provider cannot charge beyond that amount.

Sources: (2003; Cnamts 2001; Cnamts 2003e)

[a] The average amount of extra-billing is given for physicians allowed to charge beyond official tariff in 2002 (Cnamts 2003b). In reality, because of a conflict between physicians and sickness funds, extra-billing has been often practiced in 2002 by "non allowed" physicians but for those physicians the average extra-billing was lower (€ 2.4 for GPs and 4.1 for specialists).

[b] Per item on average, authors' estimate based on social security claims files for 2000.

Tables of results

Author + date	Study period	Study population + data source	Outcomes	Price variation	Type of study / design	Results
(Aligon & Grignon1999)	1992	4,361 non-institutionalized individuals covered by the general health insurance fund ESPS-EPAS: CREDES Health and Health Insurance Survey merged with social security claims data over a year	Total user charges and co-insurance related user charges.	Variation in user charges depending on VHI status taking into account whether individuals are poor or not.	**Observational** Regression control	Lower user charges for the poor explained by lower total expenditure and focus on services with no or low extra-billing (hospital, GPs vs. dental care and specialists). Co-insurance represents a higher proportion of the user charges faced by the poor. Once VHI is controlled for, the difference in the amount of user charges between the poor and the non-poor is not significant.
(Raynaud 2002b)	1992-95-97 (grouped)	13,113 individuals in the non-institutionalized population covered by the general health insurance fund ESPS-EPAS: CREDES Health and Health Insurance Survey merged with social security claims data over a year	Probability of any expenditure and amount, global and per type of care	Variation in user charges depending on VHI status: non-covered, covered by VHI, covered by AMD (complementary public insurance policy for poor)	**Observational** Regression control	Compared with non-covered, those with AMG have a 12 percentage point higher probability of having any ambulatory expenditure, and those with VHI a 15 higher one. Expected ambulatory expenditure, compared with non covered: 25% higher for VHI, 18% lower for AMD. AMD beneficiaries have more frequent access to GPs (and services prescribed by them) than non-covered, yet their expected expenditure is lower. For services with large extra-billing (not covered by the AMG: specialist, dental and optical care) there are few differences between AMG beneficiaries and non covered individuals. One the other hand, VHI has a positive impact on the probability of using these services thought the impact of expected expenditure is only significant for dental care. Compared with non-covered, AMD have a lower probability of going to the hospital. The AMD consumption pattern is assumed to be explained by early access.

Author + date	Study period	Study population + data source	Outcomes	Price variation	Type of study / design	Results
(URCAM des Pays de la Loire2002)	2000	4,362 patients for which dentists identify a need for care Survey of dentists in the Pays de Loire Region merged with social security dental claims	Probability of not completing the treatment	Variation in user charges depending on VHI status (covered vs. not covered).	**Observational** Regression control (no income variable)	The risk of not having completed the treatment increases by 240% if the person is uninsured.
(Caussat & Glaude 1993)	1980	16,766 non-institutionalized individuals excluding those exempted from co-insurance and those in very bad health. 1980 national health survey (INSEE)	Probability of consuming care in a 3 months period (declared) and induced amount, global and per type of care	Variation in user charges depending on VHI status (covered vs. not covered).	**Observational** Regression control	Covered individuals have a 12 percentage point higher probability of having any consumption and their expected expenditure is 30% higher. Those covered have a lower hospital expenditure. The positive impact of coverage on the probability is significant for all types of ambulatory care, highest for specialists and prescribed medicines. Conditional expenditure is significantly higher for specialists, medicines and lower for hospital.
(Genier 1998)	1991-1992	21,433 non-institutionalized individuals 1991-1992 national health survey (INSEE)	Probability of entering an episode of care (episode reconstituted based on consumption declared in a 3 months period) number and duration of these episodes. Probability and number of ambulatory visits (GP, specialists, all providers) Ambulatory expenditure	Variation in user charges depending on VHI status (covered vs. not covered).	**Observational** Regression control	Covered individuals have a 16 percentage point higher probability of entering an episode of care, a higher number of episodes and a comparable duration of episodes. The probabilities and number of visits for those covered are higher for all types of providers. Ambulatory expenditure is not significantly different.
(Dourgnon & Sermet 2002)	1998	15,200 non-institutionalized individuals ESPS : CREDES Health and Health Insurance Survey	Drug consumption in 8 pharmacological classes of individuals that suffer from the relevant diseases (monthly consumption record).	Variation in user charges depending on VHI status (covered vs. not covered).	**Observational** Regression control	In all cases, those without insurance have a significantly lower probability of consuming drugs and the conditional expenditure is significantly lower.

Author + date	Study period	Study population + data source	Outcomes	Price variation	Type of study / design	Results
(Chiappori, Durand, & Geoffard 1998)	1993-1994	4,578 bank and insurance employees (and family members) that are covered by one of two comparable complementary VHI contracts CECAR claims files (CECAR is a French broker firm that manages insurance contracts on behalf of companies)	Probability of a GP home visit, a GP office visit, a specialist (office) visit in the year before and after.	Introduction of a 10% co-insurance for ambulatory care in one of the two insurance contracts	**Quasi-experimental** Before and after, control group	No (differential) change in the probability of visit a GP or a specialist office. Comparatively, a decrease in the probability of having one GP home visit.
(Buchmueller et al. 2002)	1998	8,161 non-institutionalized individuals over 25 excluding those exempted from co-insurance ESPS : CREDES Health and Health Insurance Survey	Probability of a physician visit, choice between a GP and a specialist for a subset of diseases for which substitution is possible.	Variation in user charges depending on VHI status (covered vs. not covered).	**Observational** Regression control	With insurance, the probability of having at least one physician visit is increased by nearly 13 percentage points. No evidence of substitution between generalists and specialists care for those covered.
(Raynaud2003)	2000	9,000 low-income individuals in the non-institutionalized population ESPS-EPAS: CREDES Health and Health Insurance Survey merged with social security claims data over a year	Expenditure excluding extra billing (EEE social security tariffs including coinsurance)	Variation in user charges depending on VHI status: non-covered, covered by VHI, covered by CMU (which forbids extra billing)	**Observational** Regression control	Compared with non-covered, those with CMU have a 21% higher expected EEE and with VHI a +13% higher one. CMU have higher GP EEE than other categories, Regarding specialist care, compared with non-insured, those covered by VHI have a +22% EEE, those with CMU that did not have coverage before, a 16% EEE, while ex-AMD beneficiaries (who were not covered for extra-billing before) a slightly lower EEE.

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