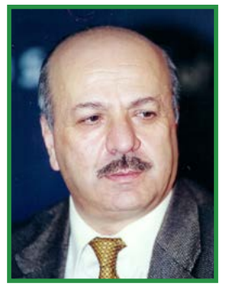
# The French Health Care System: Universal Coverage & Earthly Heaven for the Elderly



Pr Abdo Jurjus
*President,*
*Lebanese Health Society*

The French health care is a very comprehensive system. It provides universal health coverage in a wholistic approach leaving a major regulatory role for the government.
It carries with it a high level of equity and quality and deals with geriatric medicine in a very efficient way. Lebanon might benefit a lot from such a system.

## Preamble

The provision of health care in France is a national responsibility. The Ministry of Social Affairs, Health, and Women's Rights is responsible for defining national strategy. Over the past two decades, the state has been increasingly involved in controlling health expenditures funded by statutory health insurance (SHI).
In addition to setting national strategy, the responsibilities of the central government include allocating budgeted expenditures among different sectors (hospitals, ambulatory care, mental health, and services for disabled residents) and, with respect to hospitals, among regions. The ministry is represented in the regions by the regional health agencies, which are responsible for population health and health care, including prevention and care delivery, public health, and social care. Health and social care for elderly and disabled people come under the jurisdiction of the General Councils, which are the governing bodies at the local (departmental) level.

## Coverage Modalities

**Publicly financed health insurance:** Total health expenditures constituted 12 percent of GDP (EUR257 billion, or USD310 billion) in 2014, of which 76.6 percent was publicly financed.
SHI is financed by employer and employee payroll taxes (50%); a national earmarked income tax (35%); taxes levied on tobacco and alcohol, the pharmaceutical industry, and voluntary health insurance companies (13%); and state subsidies (2%).

Coverage is universal and compulsory, provided to all residents by noncompetitive SHI. As of January 2016, SHI eligibility is universally granted under the PUMA (Protection universelle maladie, or universal health care coverage) law. Citizens can opt out of SHI only in rare cases—for example, individuals employed by foreign companies.
The state finances health services for undocumented immigrants who have applied for residence. Visitors from elsewhere in the European Union (EU) are covered by an EU insurance card. Non-EU visitors are covered for emergency care only.
Private health insurance: Most voluntary health insurance (VHI) is complementary, covering mainly the copayments for usual care, balance billing, and vision and dental care (minimally covered by SHI). Complementary insurance is provided mainly by not-for-profit, employment-based mutual associations or provident institutions, which are allowed to cover only copayments for care provided under SHI; 95 percent of the population is covered either through employers or via means-tested vouchers. Private for-profit companies offer both supplementary and complementary health insurance, but only for a limited list of services.
VHI finances 13.5 percent of total health expenditure. The extent of VHI coverage varies widely, but all VHI contracts cover the difference between the SHI reimbursement rate and the service fee according to the official fee schedule. Coverage of balance billing is also commonly offered, and most contracts cover the balance for services billed at up to 300 percent of the official fee.
In 2013, standards for employer-sponsored VHI were established by law to reduce inequities in coverage stemming from variations in access and quality. By 2017, all employees will benefit from employer-sponsored insurance (for which they pay 50% of the cost), which will cover at least 125 percent of SHI fees for dental care and EUR100 (USD121) for vision care per year. The population of beneficiaries without supplementary insurance is estimated at 4 million. Choice among insurance plans is determined by the industry in which the employer operates.

## Services Covered

Lists of procedures, drugs, and medical devices covered under SHI are defined at the national level and apply to all regions of the country. The health ministry, a pricing committee within the ministry, and SHI funds set these lists, rates of coverage, and prices.
SHI covers hospital care and treatment in public or private rehabilitation or physiotherapy institutions; outpatient care provided by general practitioners, specialists, dentists, and midwives; diagnostic services prescribed by doctors and carried out by laboratories and paramedical professionals; prescription drugs, medical appliances, and prostheses that have been approved for reimbursement; and prescribed health care–related transportation and home care. It also partially covers long-term hospice and mental health care and provides only minimal coverage of outpatient vision and dental care.
While preventive services in general receive limited coverage, there is full reimbursement for targeted services, such as immunization, mammography, and colorectal cancer screening, as well as targeted populations. A measure of the "Touraine law," adopted on April 14, 2015, mandated the legalization of drug-use centers over a subsequent six-year period. These centers will be used exclusively for treatment of especially vulnerable drug addicts, under the supervision of health professionals.
**Cost-sharing and out-of-pocket spending:** Cost-sharing takes three forms: coinsurance; copayments (the portion of fees not covered by SHI); and balance billing in primary and specialist care. In 2014, total out-of-pocket spending made up 8.5 percent of total health expenditures (excluding the portion covered by supplementary insurance), a lower percentage than in previous years—possibly because of the agreement signed between physicians' unions and government to limit balance billing in exchange for its voluntary capping at twice the official fee. This contract offers patients partial reimbursement of balance billing by SHI and reduced social charges for physicians.
Most out-of-pocket spending is for dental and vision services, for which official fees are very low, not more than a few euros for glasses or hearing aids and a maximum of EUR200 (USD241) for dentures, but all of these are commonly balance-billed at more than 10 times the official fee. The share of out-of-pocket spending on dental and optical services is decreasing, however. At the same time, out-of-pocket expenditures on drugs are increasing, owing to increased VHI coverage of dental and optical care and increasing numbers of delisted drugs, as well as a rise in self-medication.
Coinsurance rates are applied to all health services and drugs listed in the benefit package and vary by:
• type of care (inpatient, 20%; doctor visits, 30%; and dental, 30%)
• the effectiveness of prescription drugs (highly effective drugs, like insulin, carry no coinsurance; rates for all other drugs are 15% to 100%, depending on therapeutic value)
• compliance with the recently implemented gatekeeping system

The table below lists nonreimbursable copayments for various services. These apply up to an annual ceiling of EUR50 (USD60). There are no deductibles.

| Service | Copayment | |
|---|---|---|
| | Euros | U.S. Dollars |
| Inpatient hospital day | 18.00 | 22.00 |
| Doctor visit | 1.00 | 1.20 |
| Prescription drug | 0.50 | 0.60 |
| Ambulance | 2.00 | 2.40 |
| Hospital | 18.00 | 22.00 |

**Safety net:** People with low incomes are entitled to free or state-sponsored VHI, free vision care, and free dental care, with the total number of such beneficiaries estimated at around 10 percent of the population. Exemptions from coinsurance apply to individuals with any of 32 specified chronic illnesses (13% of the population, with exemption limited to treatment for those conditions); individuals who benefit from either complete state-sponsored medical coverage (3%) or means-tested vouchers for complementary health insurance (6%); and individuals receiving invalidity and work-injury benefits (2%). Hospital coinsurance applies only to the first 31 days in hospital, and some surgical interventions are exempt. Children and people with low incomes are exempt from paying nonreimbursable copayments.

**Primary care:** There are roughly 221,000 general practitioners (GPs) and 119,000 specialists in France (a ratio of 3.4 per 1,000 population). About 59 percent of physicians are fully or partly self-employed (67% of GPs, 51% of specialists). Over 50 percent of GPs, predominantly younger doctors, are in group practices. An average practice is made up of two to three physicians. Seventy-five percent of practices are made up exclusively of physicians; the remaining practices comprise a range of allied health professionals, typically paid fee-for-service.

There is a voluntary gatekeeping system for adults age 16 and older, with financial incentives offered for registering with a GP or specialist.

Self-employed GPs are paid mostly fee-for-service (currently EUR23, or USD28, to be increased to EUR25, or USD30, in 2017) and can receive a yearly capitated per-person payment of EUR40 (USD48) to coordinate care for patients with a chronic condition. In addition, up to EUR5,000 (USD6,024) annually is provided for achieving targets related to the use of computerized medical charts, electronic claims transmission, delivery of preventive services such as immunization, compliance with guidelines for diabetic and hypertensive patients, generic prescribing, and limited use of psychoactive drugs for elderly patients. Since 2013, GPs also can enter into a contractual agreement under which they are guaranteed a monthly income of EUR6,900 (USD8,313) if they set up their practice in a region with insufficient physician supply. For those who elect to work full-time in medical centers, the guaranteed salary is around EUR50,000 (USD60,240).

The average income of primary care doctors in 2011 was EUR82,020 (USD98,820), 94 percent of which came from fees and the remainder from financial incentives and salary.9 Fees, set by the health ministry and SHI, have been frozen since 2011, but revenues from other sources have increased.

Experimental GP networks providing chronic care coordination, psychological services, dietician services, and other care not covered by SHI are financed by earmarked funds from the Regional Health Agencies. In addition, over 1,000 medical homes, providing multiprofessional services (usually with three to five physicians and roughly a dozen other health professionals) and after-hours care, are in operation.

**Outpatient specialist care:** About 36 percent of outpatient specialist care providers are exclusively self-employed and paid on a fee-for-service basis; the rest are either fully salaried by hospitals or have a mix of income. In October 2014, participation in pay-for-performance programs was extended to all self-employed physicians, including specialists; specialists must meet disease-specific quality targets in addition to those targets that apply to GPs. The average annual income derived from pay-for-performance is EUR5,480 (USD6,602) per physician; such income constitutes less than 2 percent of total funding for outpatient services.

Patients can choose among specialists upon referral by a GP, with the exception of gynecologists, ophthalmologists, psychiatrists, and stomatologists. Bypassing referral results in reduced SHI coverage.

**Administrative mechanisms for direct patient payments to providers:** Patients pay the full fee (reimbursable portion and balance billing, if any) and claim reimbursement covering the full sum or less, depending on coverage, minus EUR1.00 (USD1.20), capped at a maximum of EUR50.00 (USD60.00) per patient per year. A very controversial article in the 2015 Touraine law was the third-party payment management system (Système du tiers-payant) as a safety net for the poorest populations. Third-party payment makes physicians' consultations totally free at the point of care: practitioners will be paid directly by social security and supplementary health insurance.

After-hours care: After-hours care is delivered by the emergency departments of public hospitals, private hospitals that have signed an agreement with their Regional Health Agency, self-employed physicians who work for emergency services, and medical homes financed by SHI and staffed by health professionals on a voluntary basis. Primary care physicians are not mandated to provide after-hours care.

**Emergency services:** They can be accessed via the national emergency phone number, which is staffed by trained professionals who determine the type of response needed. The feasibility of telephone or telemedicine advice is undergoing experimentation; it would include sharing information from the patient's electronic medical record with the patient's primary care doctor. Publicly funded multidisciplinary health centers with self-employed health professionals (physicians and nonphysicians) allow better after-hours access to care in addition to more comprehensive care; fee-for-service payment is the rule for these centers.

**Hospitals:** Public institutions account for about 65 percent of hospital capacity and activity, private for-profit facilities account for another 25 percent, and private nonprofit facilities, the main providers of cancer treatment, make up the remainder. As of 2008, all hospitals and clinics are reimbursed via the diagnosis-related group (DRG) system, which applies to all inpatient and outpatient admissions and covers physicians' salaries in public and not-for-profit hospitals. Bundled payment by episode of care does not exist.

Public hospitals are funded mainly by statutory health insurance (80%), with voluntary insurance and direct patient payment accounting for their remaining income. Public and private nonprofit hospitals also benefit from grants that compensate research and teaching (up to an additional 13% of the budget) and from the provision of emergency services, organ harvesting, and organ transplantation (on average, an additional 10%–11% of a hospital's budget). Private, for-profit clinics owned either by individuals or, increasingly, by large corporations have the same funding mechanism as public hospitals, but the share of respective payers differs. Doctors' fees are billed in addition to the DRG in private clinics, and DRG payment rates are lower there than they are in public or nonprofit hospitals. This disparity is justified by differences in the size of facilities, the DRG mix, and the patients' characteristics (age, comorbid conditions, and socioeconomic status). Rehabilitative hospitals also have a prospective payment system based on length of stay and care intensity.

**Long-term care and social supports:** Total expenditure for long-term care in 2013 was estimated to be EUR39 billion (USD47 billion), or 17 percent of total health expenditures. Statutory health insurance covers the medical costs of long-term care, while families are responsible for the housing costs in hospices and other long-term facilities—on average, EUR1,500 (USD1,809) per month. End-of-life care in hospitals is fully covered. Some funding of care for the elderly and disabled comes from the National Solidarity Fund for Autonomy, which is in turn financed by SHI and the revenues from an unpaid working "solidarity" day. Local authorities, the general councils, and households also participate in financing these categories of care.

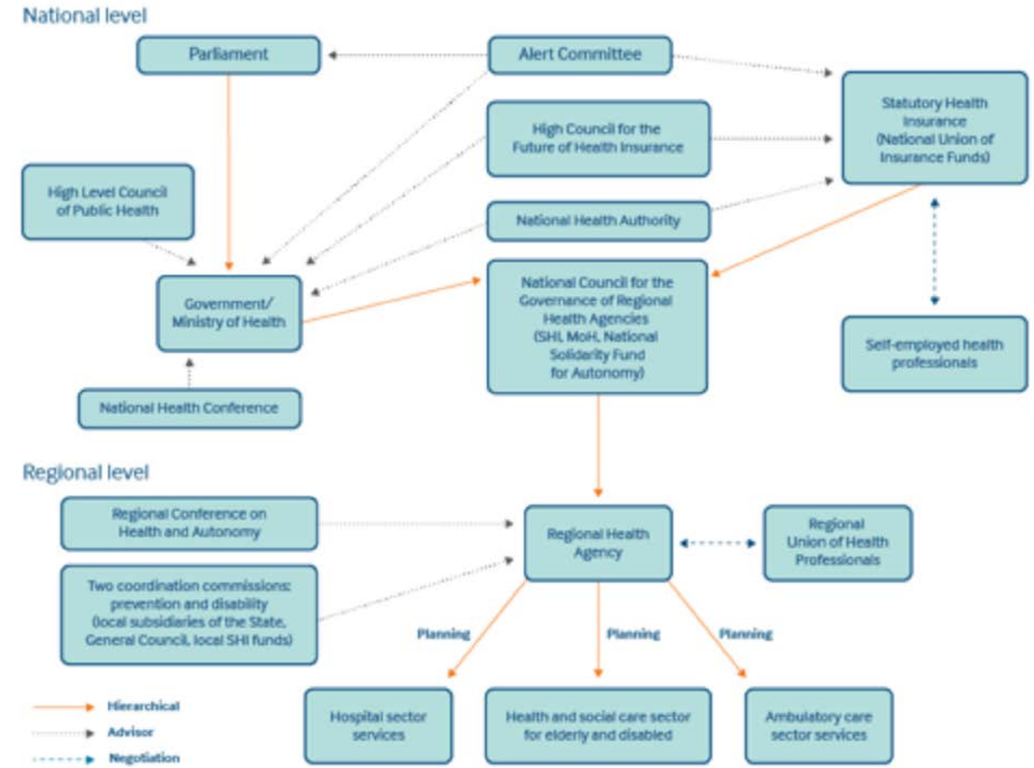
**Home care for the elderly:** It is provided mainly by self-employed physicians and nurses and, to a lesser extent, by community nursing services. Long-term care in institutions is provided in retirement homes and long-term care units, totaling roughly 10,000 institutions with a total of 720,000 beds. Of these institutions, 54 percent are public, 28 percent private nonprofit, and 18 percent for-profit, although the percentage of for-profit institutions is increasing.

In addition, temporary care for dependent patients and respite services for their caregivers are available without restrictions from the states or regions.

Means-tested monetary allowances are provided for the frail elderly. The allowances are adjusted in relation to the individual's dependence level, living conditions, and needs, as assessed by a joint health and social care team, and may be used for any chosen service and provider. About 1.1 percent of the total population is estimated to be eligible. Informal caregivers also benefit from tax deductions.

To address loss of autonomy among the elderly, a law enacted at the end of 2015 established local conferences to define priorities, identify existing services, and create new programs as necessary.

## Organization of the Health System in France




*Notes:* SHI: Statutory health insurance. MoH: Ministry of Health.

**Source:** Adapted from K. Chevreul, I. Durand-Zaleski, S. B. Bahrami et al., "France: Health System Review," *Health Systems in Transition*, vol. 12, no. 6, 2010, pp. xxi–xxii.

### What are the key entities for health system governance?

The health ministry sets and implements government policy in the areas of public health and the organization and financing of the health care system, within the framework of the Public Health Act. It regulates roughly 75 percent of health care expenditure on the basis of the overall framework established by Parliament, which includes a shared responsibility with statutory health insurers for defining the benefit package, setting prices and provider fees (including DRG fees and copayments), and pricing drugs.

The French Health Products Safety Agency oversees the safety of health products, from manufacturing to marketing. The agency also coordinates vigilance activities relating to all relevant products.

The Agency for Information on Hospital Care manages the information systematically collected from all hospital admissions and used for hospital planning and financing.

The remit of the National Agency for the Quality Assessment of Health and Social Care Organizations encompasses the promotion of patient rights and the development of preventive measures to avoid mistreatment, particularly in vulnerable populations such as the elderly and disabled, children, adolescents, and socially marginalized people. It produces practice guidelines for the health and social care sector and evaluates organizations and services.

The National Health Authority (HAS) is the main health technology assessment body, with in-house expertise as well as the authority to commission assessments from external groups. The HAS remit is diverse, ranging from the assessment of drugs, medical devices, and procedures to publication of guidelines, accreditation of health care organizations, and certification of doctors. Competition is limited to VHI, whose providers are supervised by the Mutual Insurance Funds Control Authority.

The Public Health Agency (Santé publique France) was created in 2016 to protect population health.

### What is being done to promote delivery system integration and care coordination?

Inadequate coordination in the health care system remains a problem. Various quality-related initiatives piloted by the health ministry or by regional agencies aim to improve the coordination of hospital, out-of-hospital, and social care. They target the elderly and fragile populations and attempt to streamline the health care pathway, integrating providers of health and social care via a shared portal and case managers.

### Major innovation and reforms

The two major reforms of 2016 have been the universal access to statutory health insurance (effective January 2016) and the deployment of third-party payment for physicians' consultations (to go into effect in 2017). Both reforms have a clear Beveridgian inspiration and are part of the policy to reduce social inequities in access to care; the latter has also been denounced by physicians' unions as the "nail in the coffin" for private providers. While universal insurance access was implemented at once and without political difficulty, third-party payment is being implemented in stages. Starting in July 2016, patients with chronic conditions and pregnant women can obtain it, and by 2017 all patients were able to do so, with use becoming mandatory. The impact on health inequities is being assessed by monitoring the uptake and patients' use of medical resources.