The French Health Care System: A brief overview.
Presentation prepared for the PWG meeting[1]
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Health Insurance and access to care

To best understand how the French health care system works, I think it is best to begin with a look at the French health insurance system.

First of all, all legal residents of France are covered by **public health insurance**, which is one of the social security system's entitlement programs. The public health insurance program was set up in 1945 and coverage was gradually expanded over the years to all legal residents: indeed, until January 2000, a small part of the population was still denied access to the public health insurance.

The funding and benefits of **the French public health insurance system (PHIS), much like Germany's, were originally based on professional activity**. The main fund covers 80% of the population. Two other funds cover the self-employed and agricultural workers.

Once varying depending on the fund, **disparate reimbursement rates were replaced by uniform rates**. The funds are financed by employer and employee contributions, as well as personal income taxes. The latter's share of the financing has been ever-increasing in order to:

- compensate for the relative decrease of wage income,
- limit price distortions on the labor market,
- and more fairly distribute the system's financing among citizens.

Most health insurance funds are **private entities which are jointly managed by employers' federations and union federations, under the State's supervision**. The joint labor/management handling has always sown discord within the funds' boards, as well as between the boards and the State. As a consequence, the responsibilities of the various actors in the system are not always shared in the most coherent manner. For example, the parliament's budget provisions determine how much public money will go to health expenditure, the cabinet decides reimbursement rates and sets the amount of contributions earmarked for the funds, while the funds themselves negotiate with health care professions to set tariffs designed to ensure the system operates at the breakeven point. Responsibilities are frequently redefined, but never to satisfaction of all involved.

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The public health insurance system covers about 75% of total health expenditures. Half of the outstanding amount is covered by patients' out-of-pocket payments and the other half is paid by private health insurance companies. These supplementary health insurance policies can be taken out by individuals or groups. About 85% of the population own such policies.
An important peculiarity of the French PHIS is that the funds **cover a very wide range of goods and services**, including for example, stays in thermal spas.
In the hope of curbing consumption and expenditures, copayments were implemented and have increased over time. These copayments are **relatively high for many out-patient services**. For example, patients must pay 30% of Social security's tariff for a physician's visit, moreover, roughly 40% of specialists and 15% of GPs are allowed to charge more than the tariff. Copayments are also high for dental prostheses and eye-ware. This tended to deter the poorest citizens (few of whom had supplementary insurance) from seeking care. Concerns grew over the system's inequity.

In January 2000, a **means-tested, public supplementary insurance program called CMU** (*Couverture maladie universelle*) was implemented to ensure the poor access to health care. For those whose income is below a certain threshold (about 10% of the population is eligible), this insurance covers all public copayments and offers lumps-sum reimbursements for glasses and dental prostheses. Health professionals are not allowed to charge more than the public tariff or the lump-sum for CMU beneficiaries, which means that in theory, access to care is free of charge.

In passing, I'd like to mention that many experts **advocate a change in the way health insurance covers care**. They think 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 should be 100% publicly financed. The remaining goods and services would be available to those who desire and can afford them, with or without relying on private insurance.

To close this aside on access to care, I'd like to add that, as far as I know, France is the only country in which access to care is unlimited: patients can see as many physicians as often as they like. Patients do not need referrals to see specialists, and in general, there is no gate-keeping system of any kind. This may partially account for the World Health Organization's high ranking of France's health care system last year: the rating system emphasized the system's responsiveness (a measure of patients' freedom and flexibility), a quality the French system provides, undeniably at the expense of overall efficiency.

The State's Role

1. The State decides on what care is to be reimbursed and to what extent, defines the responsibilities of the various actors, and ensures that the entire population has access to care.
2. The State **defends patients' rights, drafting and enforcing relevant policy**. The State is thus responsible for safety within the health system. The disaster and subsequent cover-up of the contamination of the nation's hemoglobin supply with HIV-tainted blood resulted in the revamping of public health policy. New agencies were created to oversee safety measures concerning the nation's blood supply, organ donor programs, food, and medical goods and services. The recent handling of the mad cow crisis indicates that these changes have improved public safety.

3. The State is also in charge of **planning**. Health authorities decide on the size and number of hospitals, as well as the amount and allocation of highly technical equipment (MRI, CT-scans...). It organizes the supply of specialized wards (transplants, neurosurgery...) and ensures the provision of care at all times, like emergency rooms.

Since 1991, some of the planning has taken place **at the regional level**. Indeed, more and more policy-making and negotiation are undertaken at the regional level, and this tendency is likely to continue in the coming years.

The Care Supply

Hospitals

In France, hospitals have always been the core of the health care system. This probably accounts for the extremely specialized, technical, curative nature of our care, arguably to the detriment of prevention and community services.

The number of hospital beds has decreased over time: it currently stands at 8.4 per 1,000 inhabitants, which is close to the European average. Hospitals can be roughly divided into two categories: public, and private for-profit.

- The public sector represents about 65% of the beds. Public hospitals have specific obligations such as ensuring the continuity of care, teaching, and training. They receive a budget which is largely based on a historical basis.
- Private for-profit hospitals concentrate on surgical procedures and rely mostly on fee-for-service remuneration for their funding.

A uniform hospital information system has been implemented to monitor the various establishments activity. Gradually, all public and private establishments are to switch to DRG payment systems.

Health Professionals

Of the many types of health professionals, I would like to focus on physicians, as they play a key political role in the system. There are currently about 200,800 physicians licensed to practice in France. In the last thirty years the number of physicians has tripled, but the rate of increase is now very slight. Indeed, since 1971, the Ministry of Health has limited the number of medical students, a measure which, along with the retirement of currently active doctors, will result in a decrease in the number of physicians in the near future.

Half of the physicians are **specialists**.

In France, physicians (and other professionals) generally work in two kinds of environments: public hospitals and private practices. 25% of physicians work in public hospitals (another 11% work in other types of public establishments). They are in essence public servants and paid an amount that is fixed by the government. Today, many physicians feel that the prestige of working in a hospital does not compensate for the trying working conditions. 56% of physicians work in private practices[3], and are paid on a fee-for-service basis. The relative weight of the procedures is set by experts and the prices are negotiated by physicians' unions and public health insurance funds[4].

Since the creation of Social Security, the relationship between private practice physicians and the State and public insurance funds has always been strained. A contract (*convention*) which sets the general regulatory framework and the remuneration of the profession is supposed to be signed every 5 years by physicians unions. The first one was signed in 1971, 26 years after public health insurance was created. Subsequent *conventions* allowed some physicians to charge more than social security tariffs (1980), limited this right (1990) and implemented official medical practice guidelines (*RMO, Références médicales opposables*) in 1993.
The current situation is particularly strained: negotiations between doctors' unions and the funds have stalled, leaving the specialists without a convention and isolating the GP union which signed a convention in 1998. The root of the problem is that private practice physicians are strongly opposed to the setting caps on outpatient expenditures. They have always had a great deal of freedom over where they set up shop, how they practice, and what they prescribe (compared to their counterparts in other countries). Yet the bulk of their income is paid by public funds. This contradiction has become more glaring as the concerns about soaring health expenditures grew.

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[3] *16% of these work part-time in public establishments, and 7% practice in private for-profit hospitals.*

[4] *The remaining physicians declare either no practice (7%) or other types of activities (1%).*

In conclusion, I would like to call special attention to two features of the health care system:

1. Despite the fact of universal coverage, there is considerable inequality in the availability of health care in France. For example, on average, there are 335 physicians per 100,000 inhabitants. But there are twice as many specialists per person in the Greater Paris region than in the region of Picardie.
2. The coordination of the various health care actors is clearly insufficient. The system breeds competition and undermines cooperation: there is friction between the private and public sectors, between out-patient facilities and hospitals, and between various health care professions. Concern is growing among patients, providers, and regulators. Incentives have been created to spur the development of managed-care networks, though progress has been slow.

The Financial Management of the Health Care System

Social security has been cumulating deficits for the last quarter century. Health policy-makers, their efforts focused on curbing expenditures, have introduced measures like copayments and regulating the quantity of available care (by limiting the number of hospital beds and physicians).
Prices and tariffs for ambulatory procedures are negotiated (and therefore controlled) and prescription drug prices are regulated.

Since the 90s, **yearly expenditure caps have also been set for some sectors** like private hospitals and laboratories. Prices within the sector are raised or lowered depending on whether or not the objectives have been met.

Since 1996, parliament has determined the national health insurance system's annual budget.

- That amount is then broken down and appropriated to the various sectors (public hospitals, private hospitals, ambulatory expenditure - which includes prescription drugs).
- The public hospital funds are allocated to regions in such a way as to better tailor the distribution of available care to the needs of the population.

Once the caps are set, the government or the health insurance funds (depending on the sector) is responsible for enforcing them. Such direct financial regulation has not been effective in achieving its goal and has worsened the already strained relationship between health care providers and authorities.

But hey! Who cares? We've got the best health care system in the world.