Utilization Fees imposed to Public Health Care Systems Users in France.

Workshop organized for the Commission on the future of health care in Canada[1]

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1. A brief overview of the French health care system

1.1. Health insurance and access to care

All legal residents of France are covered by public health insurance, which is one of the social security system's entitlement programs. Set up in 1945, the coverage was gradually expanded to all legal residents: as late as December 1999, a small part of the population was still denied public health insurance[3].

The funding and benefits of the French public health insurance system, 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.

The funds are financed by employer and employee contributions, as well as personal income taxes. The latter's share of the financing steadily increased 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 that the system operates at the breakeven point. Responsibilities are frequently redefined, but never to satisfaction of all involved.

The public health insurance system covers about 75% of total health expenditures. Half of the outstandig amount is covered by patients' out-of-pocket payments and the other half is paid by private health insurance companies.

In France 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.

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1 *November 29 2001.*

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3 *This is the first aspect of the* Couverture Maladie Universelle *reform, another aspect of which we will study in section four. Before 2000, public coverage was aimed at workers and their families. The eligibility criteria is now residency.*

1.2. The State's role

1. The State decides what kinds of care are 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.
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. Starting in the 90s, the planning has been increasingly organized at the regional level.

1.3. The care supply

1.3.1. 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 care in France, and doubtless explains the dearth of prevention programs 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 diagnosis related group payment systems.

1.3.2. Health professionals

This analysis focuses 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. 56% of physicians work in private practices[4], and are paid on a fee-for-service basis. Prices are negotiated by physicians' unions and public health insurance funds[5].

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4 16% of them work part-time in public establishments, and 7% practice in private for-profit hospitals.

5 The remaining physicians declare either no practice (7%) or other types of activities (1%).

Since the creation of Social Security, the relationship between private practice physicians, 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 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 grow.

In conclusion, two features of the health care system should be mentioned:

1. Despite the fact that public health insurance has been extended to all legal residents, 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. There is clearly a lack of coordination among the health care actors. The system breeds competition and undermines cooperation: there is friction between the private and public sectors, between outpatient 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.

1.4. 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.

2. Description of copayments

While health insurance covers the whole population for a wide range of medical goods and services, it only finances three-quarters of the total costs of medical consumption.

2.1. Institutional design[6]

The State decides which goods and services are covered by public health insurance and to what extend. The State therefore establishes the levels of out-of-pocket payments since these copayments are inversely proportional to social security reimbursements. It is therefore essential to understand Social Security's rules for financing goods and services.

2.1.1. General rules governing the reimbursement of health care costs by social security

The rules for reimbursement are based on a number of general principles:

1. health insurance allows a patient free access to the medical professional of his choice, and in general there is no limit to the volume of consumption of goods and services reimbursed. For their part, doctors have freedom to prescribe, though they are expected to comply with a set of Official Medical Practice Guidelines.
2. to be covered, diagnostic, treatment services, drugs, and prostheses should:
    - have been produced or prescribed by a doctor, a dentist or a midwife and distributed by health professionals or institutions registered with the health insurance system[7];
    - figure among one of the official lists of approved procedures[8], medicines[9] or medical apparatus and prostheses[10].

The sums reimbursed by the public health insurance system are calculated for each product or service by applying a coverage rate (a percentage) to a negotiated tariff.

The following paragraphs describe in more detail which treatments are eligible or ineligible for reimbursement by the public health insurance system and the terms of financial coverage for various types of medical goods and services.

2.1.2. What care is reimbursed

Medical goods and services qualifying for health insurance reimbursement include:

- hospital care and treatment in public or private institutions providing health care, rehabilitation, or physiotherapy;
- out-patient medical treatment provided by general practitioners, medical and surgical specialists, dentists, and midwives;

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6 *This part draws largely from Sandier, Polton and Paris (2002, forthcoming).*

7 *99.4% of physicians are registered.*

8 *These lists, which are established jointly by the representatives of the public health insurance system and the medical professions on the Permanent Committee on Official Schedules of Professional Procedures, indicate which procedures can be provided by which professionals. They have to be approved by the Ministry.*

9 *Established and updated by the Economic Committee for Medical Products.*

10 *TIPS established by an inter-ministerial order.*

- diagnostic services and treatment prescribed by doctors and carried out by medical laboratories or paramedical professionals: nurses, physiotherapists, speech therapists, orthoptists...;
- pharmaceutical products, medical appliances and prostheses prescribed and included in the lists of products accepted for reimbursement;
- prescribed health-care related transport.

While part of the medical consumption covered by health insurance corresponds to secondary preventive measures, individual prevention as such does not generally give rise to reimbursement. Health insurance does cover the monitoring of pregnancy and of infants' health and systematic screening for certain ailments. There are also certain vaccinations which are reimbursed: in recent years the anti-flu' vaccine has been reimbursed for those suffering from chronic illnesses and for those over 65.

The range of treatment covered by health insurance does not include either cosmetic surgery or most types of thermal spa cures; nor does it include certain services of uncertain effectiveness. In addition, in order to limit expenditures certain procedures and tests are not included on the lists (osteodensitometry) or their frequency is limited (mammography for screening purposes).

For certain kinds of treatment, such as physiotherapy massage and thermal spa cures, the fact that a physician prescribes the procedure does not guarantee that the patient will receive reimbursements. Coverage by health insurance is subject to the prior agreement of the doctors advising the insurance funds, after examination of the case history and possible interviewing of the patient.

2.1.3. The level of reimbursement and the various types of copayments

For each type of product or service reimbursed by public health insurance there is a corresponding negotiated tariff, which serves as the basis for the calculation of the sum reimbursed to the patient.

In general, social security reimburses a fixed percentage of this tariff, which varies according to the type of treatment, and is lower for outpatient services and medicines than for hospital treatment. While reimbursement rates once varied from fund to fund, they are now uniform.

- The rate of reimbursement by public health insurance varies from 70 % for doctors and dentists to 60 % for medical auxiliaries and analyses.
- In principle the rate for reimbursement of hospital treatment is 80 %, but it rises to 100 % in a number of cases, in particular after the 31st day of a hospital stay and when the hospital treatment involves surgery of a certain degree of seriousness (appendectomy, for instance) as well as for maternity patients.
- For the majority of medicines the rate of reimbursement is 65 %. But it varies from 100 % for non-substitutable or costly drugs to 35 % for medicines considered «convenience medications».

The first type of patient's contribution (*ticket modérateur*) is the remainder that makes up 100% of the tariff for each type of care.

In addition, the patient sometimes pays more than the social security tariff, notably:

- the services of some private practice physicians (38% of specialists and 15% of general practitioners) who are allowed to charge more than the standard negotiated tariff (i.e. to balance bill);
- some categories of medical goods such as prostheses (dental and otherwise) and eye-ware, for which actual (unregulated) prices tend to be much higher than the official tariffs and the levels of reimbursement are thus particularly low.

The difference between the actual price and the official tariff is not eligible for reimbursement by the public health insurance system.

Another form of copayment is a per diem amount paid by patients during a hospital stay (*forfait hospitalier*). It amounts to 70 Francs (about 11 Euros) and contributes to the financing of

accommodation. Services in the hospitals which only aim at improving the patients' comfort (single room for instance) are directly charged to the patient and are not reimbursed by social security.

Lastly, patients pay out of their pockets for medical goods and services which are not on the approved reimbursement lists (some blood tests, osteodensitometry etc.) or which they purchase or use without prescription (for instance, physiotherapists services, some medicines).

In summarizing these different types of copayments, it is useful to distinguish two categories:

- "statutory copayments" the result of a deliberate choice to leave some part of the cost of care to be paid directly by the patient (*ticket modérateur* and *forfait hospitalier*).
- the other copayments which emerged as a consequence of more implicit (which is not to say passive) policy measures: the decision not to add (new) procedures to the list or decision to let the gap between the tariff and the price be set outside of the health insurance system.

The historical and political analysis of copayment policies will be further developed in the last section of this paper.

If the term of copayment is meant to designate all the financial costs (and barriers) associated with public health insurance, the way reimbursements are made should be mentioned here. As a general rule (except for hospital care), patients are expected to pay the treatment provider by advancing the cost of the charges. After the paperwork is processed, they receive reimbursement – usually partial –from the health insurance fund. Although there are increasingly frequent exceptions to this rule, this cash advance is believed to create, for some people, a financial barrier to care, and for that reason is can be considered as a *de facto* copayment.

2.1.4. Exemption of statutory copayments

The analysis above shows that reimbursements by public health insurance depend on the type of care. However, in certain circumstances the patients can be exempted from "statutory copayments" (directly controlled by the public system). Exemption criteria are linked to:

- the *pathology*, in particular when the person insured is suffering from one of 30 identified "serious illnesses" (diabetes, AIDS, cancer, psychiatric illness), or if the patient is suffering from one or several pathologies involving an incapacitating state;
- the *nature of the treatment,* in particular certain hospital treatments and sterility treatment;
- the *person concerned*, in particular in cases of workplace accidents, women more than 5 months pregnant, the disabled, handicapped adults and children, veterans...

Most of these exemptions are meant to ease the out-of-pocket cost of care for those who have higher needs. Obviously, they only concern the so-called statutory copayments which apply to the expenditure officially acknowledged by social security.

Table 1: Exemption of statutory copayments depending on age (% the population)

Age	Serious illness	Other criteria	Total
Under 16 years	1,2 %	0,4 %	1,6 %
16-39 years	2,0 %	1,3 %	3,3 %
40-64 years	7,6 %	2,5 %	10,1 %
65 and above	26,5 %	3,3 %	29,8 %
Total	6,8 %	1,7 %	8,5 %

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

2.2. Private expenditure on health

Private agents finance roughly a quarter of overall expenditure on medical goods and services (24% in 2000), but the level of copayments varies with the type of care and micro-data shows how the burden is distributed among citizens.

2.2.1. Copayments per type of care

The following table shows that the extent and the nature of copayments depends on the type of care.

Table 2: Private participation in the financing of care (1999-2000)

	Theoretical *ticket modérateur*[1] (as a %)	Actual rate of statutory copayment[2] (as a %)	Share of the cost privately borne[3] (as a %)
Treatment by physicians	30	19	24
Dental treatment	30	27	65
Medical Auxiliaries	40	8	20
Laboratories	40	23	26
Medicines	0, 35, 65	27	37
Hospital care	20	n.a.	9

[1] *value set by government.*
[2] *for the main public fund.*
[3] *National Health Accounts 2000.*
Source : inspired by Sandier et al. (2002, forthcoming)

The first column presents the official rates applied to social security tariffs in order to calculate the *ticket modérateur*: For instance, since social security reimbursement of the official tariff is 70% for physician treatments, the complement (30%) represents the theoretical statutory copayment rate.

As some patients are exempted from these copayments, the actual rate of statutory copayment is always lower than the *ticket modérateur*. Column 2 represents the share of expenditure valued with the official tariffs which is paid by patients who belong to the main insurance fund. For instance, taking into account the respective weight of the different types of medicines in the total medical consumption eligible for reimbursement (i.e. prescribed by a health professional), and the proportion of spending reimbursed without statutory copayments, it can be estimated that the average rate of reimbursement by health insurance of prescribed pharmaceutical products is 73 %. Since the prices of medicines are regulated,

patients therefore pay 27% of all prescribed drugs.

Another way of estimating private participation in the financing of care is to calculate the difference between total expenditure and public financing (column 3). Taking into account pharmaceutical products bought without prescription, the cost of medicines privately borne is 37% of the overall expenditure. For physicians' treatments the amount non-reimbursed in the third column is higher because balance billing and non-reimbursed services such as plastic surgery are taken into account. Non-reimbursed services of medical auxiliaries also probably explain the 20% rate of out-of pocket payments. Regarding dental treatments, the difference between prices and tariffs for dental prostheses account for the very high share of privately borne cost. For all these items, it is also possible that some individuals, who use services covered by social security, do not actually seek reimbursement.

2.2.2. Distribution of copayments in the population

One major concern regarding copayments is whether or not they are equitably distributed among the population. Grignon and Aligon (1999) estimate the actual amount of copayments paid by a sample of individuals covered by the main health insurance fund. These individuals' households were surveyed by the CREDES and information on their income per consumption unit is thus available. Data on the individuals' consumption of care over a year comes from public health insurance reimbursement files for 1992.

Grignon and Aligon show that 11% of the poor (income less than 3,000F. monthly per consumption unit - 458 Euros) spend more than 13% of their monthly budget on copayments. On average however, the out-of-pocket payments of the poor are slightly lower than those paid by the whole population.

Table 3 compares the overall population and the poor. It first shows that the poor spend 8% less than the overall population on heath care, which provides a first explanation for these lower out-of-pocket payments. This under-consumption is partially explained by the fact that a higher proportion of the poor does not consume any health care during the year. Yet, if age and sex are controlled for, Mizrahi and Mizrahi (1995) show, using similar data, that the poor are in worse health than the rest of the population. Regarding the structure copayments, it is interesting to note that statutory copayments (*ticket modérateurs*) represent a higher share of the poor's out-of-pocket payments. They tend to seek care eligible for reimbursement and the structure of their consumption differs from that of the overall population (for example they spend less on dental care and more in hospitals than the overall population). The latter could be directly attributed to the effect of copayments as people can be admitted to hospitals without prior referral and because copayments are lower than for ambulatory care. It could also be an indirect consequence of the relatively high cost of access to ambulatory care, and obstacle that encourages individuals to wait until the condition is serious (and therefore requires more intensive and costly care[11].

[11] *Testing this hypothesis requires longitudinal data over a long period which is currently unavailable.*

Table 3: Out-of-pocket payments and income (1992)

	The Poor	Overall
Annual average out-of-pocket payments	150 Euros	215 Euros
Share of statutory copayments in the OOP *(tickets modérateurs)*	82 %	76 %
Overall expenditure	936 Euros	1018 Euros
Share of out-of-pocket payments in overall expenditure*	16 %	21 %
Share of hospital in overall expenditure	11 %	8 %
Share of dental care in overall expenditure	9 %	12 %
Proportion of the population with no health expenditure	19 %	14 %

Source: Grignon et Aligon 1999.

** This percentage is lower than the National Health Accounts' 24% because a) the expenditure corresponds to social security claim files (non-reimbursable items are not recorded) b) the survey does not encompass the institutionalized population and households in which a person is in very bad health tend to respond less to health surveys, hence biasing downward all estimates of expenditures, and most likely their structure.*

Grignon and Aligon therefore give mixed evidence on the distribution of out-of pocket costs for the population. The fact that the poor have lower copayments reflects lower expenditure and a difference in the pattern of consumption. It is not possible to determine the extend to which the nature and the level of copayments is responsible for these differences, deterring the poor from seeking (certain categories of) care, but most experts believe that there were financial barriers to access in France. In 2000, a reform (see section 4) changed the situation.

3. Impact of copayments

3.1. A major payer: supplementary insurance

Private insurance in France finances 12.3% of total expenditures on medical goods and services, i.e. a little more than half of the private expenditure[12]. We will first describe the organization of the sector and then present the distribution of coverage among the population.

3.1.1. Scope of intervention

Private insurance, as described in the literature, provides four main services: it can cover user charges imposed by the public health insurance system, or goods and services excluded from public coverage. In some cases it provides access to better quality care, by covering the cost of private services judged of higher quality than those provided in the public health care system or by providing faster access or increased consumer choice. Lastly, it can be the sole source of coverage, possibly as a substitute for public insurance. Various terminologies have been proposed to designate the possible roles of private insurance (Table 4).

[12] *National Health Accounts 2000.*

Table 4: Terminologies of the role of private health insurance

	van Doorslaer Wagstaff (1993)	Wasem (1995)	Rovira et al. (1998)	Schneider (1995)	European Commission
coverage of user charges	complementary	complementary	supplementary	residual	complementary
coverage of excluded services and goods				supplementary	
access to higher quality care	supplementary	double cover	alternative	parallel / alternative	supplementary
sole coverage	alternative	alternative	substitutive	substitutive	substitutive

Source: Couffinhal 1999

In France, virtually all private insurance contracts cover (at least) the statutory copayments (*ticket modérateurs* and hospital per diem)[13]. Additionally, for physician services and medical goods, contracts may cover part of the difference between the official tariff and the price paid by the patient. The extent of that coverage varies greatly and until recently (see below in section 3.1.3) very little was known about the content of contracts. However, in general, private insurers' coverage only applies to goods and services which are listed as reimbursable by social security. In other words, they act as secondary payer but rarely cover excluded goods and services. A notable exception (in some cases) is contact lenses which are rarely covered by social security but are considered by insurers a substitute to glasses (covered, however insufficiently by social security). Recently an insurer proposed a contract which covers osteodensitometry but the simple fact that this information became public knowledge confirms that it is an exception rather than the rule.

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

All in all, private insurance's primary function in France is to cover user charges (line one of Table 4), and from now on will be designated as "complementary" insurance.

3.1.2. General organization of the market

In France, complementary coverage is provided by three types of institutions: mutual insurance companies, private insurance companies, and provident institutions. Mutual insurance companies are not-for-profit establishments, and they have always portrayed themselves as socially-oriented (in favour of cross-subsidisation, against discrimination according to risk, etc.). They are the historical operator in the market. Insurance companies arrived on the health insurance market in the 80s. They are for-profit enterprises and they consider themselves risk managers, their premiums seem to vary more with risk than those of the mutual insurance companies. The provident institutions arrived on the scene even later, but are fast increasing their market share. They are jointly run by employees unions and employers and mostly provide group insurance for firms' employees.

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

Table 5: Market share of the three types of institutions offering health insurance (% of total health expenditures)

	1989	1994	1998
Mutual insurance companies	6.2	6.8	7.1
Insurance companies	2.5	3.2	3.0
Provident institutions	n.a.	1.5	1.8

Source: GAP Directory, 1999.

Health insurance policies can be taken out by individuals or groups.

34% of the population purchase individual insurance[14]. Most often, policies are taken out in the context of employment, i.e. the employer buys groups insurance for his staff. Participation in the group insurance contract can be mandatory for employees.

3.1.3. Extend of the coverage

The offering of complementary coverage has burgeoned over past years in response to the slow but steady decline of the percentage of health costs reimbursed by the public insurance system (see section 4.1). While a third of the population had private health insurance in 1960, and half in 1970, the figure stands ate 86 % in 2000.

As Table 6 shows, the proportion of people covered varies with employment-related factors: the employed and pensioners are more often covered than the unemployed or other non-working persons; unskilled workers are less often covered than managerial staff or office workers.

Table 6: Private health insurance coverage* depending on employment status and occupation (% of the population)

Employment status	%
Working	89,9
Unemployed	60,1
Retired / widower	88,7
Housewife	80,1
Other inactive	66,1
Students, children	84,6
Occupation	**%**
Farmers	89,3
Artisans, retailers	82,0
Executives, intellectual professions	93,5
Intermediary professions	94,4
Office clerks	85,2
Customer service clerks	69,2
Skilled workers	84,0
Unskilled workers	71,8
Total	**85,7**

**Not including CMU coverage*

[14] *Source: Health and Health Insurance Survey (ESPS) 2000.*

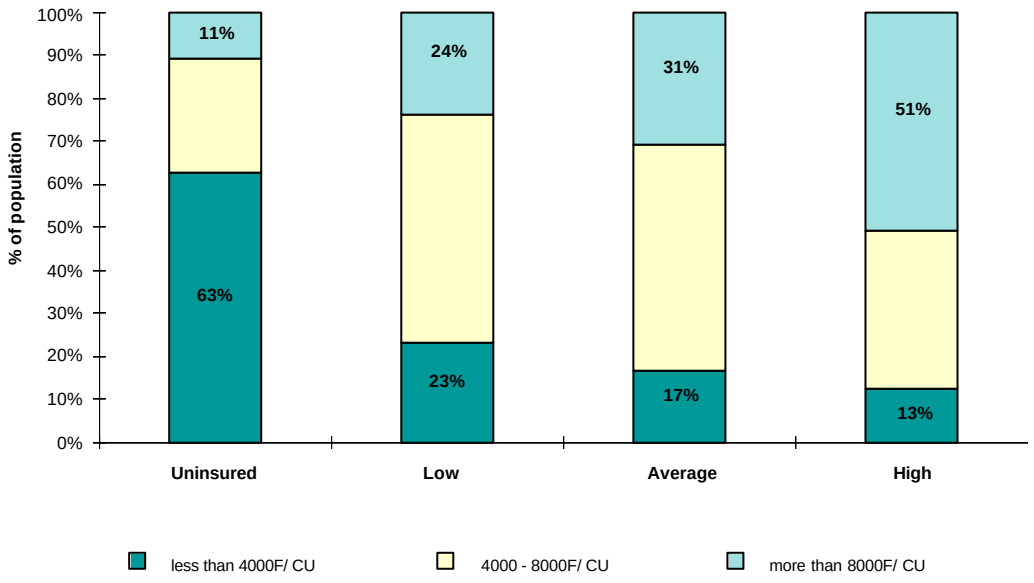
Source: Health and Health Insurance Survey (ESPS) 2000.

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

A legitimate question is whether all those who have access to insurance are equally well protected. Until recently in France, there was no reliable information on the content of health insurance contracts. In its 1998 Health and Health Insurance Survey (ESPS), CREDES introduced a set of detailed questions on heath insurance contracts. Based on this information, Bocognano et al. (2000) distinguish groups of contracts which differ by their levels of coverage[15] and show that the extent of the coverage varies among social groups.

Figure 1 represents the distribution across income groups of the persons who are not covered by private health insurance, and whose private coverage is low, average or high. It is obvious that the higher the coverage, the more likely it is that the insurees are rich and the less likely they are to be poor.

Figure 1: Distribution of the population with respect to income per consumption unit for various levels of insurance

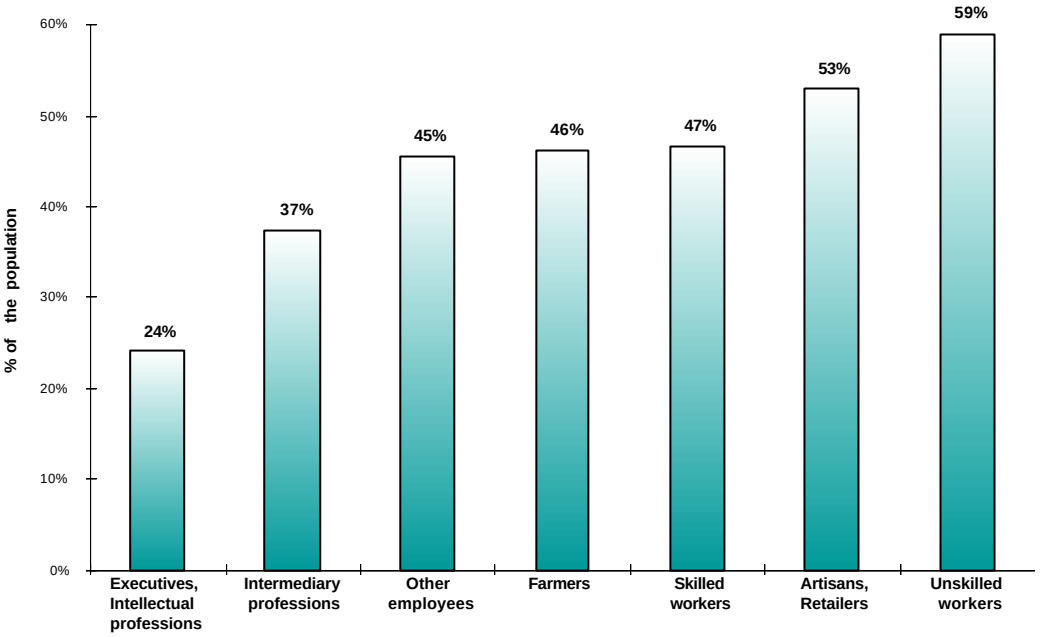


Source: Health and Health Insurance Survey (ESPS) 1998.

[15] *Bocognano et al. (2000) for detailed explanations and results.*

Figure 2 displays the proportion of individuals with little or no coverage depending on the occupation of the family head and confirms that less favored groups are more likely to directly bear the cost of copayments.

Figure 2: Percentage of the population with no or little insurance depending on the occupation

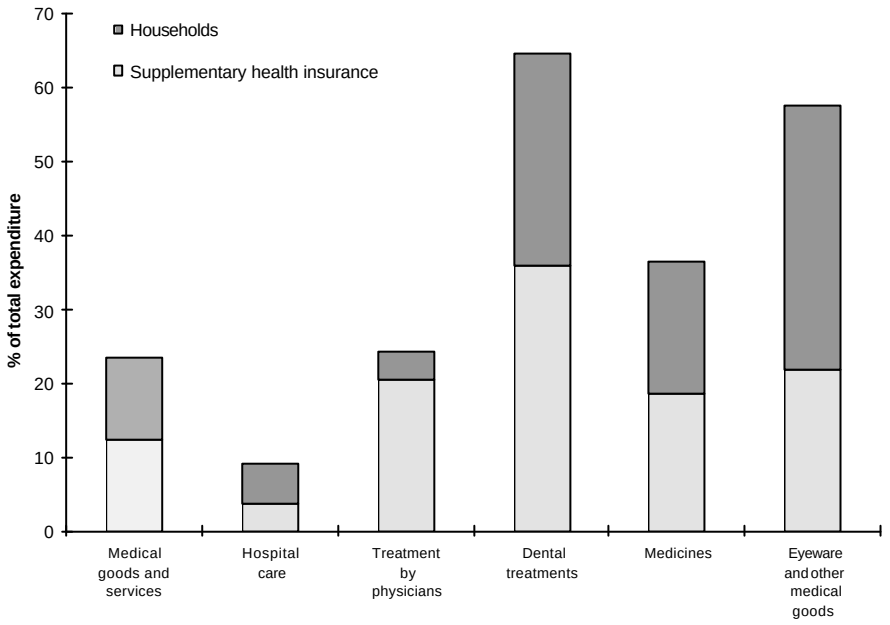


Source: Health and Health Insurance Survey (ESPS) 1998.

3.2. Copayments financed by households

In 2000, consumers of care directly finance 11.1% of the total expenditure on medical goods and services. Financing by the patients themselves represents a distinctly larger proportion of the costs of provision of eye-ware and other medical goods (36%), of dental treatment (29%) and of medicines (19%) than of hospital treatment (5%). Figure 3 also shows that in general private insurance covers half of private copayments, with the exception of physician treatments, for which it covers the bulk of copayments. On the other hand, if one looks at the absolute value of the total amounts which patients ultimately have to pay, the list is topped by pharmaceutical products (4.5 billion Euros in 2000), followed by hospital treatment (3 billion Euros), ahead of eye-ware and other medical goods (2.3 billion), and dental treatments (1.8 billion).

Figure 3: The level of copayments for different types of care and the distribution of the burden between private insurance and households



Source: National Health Accounts, 2000. The category "Medical goods and services" is an aggregate figure.

The impact of copayments on households can also be studied by looking at micro-data which tries to take into account the role of private insurance in an effort to evaluate the real impact of copayments on households' direct payments.

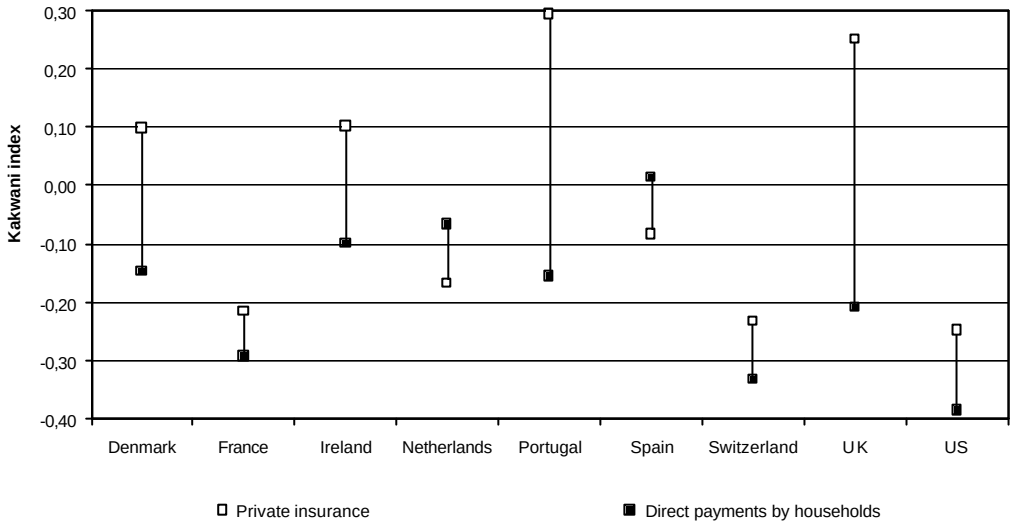
Grignon and Aligon (Op. Cit.) complete their study of private copayments by a multivariate analysis which compares the out-of-pocket payments of the poor to those of the rest of the population. They show that once coverage by private insurance is taken into account, the difference between the poorest and the rest of the population becomes insignificant. According to this study, access to private insurance restores a level of access to care which is comparable (all other factors being equal) to that of people with higher income. Conversely, it confirms that copayments deter the poorest from seeking care. These results are partially contradicted by Breuil-Genier et al. (1999) who study a series of care consumption indicators (probabilities of recourse to different types of care, number of visits, etc.). They show (using other data) that the income effect persists once sex, age and the insurance status are taken into account and they conclude that there are also non-financial barriers to access to care.

The only study which explicitly measures equity in the finance of the French health care system's

financing was undertaken by a group of European researchers and has the advantage of enabling a comparison between France and other countries.

Based on survey data, Kakwani indices were computed by van Doorslaer et al. (1993) according to a uniform methodology. These indices[16] reflect the progressive nature of payments; their value is positive if a system is progressive and negative if the opposite is true. Figure 4 shows that both insurance and direct payments in France are regressive, in other words, those with lower income assume a bigger share of private expenditure, and contribute relatively more to the private financing of care than those with higher income. A glance at Figure 4 shows that private expenditure on care is more regressive in France than in every other country with the exception of the US and Switzerland, both countries in which private insurance is the main source of coverage.

Figure 4: Kakwani indices for private health expenditures



Source: van Doorslaer and Wagstaff (1993).

This study confirms the regressive character of private payments towards health care in France, even with private insurance taken into account. The following section presents the policy motivations which explain the introduction and the increase of copayments over time. The realization of their negative consequences on access to care explains why a public complementary insurance plan was introduced in 2000. This measure questions some of the principles the public health insurance system is founded on and probably prefigures a more fundamental reorganization of the way public insurance operates.

[16] *They reflect the difference between the distribution of income in the population before and after private payments towards care. These distributions are represented by Lorentz curves which plot cumulative proportions of the population (ranked according to income) against their cumulative proportions in income or payments.*

4. Political aspects

4.1. The origin and the development of copayments

In section 2.1.3 above, we made the distinction between statutory copayments, which result from an explicit decision to share the financing of care with the publicly insured (and include *ticket modérateur*), and other types of copayments.

Ticket modérateurs were introduced in 1930 for those covered by the health insurance funds which existed before social security was created. The patients had to pay a percentage of the tariff which served as a basis to calculate the reimbursement. Over time several reforms took place which changed the levels of copayments and the conditions under which patients could be exempted from their payments.

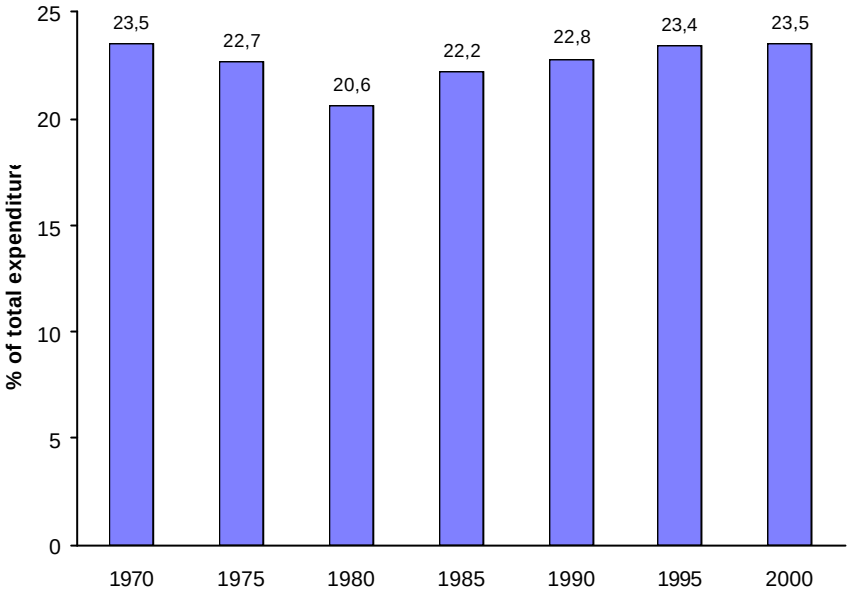
- Copayment rates tended to decrease until 1967 and increased five times afterwards (the last hike was in 1993). A 3 Euro daily rate per diem for hospital days was created in 1982 and was raised 4 times to reach its current level of about 11 Euros.
- The range of people exempted from statutory copayments has increased over time. The criteria are medical rather than strictly financial (see 2.1.4) in the sense that they concern cases when individuals face high care costs rather than specific types of individuals. This reflects a general principle in France's public insurance system that only medical need should govern access and that all citizens (regardless of their income) should have the same rights. Even if in reality copayments represent a higher budget share for low-income households, and even if the health insurance funds physicians who decide who is to be exempted probably take into account the patients financial circumstances, until 2000 (and the creation of a means-tested "complementary" insurance), the exoneration criteria were based on higher medical needs.

The prime motivation behind the increase of statutory copayments was to curb public health expenditures. The official line was that copayments were meant to make patients consume in a more responsible fashion. However, as private insurance developed and increasingly covered statutory copayments, any impact these measures could have had on moral hazard was canceled. An attempt was made in 1967 to forbid the re-insurance of statutory copayments but the project was never completed. In the 80s it became clear that increases in copayments were essentially way to decrease public payments.

The increase of copayments over time can also be explained by the decisions not to reevaluate social security's tariffs for some categories of goods and services, and to slow the addition of new products and procedures to the lists of reimbursable items. Inversely, very few decisions were made to drop items from the lists, with the exception of a few pharmaceutical products (1991 for instance).

Overall, the privately financed share of expenditures tended to decrease until the 80s and increase afterwards, though it has stabilized in the last 5 years.

Figure 5: Private participation in the financing of medical goods and services 1970-2000



Source: National Health Accounts, 2000.

4.2. The new public complementary insurance

The increase of copayments over time tended to deter the poorest citizens (few of whom had private complementary insurance) from seeking care, and concerns grew over the system's inequity.

Until 2000, programs covering statutory copayments (and sometimes other copayments) existed for very poor citizens. These programs of "medical assistance" (*Aide médicale*) were managed by local authorities or the State if the person was homeless. The extent of the coverage and the income thresholds below which people were entitled to be covered varied across *départements* (regions' geographic subdivisions). In 1998, roughly 2% of the population was covered by these programs[17].

These programs were replaced in January 2000, by a uniform means-tested public supplementary insurance program called CMU (*Couverture maladie universelle*). Its purpose is to decrease the existing financial barriers which limit access to care for those whose income is below a certain threshold (about 10% of the population is eligible)[18].

CMU beneficiaries are exempted from all statutory copayments. Additionally, the CMU acknowledges the existence of the other type of copayments: those physicians who are in general allowed to balance bill may not charge CMU beneficiaries above the official tariff. Moreover, beneficiaries are entitled to lump-sum reimbursements for glasses, dental prostheses and other goods whose prices were way above the official tariffs. Health professionals are not allowed to charge CMU beneficiaries beyond these thresholds. In other words, access to care is supposed to be completely free of charge for CMU beneficiaries. Finally, they do not have to advance the cash at the point-of-service, and professionals are directly paid by health insurance.

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[17] *Source: Health and Health Insurance Survey (ESPS) 1998.*

[18] *Eligibility thresholds: 3600 F. (549 Euros) for a single person, 823 Euros for two people, etc.*

Table 7, based on a survey conducted in 2000 shows, as expected, that vulnerable populations were the primary beneficiaries of the CMU.

Table 7: Coverage by the Couverture Maladie Universelle depending on employment status and household structure

Employment status	%
Working	2,2
Unemployed	20,3
Retired / widower	1,5
Housewife	9,1
Other inactive	12,8
Student, children	6,9
Household structure	**%**
Single	4,8
Single parent	17,1
Couple without child	1,6
Couple with chidren	4,6
Total	**5,0**

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

By the end of June 2001, 4.5 million people benefited from the CMU (about 7% of the population)[19]. Even if it seems that some professionals do not respect their obligations towards CMU beneficiaries (to treat them at the expected prices), it is most likely that the CMU will tremendously decrease the deterring effect copayments had on access to care. Other socio-cultural barriers yet have to be measured.

4.3. Towards a reform of the way health insurance operates?

The introduction of the CMU was primarily a means to alleviate the growing inequity of the system, but this reform goes beyond a simple reorganization of copayments. Indeed, the policy-makers acknowledged the fact that everybody, including the poor, should have access to a set of goods and services (dental prostheses for instance).

This idea is part of a larger debate spurred by growing dissatisfaction with the way public health insurance covers care. Many experts believe that it would be more efficient and equitable to clearly define a set of indispensable goods and services which should be available to everyone and which would be extensively or completely financed by public health insurance. The remaining goods and services would be available to those who desire and can afford them, with or without relying on private insurance.

In France, the lists of reimbursable items have always been managed on a day-to-day basis, by the State, sometimes based on advice by the health insurance funds and health professionals. The process is not always rational and is never transparent (at least to the public). Rather than increasing copayments on a wide range of goods and services, it would be preferable to collectively decide where the public intervention should be concentrated, in other words, to elaborate a basic benefits package.

Public health experts and some authorities in France are strongly in favor of such a reform. They

[19] *Boisguérin 2001.*

recommend that priorities be defined by extensive public debate and that the cost efficiency of included services be evaluated by experts. This debate is in keeping with the increasing concern in many countries on health care evaluation and cost-effectiveness.

In spite of a large consensus on the necessity of such a reform, its design and implementation are likely to be slow. In fact, a first attempt to rationalize the list of reimbursable medicines has already met with failure.

A decree published in October 1999 stated that only medicines with sufficient medical value[20] could be listed as reimbursable and that a drugs' inclusion on the list would have to be reassessed every 5 years.

A panel of experts was appointed to re-evaluate the entire pharmacopoeia with respect to the new criteria. The panel attributed an insufficient medical value to 835 products (18% of all reimbursed medicines) and recommended that they be struck from the list. Until now, none of them have been excluded from reimbursement.

[20] *This is based on five criteria: (1) the product's effectiveness as well as its undesirable effects, (2) its place in the therapeutic strategy in relation to the alternative therapies available, (3) the seriousness of the pathology in question, (4) the curative, preventive or symptomatic properties of the product, and (5) its importance in terms of public health. The medical service has to be evaluated in absolute terms, for the various circumstances of use.*

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