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Providing Healthcare Coverage to Undocumented Immigrants in France

What We Know, and What We Don't, about State Medical Aid (AME)

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Since its implementation in 2000, State Medical Aid (Aide Médicale de l'État, AME), a public health insurance programme for undocumented immigrants, has provoked intense debate. Some underscore the need to protect a vulnerable population and the universality of the right to healthcare coverage in France, while others perceive the scheme as an abuse of the social protection system that encourages illegal immigration. In a context of severe financial constraints on the healthcare system, issues relating to the legitimacy, cost, and effectiveness of State Medical Aid (AME) are becoming pressing. However, information about illegal immigrants access and use of the scheme has for a long time been incomplete. The "Premier pas" project, conducted by the University of Bordeaux and the Institute for Research and Information in Health Economics (Institut de Recherche et Documentation en Économie de la Santé, IRDES), aimed to study undocumented immigrants' access to State Medical Aid and healthcare utilisation in France.

Three *Questions d'Économie de la Santé* ("Issues in Health Economics") present: a description of the context and issue of the coverage of undocumented immigrants in France; a description of the "Premier pas" survey conducted with people eligible for State Medical Aid; and, lastly, the first findings of the survey on their access to State Medical Aid. This first article looks back at the history of undocumented immigrants' rights to healthcare in France and provides an overview of the information –and need for information– about the scheme.

The existence of a public health insurance scheme, State Medical Aid (Aide médicale de l'État, AME), for undocumented immigrants, has been the subject of considerable criticism since its creation in 2000. Indeed, State Medical Aid (AME) has polarised public debates. Some reiterate the need to protect a vulnerable population, and the universality of the right to health protection in France, while others perceive the scheme as an abuse of the social protection system that facilitates –and even encourages– illegal immigration. A context of severe financial constraints on the healthcare system makes questions relating to the scheme's legitimacy, the cost of the scheme for the healthcare system, and its effectiveness more pressing. These questions are particularly difficult to tackle as it is not simply a question of evaluating the health system resources available for this population, but also the costs avoided through effective healthcare.

The difficulty of holding an informed debate is attributable to the lack of information about the scheme, and in particular the lack of information about the population it is supposed to cover

I1

State Medical Aid (AME) is comprised of three distinct schemes

The term State Medical Aid (AME) is in fact comprised of three distinct schemes (Assemblée Nationale, 2015 and 2016): "statutory" State Medical Aid, which represents 95% of AME expenditure, the 'emergency treatment' scheme, which represents around 5% of AME expenditure, and "humanitarian" State Medical Aid, which is marginal.

Statutory State Medical Aid (AME) makes it possible to provide healthcare for undocumented immigrants in France; it is subject to a certain period of residence and is means tested. Treatment is covered in accordance with social security rates. The basket of care covered is that covered by social security, with the exception of fertility treatment, thermal treatment, and drugs with a low therapeutic value.

The "emergency treatment" scheme makes it possible to provide healthcare for undocumented immigrants in France and not of the persons covered by "statutory" State Medical Aid, because they do not fulfil the three-month residence requirement in France, their application is being considered, or, more rarely, because they do not fulfil the income requirements to receive State Medical Aid. In that case, only emergency treatment can be covered. It is defined as care whose absence would be life threatening or could lead to a serious and lasting deterioration in a patient's health or that of an unborn child. State Medical Aid –via a fixed sum paid by the State– generally only covers part of the expenditure associated with the 'emergency treatment' scheme (62% in 2017), as the remainder is *in fine* funded by the French health insurance system.

"Humanitarian" State Medical Aid (AME) enables people who are not resident in France to be admitted for *ad hoc* hospital care. Unlike "statutory" State Medical Aid, it is not a right but a derogation resulting from an individual decision taken by the minister of health. Less than 100 people per year use this scheme.

State Medical Aid is not for asylum seekers. They are covered by the universal health cover system, which replaced basic CMU coverage, and also benefit from Complementary Universal Health Insurance (CMU complémentaire) –which has become Public Universal Health Coverage (Protection Universelle Maladie, PUMA)–, as they are lawfully resident in France. In the event that their request for asylum is rejected, and they remain in France, they can benefit from health insurance coverage for a year.

—undocumented immigrants residing in France— and, more specifically, their health status, their access to health insurance, and their use of healthcare services. The information available appears so far scarce, incomplete, and dispersed.

The purpose of this paper is to provide an overview of the information and evidence –and also the need for information– about State Medical Aid and the population that the scheme is designed to cover. Firstly, we will look back at the history of illegal immigrants' rights to access healthcare in France, and will then present and discuss the evolution of the number of persons covered by State Medical Aid and their healthcare consumption. Lastly, we discuss a tentative framework to assess the scheme with regard to the fragmentary research completed to date. Our findings about the need for information to assess State Medical Aid underpin the "Premiers Pas" project, which, conducted by the University of Bordeaux and the Institute for Research and Information in Health Economics (IRDES), aimed to study undocumented immigrants' access to State Medical Aid and healthcare utilisation in France.

Healthcare coverage for undocumented immigrants has existed in various forms since the nineteenth century

In France, access to public health insurance is based on a constitutional principle of equality between foreign residents and French citizens. This equality does, however, depend on the principle of lawful residence. However, undocumented immigrants in France have always had a right –since the inception of a national social security system in 1945, and even since the end of the nineteenth century– to healthcare coverage (the Professional Union for Assisted Housing (UNAFO), 2016; the National Council of Policies Against Poverty and Exclusion (CNLE), 2016).

Free Medical Assistance (Assistance Médicale Gratuite, AMG; Act of 15 July 1893), with which the *départements* were entrusted, gave "deprived" patients, including foreigners from countries that had concluded a treaty of reciprocal assistance with France, free access to healthcare. This law was reformed in 1953 –the State was entrusted with this free medical assistance in order to avoid regional disparities. The law also introduced the notion of the "right to social assistance", associated with the local authority's duty to protect the poorest people. Henceforth, social assistance had the particularity of being granted without prior contributions from the beneficiary or any mention of the legal residence requirements for foreigners.

Departmental Medical Assistance (Aide Médicale Départementale, AMD), created through the decentralisation laws (Law of 22 July 1983), once again entrusted the *départements* with a series of social assistance benefits, including medical assistance. Departmental Medical Assistance (AMD), an integral part of the decentralised social assistance, guaranteed all persons residing in France the right, for themselves and their dependants, to receive assistance with medical expenses that they cannot afford. Hence,

CONTEXT

The "Premiers Pas"* project, which addressed rights access, healthcare trajectories, and access to State Medical Aid (Aide Médicale de l'État, AME) in France, set out to study the experience of undocumented immigrants living on French territory with regard to their access to rights and healthcare, using a multidisciplinary approach.
The project adopted an approach involving social anthropology, and comprised a survey conducted amongst individuals without a residence permit —the "Premiers Pas" survey—, and a panel of administrative data relating to State Medical Aid (AME).
The "Premiers Pas" project was carried out by a multidisciplinary research consortium that brought together researchers in anthropology, sociology and health economy, as well as a GP.
The teams taking part in the project came from the University of Bordeaux, the Paris-Dauphine University, and the Institute for Research and Information in Health Economics (IRDES). The Fondation des Amis de Médecins du Monde and the Regional Health Agency (Agence Régionale de Santé, ARS) in the Nouvelle Aquitaine region also took part in the project.
"Premiers Pas" was funded by the National Research Agency (Agence Nationale de la Recherche, ANR) in 2016.

* https://premierspas.hypotheses.org/
www.irdes.fr/recherche/enquetes/premiers-pas/actualites.html

medical costs, as defined in the Code de la Sécurité Sociale (in particular, patients' contributions and daily hospital charges) were covered; however, certain *départements* provided more extensive coverage by ensuring the reimbursement of costs not covered by the social security system (the most common dental and optical expenses).

Until 1993, there were no legal residence requirements for both health insurance and Departmental Medical Assistance (AMD), which complemented or replaced health insurance for people without entitlements, and which benefitted the poorest individuals, who were often young adults who had never been employed. The law on the control of immigration and the conditions governing the entry, reception, and residence of foreigners in France, called the "Loi Pasqua" (24 August 1993), changed the system by introducing legal residence requirements for foreigners applying for health insurance. The law therefore eliminated the entitlement to social protection for illegal or "undocumented" immigrants ("sans-papiers" as they are known in France) who, like the poorest individuals, turned to Departmental Medical Assistance (AMD).

Subsequently, the law on Universal Health Insurance (Couverture Maladie Universelle, CMU) [27 July 1999]was initially intended to replace Departmental Medical Assistance (AMD) and universalise rights to health insurance for all residents in France, effectively establishing a real "universal" cover. But the retention of legal residence requirements for health insurance led to the introduction of a special state medical assistance scheme for undocumented immigrants, which was funded by the State like all the preceding schemes. The special scheme is called State Medical Aid.

State Medical Aid is a scheme intended for undocumented immigrants. Entitlement is conditional, on the one hand, on the same resources ceiling for free Complementary Universal Health Insurance (Couverture Maladie Universelle Complémentaire, or CMU-C) and, on the other hand, on an uninterrupted term of more than three months of residence in France. Claims for State Medical Aid are examined by Health Insurance Local Branches (Caisses Primaires d'Assurance Maladie, CPAM), which are also responsible for controlling the scheme.

Slightly less coverage than Complementary Universal Health Insurance (CMU-C)

Once acquired, State Medical Aid entitles the persons covered to a "basket of care" that is slightly more restricted than that for beneficiaries of free Public Complementary Universal Health Insurance (CMU-C). Excluded from the coverage are fertility treatment, thermal treatment, and drugs with a low ther-

I2

Incomplete information about health status, healthcare requirements, and social situation of 'undocumented' immigrants

Studies of immigrants from developing countries show that they often have specific healthcare requirements, associated with the prevalence of infectious diseases, such as tuberculosis and hepatitis B, in their country of origin. Recent decades have witnessed the emergence of chronic diseases amongst immigrant patients (Médecins du Monde (Doctors of the World), 2015). Furthermore, mental health problems resulting from the experience of migration, or the experience prior to migration, are also more frequent (Comiti-Patureau, 2005; Guillou, 2007; Lot, Aïna, 2012; and Demagny, Veisse, 2012). Furthermore, the recent relative feminisation of the migrant populations suggests an increase in the need for reproductive healthcare (Beauchemin et al. (eds.), 2010; Sargent, Kotobi, 2012; and Kotobi et al., 2013).

With regard to the social situation of undocumented immigrants, the European survey on undocumented migrants' access to healthcare in Europe, conducted by the Doctors of the World's European Observatory on Access to Healthcare in 2007, showed that 93% of undocumented immigrants were living under the poverty line. Likewise, 6 out of 10 migrants had a chronic disease, for which only 2 out of 10 received treatment. The survey conducted by the Directorate for Research, Studies, Assessment and Statistics (DREES, French Ministry of Health) in 2007 also showed that the perceived health status was significantly poorer amongst those covered by State Medical Aid (AME), and a higher rate of healthcare renunciation than in the rest of the population.

Although most general population surveys, including surveys on immigrants, do not make it possible to study undocumented immigrants, the existing sources (the Trajectoires et Origines (TeO) survey, conducted by the French National Institute for Demographic Studies (INED) and the French National Institute of Statistics and Economic Studies (INSEE), 2008; the Health, Health Care and Insurance Survey (ESPS), 2008 to 2012) suggest that immigrants' health is poorer than that of French citizens, whether they are legally resident (Berchet, Jusot, 2010, 2012; Cognet et al. 2012; Jusot et al., 2009, and Khlat and Guillot, 2017) or illegally resident (Boisguérin, Haury, 2008). Living and working conditions (Aïach, Fassin, 2004; Jusot et al., 2009; Berchet, Jusot, 2009), and the access to healthcare services, including refusals of treatment (Dourgnon et al., 2009; Gabarro, 2012; Berchet, 2013; Kotobi, 2000; and Carde, 2007), may in part explain this situation.

Several studies have highlighted social rights access as one of the main barriers to immigrants' access to healthcare (Boisguérin, Haury, 2008; Berchet, Jusot, 2012; Dourgnon et al., 2009; Berchet, 2013; Guillou, 2007; and Kotobi, Lemonnier, 2015). The survey conducted by the Directorate for Research, Studies, Assessment and Statistics (DREES, French Ministry of Health) with persons covered by State Medical Aid (AME) showed that more than half of them had heard about the scheme from their friends and family, which indicates that there is a lack of awareness amongst people eligible to join the State Medical Aid (AME) scheme. Most of these studies have, in addition, shown the difficulties faced by immigrants in their interaction with the authorities (particularly when they attempt to renew their rights) and the medical profession. These difficulties are often compounded by a poor knowledge of French and, therefore, a lack of information in foreign languages.

Two parliamentary reports in 2011 and 2013 highlighted the fact that many people who were eligible for State Medical Aid (AME) did not exercise their rights, stating that "However, it is not clear whether the people who actually benefit from the scheme are the poorest". They also highlighted "the worrying lack of reliable statistical data", linked to the high renewal rate of persons covered by State Medical Aid and the absence of data on their health status. The report issued by the Inspector General of Social Affairs-the Inspector General of Finances (IGAS-IGF) in 2010 (Cordier, Sallas, 2010) described the situation as a "statistical dead-end" and the last IGAS-IGR report (2019) faced the same difficulties. The reluctance in France to publish statistics relating to the national and/or ethnic origin of people or minorities (COMED, chaired by F. Héran, 2010) also makes it difficult to assess the situation.

apeutic value, which are reimbursed at the rate of 15% by public health insurance. Persons covered by State Medical Aid can benefit from certain types of healthcare free of charge: the treatment of illnesses and maternity care, as well as hospital stays are covered at the rate of 100%. However, in the case of dental and optical care, State Medical Aid coverage is restricted to the fees agreed on by the social security system. State Medical Aid-insured do not have to contract with a gatekeeper ("médecin traitant") and are exonerated from financial contributions, just as those covered by the Public means tested Complementary Universal Health Insurance (CMU-C).

The State reimburses the costs paid by the National Health Insurance Fund (Caisse Nationale de l'Assurance Maladie, CNAM). State Medical Aid is therefore funded by the State budget and not the Social Security budget.

The recent law that introduced Public Universal Health Coverage (Protection Universelle Maladie, PUMA; 21 December 2015), which aimed to simplify and complete the universalisation of health protection, did, however –like the law that created the CMU sixteen years earlier–, not provide coverage for undocumented immigrants as part of the universalisation of healthcare. A dual system therefore continues to exist, with, on the one hand, universal health insurance for legally resident persons, and, on the other hand, State Medical Aid funded by the State for undocumented immigrants.

State Medical Aid expenditure represents around 0.5% of total public health expenditure

The total expenditure of State Medical Aid, as estimated by the Commission des Finances as part of the 2019 State budget, is estimated at €934.9 million for the funding of State Medical Aid (AME), that is to say €893.4 million for "statutory" State Medical Aid, a fixed-sum allocation of €40 million for the "emergency treatment" scheme, and €1.5 million for other schemes, including "humanitarian" State Medical Aid (see Inset 1). However, the total cost of providing undocumented immigrants with access to healthcare is higher, since part of the 'emergency treatment' scheme is funded by the French health system (in 2017, State funding covered 62% of "emergency treatment" expenditure). Lastly, State Medical Aid is not available in the Mayotte Island *département*.

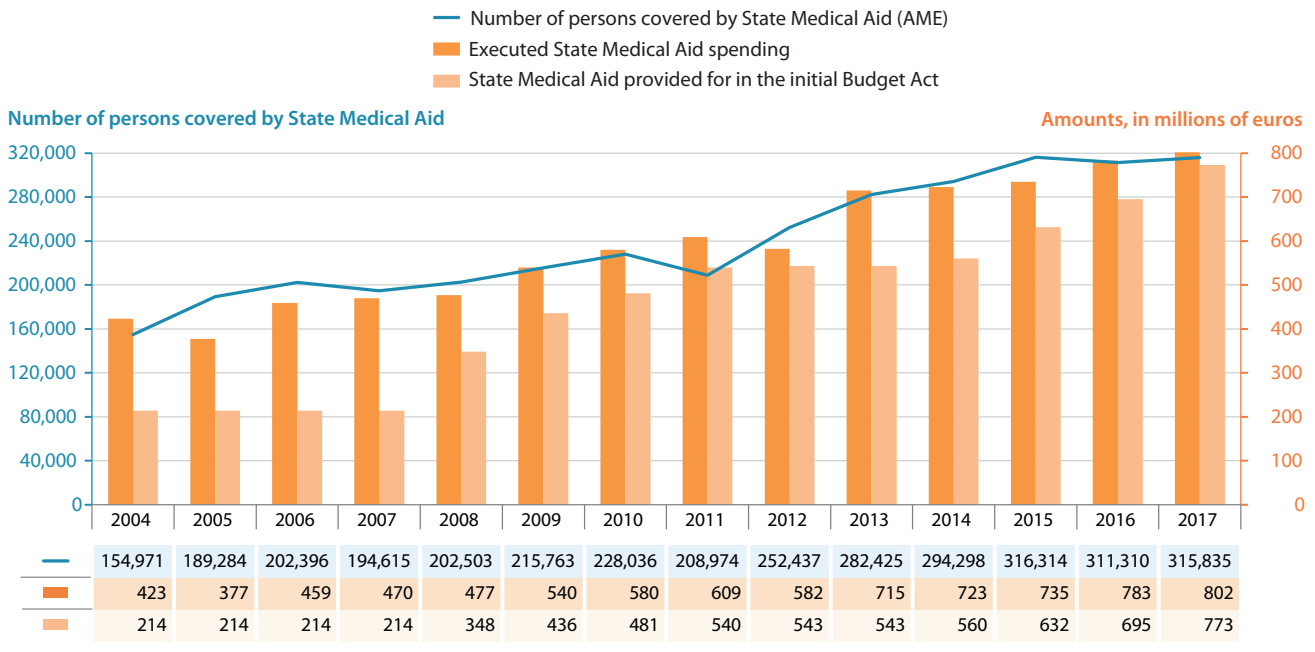
In 2017, "statutory" State Medical Aid expenditure was €802 million, which represented just under 0.5% of the publicly funded Consumption of Medical Care and Goods (Consommation de Soins et de Biens Médicaux, CSBM), estimated at €155 billion in the Comptes de la Santé (national health accounts) in 2017 (Directorate for Research, Studies, Assessment and Statistics (DREES, French Ministry of Health), 2018).

The increase in expenditure followed the increase in the number of State Medical Aid-insured, while per capita expenditure remained stable

State Medical Aid is granted to persons who apply for it and fulfil the conditions of eligibility, making it "de guichet" expenditure (social payments that are automatically paid if the applicant fulfils the criteria laid down in the law), which evolves according to the number of State Medical Aid-insured, on the one hand,

G1

Evolution of State Medical Aid (AME) expenditure and the number of State Medical Aid-insured between 2004 and 2017

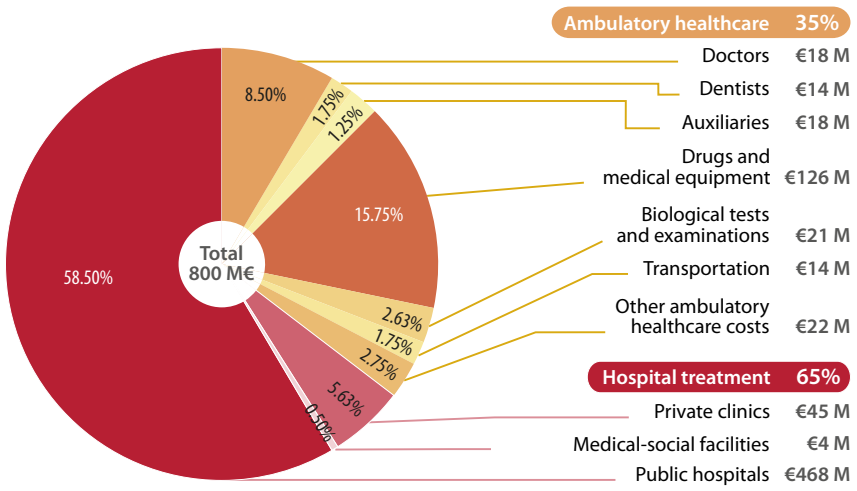


	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
—	154,971	189,284	202,396	194,615	202,503	215,763	228,036	208,974	252,437	282,425	294,298	316,314	311,310	315,835
■	423	377	459	470	477	540	580	609	582	715	723	735	783	802
■	214	214	214	214	348	436	481	540	543	543	560	632	695	773

Reading: After a sustained increase until 2015, the number of persons covered by State Medical Aid stabilised. State Medical Aid expenditure has continued to grow.
Source: The National Health Insurance Fund (CNAM); Administrative databases for the counts and accounts with regard to expenditure.

G2

Statutory State Medical Aid (AME) expenditure in 2017



Reading: In 2017, hospital treatment (public hospitals, private clinics, and medical-social facilities) represented 65% of statutory State Medical Aid expenditure and ambulatory healthcare represented 35%.

Source: The National Health Insurance Fund (CNAM); Administrative databases for the counts and accounts with regard to expenditure.

and according to healthcare costs, on the other hand.

Expenditure relating to "statutory" State Medical Aid has increased dynamically: it has increased by around 50% since 2008 (see Graphs 1 and 2). This increase is mainly attributable to the increase in the number of persons covered by "statutory" State Medical Aid, which increased from 202,503 on 31 December 2008 to 315,835 on 31 December 2017. The average expenditure per beneficiary was around €2,550 in 2017, which was lower than the average expenditure per French citizen[1]. However, it is very difficult to make a comparison because the population of State Medical Aid-insured is on average younger (according to the National Health Insurance Fund (CNAM) administrative databases, 49% of the persons insured were aged between 18 and 39 in 2017), but also in a poorer health status (see Inset 2). Compared with the general population, the expenditure associated with State Medical Aid is more concentrated on hospital costs. Apart from epidemiological causes, the difficulty in accessing ambulatory healthcare and significant non-use of the scheme may explain this heavy concentration of expenditure: two thirds of the expenditure relate to hospital care and a third relates to ambulatory healthcare, while drugs represent the biggest item of expenditure in towns and cities (see Graph 2). All in all, there was a priori no abnormally high average consumption per beneficiary or significant upward trend.

The number of State Medical Aid-insured (see Graph 1) increased regularly since the creation of the scheme until 2015. The temporary decrease in the number of covered in 2011 is attributable to the establishment of a €30 "access fee" per person, which represented a barrier to access to rights and was discontinued in 2012. The implementation of this access fee led to a drop of 20,000 State Medical Aid-insured between 2010 and 2011, whereas there was an upward trend. Between 2002 and 2017, the number of persons covered by "statutory" State Medical Aid doubled. After a sustained increase until 2015, the number stabilised.

A complex assessment

Assessing the effectiveness of State Medical Aid remains a challenging exercise because there is very little literature available and it is difficult to collect data on such populations. The annual reports issued by Médecins du Monde (Doctors of the World) are a valuable source of information (Médecins du Monde, 2015), but they primarily cover a population that does not fall within the scope of "statutory" State Medical Aid (migrants who arrived less than three months ago in France), or a population that could benefit from State Medical Aid, but that has not yet taken the necessary steps to obtain it or is struggling to claim its rights. For example, undocumented persons may find it difficult to prove that they have resided in France for an uninterrupted term of three months. Administrative reports (the Inspector General of Social Affairs-the Inspector General of Finances (IGAS-IGF), the Assessment and Monitoring Mission for the Laws Governing Social Security (MECSS), the Commission des Finances, the Défenseur des Droits (Ombudsman), etc.) provide information about the budgetary framework, the implementation of the scheme, and potential problems (cost, fraud, refusal of treatment, etc.), but do not make it possible to assess the global effectiveness of the scheme. Indeed, there is a lack of information on the health status and the conditions of access to healthcare of persons covered by State Medical Aid (Cordier, Salas, 2010; Dourgnon et al., 2008). The Directorate for Research, Studies, Assessment and Statistics (DREES, French Ministry of Health) conducted a study in 2007 with State Medical Aid-insured and potential insured encountered in healthcare facilities (Boisguérin and Haury, 2008). The data is relatively old and relates to a specific population of State Medical Aid-insured who were questioned in healthcare facilities and were over-represented, particularly the sick and pregnant women.

Barriers in access to rights

Immigrants' health status is exacerbated by the difficulties they experience in gaining access to healthcare. The indicators of the Migrant Integration Policy Index (MIPEX) [in Europe] (Dourgnon and Kassar, 2014; Kassar and Dourgnon, 2014), which measures migrant integration policies across the European Union and in other industrialised countries, show that France is one of the countries in which rights to healthcare granted to migrants seem to be the most beneficial. However,

[1] This estimate is an approximate figure, obtained by dividing the annual executed expenditure by the number of persons covered by State Medical Aid (AME) on 31 December.

administrative and legal barriers are the some of the primary obstacles: the complexity of immigration law and the succession of reforms and new pieces of legislation; and the complexity of situations regarding entitlement to health insurance. This is compounded by communication difficulties arising from linguistic and cultural registers, as well as the problem of discrimination against migrants.

Hence, according to the Défenseur des Droits (Ombudsman) [2016], the heterogeneous practices of the Health Insurance Local Branches (CPAM) with regard to the processing of State Medical Aid applications may have made it more difficult for migrants to obtain healthcare rights in certain regions. These diverse practices may be attributed to different ways of dealing with applications (specific systems that include a "State Medical Aid interview" designed to combat fraud by examining the applicant's actual resources). The diverse practices are the result of the centres' autonomous management and also different interpretations –and even the poor application– of the legislation ("applications that are excessive and contrary to the applicable provisions"). This barrier is both detrimental to equity in the access to healthcare rights and unjustifiable as a matter of principle. In particular, checking compliance with the three-month residence requirement in France is the main difficulty: some centres accept supporting documentation from private individuals, in accordance with a decree (28 July 2005), while others often do not accept such documentation in accordance with a circular on the application of the decree that specifies its scope (27 September 2005). The Défenseur des Droits (Ombudsman) contested the interpretation of the circular on the application of the decree, which is even more restrictive than the decree whose scope it defines. This highlights the extent to which the complexity of the legislation leads to interpretations that vary according to the *département*, and is a veritable obstacle to the access to rights and, *in fine*, access to healthcare.

Furthermore, since State Medical Aid-insured do not have a Carte Vitale (health insurance card), healthcare professionals may face additional administrative costs. The administrative payment procedures are complex for ambulatory doctors (treatment forms in paper format or simplified teletransmission of care sheets) and may lead to payment delays for healthcare professionals that are longer than those for patients. According to the survey conducted by the Directorate for Research, Studies, Assessment and Statistics (DREES, French Ministry of Health) in 2007, more than one out of three State Medical Aid-insured declared that they had already been refused treatment by a healthcare professional, most often by a doctor or a pharmacist. These practices seem to persist, as attested by the Défenseur des Droits (Ombudsman), which has found that foreigners are particularly vulnerable to the risk of a refusal of treatment due to their nationality or the type of their social protection. The reimbursement periods and the additional administrative costs borne by healthcare professionals discourage them from treating State Medical Aid-insured, compared with other patients.

To address these issues, Hospital Health Insurance Access Services (Permanences d'Accès aux Soins de Santé, PASS) in hospitals, established by the 1998 Orientation Law on the Fight Against Exclusion (Loi d'orientation de lutte contre les exclusions, LOLE), ensure healthcare and social care provision for people who need healthcare but have difficulty in accessing healthcare due to the fact that they have no social protection, their living conditions, or their financial difficulties. These offices give people access to consultations with GPs and specialists, and the possibility of talking to a social worker who helps them with the administrative procedures required to access social rights. State Medical Aid-insured, who are rather wary of administrative organisations, often only claim their rights when there is a pressing need for care: when they are treated by the emergency services, for example, they are referred to Hospital Health Insurance Access Services (PASS), which serve as a gateway to care (Pfister et al., 2014).

Lastly, the existence of illegal immigration networks that exploit the State Medical Aid scheme in order to benefit from free healthcare is sometimes evoked in public debates. It is difficult at this stage to assess the extent of this phenomenon and its eventual impact in terms of cost. All that can be said is that the number of State Medical Aid-insured has remained stable since 2015, which does at least suggest that the impact of these networks on healthcare consumption has thus far remained moderate, at least with regard to healthcare consumption funded by "statutory" State Medical Aid.

State Medical Aid (AME) cannot be assessed solely in terms of cost

"Statutory" State Medical Aid (AME), despite the difficulties in accessing the rights described above, can provide individuals who have been illegally resident in France for more than three months access to care. The increasing cost of the scheme is sometimes put forward in public debates to justify –in a context of persistent public deficits– proposals to reduce the scope of the scheme.

However, it would be restrictive to analyse State Medical Aid only in terms of its budgetary cost, on the grounds that it can be easily ascertained. It would be more interesting to evaluate its economic cost, which could be defined as a net cost, which would also take into account costs avoided by State Medical Aid. This is not an easy exercise and this article does not aim to provide an answer to this complex question, which requires more extensive research. It is however possible to look at –without providing figures– the reasons why the net cost of State Medical Aid would be significantly lower than its budgetary cost.

Firstly, in line with the National Health Strategy (Stratégie Nationale de Santé, SNS) and the law on the modernisation of the healthcare system, which promotes a shift to ambulatory care with the aim of providing better medical follow-up and promoting a more efficient use of the healthcare system, State Medical Aid makes it possible to provide medical treatment in a ambulatory healthcare structure, thereby avoiding the possibility of a deterioration in health that may lead to a more costly hospitalisation. If this argument is valid for insured individuals, then it is also valid for undocumented immigrants. The

elimination of the €30 premium in 2012, which had been implemented the previous year, was thus justified from a point of view of access and costs.

Secondly, State Medical Aid has also led to a reduction in hospitals' bad debts. Indeed, it meets healthcare demand for emergency and vital treatment in hospitals, and their historic mission is to fulfil this demand. The change in fees for hospital care implemented in 2012 –which resulted in a reduction of the payments to hospitals treating persons covered by State Medical Aid–, was complemented by financial measures that compensated hospitals for the losses. Hence, any savings on State Medical Aid that would result in an increase in hospitals' deficits or increased funding for hospitals via alternative channels (fixed tariffs (Groupes Homogènes de Séjours, GHS), capitation, etc.) would be deceptive. In the United States, the extension of health insurance to populations that often had no coverage, following the Obama Care reform, significantly reduced the number of unfunded hospital stays (Nikpay et al., 2016).

Lastly, State Medical Aid is also a scheme that is conducive to better public health. The State Medical Aid-insured are more likely than other insured persons to suffer from serious infectious diseases, such as tuberculosis, hepatic diseases, and HIV. There is evidence in the case of AIDS that early treatment of migrants living with the condition in France would be an effective strategy from both a public health and economic point of view (Guillon et al., 2015). It is in the interest of the entire population that better medical monitoring of these populations contributes to limiting the spread of infectious diseases.

A lack of information

Although the scheme was introduced almost twenty years ago, it is still very difficult to assess State Medical Aid, as the data is incomplete (see Inset 2). This represents a vast field of study for research and public statistics institutions in order to better document access to healthcare of persons covered by the scheme and assess and quantify assumptions that State Medical Aid makes it possible to avoid future costs thanks to better upstream healthcare. The Institute for Research and Information in Health Economics (IRDES) and the University of Bordeaux[2] have collaborated on a research project on undocumented immigrants' access to healthcare (the "Premiers Pas" project, supported by the National Research Agency (Agence Nationale de la Recherche, ANR)) [see Context]. The aim of this programme, which complements research conducted by IRDES on migrants' health status and access to healthcare in France (Dourgnon et al., 2008; Dourgnon et al., 2009; Berchet and Jusot, 2012; Dourgnon and Kassar, 2014; Kassar and Dourgnon, 2014; and Moullan and Jusot, 2014), is to provide a better understanding of the means by which persons covered by –and those eligible for– State Medical Aid can access social rights and healthcare. The project is based on qualitative studies conducted by a team of sociologists and anthropologists with illegally resident migrants and healthcare professionals involved in their treatment. The knowledge generated by the studies was used to carry out a quantitative survey with more than a thousand migrants, by looking for the representativity of the populations studied. The programme is focusing on a study of the means by which persons covered by –and those eligible for– State Medical Aid can access social rights and healthcare. These studies will be complemented by the monitoring of medical administrative data on the healthcare consumption of a cohort of State Medical Aid-insured. This project thus aims to better understand the populations concerned by State Medical Aid, from the point of view of their socio-economic and health characteristics and their access to the French health system.♦

[2] Bordeaux Population Health Research Centre (INSERM, UMR 1219) and the Passages laboratory (CNRS, UMR 5319).

For further informations

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