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Is the Public-Private Mix in French Health System Sustainable?

Aurélie Pierre, Zeynep Or (IRDES)

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Is the Public-Private Mix in French Health System Sustainable?

Aurélie Pierre[a], Zeynep Or[a]

Abstract: France is known for having one of the best health care systems in the world. Indeed, its responsiveness is rated high; patients have a large choice of public and private providers without chronic waiting time problems observed in some OECD countries. Out-of-pocket payments are among the lowest in OECD area and the health status of the population ranks amongst the best in the world. However, promoting a universal health system built on a mix of public and private funding and provision raises numerous challenges to ensure equity and efficiency in the system. In this *Working Paper*, we present the unique public/private mix of healthcare funding and delivery in France and discuss to what extent this mix contributes to achieving overall health system goals of better health outcomes, equity and efficiency. We first explain the role of public and private insurances in healthcare funding and discuss the increasing regulation of private health insurers to align them with public objectives as an attempt to overcome the limits of current public insurance model. We then describe the place of private providers in care delivery and the implications of this plurality on care quality, efficiency, and access to care. By discussing the most recent measures tackling the issues in public-private mix in French health system, we suggest some avenues for improvement.

JEL codes: I13, I18, I11.

Keywords: Public health insurance, Private insurance, Health care delivery, Health funding, Access to care, Equity, France.

[a] Institute for Research and Information in Health Economics (IRDES).

Le modèle mixte public/privé du système de santé français est-il soutenable ?

Aurélie Pierre[a], Zeynep Or[a]

Résumé : Le système de santé français est considéré comme l'un des meilleurs au monde : les patients disposent d'un large choix de professionnels de santé, publics et privés, les dépenses de santé à la charge directe des assurés sont les plus faibles des pays de l'OCDE, il y a moins de problèmes structurels de délais d'attente que dans d'autres pays, et l'état de santé de la population se classe parmi les meilleurs à l'échelle internationale. Mais promouvoir un système de santé universel qui repose sur un partage public/privé des financements et des offreurs de soins s'accompagne de nombreux défis pour garantir l'équité et l'efficacité du système de santé. Ce *Document de travail* décrit la combinaison unique publique/privée du financement et de la délivrance des soins en France et discute des avantages et des contradictions d'une telle organisation pour atteindre des objectifs d'équité, de qualité des soins et d'efficience. Nous commençons par décrire le rôle des assurances publique et privée dans le financement des soins et discutons de la régulation massive du marché de l'assurance privée pour tenter de pallier les limites du système d'assurance publique en France. Nous présentons ensuite la place des offreurs de soins privés dans l'organisation et la délivrance des soins et discutons des implications de la pluralité de l'offre sur l'efficience du système et sur l'accès aux soins de la population. Nous concluons en présentant des mesures récentes et des pistes d'amélioration qui pourraient permettre de réduire les effets pervers d'un système mixte public-privé dans le système de santé français.

Codes JEL : I13, I18, I11.

Mots clés : Assurance maladie publique, Assurance privée, Offre de soins, Financement de la santé, Accès aux soins, Équité, France.

[a] Institut de recherche et documentation en économie de la santé, Irdes.

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1. Introduction

Three major values —solidarity, liberalism, and pluralism— define the foundations of the French health system and shape care organization and its funding. Solidarity requires equal access to care by need and a financing system where the healthy and rich support the less wealthy and sick. Liberalism refers to the freedom for health professionals to be able to decide the type and place of their practice and for patients to choose their care providers and insurance levels. Pluralism relates to a wide range of health care providers and multiple private health insurers. The complex hybrid public/private organisation and funding of the French health system reflects the weight of these values, as well as, in some respect, their contradictions. Solidarity is mainly provided by the universal health insurance allowing the redistribution of resources for supporting the sick and low-income individuals while plurality can be seen in the mix of public and private providers and private insurance schemes. Nevertheless, this plurality in care provision and funding, together with a high degree of freedom for care providers and patients have been challenging the objectives of solidary, equal access to high quality health care and system-wide efficiency.

The public health insurance scheme is a non-competitive statutory health insurance (SHI) model which covers all of the French population. It provides a comprehensive basket of care and funds about 79% of health expenditure[1] in 2021 but requires cost sharing for all services, including doctor visits and hospitalizations (Arnaud et al., 2022). About 96% of the French population holds a complementary private health insurance (CHI) to cover mainly these copayments (Pierre, 2022). Therefore, France has one of the lowest average out-of-pocket expenditure (around 9%) amongst the OECD countries. Private complementary insurance finances around 13% of the health expenditure covering all or part of the costs left to patients by the SHI, and plays a key role in assuring access to care (Franc et al., 2016; Grignon et al., 2008; Buchmueller et al., 2004), especially to services for which the costs are not well covered or regulated by the SHI, such as specialist and dental care. In other words, health care in France is funded by a mixture of public and private health insurance schemes reimbursing the same benefit package. Different from some other countries, private health insurance is not used for getting faster access to certain treatments or for jumping public sector queues. Waiting times, while could be problematic in some areas due to the unequal distribution of doctors in the territory, are by no means big as an issue as in some other countries, such as Canada and England (Flood and Thomas, 2020). No matter the level of their private insurance, patients have a large choice of public and private health care providers mostly paid on a fee-for-service (FFS) basis.

The health outcomes of the French population ranks among the best in the OECD area, with one of the highest life expectancy (OCDE, 2019). Patients have a large choice of providers and the health system's responsiveness is rated high. However, promoting a universal health system built on a mix of public and private funding and provision raises numerous challenges for assuring the equity in access, solidarity and efficiency of the system. The system is expensive, complex, and fragmented in its organization and funding. Large differences in health status between socio-economic groups as well

1 Health expenditure covers all type of care, included long-term care and prevention, as well as those related to the governance of the health system.

as social and geographical inequalities in access to care have been a persistent problem (Devaux, 2015; Chevillard et al., 2018). High concentration of out-of-pocket expenditure by the poorest and the sickest part of the population is a real concern (Franc and Pierre, 2016; Perronnin, 2016). Therefore, the equity principle which is rooted in law and reinforced in all health plans as a strategic objective requires continuous tunings of the health system (*Ministère des solidarités et de la santé*, 2017, 2022).

In this chapter we present the unique mix of public/private health care funding and delivery in France and discuss to what extent this mix contributes to achieving overall health system goals of better health outcomes, quality, equity and efficiency. The first section explains the role of private insurance in health care funding and shows how public decision-makers regulate private insurance market to reduce the issues for equity of access to care and efficiency. The second part focuses on the role of private providers in care delivery and implications of this plurality on care quality, efficiency and access. We then summarise in a last part the most recent measures tackling the majors issues with the organization and funding of public-private mix in French health system and suggest some avenues for improvement.

2. An unusual hybrid public-private health insurance system

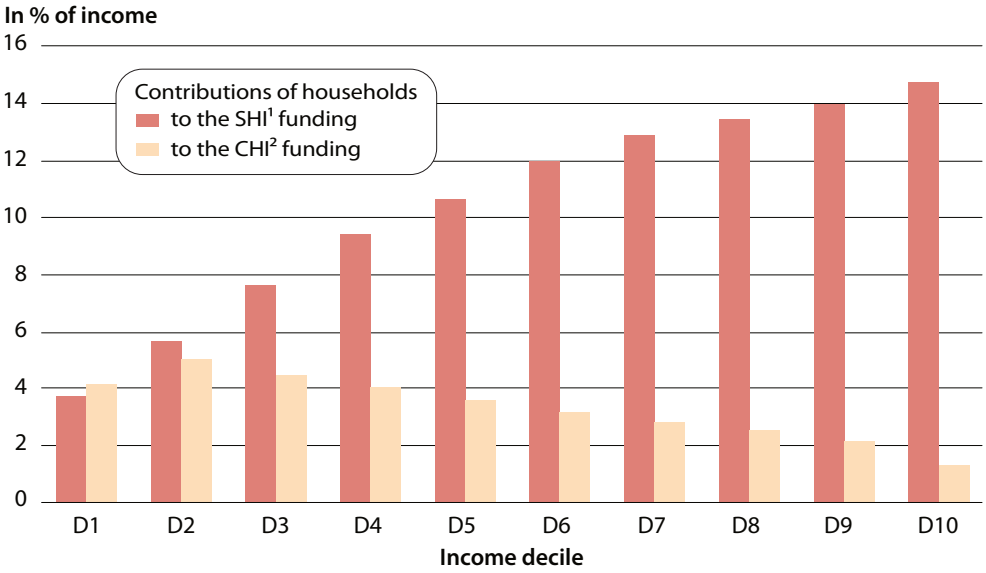
France stands out from other countries with similar public and private insurance organization (such as Switzerland, Germany and South Korea) by the fact that public and private insurances reimburse jointly the same health services on almost all type of care. The unique place of private health insurance in France is reflected in the high complementary insurance coverage in the general population (96% in 2019), and the high share of private insurance (13% in 2021) in total health expenditure. Funding for the public SHI comes mainly from income-based contributions from employers and employees, as well as, increasingly, through taxation. CHI is based on contractual freedom; while insurers are not allowed to deny to insure someone, premiums are mostly conditioned on age (i.e. on risk) without considering ability to pay, and the level of benefits vary mainly according to income.

2.1. The public health insurance: solidarity in French system

2.1.1. Universal coverage with contributions on the basis of means

Since its creation in 1945, public health insurance in France has been based on two founding principles, namely access to care depending on need, not income (the principle of horizontal equity), and solidarity between high- and low-income classes for financing the system (vertical equity). The principle of horizontal equity is reflected by the SHI's reimbursements and depends on health needs, resulting in solidarity between the healthy and the sick, and the principle of vertical equity is reflected in the progressive nature of financial contributions to the SHI, which are proportional to income with a higher contribution for wealthier individuals (Figure 1). Until 1970s, the funding of the SHI was based almost exclusively on payroll contributions. In the past few decades, to assure financial sustainability, the sources of funding have been broadened to include

Figure 1 **Contributions of households to the SHI and the CHI funding in 2012, by income decile**



[1] SHI: Statutory Health insurance; [2]: CHI: Complementary Health Insurance.
Note: D1 corresponds to 10% of the population who has the lowest income, and D10 to top 10%. Contributions of households to the CHI funding were simulated as there is no data in France that allow studying the distribution of CHI coverage in the overall population
Source: Jusot et al ., 2016.

a wider range of income. The most important change has been the introduction of the *Contribution Sociale Généralisée* (CSG) –taxes applied to a broader range of income such as financial assets and investments, pensions, gambling, etc.– to finance the SHI. A number of earmarked taxes on alcohol, tobacco and pharmaceutical companies have also been introduced to support public health financing over time. In 2021, about 40% of revenues for the SHI came from payroll contributions, 25% from the CSG, and 35% from other taxes (Commission des Comptes de la Sécurité sociale, 2022).

The SHI is compulsory and universal for all individuals who work or reside regularly in France. It is provided under various insurance schemes, with mandatory enrollment determined by employment status (wage earners, self-employed, farmers and agricultural employees, students, etc.) or by previous employment status for the retired. Individuals cannot choose their scheme or insurer, nor can opt out. Thus, there are no competing health insurance markets for public health coverage in France. Three main SHI schemes cover the entire French population. The first one, *le Régime Général*, insures wage and salary earners, self-employed, and their dependents, and covers about 88% of the population. The second one, *la Mutualité sociale Agricole*, for farmers and agricultural employees, covers about 10% of the population. The last one, *les Régimes spéciaux*, includes about ten small schemes that cover specific professional categories (e.g., notaries, military, etc.), representing less than 2% of the population. All SHI insurers provide the same basket of services and goods.

The SHI became universal in 2000 after the implementation of the "Universal Health Insurance" law (CMU[2]), that allowed covering the 2% of individuals who were not un-

[2] Which became the *Protection Universelle Maladie, PUMA* in 2016.

der any scheme given their employment status. There is also a fully state-funded scheme, *l'Aide médicale de l'Etat*, which provides access to a specific standard benefit package for illegal immigrants (that differs from the SHI benefit package). It is means-tested, and applicants must be resident for more than three months in the French territory. In 2021, about 380,000 people benefitted from this scheme.

2.1.2. A comprehensive benefit package

The standard benefit package under the SHI system covers a wide range of goods and services including in-patient hospital and rehabilitation care (both in private and public facilities), home care, dental care, prescription drugs, cost of transport, and care provided by paramedical professionals (physiotherapists, speech therapists, etc.). Patients usually pay the cost of ambulatory services at the point of delivery and then are reimbursed from their insurance funds. The SHI reimbursements are based on predefined rates of regulated prices that vary according to the type of care, reflecting stronger solidarity for the most severe diseases. Patients' copayments are calculated on the basis of regulated prices, called tickets modérateurs, varying from 20% of regular fees for hospital care to 30% for physician visits, and from 0% to 85% for approved prescription drugs[3]. There are also a number of small deductibles for physician visits, paramedical procedures, drugs, and medical transport, cumulated with extra-billing fees from some physicians. As a result, while the SHI covers on average about 80% of the total cost of health care in 2021, this goes up to 93% for hospital care, 68% for ambulatory treatments, and 44% for drugs and medical goods, including optical and dental devices (Table 1).

Table 1 **Percentage of Health Expenditure funded by the SHI, from 2010 to 2021**

	2016	2017	2018	2019	2020	2021
All	**77.6**	**77.8**	**77.8**	**77.9**	**79.6**	**79.8**
Hospital care	91.7	91.8	91.7	91.8	93.1	93.3
Outpatient care	65.0	65.0	65.5	65.7	67.8	67.9
Transport	92.9	92.9	92.9	92.9	93.0	93.5
Drugs	71.4	72.1	71.8	72.6	73.6	750.
Medical goods	43.9	44.7	44.7	44.3	43.9	44.4

Source: DREES, 2022.

There are exemptions from copayments for individuals who suffer from specific chronic conditions. The *Affection Longue Durée* (ALD) scheme, which covers today 32 groups of diseases (cancer, tuberculosis, poliomyelitis, mental illness, etc.) allows patients being exempted from the copayments concerning treatments associated with their ALD conditions, irrespectively of their income status. However, they still have to pay copayments that concern other conditions, as well as, regardless of their condition, deductibles and extra-billing charges. In 2017, over ten million individuals were covered by the ALD scheme, representing about 17% of SHI beneficiaries and accounting for roughly 60% of the health expenditure reimbursed by the SHI fund. The number of ALD beneficiaries has continuously increased in the last decade (10.7 billion in 2017 versus 8 billion

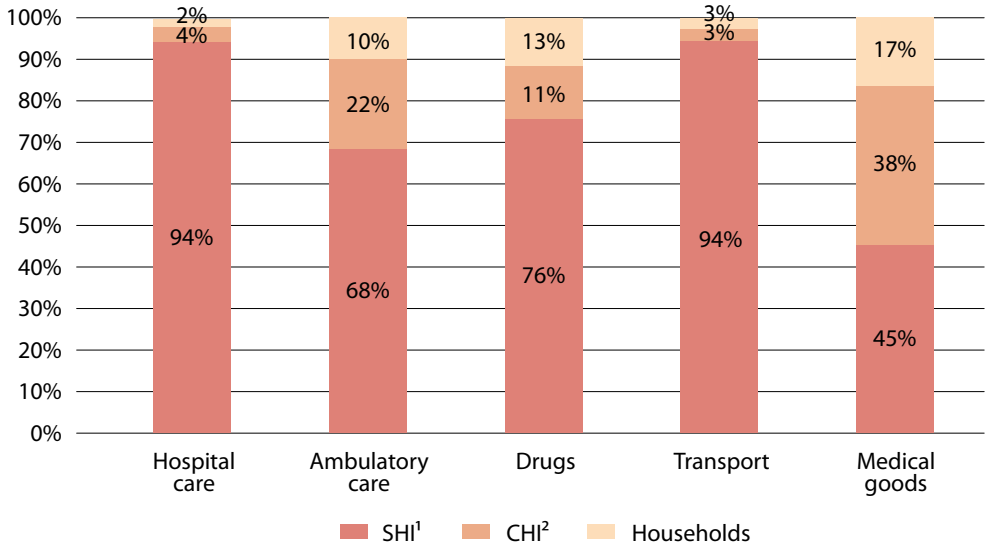
[3] The reimbursement level by the SHI is determined by the effectiveness of a given drug and the gravity of the disease treated: 100% for rare, highly effective or expensive drugs (e.g., for cancer); 65%, 35%, or 15% for diminishing therapeutic value, respectively. Drugs evaluated as ineffective are not reimbursed by the SHI.

in 2005). Despite the increasing demand for the ALD scheme, the average share of the SHI in total health expenditure has remained quite stable in the past fifteen years (around 78% before the Covid-19 pandemic and 80% after the pandemic) mainly because of a better control of drug benefit basket and regulation of prices.

2.2. The crucial role of private complementary insurance

About 96% of the French population hold a private CHI policy that finances about 13% on average of health care expenditure. CHI funds more expenditures of outpatient care (22% of health expenditure), drugs (11% of health expenditure), and, "other medical goods" including optical devices (38%) than of hospital care (5%) [Figure 2].

Figure 2 **The share of public and private complementary health insurance and out-of-pocket payments in health expenditure in 2021**



[1] SHI: Statutory Health insurance; [2]: CHI: Complementary Health Insurance.
Source: Arnaud et al ., 2022.

Historically, private CHI providers have focused on reimbursing copayments left to patients. Most CHI plans also offer better coverage for medical goods and services that are poorly covered by the public scheme, especially dental and optical devices. Some CHI plans also pay for a part (or the totality) of extra-billing charges asked by some physicians, and some would offer an extended benefit basket including goods and services that are not covered by the SHI, such as surgery for myopia, or access to an individual room in hospital. The CHI contracts are not allowed to reimburse deductibles that are capped by the SHI (maximum of €50 per year for medications and €50 for consultations).

2.2.1. Types of private insurance

CHI policies can be purchased either through an employer, i.e., a collective contract, for private-sector employees and their dependants; or individually, i.e., an individual

contract, for public sector employees, self-employed individuals, and those unemployed or retired. Collective CHI contracts, partly paid by the employer, have been subsidized since 1979 via tax and social contribution exemptions. CHI premiums vary depending in particular upon the age of the policyholder for those insured individually, or on the average age of the pool of those insured for collective contracts where the premiums are uniform for all persons insured under the same contract. Those enrolled in individual CHI market — students, civil servants, self-employed, unemployed, retired — are free to buy (or not) a CHI and choose their level of coverage. Subscription to a collective CHI has been required by law for all private-sector employees since 2016 (Franc and Pierre, 2015). In general, collective CHI contracts are more advantageous than individual ones in terms of guarantees and premiums, because of the bargaining power of employers and the concentration of individuals with good health risks (e.g., younger, of working age). Thus, at equivalent coverage level, premiums for collective contracts are often lower than for individual contracts, even before the contribution made by the employer. In 2014, about 58% of the French population was insured by an individual CHI contract while 32% was insured by a collective contract. The rate of people insured in the collective market has slightly improved since 2016: it is estimated around 38% in 2019 (Pierre, 2022).

2.2.2. Mix of CHI providers

The private CHI market is quite competitive. Around four hundred providers offer different kinds of CHI policies. There are three distinctive categories of insurers. First, the *mutuelles*, which are non-profit mutual insurance companies that have traditionally dominated the health insurance market. In 2021, 68% of CHI contracts' premiums collected by the *mutuelles* come from individual contracts. Second, the *institutions de prévoyance*, which are non-profit institutions jointly managed by representatives of employers and employees. They offer almost exclusively collective contracts (i.e., they cover mainly working-age individuals): 86% of premiums collected by *the institutions de prévoyance* in 2021 come from collective contracts. Last, the *assurances*, private for-profit companies, which have entered into health market more recently. 54% of their premiums collected come from collective contrats in 2021. These three types of providers operate under distinct regulatory schemes[4] but the differences in their premium rates (prices) have diminished over time because of the high competition.

2.3. Regulation of the complementary health insurance

In free and competitive markets, health insurers adjust their insurance premiums to the risk of the insured. This can be done directly, using health status and morbidity, or indirectly, using age as an indicator of health status. Access to private health insurance is therefore inequitable since older and sicker individuals, who need care the most, would pay higher premiums. Moreover, private insurers are not required to pursue the system-wide efficiency and cost containment objectives that is pursued by the public payers. For all these reasons, the CHI market in France is highly regulated (Pierre, 2018).

[4] *Mutuelles* are regulated by the *code de mutualité*, non-profit provident institutions are regulated by the social security code, and private insurance companies by the commercial insurance code.

2.3.1. Tackling risk selection

As early as 1989, French authorities have required CHI providers to give a lifetime guarantee for anyone insured so that their premium cannot increase over time, upon renewal of a contract, above the price set for others in the same pool of insured for that contract (as part of the *loi Évin*). This law also aims to protect young pensioners, benefiting from a collective contract, who may face higher insurance premiums in individual markets upon retirement. Moreover, since 2002, a tax reduction was applied to contracts in which the health status of the insured is not used as a variable of risk adjustment (selection) when defining the price. These contracts, called *contrats responsables*, prohibit private insurers to use a health questionnaire when setting the insurance plan.

2.3.2. Improving CHI coverage in the population

Given the importance of copayments and the role of CHI in assuring access to care in France, the expansion of CHI among the poorest, but also for other segments of the population, has been a constant objective of successive governments for decades.

Two schemes were introduced in 2000 and 2005, for supporting low-income individuals to acquire CHI. The first, the *Couverture maladie universelle complémentaire* (CMU-C), a state-funded insurance scheme, allows people whose monthly income is about 20% below the poverty line to benefit, free of charge, from a CHI contract. The CMU-C covers 100% of negotiated prices of all drugs and services included in the benefit package of the SHI (no copayment required). It further covers, albeit modestly, a number of dental and orthodontic treatments and eyeglasses. Moreover, patients are exempted from upfront payments, and physicians are not allowed to extra-bill CMU-C patients. The second measure, the *Aide à la complémentaire santé* (ACS), provides public subsidies in the form of vouchers for buying a private CHI contract. It targets individuals under the poverty line who are not eligible for the CMU-C. ACS provides cash support in the form of vouchers that can be only used to buy a CHI contract. Since 2013, the beneficiaries of ACS have also been exempted from extra-billing. These two schemes supporting CHI for the poorest are funded through specific taxes on private health insurance (*taxe de solidarité additionnelle*; TSA), which amounted to €2 billion in 2012, and, marginally, from taxes on tobacco. In 2019, CMU-C and ACS schemes covered, respectively, 8% (5.8 million individuals) and 2% (1.3 million individuals) of the population[5]. In November 2019, CMU-C and ACS were joined under a single scheme called *Complémentaire santé solidaire* (CSS) to simplify the system and to reduce non-take-up issues. In 2022, 7.2 million individuals benefited from the CSS (public complementary insurance) of which 5.8 millions without any contribution (low income).

There has been also continuous political support for ensuring that all workers can have access to CHI—first with tax incentives for private-sector employees and employers (since 1979), for the self-employed (since 1994), then by a mandate for all private sector employees. Indeed, with the *Accord national interprofessionnel* law, all private-sector employers must, as of 2016, offer a private CHI to all their employees, and pay at least 50% of their premium (they can choose to pay a higher share). Moreover, in case of unemployment, individuals can benefit, free of costs, from the collective contract of

[5] The number of people eligible for these schemes are estimated to be higher: about 30% of the individuals who are eligible to CMU-C and 60% of those eligible to the ACS are not exercising their rights.

their previous employer for up to twelve months (Franc and Pierre, 2015). These contracts have to provide minimum coverage that extend beyond the minimum coverage imposed for the *contrats responsables*, especially concerning dental and optical care. A recent reform implemented from 2019, *100% santé*, required also these contracts to include a basket of care with zero out-of-pocket costs for dental protheses, hearing aids and optical devices.

2.3.3. Controlling health expenditure growth

While supporting access to CHI, successive governments have been constantly looking to regulate, legitimize, and enlarge the responsibility of the private health insurers in containing health expenditure. Therefore, although there is no restriction on what insurers are allowed to cover, CHI contracts have to respect certain conditions in order to benefit from tax advantages and public subsidies. These contracts called *contrats responsables* are required to respect certain restrictions in reimbursement in order to promote good consumption behaviour. For example, they cannot reimburse out-of-pocket payments when patients visit an outpatient specialist directly without a referral from a general practitioner (GP) [to support the voluntary gatekeeping reform introduced in 2004] nor refund certain deductibles (0.50€ for each drug and paramedical act, 1€ for each health care visit, and 2€ for transport). In 2016, new constraints were introduced to limit differences in coverage levels between individual and collective contracts in order to reduce the impact of too generous collective contracts on health care prices. These contracts must now respect some price/reimbursement ceilings for optical devices and extra-billing charges, to control the price inflation for optical devices, and cap excess fees in sector 2. Today, almost all CHI contracts subscribed by individuals are defined as *contrats responsables*.

2.4. Issues in terms of equity and efficiency of the system

While the SHI is universal, offers a comprehensive basket of care, and on average, the French population has very low levels of out-of-pocket payments compared with other OECD countries, the combination of public/private health insurance does not fully protect the most socially vulnerable households against the risk of high health spending. Indeed, out-of-pocket payments are not capped, and the mix of funding raises a number of issues about the horizontal equity in access to care, redistribution of public resources and efficiency in containing the health expenditure growth.

2.4.1. Concerns for equity

The public-private mix of the French health insurance system challenges the objective of horizontal equity, that is equal access to care by equal need, with significant inequalities in access to care. While on average the out-of-pocket expenditure per capita is very low in France, a small group of low-income individuals with poor health status appear to concentrate a high share of this expenditure. In 2017, 1% of the population faced an average of almost €5,400 per year in out-of-pocket payments for health care before CHI reimbursements (Adjerad and Courtejoie, 2020). Thus, patients with multiple and complex conditions have higher out-of-pocket payments left by the SHI despite the existence of the ALD scheme (Franc and Pierre, 2016; Geoffard and de Lagasnerie, 2012). Yet, there is still a small part of the population who do not own a CHI. While only 4%

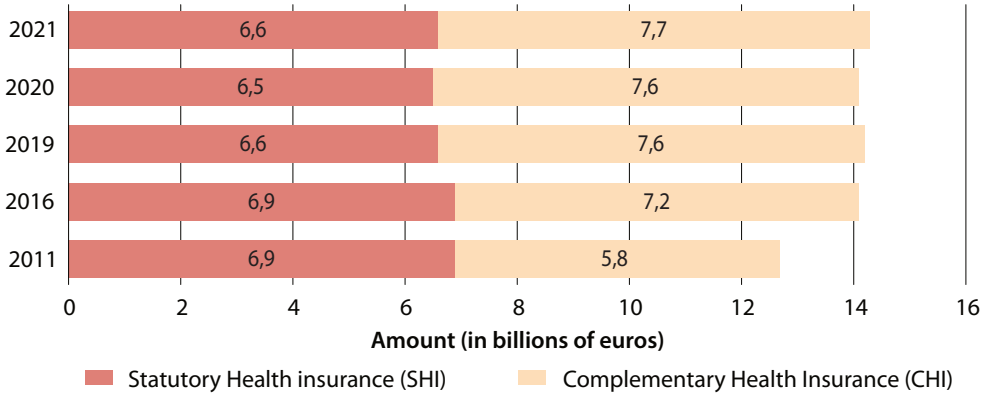
of the population lacked CHI in 2019, the rate was 15% for the unemployed and 11% for individuals in the lowest income quintile, despite the existence of CMU-C and ACS (Pierre, 2022b). Moreover, even when they own a CHI, low-income and older groups have less generous insurance contracts. This is mostly due to the basic functioning of the private insurance market, where premiums increase with risk (i.e., age). Therefore, the level of services covered for the insured is associated with income rather than needs. Individuals insured by individual contracts with lower income spend proportionally more of their income on private health insurance, despite owning lower quality or less generous contracts (Figure 1) [Jusot et al., 2016; Jusot et al., 2012; Kambia-Chopin et al., 2008]. Also, the CHI contracts, even when they are *contrats responsables*, adjust their premiums as a function of age, hence requiring higher payments from those with higher needs, against the horizontal equity principle. Moreover, group contracts, which, by design, are more generous than individual contracts are not accessible for the most vulnerable individuals (economically and health wise) since they are often out of employment. As a result, good CHI contracts with lower prices and better coverage are more often subscribed by the wealthier.

To tackle the issues in equity in access to care, the solution proposed by successive governments has been to increase private CHI coverage for a larger part of the population, including with public subsidies. Nevertheless, this policy has also been a source of a two-tier treatment in the system. In fact, the public subsidies given to private companies and employees for supporting collective contracts are considerable compared to those dedicated to the low-income individuals (Fouquet and Pollak, 2022; Del Sol and Turquet, 2021; Franc and Pierre, 2015). However, the employer CHI mandate implemented in 2016 for all private sector employees, i.e for people in employment, does not allow reducing social inequalities in CHI coverage within the whole population (Pierre, 2022b; Abecassis et al., 2017; Pierre et Jusot, 2017). But by altering the composition of risk pools in the individual and group markets, this policy may have increased individual contracts' premiums which more often involve retired and sick people (Pierre, 2022b, Pierre et al., 2018). Moreover, the fact that health professionals are not allowed charging extra fees for the beneficiaries of the public CHI schemes (CMU-C, ACS) appears to create a two-tier treatment. Patients who are part of these schemes may face discrimination and have difficulties in getting an appointment with some physicians (Desprès et al., 2009), although it is illegal to refuse a patient because of the insurance status.

2.4.2. Efficiency concerns

The hybrid public-private insurance system, where private insurance complements the public funding for almost all types of care, implies a multiplicity of payers for the same basket of care and is not forcibly the most optimal way of using resources. First, the generous coverage offered by some private CHI contracts can be inflationary. This is especially the case for collective CHI contracts since they often reimburse high extra-fees charged by some health professionals. Second, the reimbursement of copayments by the private CHI cancels the incentives initially sought to reduce moral hazard in the core public plan (Askenazy et al., 2013; Geoffard, 2006). Third, this combination of public-private insurance comes with a high management cost: France has the second highest administrative costs (almost 6% of the health spending) in the OECD, just after the United States, and almost half of this expenditure is related to CHI (Figure 3).

Figure 3 **Amount of the SHI and CHI management cost (in billions of euros)**



Source: DREES, 2019.

Finally, even if the regulation of CHI market is crucial to limit the most harmful effects of risk selection operated by insurers, the extent of this regulation may appear nonoptimal. Private insurers must adjust insurance premiums to the risk of insured to face adverse selection. Thus, overly restrictive regulations push insurers to find new solutions to select risks, which can lead to a vicious circle that exacerbates market distortions without allowing people to be fully protected from risk selection.

3. A rich mix of public and private providers

3.1. Organisation of care delivery

With 3.2 physicians and 10.5 nurses per 1,000 population in 2019, health human resources in France is close to the OECD average (OECD, 2019). This average hides however contrasting realities. Health professionals are free to practice in different settings (solo practice, medical centres, clinics, etc.) with different payment arrangements and obligations).

3.1.1. Ambulatory care

Ambulatory care is mainly provided by private, self-employed health professionals – doctors, nurses, dentists, and medical auxiliaries – working in their own individual practice, in health centres or private clinics. In 2016, 47% of all doctors and 65% of the GPs were self-employed, while 42% were employed in hospital or another health care facility and 11% had a mix (public and private) activity (DGOS, 2018). Self-employed health professionals are paid according to a national fee-for-service (FFS) schedule. The official tariffs for reimbursement are set via a formal national negotiation process between the government, the union of the SHI funds, the union of CHI schemes, and unions of health professionals. Doctors usually contract with the SHI to define their practice mode and pricing. Those who charge the negotiated fee are known as "sector 1" contractors (Box). They get in return their social contributions (including pension) paid by the SHI fund. Some doctors known as "sector 2" contractors, are

Box. Different sectors of private practice in France

- **Sector 1:** Health professionals are required to bill the conventional tariffs set out in the national agreements with the SHI. Extra-billings above these amounts are limited to a very few circumstances (out-of-hour visits, etc.). In return, health professionals get a part of their compulsory social contributions paid by the SHI. In 2018, 52% of specialists and 95% of generalists were working in sector 1, adhering to the national tariffs.
- **Sector 2:** Health professionals who have signed the medical convention with the SHI are permitted to extra-bill. They must purchase their own pension and insurance coverage. There is no official limit to how much care providers can charge extra, but the social security code and the medical code of ethics requires that extra-billing to be of a "reasonable amount" –without defining the term[a]. The entry to sector 2 was restricted since 1990. In 2018, 47% of specialists and 5% of generalists were working in sector 2, with a high degree of variation across specialities (37% of doctors in sector 2 among psychiatrists versus 65% and 31% among gynecologists and ophthalmologists, respectively), and across regions (75% of ophthalmologists are in sectors 2 in Paris area versus 40% in Bretagne).
- **Sector 3:** Health professionals, who have not the convention with the SHI, have complete freedom to set their fees, but the reimbursement from the SHI is lower than for sector 1 and 2. Less than 1% of generalists and specialists work in sector 3.

[a] Section L162-1-14-1 of the social security code and section 53 of the medical code of ethics.

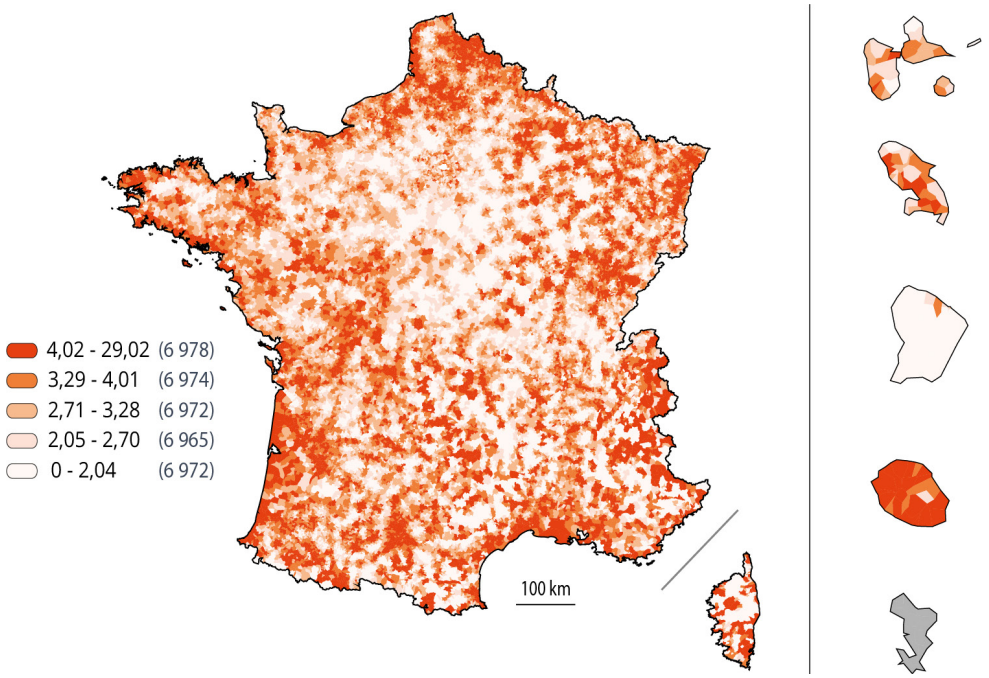
allowed to charge higher fees but must purchase their own pension and insurance coverage. The creation of sector 2 in 1980 aimed to reduce the cost of social contributions for the SHI fund, but it did not have the expected impact and the entry in the sector 2 was much higher than predicted. Consequently, access to sector 2 has been limited since 1990. In 2016, the average fees for physicians in sector 2 was about 52% higher than conventional tariffs, over-billing rates varying between 10% (for Cantal) and 115% (for Paris area).

3.1.2. Inpatient care

Inpatient care is delivered by a large number of public, private for-profit, and non-profit hospitals. Patients can freely choose between public and private hospitals without needing a referral. Doctors and other health professionals (nurses, etc.) working in public hospitals are usually paid by salary while doctors working in private hospitals are paid by FFS. While the total number of hospital beds has decreased over the past decade, the French system remains highly hospital-centric with one of the highest hospitalisation rates in the OECD area, and hospital care representing almost half of all health spending (OECD, 2019).

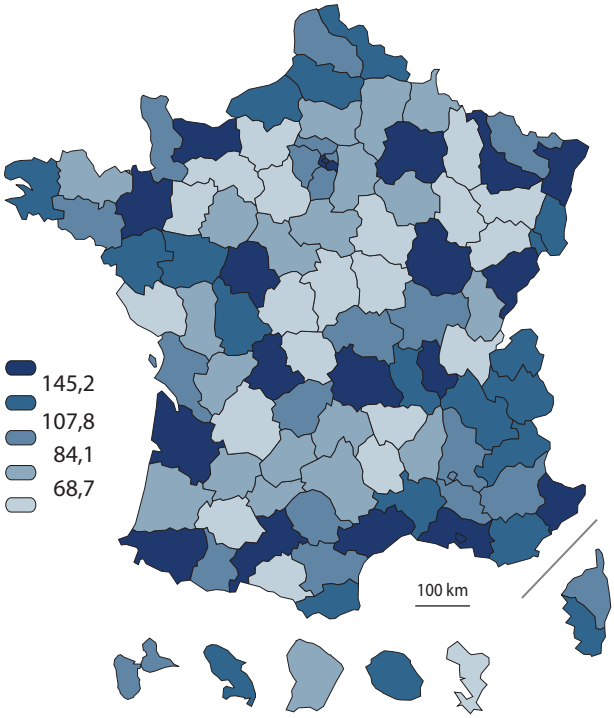
Public hospitals have the legal obligation of providing a range of services including twenty-four-hour care and have to take part in activities related to national/regional public health priorities. They represent 45% of all hospitals and 62% of all acute in-patient beds in 2018 (DREES, 2021). The private for-profit sector represents 25% of all in-patient beds and is specialized mostly in elective surgery. About 55% of all surgery and 20% of obstetric care are provided by private for-profit hospitals. Their market share goes up to 65% for knee replacement, more than 80% for certain ambulatory surgery, such as cataracts, and endoscopies. On the other hand, certain complex care/procedures such as stroke care, burn treatment, or surgery for multiple traumas are

Figure 4 **Number of GPs consultations accessible per year and per inhabitant in France in 2021**



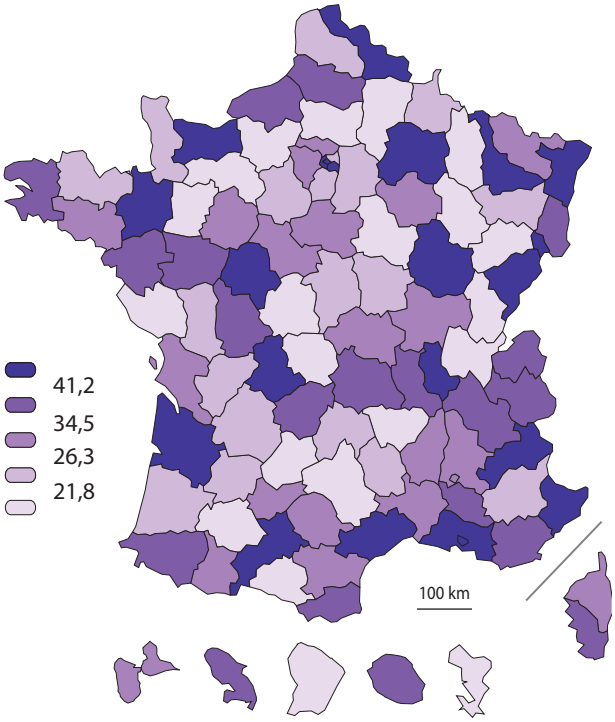
Source: DREES, application Shinny apps. **Map:** IRDES, 2023

Figure 5 **Density of medical specialists in France in 2022 at departmental level**



Source: Conseil national de l'Ordre des médecins, Atlas de la démographie médicale en France. Situation au 1er janvier 2022. **Map:** IRDES, 2023

Figure 6 **Density of surgical specialists in France in 2022 at departmental level**



Source: Conseil national de l'Ordre des médecins, Atlas de la démographie médicale en France. Situation au 1er janvier 2022. **Map:** IRDES, 2023

provided almost exclusively by public hospitals. Three-quarters of private non-profit hospitals, which represent about 14% of acute-care, have a special agreement with the state to provide "public services", such as emergency care, and are eligible for public subsidies. Private hospitals also contract with the SHI and respect the same quality and safety regulations as public hospitals in order to be funded.

Until 2004, public and private hospitals were paid under two different schemes. On the one hand, public and most private not-for-profit hospitals had global budgets mainly based on historical costs. On the other hand, private for-profit hospitals had an itemized billing system that was inflationary with daily tariffs covering the cost of accommodation, nursing and routine care, and a separate payment based on the diagnostic and therapeutic procedures carried out (Or and Gandré, 2021). The difference in payment between public and private hospitals has always been a subject of conflict: public hospitals considered global budgets as an instrument of rationing, insensitive to changing demand, while private hospitals advocated that global budgets rewarded inefficiency of public hospitals. The introduction of Activity-Based Payment, ABP (*tarification à l'activité*, or T2A in French) in 2005 to pay for acute hospital services was therefore very welcomed by all parties initially. The major objectives of ABP were to increase hospital efficiency and to create a "level playing field" for payments to public and private hospitals. While it achieved half of its objectives by increasing productivity in both sectors, ABP also raised new issues on quality and appropriateness of care.

From patients' point of view, while the competition between public and private hospitals improves choice and contribute to innovation in care (Or et al., 2020), the extra-billing for physician services, common in private for-profit hospitals, is a source of inequality in access. While some doctors are also allowed to extra bill in public hospitals, this is much less common. Until recently, there was little information on the extra fees charged in hospitals, but some reports have shown that extra-billing charges can be up to four times higher than regulated prices in hospital settings (France Assos Santé, 2015). However, according to the observatory of tariffs, different measures introduced by the SHI in recent years have been successful in containing extra fees in hospitals; the fees were (on average) about 45% over the regulated fees in 2016, versus 80% in 2005.

3.2. Unsustainable freedom in "liberal medicine"

Historically, liberal medicine in France is organized around four principles delineated by law: confidentiality of medical information, office-based fee-for-service practice in the ambulatory sector, freedom of practice for physicians, and patient's free choice of provider. These principles have been challenged over time to limit the escalating health care costs and chronic problems with unequal geographic distribution of doctor supply (Cour des comptes, 2017), but they are still strongly rooted in the system.

Freedom of practise for physicians implies that doctors (and medical auxiliaries) are free to choose their place of practice as well as, their practice mode and sometimes prices. While pricing rules have been strengthened over time, freedom to choose the place of practice remain a historic right for doctors to which medical unions are very attached (Hassenteufel, 2008). Notwithstanding a relatively high density of doctors, the unequal geographical distribution of health workers, skewed to the well-off urban areas, has been a long-standing problem for access to care (Figures 4, 5 and 6). The

lack of specialists such as gynaecologists, ophthalmologists, and anaesthetists, but also general practitioners in some areas, has become a serious policy concern in the past decade (Lucas and Chevillard, 2018). The average waiting time for an appointment was 44 days for gynaecologists, 50 days for cardiologists, and 80 days for ophthalmologists (Millien et al., 2018). While 95% of the French population live 15 minutes drive from a GP (Coldefy et al., 2011) and 50% of GP appointments are obtained within 48 hours, there are wide variations across regions.

Also, in areas where there is a shortage of providers, access to specialists who do not extra-bill patients can be difficult (Cour des comptes, 2017). The fact that patients are not systematically asked for a referral from a GP to visit a specialist (especially for gynecologists, ophthalmologists and stomatologists) makes it difficult to orient patients' access to services as a function of their need. The gatekeeping reform, introduced in 2004, financially punishes patients (with lower reimbursement rates) when they do not have a regular GP as a gatekeeper. However, this reform did not have a significant impact on improving care pathways (Naiditch and Dourgnon, 2009; Bras, 2020), since primary care physicians and specialists, mostly paid on a FFS basis and in competition for patients, have little incentive to invest in collaboration and care coordination.

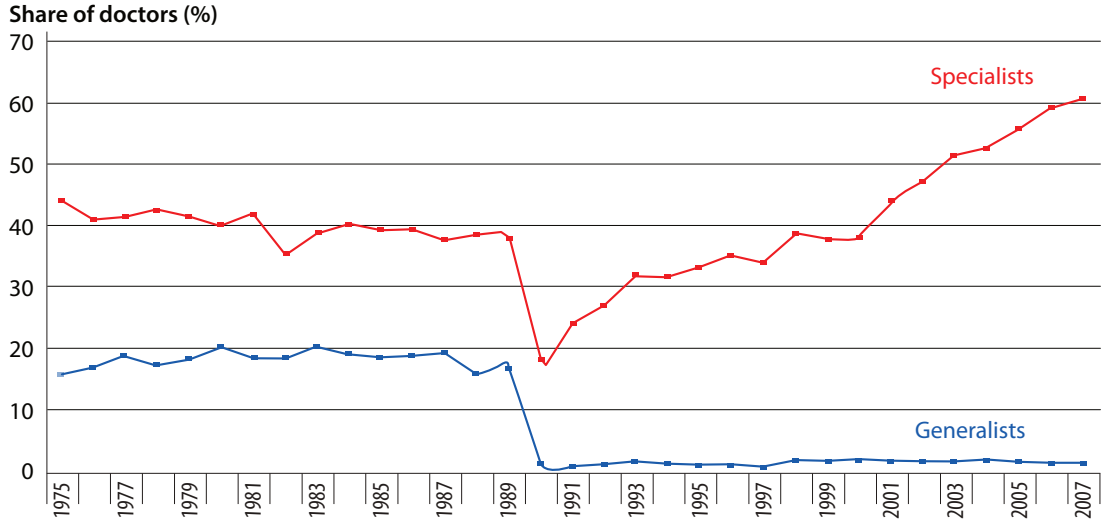
3.3. Tackling inequities in access to care

3.3.1. Incentives for improving geographical access

Following the national ranking exams, medical students choose a specialty and a region in which they will do their internship. Since 2005, successive governments have been subsidizing medical students to choose certain under-served areas. Financial aids in the form of housing aid, study grants, etc., have been offered to students who choose to study in these areas. Financial aid also target health workers already in practice to encourage them to move in under-served areas. Doctors and nurses who settle in deficit areas benefit from subsidies from local authorities (settlement bonuses, loan of premises, income guarantees). The government also encourages group practices in primary care by paying 50,000€ over 2 years to GPs who settle, for at least 3 years, in health centers in under-served areas. Moreover, doctors who practice in deficit areas are exempted from some social and fiscal charges.

Nevertheless, these measures aiming to improve geographic distribution of health care professionals had only a limited success. The measures targeting medical students are based on the assumption that physicians trained in a region will choose to exercise in that region. However, quality of life, expected income and working conditions are also major factors determining physicians' choice. Financial incentives are considered to be too low compared to the financial benefits expected from settling in a richer region. It is also shown that young doctors consider family life and working conditions more than their potential income when deciding their place of practice (Barriball et al., 2015; Munck et al., 2015). In rural or underserved areas, group practice appears to be more attractive for young generalists than solo practice (Chevillard and Mousquès, 2020). Hence, encouraging group practice in primary care has been a lever for increasing the density of GPs in underserved areas.

Figure 7 Share of doctors who choose the sector 2, each year from 1975 to 2007



Source: Bellamy and Samson, 2011.

3.3.2. Reducing the burden of extra-billing

The question of extra-billing or how to limit their amount has been a public concern for several decades, even though the prices were poorly monitored by the public authorities. In 2007, the General Inspectorate of Social Affairs revealed that the average amount of extra-billing between 1995 and 2004 increased 3 times faster than average incomes in France (IGAS, 2007). Also, despite the restrictions on access to sector 2 for general practitioners, the proportion of specialists who settle in sector 2 each year is increasing (Figure 7). As a result, in 2017, on average 45% of the specialists worked in sector 2 (Dixte and Vergier, 2022), with significant variations depending on the specialty.

The public health code requires physicians to inform their patients of all costs related to their visit displaying prices inside their medical practices. Most patients are not informed about the cost of a visit to a sector 2 physician before the appointment. Furthermore, there is no platform allowing to compare prices of providers. In 2012, the SHI created an observatory of tariffs to follow up more closely extra-fees charged by physicians. Moreover, since 2013, voluntary contracts (called contracts with Mastered tariffs[6]) have been introduced to encourage sector 2 physicians to freeze their fees and not to charge more than the average price observed during the last 3 years. They are also asked to perform a share of their services at regulated SHI-tariff levels. In return, they receive a partial payment of Social security contributions, usually dedicated to sector 1 doctors (up to € 4,300 per year on average). In 2018, about 50% of doctors had signed this contract.

Despite all these attempts to regulate extra-billing, the financial burden of extra-billing for patients is still an issue with a high concentration of extra-billing costs among the sickest (Franc and Pierre, 2016; Perronnin, 2016). In some regions and areas, patients

6 Two contracts were introduced: CAS (*Contrat d'Accès aux Soins*) in 2013 and OPTAM (*OPtion TArifaire Maitrisée*) in 2016.

have no other choice than to pay extra fees to consult a specialist. While the implementation of new contracts in 2016 aiming to slightly reduce the average amount of extra (about 3%), sector 2 physicians have still great latitude in fixing their prices. Moreover, the small reduction in fees should be put against the amount the SHI devotes to subsidize social security contributions for these doctors who can even benefit from a windfall effect: sign up to the contract to reduce social charges even if they did not intent to increase their fees (Bras, 2015). Ultimately, extra-billing introduces strong disparities in remuneration between doctors which are not justified by their level of qualification or quality of care provided. They allow sector 2 doctors to reduce their level of activity compared to sector 1 doctors or simply to compensate for lower productivity. Hence, they contribute to accentuating the problems of territorial access to care.

3.4. Concerns for efficiency and quality of care delivery

3.4.1. Growing health expenditure

With about 11% of GDP dedicated to health, the rising cost of health care has been a major concern in France in the past decades. Traditionally, most of the cost containment efforts have been concentrated in regulating prices of health care. While France had visible success in controlling prices of health care services and pharmaceuticals, low prices seem to have a limited impact on health expenditure growth. Health care providers, mostly paid by FFS or activity volumes, tend to compensate for reduced revenues by increasing the volume of services they provide. The system encourages more hospital utilization, medical tests and medications with high risk of duplication of services and inefficient care process. Ambulatory physicians and other health care providers, paid by fee-for-service, have little interest or incentive to control the volume and the cost of their prescriptions or to invest in prevention, health promotion, and care coordination. In the hospital sector, while the introduction of ABP globally improved hospital productivity in both public and private hospitals, it has also raised issues on the quality and appropriateness of hospital care. Since 2005, both the number of beds per capita and the average length of stay fell significantly with an increase in ambulatory surgeries but avoidable hospital admissions, readmissions and emergency visits has also increased visibly over this period especially for older people (DREES, 2021; Bricard et al., 2020).

The macro-level budgetary management of health care specific to France has exacerbated some of the issues of quality and allocative efficiency in the system. Since 2010, the specification of an overall expenditure target for health care, known as the National Objective for Health Insurance Spending (*Objectif National de Dépenses de l'Assurance Maladie*, ONDAM), has been the key strategy to contain health spending in France. There are different budget targets for ambulatory, hospital and social care sectors. To control hospital expenditure, national level expenditure targets for acute care are set by the Parliament each year. If the actual growth in total hospital volume exceeds the target, the prices go down the following year. But the growth of activity is monitored only at an aggregate level (separately for the public and private sector), and prices have been adjusted downwards regularly since 2006 as the hospital volumes have been increasing faster than the targets set. This mechanism meant that the prices have become (progressively) unrelated to hospitals' costs (and quality), and created a financially unstable and opaque environment, which fostered frustration and resentment especially

in public hospitals (Or, 2014). Contrary to private hospitals, public facilities have little flexibility in their management and cannot specialize in a few profitable services as they would like. In the absence of clear price and quality signals, public hospitals have been concerned with balancing their accounts, and by increasing their volume of activity. Moreover, there has been a gradual underinvestment in public hospital infrastructure since the hospital prices were to cover partly the cost of investment. Following the Covid-19 pandemic, the Ministry of Health launched a reform package (*Ségur de la santé*) with a significant investment package to improve the conditions in public hospital over next the ten years.

3.4.2. Regulating volumes rather than quality

In a context of rapidly rising volume of activity in hospital sector, several measures were introduced to assure quality and appropriateness of care. One major regulatory tool has been to link authorizations to minimum activity thresholds. There are volume norms for cardiac surgery, obstetrics services, cancer care, etc. Furthermore, at the regional level, hospital volumes are monitored to identify hospitals that have high levels of activity/growth within the region. A list of 32 interventions (including cholecystectomy, cataract, hysterectomy, prostatectomy, etc.) are defined as priorities, based on three criteria: strong growth rate in the past three years, high variations between/within regions and/or potentially harmful consequences for patients. Since 2014, for a number high volume/fast growing surgeries (including knee prosthesis and cataract surgery), the Ministry of Health sets a national rate of activity growth. If a hospital's case load (for a given surgery) grows faster than the threshold set, the corresponding tariff goes down by 20%. There is not enough information on the impact of this policy on the hospitals, but there is an increasing consensus now for concentrating on "appropriateness of care" and reducing interventions considered as "low value" care.

Nevertheless, France has been backward in monitoring and reporting publicly the quality of care providers. While important progress has been made for collecting data on quality, in particular security of care in hospitals, most indicators are focused on process. Major indicators such as 30-day readmission rates, mortality and adverse events are not monitored regularly across providers or across regions/territories. More recently, data on patient experience in hospitals were collected but benchmarking of efficiency and care quality is not encouraged even when data is available. In primary and long-term care sectors there is almost no information available to public on patient experience and quality of care of different providers. This reduces France's capacity to identify problem areas as well as good practices to push forward policies for improving care quality and efficiency (Or and Gandré, 2021).

3.4.3. Problems with care coordination

The lack of coordination between ambulatory, hospital, and social care has been recognized as a major drawback both in terms of cost-control and quality of care (Larcher, 2007). The fact that most providers work as independent providers – and with little collaboration between hospital, primary, and social care/services – means that patient care is fragmented and patients need to navigate in a complicated system. Moreover, uncoordinated care, coupled with the high degree of independence and choice both for providers and patients, have been identified as key drivers of health care cost. Increasingly,

health care providers are asked to account for the cost and quality of services they provide.

It is largely recognized that organizational changes which contribute to better service delivery such as formal collaboration between different health professionals are less likely to occur in solo practice. Therefore, the latest reforms encourage group practice in primary care settings and test alternative payment models for improving care provision and efficiency. Finding an effective way of funding group practice which will give more emphasis to prevention and care coordination in primary care has been a strong policy objective.

4. Perspectives for improving the equity and efficiency of the French public-private model

The recent sanitary crisis provoked by Covid-19 has highlighted some of the major structural weaknesses of the French public-private model and accelerated ongoing reforms tackling long-standing issues. The segmented approach to the management and funding of primary, secondary and long-term care is increasingly criticized. It is also recognized that the division between health care providers in different sectors are reinforced by the payment models based on volumes (FFS or activity-based payment) at the local level. Moreover, the Covid-19 crisis revealed that the cost-sharing imposed by the SHI for all services including hospitalizations without surgery is problematic for fully protecting the population against financial risk associated with serious conditions (Or and Gandré, 2021).

4.1. Reforming the payment models of care providers

In order to improve the efficiency and quality of health care provision, it is necessary to have a holistic approach to care provision and funding across different settings. While the implementation of macro-level ONDAM targets has been quite successful in containing overall expenditure in the past decade, this strict budgetary process has accentuated a segmented approach to health care. The division of budgets between providers ignores the fact that health care provided in one sector have consequences on the others: the care provision in the community determines the need for hospital care, home care services impact the need for long-term care facilities, etc. This reinforces the division of health care supply at the local level, and reduces the capacity to improve the coordination of service delivery across sectors in order to strengthen the resilience of the health system to effectively serve an aging population with chronic diseases.

In 2019, a new financing law with a dedicated budget (Article 51 of the 2018 Social Security Financing bill) was introduced to encourage new care models based on new funding modes. It waives regulatory barriers for testing innovations in care organization and payment, encouraging bottom-up proposals. All health professionals and health care organizations were given the possibility of experimenting new health care models, including alternative funding models, provided that pilots aimed to improve quality of health and social care services and patient experience. This new bottom-up approach aims to remove financial barriers to innovation in order to promote efficiency, preven-

tion and care coordination. During the first wave of the pandemic some of the initiatives born under this law have been reactive and developed quick solutions locally to ensure the continuity of care for their patients. The Ministry of Health has announced that this law will support the sustainability of innovations born during the Covid-19 crisis.

4.2. Less competition and more collaboration in care delivery

The fact that health care professionals are paid by fee-for service and patients are free to choose their care providers from a wide range of options, with almost no restriction, creates a highly competitive environment for care providers in France. Health professionals aiming to retain a certain income level need to maintain a certain level of activity (procedures, visits, etc.). This in turn creates an unfavorable environment for collaboration and task shifting since "sharing patients" and "delegating tasks" may present a financial risk. In hospital sector, the competitive environment created by the ABP, while contributed to some efficiency gains in hospitals, also raised questions on care quality and allocative efficiency of the system. The recent health crisis highlighted the weaknesses of fragmented management of public health, primary, secondary and social care (Ferrand, 2020; Or and Gandré, 2021), and revealed the need for a health prevention and promotion culture involving all health care providers.

Several recent policies have aimed at increasing local coordination between health care providers. These include the creation of local hospital groups (*Groupements hospitaliers de territoire*, GHT) and the development of regional/local care networks (*Communautés professionnelles territoriales de santé*, CPTS) incorporating hospital and primary care physicians, nurses, and other professionals (in particular social workers, administrative staff, etc.). In addition to the experiment of new payment models, including bundled payments, these reforms aim to improve the continuum of care throughout the entire patient care pathway and to reduce competition between local care providers. The local hospital groups encourage reorganization of hospital services around local population allowing hospitals to share their resources and activity by specializing on certain services. Currently, these groupings concern only public hospitals, but they supposed to include also private hospitals in near future.

However, in order to support collaboration between health care providers while preserving the benefits of a yardstick competition, France needs to refine and diffuse indicators for benchmarking the quality of care across settings, in particular to monitor patient experience in and out of hospitals including readmissions, complications rates, inappropriate prescriptions, etc. (for specific patient groups) across local areas and providers. There is also a need to improve public information on prices of different care providers. Even though there has been a visible improvement in this area with the creation of observatories of prices, it is still very difficult for patients to compare prices of care providers in ambulatory and hospitals settings.

4.3. Altering the role of private insurance

The general policy of promoting private CHI as a means to achieve public system goals of equity of access and cost containment, may not be sustainable. The specific set-up of public/private health insurance in France has perverse consequences both for

patients, and for public and private insurers. On the one hand, the SHI operates in a market were incentives for reducing moral hazard are counterbalanced by the extensive use of private CHI for which generosity depends on income rather than needs. On the other hand, private insurers operate in a highly regulated market with constraints that appear contradictory to deal with adverse selection issues (Pierre, 2018; Paris et Polton, 2016; Franc and Pierre, 2016b; Dormont et al. 2014; Buchmueller and Couffinhal, 2004; Polton and Rochaix, 2004). A recent report by the High Council for the Future of Health Insurance (*Haut Conseil pour l'Avenir de l'Assurance Maladie*, HCAAM) proposed four different scenarios for restructuring the roles of public and private insurance in health care financing (Hcaam, 2022; Acker et al., 2022; Batifoulier and Da Silva, 2022; Batifoulier et al., 2021; Dormont, 2021; Jusot et Wittwer, 2021). Among these, the one called "*la grande sécu*" proposes to integrate the current compulsory reimbursements of CHI in SHI, so that the SHI pay 100% of the regulated prices to make CHI supplementary to cover extra fees and expenses not reimbursed by the SHI. It is estimated that this increase in SHI coverage will require an increase in social contributions, but this would be compensated by the decrease in CHI premiums for almost all of the population, especially for the low-income and older ones. Nevertheless, this scenario, that would dramatically reduce the market share of the private health insurers and would require a stricter control of the level of extra fees, seems to be politically hard to implement.

5. Conclusion

The French health care system is founded on the main principles of solidarity, plurality, and liberalism. Equal access to quality health care is one of the major objectives of the system routed in public health law. The population health status ranks amongst the best in the world, French patients have a large choice of public and private providers, without the chronic waiting time problems observed in other OECD countries, and have generally high satisfaction rates. Nevertheless, the system is expensive, complex for users, fragmented in its organization and characterized by many inequalities in access to care and in health status. The unsustainable growth of health spending has also been a long-standing concern.

Despite the high share of public funding of health expenditure, increasing reliance on private insurance to cover some of the costs of health care raises concerns for solidarity, equity in access to care and efficiency of the system. A mixture of regulatory measures and financial incentives are used to alleviate the difficulties that the sickest and the poorest would otherwise face in a competitive health insurance market, but the cost and efficiency of this complex system is increasingly questioned. At the same time, the French system promotes plurality and choice for patients. The health insurance model operates with self-employed health care professionals and care facilities paid mainly based on volume. While this allows a variety of care options and choice for patients, it also causes problems of care coordination, access to care and induced demand. The high level of freedom for care providers (in deciding where to practice) coupled with dominant FFS payment and extra-billing by most specialists results in persisting inequalities in access between socio-economic groups and geographical regions. In the hospital sector where a high number of public and private facilities operate in the same market, the highly competitive environment created by the activity-based payment allowed increasing productivity but also exacerbated the issues of care quality and appropriateness. In order to improve its sustainability while pursuing equity goals, the French system needs to ensure that care providers are working together with the same quality and efficiency objectives in a collaborative approach.

Several initiatives are currently being implemented to test and encourage new payment models and to improve the organization of health care delivery. The Covid-19 pandemic in 2020 accelerated some of these initiatives by shifting the traditional division between the public and private sectors and the traditional boundaries between medical professions. During the pandemic, regional health authorities have gradually included private capacity in their planning and provided temporary authorizations for setting up intensive care units in private hospitals (Or and Gandré, 2021).

Overall, the French system has been torn between the pressures to curb the growth in health expenditure and to assure equity of access and quality of care, while maintaining a unique public-private mix allowing plurality and choice. The recent measures put in place suggest that there are opportunities for improvement which should be monitored over time, even though changing the public-private funding model may become more complicated.

6. Bibliography

Abecassis P., Batifoulier P., Coutinet N. *et al.* (2017). « La généralisation de l'assurance maladie complémentaire. Comment faire rimer inefficacité avec inégalité ? », *Revue française de socio-économie*, 2017/1, n° 18, p. 13-22.

Acker F., Perraut Soliveres A., Vignes J., Jégot R., Pierru F., Canil I., Dormont B., Denantes M, Cognard S., Rouquet T., Valat E., Sadois S., Teper B., Laurent E., Collet C., Méneton P., Meunier D., Bras P. (2022). « La grande sécu que nous voulons ». *Pratiques, Les cahiers de la médecine utopique*, n° 97. avril.

Arnaud, F., *et al.* (dir.) (2022). *Les dépenses de santé en 2021*. Paris, France : DREES, coll. Panoramas de la Drees-santé.

Askenazy P., Dormont B., Geoffard P.Y., ParisV. (2013). « Pour un système de santé plus efficace ». *Les notes du Conseil d'Analyse Economique*, n°8, juillet.

Barlet M., Gaini M., Gonzalez L., Legal R. (2020). « La complémentaire santé : acteurs, bénéficiaires, garanties - édition 2019 ». *Panoramas de la Drees.*

Barriball L. et al., (2015). *Recruitment and Retention of the Health Workforce in Europe.* Brussels: European Commission.

Batifoulier P., Da Silva N. (2022). « La petite reforme de la « grande secu ». illustration d'un capitalisme politique en sante ? », *Revue française de socio-economie*, n° 29, p. 3-17. doi : 10.3917/rfse.029.0003. https://www.cairn.info/revue-francaise-de-socio-economie-2022-2-page-3.htm

Bellamy V. et Samson A.L. (2011). « Choix du secteur de conventionnement et déterminants des dépassements d'honoraires des médecins », *Les Comptes Nationaux de la Santé* 2010, Drees, novembre.

Bras P.-L. (2015). « La liberté des tarifs médicaux : la victoire des médecins spécialistes ». *Les Tribunes de la santé*, 2015/3 (n° 48), p. 73-92.

Bras P.-L (2020). « La rémunération des médecins à la performance : efficacité clinique ou efficacité symbolique ? » *Les Tribunes de la santé.* 2020/2(64):61-77.

Bricard D., Or Z., Penneau A. (2020). *Évaluation d'impact de l'expérimentation Parcours santé des aînés (Paerpa).* IRDES. Final report. 575, 2020/11.

Buchmueller T., Couffinhal A., Grignon M., Perronnin M. (2004). "Access to Physician Services: does Supplemental Insurance Matter? Evidence from France". *Health Economics* 13(7): 669–687.

Chevillard G., Lucas-Gabrielli V., Mousquès J. (2018). « Déserts médicaux en France : état des lieux et perspectives de recherches ». *L'Espace géographique*, 2018/4, tome 47, 362-380.

Chevillard G., Mousquès J. (2020). « Les maisons de santé attirent-elles les jeunes médecins généralistes dans les zones sous-dotées en offre de soins ? ». *Questions d'économie de la Santé*, Irdes, n°247. Mars.

Chevillard G., Lucas-Gabrielli V., Mousquès J. (2021). « Comment améliorer l'accès aux soins primaires selon les spécificités des territoires ? » In *Le système de santé français*

aujourd'hui : enjeux et défis. Ouvrage collectif du Collège des Economistes de la santé (CES). Coordonné par Barnay T.,; Samson A.L., Ventelou B. Paris: Editions Eska, chapitre 11, 2021/07.

Coldefy M., Com-Ruelle L., Lucas-Gabrielli V., Marcoux L. (2011). *Les distances d'accès aux soins en France métropolitaine au 1er janvier 2007*. Rapport Irdes n°550.

Commission des Comptes de la Sécurité sociale (2022). *Les comptes de la Sécurité sociale : Résultats 2021 et prévision 2022*. Rapport des comptes de la Sécurité Sociale.

Cour des comptes (2016). *La participation des assurés au financement de leurs dépenses de santé : une charge croissante, une protection maladie à redéfinir*. Rapport de la cour des comptes.

Cour des comptes (2017). *La médecine libérale de spécialité : contenir la dynamique des dépenses, améliorer l'accès aux soins*. Rapport sur l'application des lois de financement de la sécurité sociale. Chapitre 5.

Del Sol M., Turquet P. (2021). « L'assurance maladie complémentaire des salariés au prisme du fiscal welfare… what's going wrong in France? », *La Revue de l'Ires*, (1), p. 45-73

Després C., Guillaume S., Couralet P.E. (2009). *Le refus de soins à l'égard des bénéficiaires de la Couverture maladie universelle complémentaire à Paris.* Fonds de financement de la protection complémentaire de la couverture universelle du risque maladie, La documentation française, collection des rapports publics.

Devaux M. (2015). "Income-related Inequalities and Inequities in Health Care Services Utilisation in 18 Selected OECD Countries". *European Journal of Health Economics*. 16(1):21-33. doi: 10.1007/s10198-013-0546-4. Epub 2013 Dec 14. PMID: 24337894.

Direction Générale de l'Offre de Soins (DGOS). (2018). *Les chiffres clés de l'offre de soins.* Edition 2018. Ministère des solidarités et de la santé.

Direction de la Recherche, des Études, de l'Évaluation et des Statistiques (Drees) [2020]. *Les dépenses de santé en 2019, résultats des comptes de la santé.* https://drees.solidarites-sante.gouv.fr/publications-documents-de-reference/panoramas-de-la-drees/les-depenses-de-sante-en-2019-resultats

Direction de la Recherche, des Études, de l'Évaluation et des Statistiques (Drees) [2021]. *Panorama des établissements de santé, édition 2020*.

Dixte C., Vergier N. (2022). « Revenu des médecins libéraux : une hausse de 1,9 % par an en euros constants entre 2014 et 2017 », *Etudes et Résultats* n°1223, Drees.

Dormont B. (2021). « Grande Sécu » : « Les citoyens, malades ou bien portants, auraient gros à gagner avec cette réforme ». *Le Monde*. 26-28 novembre 2021.

Dormont B., Geoffard P.-Y. Tirole J. (2014). « Refonder l'assurance maladie », *les notes du conseil d'analyse economique*, n° 12, en ligne.

Ferrand R. (2020). *Rapport d'information sur l'impact, la gestion et les conséquences dans toutes ses dimensions de l'épidémie de Coronavirus-Covid-19*. Assemblée nationale. N°3053.

Flood C., Thomas B. (2020). *Is Two-Tier Health Care the Future?* Press of Ottawa. https://press.uottawa.ca/is-two-tier-health-care-the-future.html

Fouquet M., Pollak C. (2022). « Impact des assurances complémentaires santé et des aides socio-fiscales à leur souscription sur les inégalités de niveau de vie ». *Les dossiers de la Drees*, Drees, n°101.

Franc C., Perronnin M., Pierre A. (2016). "Supplemental Health Insurance and Healthcare Consumption - A Dynamic Approach to Moral Hazard", *Health Economics*, Volume 25, Issue 12, 2016/12.

Franc C., Pierre A (2015). "Compulsory Private Complementary Health Insurance offered by Employers in France: Implications and Current debate". *Health Policy*, 119(2), 111-116.

Franc C., Pierre A. (2016). « Restes à charge élevés : profils d'assurés et persistance dans le temps ». *Questions d'économie de la santé* n° 217, Irdes. Avril.

Franc C., Pierre A. (2016b). « Conséquences de l'assurance publique et complémentaire sur la redistribution et la concentration des restes à charge : une étude de cas ». *Economie et Statistique*, n°475-476, 2015/04, 31-49.

France Assos Santé (2015). *Dépassements d'honoraires: le "match" public – privé*, online: France Assos Santé. https://www.france-assos-sante.org/2015/01/16/depassements-dhonoraires-le-match-public-prive/

Geoffard P. (2006). « L'AMO ne suffit plus à garantir un accès aux soins sans barrière financière ». *Regards* 2016/1 (N° 49), École nationale supérieure de Sécurité sociale.

Geoffard P.Y., Lagasnerie de G. (2012). « Réformer le système de remboursement pour les soins de ville, une analyse par microsimulation ». *Economie et statistique* n° 455-456.

Grignon M., Perronnin M., Lavis J. N. (2008). "Does Free Complementary Health Insurance Help the Poor to Access Health Care? Evidence from France". *Health Economics*, 17(2), 203- 219.

Hassenteufel P. (2008). « Syndicalisme et médecine libérale : le poids de l'histoire ». *Les Tribunes de la santé*, vol. 18, no. 1, 2008, pp. 21-28.

Haut Conseil pour l'Avenir de l'Assurance Maladie (HCAAM) [2021). *La régulation du système de santé*, Rapport du Haut Conseil pour l'Avenir de l'Assurance Maladie.

Inspection Générale des Affaires Sociales (IGAS) [2007]. *Les dépassements d'honoraires médicaux*. Rapport de l'Inspection Générale des Affaires Sociales.

Jusot F., Perraudin C., Wittwer J. (2012). « L'accessibilité financière à la complémentaire santé en France : les résultats de l'enquête Budget de Famille 2006 ». *Economie et Statistique*, n° 450, 2012/11, 29-46.

Jusot F., Legal R., Louvel A., Pollak C., Shmueli A. (2016). « A quoi tient la solidarité de l'assurance maladie entre les hauts revenus et les plus modestes en France ? ». Revue française d'économie, n° 4, vol. XXXI, 2016, 15-62.

Jusot J., Wittwer J. (2021). « Vers une grande secu, enfin ? », *Blog du college des economistes de la sante*, 16 novembre.

Kambia-Chopin B., Perronnin M., Pierre A., Rochereau T. (2008). Les contrats complémentaires individuels : quel poids dans le budget des ménages ? In: Enquête sur la Santé et la Protection Sociale 2006.

Larcher G. (2007). *Les missions de l'hôpital*. Inventory prepared by the consultative commission on hospital missions.

Millien C., Chaput H., Cavillon M. (2018). « La moitié des rendez-vous sont obtenus en 2 jours chez le généraliste, en 52 jours chez l'ophtalmologiste ». Drees. *Etudes et Résultats,* n°1085.

Ministère des solidarités et de la santé (2017). *La stratégie nationale de santé 2018-2022*. Les dossiers du Ministère des solidarités et de la santé. https://solidarites-sante.gouv.fr/IMG/pdf/dossier_sns_2017_vdef.pdf

Ministère des solidarités et de la santé (2022). *Ma santé 2022 : un engagement collectif*. Les dossiers du Ministère des solidarités et de la santé. https://solidarites-sante.gouv.fr/systeme-de-sante-et-medico-social/masante2022/

Munck S., Massin S., Hofliger P., Darmon D. (2015). « Déterminants du projet d'installation en ambulatoire des internes de médecine générale ». *Santé Publique*, 27, 49-58. https://doi.org/10.3917/spub.151.0049

Naiditch M., Dourgnon P. (2009). "The Preferred Doctor Scheme: A Political Reading of a French Experiment of Gate-keeping", Irdes *Working Papers*, no. 22, 2009/03.

Organization for Economic Cooperation and Development countries (OECD) [2019]. *OECD Health Statistics, Health Expenditure and Financing*. https://stats.oecd.org/. Organisation for Economic Cooperation and Development

Organization for Economic Cooperation and Development countries (OECD) [2020]. *Health at a glance: Europe 2020. State of health in the EU Cycle*. OECD, Publishing, Paris.

Or Z. (2014). "Implementation of DRG Payment in France: Issues and Recent Developments". *Health Policy*, 117(2): 146–150.

Or Z., Gandré, C. (2021). *Sustainability and Resilience in the French Health System*. Londres: LSE, 2021/03, 42 p.

Paris V., Polton, D. (2016). « L'articulation entre assurance maladie obligatoire et complémentaire, une spécificité ? ». *Regards,* 2016/1 (N° 49), École nationale supérieure de Sécurité sociale.

Perronnin M. (2016). "Out-of-Pocket Spending for Ambulatory and Hospital Care after Reimbursement by the French Public Health Insurance: Unequally Distributed Financial Burden". *Questions d'Economie de la santé* n°218. Irdes. Mai.

Pierre, A., Jusot, F. (2017). "The likely effects of employer-mandated complementary health insurance on health coverage in France". *Health Policy*, 121(3), 321-328.

Pierre A. (2018). *Assurance maladie complémentaire : régulation, accès aux soins et inégalités de couverture*. Thèse de doctorat de Sciences Economiques. Université Paris-Dauphine.

Pierre, A., Jusot, F., Raynaud, D., Franc, C. (2018). « Généralisation de la complémentaire santé d'entreprise : une évaluation ex ante des gains et des pertes de bien-être ». *Revue économique*, 69(3), 407-441.

Pierre A. (2022a). « L'absence de couverture par une complémentaire santé en France en 2019 - Premiers résultats de l'enquête EHIS », avec la collaboration de Rochereau T. *Questions d'économie de la santé* n° 268. Irdes. Mai.

Pierre A. (2022b). « Marché de la complémentaire santé, inégalités et préférences en matière de couverture : les effets de la généralisation de la complémentaire santé d'entreprise », Document de travail, Irdes n°89.

Polton, D., Rochaix, L. (2004). « Partage optimal entre assurance maladie privée et publique : la situation française au regard d'expériences étrangères ». *Économie publique, Études et Recherches*, (14).

World Health Organization (WHO). (2021). *Quality of Care*. https://www.int/health-topics/quality-of-care#tab=tab_1

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Is the Public-Private Mix in French Health System Sustainable?

Le modèle mixte public/privé du système de santé français est-il soutenable ?

Aurélie Pierre, Zeynep Or

France is known for having one of the best health care systems in the world. Indeed, its responsiveness is rated high; patients have a large choice of public and private providers without chronic waiting time problems observed in some OECD countries. Out-of-pocket payments are among the lowest in OECD area and the health status of the population ranks amongst the best in the world. However, promoting a universal health system built on a mix of public and private funding and provision raises numerous challenges to ensure equity and efficiency in the system. In this *Working Paper,* we present the unique public/private mix of healthcare funding and delivery in France and discuss to what extent this mix contributes to achieving overall health system goals of better health outcomes, equity and efficiency. We first explain the role of public and private insurances in healthcare funding and discuss the increasing regulation of private health insurers to align them with public objectives as an attempt to overcome the limits of current public insurance model. We then describe the place of private providers in care delivery and the implications of this plurality on care quality, efficiency, and access to care. By discussing the most recent measures tackling the issues in public-private mix in French health system, we suggest some avenues for improvement.

* * *

Le système de santé français est considéré comme l'un des meilleurs au monde : les patients disposent d'un large choix de professionnels de santé, publics et privés, les dépenses de santé à la charge directe des assurés sont les plus faibles des pays de l'OCDE, il y a moins de problèmes structurels de délais d'attente que dans d'autres pays, et l'état de santé de la population se classe parmi les meilleurs à l'échelle internationale. Mais promouvoir un système de santé universel qui repose sur un partage public/privé des financements et des offreurs de soins s'accompagne de nombreux défis pour garantir l'équité et l'efficacité du système de santé. Ce *Document de travail* décrit la combinaison unique publique/privée du financement et de la délivrance des soins en France et discute des avantages et des contradictions d'une telle organisation pour atteindre des objectifs d'équité, de qualité des soins et d'efficience. Nous commençons par décrire le rôle des assurances publique et privée dans le financement des soins et discutons de la régulation massive du marché de l'assurance privée pour tenter de pallier les limites du système d'assurance publique en France. Nous présentons ensuite la place des offreurs de soins privés dans l'organisation et la délivrance des soins et discutons des implications de la pluralité de l'offre sur l'efficience du système et sur l'accès aux soins de la population. Nous concluons en présentant des mesures récentes et des pistes d'amélioration qui pourraient permettre de réduire les effets pervers d'un système mixte public-privé dans le système de santé français.

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