

The Public-Private Mix in France: A Case for Two-Tier Health Care?

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France has an employment-based statutory health insurance (SHI) system that guarantees universal access to a large basket of health care. While the SHI system imposes significant copayments, patients rely on a mix of public SHI and private complementary health insurance (CHI) schemes to defray these costs, leaving France with some of the lowest out-of-pocket expenditures in the OECD. Patients can choose from a mix of public and private providers without severe wait time problems, and the health status of the population ranks among the best in the world. At the same time, the French system is complex, with some apparent contradictions that raise concerns for solidarity, redistribution, and efficiency. Under pressure to curb growth in health expenditure without compromising equity of access and quality of care, the French funding model has been continuously fine-tuned. This chapter presents an overview of the key features of the hybrid public-private health care model in France, and assesses its advantages and principal weaknesses. By analyzing the French experience in regulating the system for sustaining its universal health care, we aim to provoke reflection about the role of private insurance and private suppliers in funding and providing health services. The chapter also discusses the extent to which the French system can be appropriately described as “two-tier.” As we will see, although a hybrid public-private insurance system, the private tier is heavily regulated

and its primary purpose is the covering of mandatory copayments imposed in the main public scheme. Moreover, through public subsidies and regulation, almost the entire population is covered by CHI. Nonetheless, there are some elements of a two-tier system. About 30 per cent of all the physicians and 50 per cent of specialists are able to extra-bill patients, allowing a measure of preferential access for those who have more generous CHI coverage or who are able to pay out of pocket. Also, despite the high density of doctors, there are profound inequalities in their distribution geographically. Therefore, CHI can be a means of faster access, especially to specialist care, in some areas.

1. Overview of the French Health System

The French health system is characterized by a hybrid public-private health insurance model, combining public and private insurance schemes that cover the entire population. The public scheme, a non-competitive statutory health insurance (SHI) model, covers 100 per cent of the resident population. It provides a comprehensive basket of care but requires cost sharing for all services, including doctor visits and hospitalizations. About 90 per cent of inpatient spending is covered by SHI, while this is about 65 per cent for outpatient physician visits and 70 per cent for medications. Prescriptions provided outside of hospital settings are reimbursed at 100 per cent, 65 per cent, or 15 per cent, depending on their therapeutic value. Therefore, about 95 per cent of the French population holds complementary private insurance, mostly for covering copayments. Patients have a large choice of public and private providers, wait times are not considered as a big problem, and the health status of the French population ranks among the best in the world.¹ There are three major principles—solidarity, liberalism, and pluralism—that define the values of the French health system and shape its organization and funding. Solidarity requires equal access to care by need and a financing system where the healthy and rich support the less wealthy and sick. This is assured via an obligatory, non-competitive statutory insurance scheme which provides standardized benefits. Liberalism means freedom for patients to choose their providers and for providers to choose their

1 OECD, *Health at a Glance 2017: OECD Indicators* (Paris: OECD, 2017) [OECD, 2017].

place and way of practice. Pluralism relates to health care delivery options, with a wide range of public and private providers and multiple supplementary private health insurance schemes. Despite a complex hybrid public-private funding system, France promotes equity in access to health care through a number of regulatory tools and policies. The equity principle has rooted ultimately in law and reinforced in all health plans as a strategic objective (article L. 1110-1 of the *Code de la santé publique*). Approximately 78 per cent of the total health care expenditure is funded by the SHI and 13 per cent is financed by private CHI schemes, making France's average out-of-pocket expenditures (around 9 per cent) among the lowest in the OECD.² Funding for the SHI comes mainly from income-based contributions from employers and employees, as well as, increasingly, through taxation. CHI is funded by individual insurance premiums, which are partly adjusted by the age of insured (as a proxy of health status), with subventions from the employers for wage and salary earners. Health care providers are also a mixture of public and private. The majority of the health care professionals are private contractors working on a fee-for-service basis. They usually contract with the SHI fund and respect the tariffs set at the national level. Private hospitals play an essential role in care provision, especially in providing surgery. About 55 per cent of all surgery and 25 per cent of obstetric care are provided by private for-profit hospitals. Private hospitals also contract with the SHI and are paid by regulated tariffs set at the national level.

This plurality in care provision and funding, together with a high degree of "liberty" for patients and providers, creates its own problems: the system is expensive, complex, and fragmented in its organization and funding. Ensuring equity in access to care between socio-economic groups and geographical regions is an ongoing struggle. Promoting a universal health system built on a mix of public and private funding and provision raises numerous challenges that have required continuous regulation of health care markets.

2 *Ibid.*

2. A Distinctive Hybrid Public-Private Health Insurance System

In France, the funding for health care comes from a mixture of public and private health insurance schemes reimbursing the same benefit package. Public health insurance covers a large range of services, but always leaves a part of the cost to patients. Hence, private health insurance is mostly a complementary health insurance in the sense that it typically covers the cost left to patients for services offered by the public health insurance. Different from other countries such as Australia and Ireland, private health insurance is not primarily used for getting faster access to some treatments or jumping public-sector queues since there are no apparent waiting lists in France, and waiting times are not considered a major problem as in other countries, such as in Australia and Canada.³ CHI is not considered as a means to obtain higher-quality services, either, since public hospitals are rated highly and public insurance also covers services from private providers. Therefore, France stands out from other countries with similar public-private insurance schemes (such as Switzerland, Germany, South Korea) by the fact that private insurance mostly reimburses a portion of the cost of services that are included in the public insurance “benefit basket”⁴. The role of private insurance in reducing financial burden of care is essential since there is no cap on out-of-pocket expenditure of patients, as in some countries. This unique place of private health insurance is reflected in the high complementary insurance coverage in the general population (95 per cent) and, compared to similar countries, the high share of health care expenditure financed by private insurance.⁵⁻⁶

This two-layer insurance scheme allows the French population to have, on average, one of the lowest rates of out-of-pocket expenditures among OECD countries (about 9 per cent of health expenditure). Given that out-of-pocket payments are the least redistributive or the most unequal mechanism for financing health care, we can say that this second layer of private insurance, which is added to a mandatory

3 Patients are three times less likely to report forgone care because of long waits than the EU27 average. See Karine Chevreul et al, “France health system review” (2015) 17:3 Health Systems Transition 19.

4 The list of services, products, and drugs reimbursed by the SHI.

5 OECD 2017, *supra* note 1.

6 *Ibid.*

public protection (78 per cent of the total expenditure), reduces the direct costs of health care for households and contributes to equity in access.

However, public and private health insurances are based on different principles. Private CHI is by nature based on contractual freedom, financed mainly on the basis of risk (age) without considering ability to pay, variable in its guarantees, etc. Therefore, it is intrinsically less equal than public insurance and challenges the solidarity and equity goals of the social protection in France. In the following sections, we present the roles and functioning of public and private insurances and then discuss the challenges of such a hybrid system to attain equity and solidarity goals.

2.1 The First Tier: Universal Statutory Public Health Insurance

Since its creation in 1945, public health insurance in France has been based on two founding principles, namely, access to care depending on need, not income (the principle of horizontal equity), and solidarity between high- and low-income classes for financing the system (vertical equity). The principle of horizontal equity is reflected in compulsory and universal public insurance (i.e., SHI), resulting in solidarity between the healthy and the sick, the latter receiving care according to their medical needs and not according to their financial contribution to the system. The principle of vertical equity is reflected in the progressive nature of financial contributions to SHI, which are proportional to income with a higher contribution for wealthier individuals. Hence, the financing of SHI comes from a mix of income-based social contributions paid by employees and employers and, increasingly, from general taxation revenues.⁷ Supplemental revenue is also sourced in specific taxes upon, for example, alcohol, cars, tobacco, and pharmaceutical companies. SHI is compulsory and universal for all individuals who work or reside regularly in France. It is provided under various insurance schemes, with automatic enrollment determined by employment status (wage

7 Since 1998, as a result of attempts to broaden the social-security system's financial base, employees' payroll contributions have been gradually replaced by a dedicated tax called the "general social contribution" (*contribution sociale généralisée*) based on total income rather than only on earned income, as was previously the case. See Helene Barroy et al, "Sustaining Universal Health Coverage In France: A Perpetual Challenge" (Discussion Paper, The World Bank, 2014), 91323 [World Bank, 2014].

earners, self-employed, farmers and agricultural employees, students, etc.). Individuals cannot choose their scheme or insurer, and cannot opt out. Thus, there are no competing health insurance markets for public health coverage in France. In 2000, universal medical coverage (*Couverture maladie universelle de base*, known since 2016 as *Protection universelle maladie*) was implemented in order to provide public health insurance to the 2 per cent of individuals who were not covered under any scheme given their employment status (e.g., those who have never worked). Three main SHI schemes cover about 97 per cent of the population. The largest one, known as the *Régime général*, insures wage and salary earners and their dependents, and covers about 85 per cent of the population. The two other schemes, covering self-employed (*Régime social des indépendants*) and farmers and agricultural employees (*Mutualité sociale agricole*), together cover about 12 per cent of the population⁸. In addition, sixteen small schemes cover specific professional categories (e.g., miners and clergy), representing 1 per cent of the population (see fig. 9.1). Since 2004, a federation of sickness funds (*Union nationale des caisses d'assurance maladie*; UNCAM) brings together the three

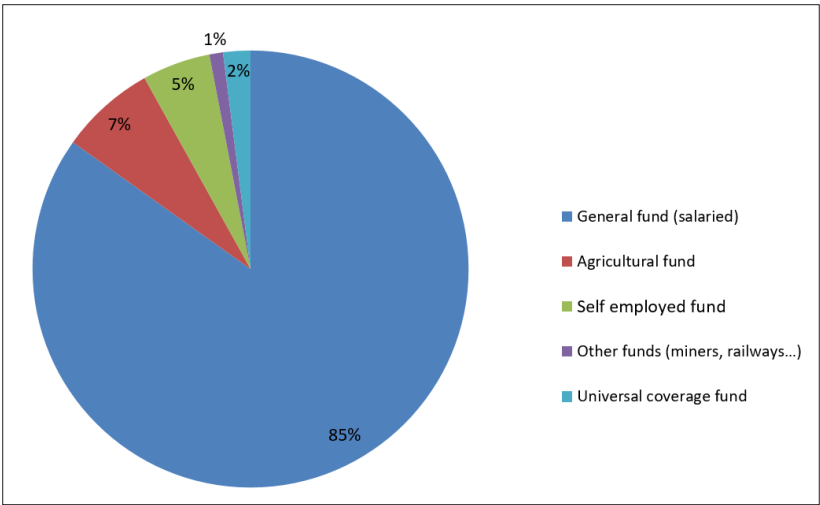


Figure 9.1. Statutory health insurance: Population coverage by affiliation, 2014

Source: World Bank, 2014, *supra* note 7 at 6.

8 Since 2019, the *Régime social des indépendants* named now “La sécurité sociale des indépendants” is also managed by the *Régime général*.

major schemes at the national level, and is now the unique representative of all the insured in negotiations with the government and health care providers. The director of the UNCAM is nominated by the government and holds the ultimate decision-making power.⁹

Although there are several distinct insurers within the core SHI scheme, they have been gradually harmonized over time. Currently, all SHI insurers provide the same basket of services and goods. The standard benefit package under the SHI system covers a wide range of goods and services: inpatient hospital care (both in private and public hospitals), rehabilitation, home care, prescription drugs, physician visits, cost of transport, and all services and drugs prescribed by doctors, including care by paramedical professionals (nurses, physiotherapists, speech therapists, etc.). The SHI covers about 78 per cent of the total cost of the services and goods.¹⁰ This goes up to 92 per cent for hospital care, 65 per cent for ambulatory treatments, and 45 per cent for drugs and medical goods, including optical and dental devices.¹¹ In general, patients are expected to pay the cost of ambulatory services at the point of service and then claim reimbursement from their insurance funds. The SHI reimbursements are based on predefined rates (negotiated tariffs) and are the same for all schemes.

Finally, there is also a fully state-funded scheme (*Aide médicale d'État*) which provides access to a standard benefit package for illegal immigrants. It is means-tested, and applicants must be resident for more than three months in the French territory. As of 2010, 227,705 people benefitted from the scheme.¹²

2.2 The Second Private Tier: Complementary Health Insurance

While the public SHI benefit package is comprehensive, it relies heavily on cost sharing for all of the services provided. People are therefore encouraged to enroll in private complementary health insurance (CHI) to limit costs that are not reimbursed by SHI. Patients' co-payments are defined as a percentage of regulated prices

9 The director of UNCAM negotiates multi-year contracts with the state defining the objectives and governing rules for the SHI.

10 France, Ministères des solidarités et de la santé, *Les dépenses de santé en 2017 — Résultats des comptes de la santé, 2018* (France: Panoramas de la DREES, 2018) [DREES, 2018].

11 *Ibid.*

12 World Bank, 2014, *supra* note 7.

and vary according to the type of care: from 10 per cent of regular fees for hospital care to 30 per cent for physician visits, and from 35 per cent to 85 per cent for (approved) prescription drugs, which are evaluated and listed in a public formulary.¹³ In addition, there are a number of small deductibles concerning physician visits, paramedical procedures, drugs, and medical transport (see the list of deductibles in table 9.1). The deductibles generally are not reimbursed by the CHI,¹⁴ but the total amount spent is capped (at a maximum of €50 per year for medications and €50 for consultations). Otherwise, there is no overall spending cap for out-of-pocket payments, and patients can face extra-billing from certain physicians (especially specialists) and for dental and optical devices, as we discuss in the next section.

Table 9.1. List of flat rate payments and deductibles

Types of services/goods	Flat rates	Limit
Flat-rate payments, not covered by CHI		
GP/specialist consultation	€1/visit	€50/year per person
Deductibles		
Drugs (prescriptions)	€0.5 /package	€50/year per person
Ancillary services	€0.5/procedure	
Medical transportation	€2/transport	
Usually covered by CHI		
Lab or radiography tests over €120	€24	none

Source: Isabelle Durand-Zaleski, “The French Health Care System,” online: *The Commonwealth Fund* <international.commonwealthfund.org/countries/france/>.

As a result, about 95 per cent of the French population hold a CHI policy.¹⁵ CHI policies can be purchased either through an

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

14 The public insurance fund provides tax benefits to private insurers respecting these rules.

15 Nicolas Célant, Stéphanie Guillaume & Thierry Rochereau, “L’enquête santé européenne — Enquête santé et protection sociale (EHIS-ESPS) 2014” (September 2017), online (PDF): *L’Institut de recherche et documentation en économie de la santé (IRDES)* <<https://www.irdes.fr/recherche/rapports/566-enquete-sante-europeenne-ehis-enquete-sante-et-protection-sociale-esps-2014.pdf>>.

employer (i.e., collective contracts) for private-sector employees and their dependants or individually (i.e., an individual contract) for public-sector employees, self-employed individuals, and those unemployed. Collective CHI contracts, partly paid by the employer, have since 1979 been subsidized via tax and social contribution exemptions. CHI premiums vary depending on the age of the policyholder or on the average age of the pool of those insured for contracts obtained via an employer (where the premiums are uniform for all insured persons under the same contract). Those enrolled in individual CHI market—students, civil servants, the self-employed, unemployed, retired—are free to buy (or not) a CHI and choose their level of coverage. Except in the case of specific exemptions, subscription to collective CHI has been required by law for all private-sector employees since 2016.¹⁶ Because of the bargaining power of employers and a high concentration of individuals with good health risks (e.g., younger, of working age), collective CHI contracts are more advantageous than individual ones in terms of guarantees and premiums. Thus, at equivalent coverage level, premiums for collective contracts are often lower than for individual contracts, even before the contribution made to the premium cost by the employer. Until 2016, about 60 per cent of CHI were individual contracts while 40 per cent were collective contracts. The rate of collective contracts is expected to reach to 50 per cent post the 2016 reform.¹⁷

Historically, CHI has focused on reimbursing *tickets modérateur*, i.e. copayments left to patients. CHI plans usually offer added coverage for medical goods and services that are poorly covered by the public scheme, especially for dental and optical devices. Some CHI plans *also cover* a part (or the totality) of extra-billing charges (*dépassement d'honoraires*) asked by some professionals. In general, collective contracts are more generous in reimbursing extra-billing charges,¹⁸

16 Carine Franc & Aurélie Pierre, “Restes à charge élevés: Profils d’assurés et persistance dans le temps.” “Compulsory private complementary health insurance offered by employers in France: implications and current debate” (2015) 119:2 Health Pol’y 111.

17 Aurélie Pierre & Florence Jusot, “The likely effects of employer-mandated complementary health insurance on health coverage in France” (2017) 121:3 Health Pol’y 321.

18 France, Ministères des solidarités et de la santé, *La complémentaire santé: Acteurs, bénéficiaires, garanties, 2016* by Muriel Barlet, Magali Beffy & Denis Raynaud (France: Panoramas de la DREES, 2016); France, Ministères des solidarités et de

although recently these reimbursements have been regulated by the government in order to reduce the cost of extra-billing (see section 5). Some CHI contracts may also offer extended benefit coverage for goods and services that are not included in the SHI benefit basket (such as surgery for myopia) and/or provide access to private amenities (such as private hospital rooms).

The French CHI market is quite competitive. Around five hundred providers offer different kinds of CHI policies. Insurers can be gathered into three types.¹⁹ First, *non-profit mutual insurance companies* (known as *mutuelles*), which have traditionally dominated the health insurance market and cover approximately 60 per cent of the insured, mostly by individual CHI contracts. Second, *non-profit provident institutions*, which are jointly managed by representatives of employers and employees and offer almost exclusively collective contracts; hence, they cover mainly working-age individuals (about 15 per cent of the population is insured via *provident institutions*). And last, *private for-profit insurance companies*, which introduced “health care” more recently in their insurance portfolio and now cover around 25 per cent of the CHI beneficiaries (mostly individual contracts). These three types of providers operate under distinct regulatory schemes.²⁰ However, differences between their premiums have diminished over time because of market competition.²¹

3. System Maintained by a Rich Mixture of Public-Private Providers

This hybrid health insurance model stimulates the diversity of health care providers in the system. With more than 3.4 physicians and 7.8 nurses per 1,000 population, France has relatively sufficient health human resources.²² Access to specialist care in hospitals is relatively easier than in many OECD countries. Indeed, patients are not systematically asked for a referral from a general practitioner

la santé, *La complémentaire santé: Acteurs, bénéficiaires, garanties*, 2019 by Muriel Barlet et al (France: Panoramas de la DREES, 2019).

19 *Ibid.*

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

21 Barlet, Beffy & Raynaud, *supra* note 17.

22 OECD, 2017, *supra* note 1.

in order to visit a specialist despite recent reforms encouraging patients to use GPs as gatekeepers. Health care providers (health care professionals and hospitals), both public and private, contract with SHI funds, which act as a single payer, and generally respect the prices set via national negotiations. Therefore, one's treatment may be funded by the SHI public payer but delivered by a for-profit facility. Historically, health care in France is organized around four principles delineated by law: confidentiality of medical information, freedom of practice for physicians, patient's free choice of provider, and office-based fee-for-service practice in the ambulatory sector. Doctors are free to choose their place of practice while patients have free access to any physician or any facility, either public or private, with no limit on the number of doctors seen or the frequency of visits. However, some of these principles have been challenged with recent reforms in order to control escalating health care costs and chronic problems with unequal geographic distribution of doctor supply.²³

Ambulatory care is mainly provided by private, self-employed health professionals (doctors, nurses, dentists, medical auxiliaries) working in their own individual practice or in health/medical centres and hospitals. Doctors working in the ambulatory sector, and those in private hospitals, negotiate with the SHI and are paid according to a national fee-for-service schedule. The official tariffs for reimbursement are set via a formal national negotiation process between the government, the union of SHI funds, the union of CHI schemes, and unions of health professionals. Doctors who agree to charge on the basis of the nationally negotiated fee (such doctors are known as "sector 1" contractors) in return get their social contributions (including pension) paid by the SHI fund. Some doctors and dentists are authorized by SHI to charge higher fees (i.e., "sector 2") based on their level and experience. Doctors working as sector 2 contractors are free to charge higher fees but must purchase their own pension and insurance coverage. The creation of sector 2 contractors in 1980 aimed to reduce the cost of social contributions for the SHI fund, but it did not have the expected impact

23 France, Cour des Comptes, *La médecine libérale de spécialité: Contenir la dynamique des dépenses, améliorer l'accès aux soins*, in *Rapport sur l'application des lois de financement de la sécurité sociale* (Paris: Cour des Comptes, 2017) [Cour des Comptes].

and the demand for the sector was much higher than predicted. Consequently, access to sector 2 has been limited since 1990; each year only 1,000 new doctors are allowed to work in sector 2. In 2012, about half of specialists and 85 per cent of generalists were working in sector 1, adhering to the national tariffs, but their distribution is uneven.²⁴ Membership in one sector or another is not an indicator of medical competence.

Extra-billing in France

Sector 1: The physician is required to bill in accordance with statutory tariffs set out in the national agreements with SHI insurers. Sector 1 doctors can only extra-bill above these amount in a few limited circumstances. In exchange for applying the statutory rates, sector 1 doctors get a part of their compulsory social contributions (including for pension) paid by SHI.

Sector 2: The physician is permitted to extra-bill any amount he or she wishes. The amount that is being extra-billed is not covered by SHI but may be covered by a CHI policy. Until 1990, physicians could choose which sector to join (1 or 2). The popularity of sector 2 led the government to restrict entry. Section 35.1 of the 2011 medical convention lists the type of physicians who are able to join sector 2:²⁵

- former medical chiefs of clinics in universities,
- former hospital assistants,
- physicians or surgeons for the army,
- hospital practitioners appointed permanently, and
- part-time practitioners of hospitals with at least five years of experience.

The difference between sector 1 and sector 2 fees has been diminishing since 2012 with the creation of an observatory of tariffs by the SHI. In 2016, the average sector 2 fees for physicians was about 52 per cent higher than conventional tariffs, but there is a high degree of variation across regions, with over-billing rates varying between 10 per cent (for Cantal) and 115 per cent (for the Paris area). There are also strong variations across specialties, with gynecologists, rheumatologists, and psychiatrists asking on average 70 per cent to 100 per cent over the regulated tariff.²⁶

24 France, Ministère des solidarités et de la santé, *Portrait des professionnels de santé, 2016* by Muriel Barlet & Claire Marbot (France: Panoramas de la DREES, 2016).

25 *Arrêté du 22 septembre 2011 portant approbation de la convention nationale des médecins généralistes et spécialistes*, JO, 11 July 2016.

26 L'assurance Maladie, "Dépassements d'honoraires des médecins: Une tendance à la baisse qui se confirme" (29 November 2017), online (PDF): *Ameli.fr pour les assurés* <http://www.ameli.fr/fileadmin/user_upload/documents/Observatoire_des_pratiques_tarifaires.pdf>.

Extra-billings in hospital settings

Approximately 40 per cent of hospital specialists are self-employed, working in private practice or private clinics, and an additional 13 per cent of specialists have mixed practices (seeing patients in their private offices and working shifts in hospitals). There is no regulation against extra-billing in a hospital setting (unless it is for a situation that requires urgent care). Until recently, there was little information on the extra fees charged in hospitals, but some reports have shown that extra-billing charges, although less frequent, can be up to four times higher than regulated prices in hospital settings.²⁷ In the past couple of years, the SHI (via the observatory of tariffs) has been following up more closely the physicians who are charging very high prices compared to the average. Also, a health directory which informs the general public on doctor fees in hospitals has been created now (annuaire.sante.ameli.fr). Patients can check the amount of extra fees asked by the specialists before choosing a hospital. According to the observatory of tariffs, different measures introduced by the SHI have been successful in containing extra fees in hospitals; the fees were (on average) about 45 per cent over the regulated fees in 2016, versus 80 per cent in 2005. But there is no direct information on actual out-of-pocket payments of patients at hospital.

Inpatient care is delivered by a large number of public, private for-profit, and non-profit hospitals. While the total number of hospital beds has decreased over the past decade, France still has 6.3 hospital beds per 1,000 inhabitants.²⁸ This is more than double the number of hospital beds per capita than in Canada (2.6 beds).²⁹ Patients can freely choose between public and private providers without needing a referral. Private hospitals also contract with the SHI fund and are paid by activity (measured by diagnostic-related groups, DRGs) based on regulated prices.

Public hospitals have the legal obligation of assuring continuity of care, which means providing twenty-four-hour emergency care, the obligation of non-discrimination (i.e., to accept any patient who seeks treatment), and to take part in activities related to national/regional public health priorities. They represent 60 per cent of all hospitals and 65 per cent of all acute inpatient beds. The private for-profit sector represents 25 per cent of all inpatient beds and is specialized mostly in elective surgery. The market share of private

27 “Dépassements d’honoraires: le “match” public – privé” (2014), online: *France Assos Santé* <<https://www.france-assos-sante.org/2015/01/16/dépassements-dhonoraires-le-match-public-privé/>>.

28 OECD Health Statistics, “Hospital Beds” (2017), online: *OECD Data* <<https://data.oecd.org/healthqt/hospital-beds.htm>> [OECD Health Statistics, 2017].

29 *Ibid.*

hospitals depends heavily on the type of hospital activity. About 55 per cent of all surgery and 25 per cent of obstetric care are provided by private for-profit hospitals. Their market share goes up to more than 80 per cent in some areas of elective ambulatory surgery, such as eye surgery (cataracts in particular), ear surgery, and endoscopies. However, certain complex care/procedures are provided almost exclusively by public hospitals; for example, in the case of stroke care, burn treatment, or surgery for multiple traumas. Finally, private not-for-profit hospitals are more specialized in medium- to long-term care; they represent about 8 per cent of acute-care activity. Three-quarters of these hospitals have a special agreement with the state, and they have the same engagement as public hospitals for providing “public services,” such as continuous care. In return, they are eligible for public subsidies.

4. Measures for Avoiding a Two-Tier System

France’s heavy reliance on CHI for coverage of copayments, together with a high degree of independence and choice for both providers and patients, has required several additional mechanisms to ensure equity of access to care and cost containment. First, given the importance of cost sharing, from its very inception the French system introduced protective mechanisms, initially to reduce the financial burden of care for patients suffering from long-term and costly illnesses, and later for those with very low incomes and, gradually, the entire population. Second, the prices of all health care services, drugs, and such are vigorously monitored and regulated in order to control the growth of health care costs. Third, since access to the private insurance market is inequitable, a mixture of regulatory measures and financial incentives is used for reducing the risk selection and dumping of patients by private insurers. Finally, CHI providers are given incentives to support public-sector objectives and policies for controlling the cost and quality of health care.

4.1 Exemptions for Chronic and Costly Illnesses

A long-term illness exemption scheme, called *Affection Longue Durée* (ALD), created at the inception of SHI in 1945, aims to reduce the financial burden of medical care for beneficiaries suffering from a list of long-term and costly chronic conditions. Initially introduced to cover four groups of diseases (cancer, tuberculosis, poliomyelitis,

mental illness), the scheme was extended over time and now covers thirty-two groups of diseases. Irrespective of their income status, patients are exempted from the copayments (*tickets modérateurs*) concerning treatments associated with these conditions. Nevertheless, they still have to pay any fees linked to extra-billings and deductibles. About 90 per cent of the health care expenditure of ALD beneficiaries are funded by the SHI (compared to 61.5 per cent on average for the rest of the population).

In 2016, over ten million individuals were covered by the ALD scheme, representing about 17 per cent of SHI beneficiaries and accounting for roughly 60 per cent of health expenditures reimbursed by the SHI. The number of ALD beneficiaries has continuously increased in the last decade (10.4 billion in 2016 versus 8 billion in 2005). Expenditures linked to ALD recorded an average annual growth rate of 4.9 per cent over the period 2005–2010, versus 1.8 per cent for other health expenditures,³⁰ but the average share of public insurance in financing health expenditure has remained stable over the past fifteen years (around 77 per cent) because of improved management of the drug benefit basket and the introduction of deductibles for certain services in 2005.

4.2 Supporting Complementary Health Insurance for Low-Income Groups

Given the constraints on public resources for increasing SHI funding, public policy has primarily focused on supporting different population groups to purchase CHI. For decades, several measures have been introduced for extending CHI coverage, first to low-income populations, then to the entire population. Since January 2016, all employers are required to offer CHI contracts to their employees and pay at least 50 per cent of their premiums (as per the *Accord national interprofessionnel*, ANI).³¹ Two specific schemes were introduced in 2000 and 2005, respectively, for supporting low-income

30 Paul Dourgnon, Zeynep Or & Christine Sorasith, "L'impact du dispositif des affections de longue durée (ALD) sur les inégalités de recours aux soins ambulatoires entre 1998 et 2008" (January 2013), online (PDF): *L'Institut de recherche et documentation en économie de la santé (IRDES)* <<https://www.irdes.fr/Publications/Qes2013/Qes183.pdf>>.

31 The reform also extended the portability of the private insurance for the unemployed up to twelve months after the end of their last job. See Franc & Pierre, *supra* note 15.

individuals to acquire CHI. The first, the universal complementary health coverage (*Couverture maladie universelle complémentaire*, CMU-C), a state-funded insurance scheme, allows people whose monthly income is effectively 20 per cent below the poverty line to benefit, free of charge, from a CHI contract. The CMU-C covers 100 per cent of negotiated prices of all drugs and services included in the benefit package of SHI (no copayment required). It further covers, albeit modestly, a number of dental and orthodontic treatments and eye glasses, which are poorly reimbursed by the SHI, like any other private CHI (e.g., €250 for a tooth crown, €500 for orthodontic treatment). Moreover, patients are exempted from upfront payments, and physicians are not allowed to extra-bill CMU-C patients. CMU-C covered approximately 5.5 million persons in 2017³². The second measure is public vouchers for buying CHI contracts (*Aide à la complémentaire santé*, or ACS). It aims to subsidize private CHI for low-income individuals who are not eligible for the CMU-C. The target population includes individuals with incomes up to 35 per cent above the CMU-C eligibility line in 2016. ACS provides cash support in the form of vouchers that can be only used to buy a CHI contract. Since 2013, the beneficiaries of ACS have also been exempted from extra-billing. By law,³³ physicians cannot deny care to a patient enrolled under CMU-C and ACS and cannot ask more than the negotiated tariffs. However, a few studies showed that some physicians, especially sector 2 specialists, nonetheless refuse appointments to CMU-C patients.³⁴

Both these schemes are funded through specific taxes on private health insurance premiums (*taxe de solidarité additionnelle*; TSA), which amounted to €2 billion in 2012,³⁵ and, marginally, from taxes

32 Fonds CMU (2017), https://www.complementaire-sante-solidaire.gouv.fr/fichier-utilisateur/fichiers/2017_RA_VF.pdf

33 *Code de la sécurité sociale*, JO, 7 June 2019, s L162-1-14; *Code de la santé publique*, JO, 1 June 2019, art L1110-3.

34 Bénédicte Boisguérin, "Enquête auprès des bénéficiaires de la CMU — mars 2003" (2004) Ministère de L'emploi, du Travail et de la Cohésion Sociale & Ministère de la Santé et de la Protection Sociale Working Paper No 63; France, Ministères des solidarités et de la santé, *Analyse des attitudes de médecins et de dentistes à l'égard des patients bénéficiant de la Couverture Maladie Universelle — Une étude par testing dans six villes du Val-de-Marne* by Caroline Desprès & Michel Naiditch (France: DIES, 2006).

35 The additional solidarity tax is about 13 per cent for responsible contracts while it goes up to 20 per cent for other contracts.

on tobacco. In 2016, CMU-C and ACS schemes covered, respectively, 8 per cent and 1.9 per cent of the French population. However, the number of people eligible for these schemes are estimated to be higher: about 30 per cent of the individuals who are eligible to CMU-C and 60 per cent of those eligible to the ACS are not exercising their rights.³⁶ The national strategy against poverty presented by the government in September 2018 proposes, among other things, to merge these two schemes to simplify the system.

4.3 Price Regulations

The public-private mix in health care provision obliges the SHI fund to closely regulate prices of providers. In France, most of the health care providers are paid on a fee-for-service basis. Tariffs for physicians (whether they work in solo practice, groups practice, or a private hospital) are set nationally through a negotiation process between the insurance funds and different medical professions. Both public and private hospitals are paid under activity-based payment (using DRGs). Private hospitals also contract with the SHI and must respect regulated tariffs. Tariffs for private hospitals are usually lower than public ones (tariffs were first based on historical costs, but the gap has closed over time). Both sectors are regulated with the same price/volume control mechanism at the macro level to steer the activity growth by sector.³⁷ Prices of drugs included in the health insurance basket are also controlled rigorously, through structured negotiations with pharmaceutical companies and resellers to contain the overall cost of medications. Various common mechanisms, such as reference pricing, comparing prices in other countries, mandatory

36 “Fonds CMU — Rapport d’activité” (January 2010), online (PDF): CMU <https://www.complementaire-sante-solidaire.gouv.fr/fichier-utilisateur/fichiers/Rapport_activite_2009.pdf>; “Références - La lettre du Fonds de financement de la couverture maladie universelle” (January 2014), online (PDF): CMU <<https://www.complementaire-sante-solidaire.gouv.fr/fichier-utilisateur/fichiers/ReferencesCMU54.pdf>>; Sophie Guthmuller et al, “Comment expliquer le non-recours à l’Aide à l’acquisition d’une complémentaire santé ? Les résultats d’une enquête auprès de bénéficiaires potentiels à Lille en 2009” (February 2014), online (PDF): *L’Institut de recherche et documentation en économie de la santé (IRDES)* <<https://www.irdes.fr/recherche/questions-d-economie-de-la-sante/195-comment-expliquer-le-non-recours-a-l-aide-a-l-acquisition-d-une-complementaire-sante.pdf>>.

37 Zeynep Or, “Implementation of DRG Payment in France: Issues and recent developments” (2014) 117:2 *Health Pol’y* 146.

price discounts, volume-price regulation, and value-based pricing, have been used with some apparent success (see fig. 9.2).³⁸

However, the presence of a sector 2, where physicians are not bound by nationally set tariffs, has required specific measures for controlling the prices in this sector.

- *Restrictions on extra-billings:* Section L162-1-14-1 of the social-security code and section 53 of the medical code of ethics requires that extra-billing be of a reasonable amount: “tact et mesure.” However, until 2012, there was no regulatory or legislative definition of the term. This changed in 2012, when the Conseil national de l’ordre des médecins defined it as a fee exceeding three or four times the regulated prices.
- *Informing patients:* Section L1111-3 of the public health code requires physicians to inform their patients of all costs

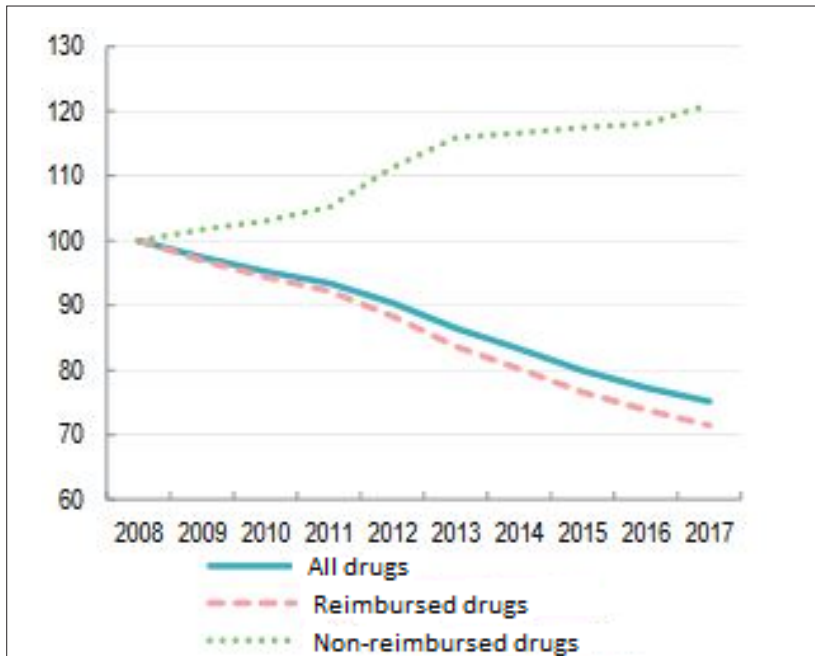


Figure 9.2. Trends in drug prices (2008=100).

Source: DREES, 2018, *supra* note 9.

38 DREES, 2018, *supra* note 9.

related to their visit: prices must be displayed inside medical practices and physicians must issue a receipt for any extra-billing exceeding €70 at the start of the appointment.³⁹ Nevertheless, this information is only available at the physician's practice. Patients cannot compare prices beforehand since there is no platform providing prices charged by sector 2 physicians.

- *Incentives to reduce extra-billings:* Since 2012, a voluntary contract (*Option pratique tarifaire maîtrisée*) signed between SHI and sector 2 physicians encourage them to freeze their fees and not charge more than double the regulated tariffs. They are also asked to perform a share of their services at regulated SHI-tariff levels. In return, they receive a partial payment of social-security contributions usually reserved for sector 1 doctors (up to €4,300 per year on average).⁴⁰ In 2014, about 11,000 doctors had signed this contract.⁴¹

4.4 Regulation of CHI Market

The CHI market is, by definition, inequitable, since premiums increase according to an individual's risk levels (unhealthy and older individuals pay higher premiums). Moreover, private insurers are not required to pursue the system-wide efficiency and cost containment that is pursued by the public insurers/payers. Therefore, the CHI market in France is highly regulated, this is to foster public-sector objectives.⁴² The primary objective is to limit the problems of access to insurance that may face high-risk individuals (e.g., low income, sick) in an unregulated market.⁴³ The second and increasingly

39 *Code de la santé publique*, JO, 1 June 2019, art L1111-3; France, Inspection générale des affaires sociales, *Evaluation de la place et du rôle des cliniques privées dans l'offre de soins* by Bartoli et al (France: 2012).

40 "L'exercice libéral de la médecine" (2017), online (PDF): *France Assos Santé, la voix des usagers* <https://www.france-assos-sante.org/publication_document/b-8-exercice-liberal-de-la-medecine-a-lhopital/>.

41 *Ibid.*

42 Michel Fromenteau, Vincent Ruol & Laurence Eslous, "Sélection des risques: où en est-on?" (2011) 31:2 *Les Tribunes de la santé* 63.

43 Thierry Lang et al, "Les inégalités sociales de santé: sortir de la fatalité" (December 2009), online (PDF): *Haut conseil de la santé publique* <hscsp.fr/Explore.cgi/avisrapportsdomaine?clefr=113>; Emmanuelle Cambois & Florence Jusot, "Ampleur, tendance et causes des inégalités sociales de santé et de mortalité en Europe: une revue des études comparatives" (2007) 2:3 *Bulletin épidémiologique*

prominent goal is to align CHI providers to support the SHI policies aimed at containing health care cost.

- *Tackling risk selection*: In an unregulated private insurance market, premiums go up with individual risk (and poorer health status), and for some health conditions, associated health expenditures can be, by definition, uninsurable.⁴⁴ Thus, as early as 1989, French authorities have required CHI providers to give a lifetime guarantee for anyone insured so that their premium cannot increase, upon renewal of a contract, above the premium offered to others in the same pool of insured for that contract (as part of the *loi Évin*). This law also aims to protect young pensioners, formerly covered by a collective contract, who may face increased insurance premiums in individual markets upon retirement. Moreover, in 2002, a tax reduction was applied to contracts in which the health status of the insured is not used as a variable of risk adjustment (selection) in defining the price. These contracts, called *contrats solidaires*, prohibit health questionnaires at the time the insurance is acquired.
- *Extending CHI coverage*: The expansion of CHI to a larger share of the population has been a constant objective among successive French governments for decades. Therefore, in addition to the specific schemes designed for low-income people (CMU-C and ACS), the French government has moved incrementally to ensure that all the workers have access to CHI coverage—first with tax incentives for private-sector employees and employers (since 1979), for the self-employed (since 1994), then by a mandate. Indeed, with the ANI, all private-sector employers must, as of 2016, offer CHI to all of their employees, and pay at least 50 per cent of their premium (they can choose to pay a higher share).⁴⁵ The idea is to secure and improve access to group CHI contracts known

hebdomadaire 10; Marcel Goldberg et al, "Les déterminants sociaux de la santé: apports récents de l'épidémiologie sociale et des sciences sociales de la santé" (2002) 20:4 *Sciences sociales et santé* 75.

44 Michael Rothschild & Joseph Stiglitz, "Equilibrium in competitive insurance markets: An essay on the economics of imperfect information" (1978) 90:4 *J Econ* 629.

45 *Loi relative à la sécurisation de l'emploi*, JO, 14 June 2013, art 1.

to be more advantageous than individual contracts because of risk pooling within employment groups. Moreover, in case of unemployment, individuals will benefit, free of costs, from the collective contract of their previous employer for up to twelve months. This agreement was introduced in response to the growing volatility in the labour market in order to protect the most precarious employees.⁴⁶ Also, employer-sponsored CHI contracts have to provide a higher minimum coverage concerning fees for dental and optical care (minimum of €100 for simple corrections, €150 for mixed, and €200 for complex corrections).

- *Controlling health-expenditure growth:* At the same time, SHI and successive governments have been constantly looking to regulate, legitimize, and enlarge the responsibility of the CHI scheme in controlling health expenditure. Copayments would, in theory, counter the problem of moral hazard—requiring patients to internalize some of the cost of care—but this effect is nullified when most of the population holds CHI-covering copayments. Therefore, while there is no restriction on what insurers are permitted to cover, in order to benefit from tax advantages and social contributions, CHI contracts have to respect certain conditions. These contracts, called *solidaires et responsables*, are designed to encourage responsible health care consumption. These contracts include various requirements designed to promote good medical practice. For example, they are not permitted to reimburse out-of-pocket payments imposed when patients visit an outpatient specialist directly (instead of using a GP as a gatekeeper) in order to support the voluntary gatekeeping reform introduced in 2004. Also, they cannot refund deductibles introduced in 2005 for controlling drug consumption, visits to health professionals, and for transportations.⁴⁷ In 2016, new constraints were introduced to limit differences in coverage levels between individual and collective contracts in order to reduce the impact of generous collective

46 Barlet, Beffy & Raynaud, *supra* note 18.

47 Monique Kerleau, Anne Fretel & Isabelle Hirtzlin, “Regulating Private Health Insurance in France: New Challenges for Employer-Based Complementary Health Insurance” (2009) Centre d’Economie de la Sorbonne Working Paper No 56.

contracts on health care prices. These contracts must now respect reimbursement ceilings for optical devices as well as extra-billings. These upper limits are intended to cap excess fees in sector 2, and also control prices of optical devices poorly regulated by the SHI. Today, almost all CHI contracts are defined as *solidaires et responsables*.⁴⁸

5. Issues

5.1 Efficiency Concerns

Health is an important area of public spending in France. In 2017, health expenditure accounted for 11.5 per cent of the GDP, making it the third highest level of spending among the OECD countries. Despite the high contribution of CHI (compared to other countries), about 78 per cent of health expenditure is still paid publicly (see fig. 10.3).⁴⁹

Therefore, in the past two decades, the rising cost of health care has been a major concern. While France has enjoyed relative success in controlling prices of health care services and pharmaceuticals through formal negotiations with health care providers and value-based pricing of drugs, low prices seem to have a limited impact on

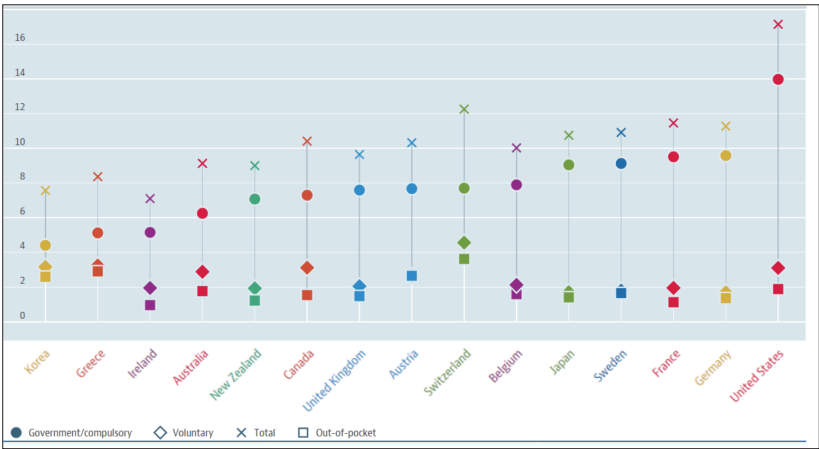


Figure 9.3. Health spending, percentage of GDP, 2017 (or latest available).

Source: OECD Health Statistics, 2017, *supra* note 28.

48 Barlet, Beffy & Raynaud, *supra* note 18; Barlet et al, *supra* note 18.

49 OECD Health Statistics, 2017, *supra* note 28.

health-expenditure growth. Health care providers tend to compensate for reduced revenues by increasing the volume of services they provide.⁵⁰ The lack of coordination between ambulatory, hospital, and social care has been recognized as a major drawback both in terms of cost control and quality of care. The fact that most providers work in solo practice—and with little collaboration between hospital, primary, and social care/services—means that patient care is fragmented and patients need to navigate a complicated system. Moreover, uncoordinated care, coupled with the high degree of independence and choice for both providers and patients, have been identified as key drivers of health care cost. Therefore, the latest reforms encourage group practice in primary care settings and testing alternative payment models for improving care provision and efficiency.

At the same time, the hybrid public-private insurance system, where private insurance complements and intersects with public funding for almost all types of care, generates a number of inefficiencies. The multiplicity of payers for the same basket of care does not always allow for an optimal use of resources: the generous coverage offered by some CHI contracts can be inflationary, and their reimbursement of copayments cancels the incentives initially sought to reduce moral hazard in the core public plan.⁵¹

Moreover, this combination of public-private insurance comes with a high management cost: France has the second highest administrative costs (6 per cent of the health spending) in the OECD, just after the United States, and almost half of this expenditure is related to CHI.⁵²

5.2 Concerns for the Solidarity and Equity of the System

Despite the high share of public insurance in funding health expenditure, the important place of CHI in the financing of care will likely to induce social inequalities in health care coverage and, ultimately, in access to care. This is mostly due to the basic functioning of the

50 DREES, 2018, *supra* note 10.

51 Philippe Askenazy et al, "Pour un système de santé plus efficace" (2013) 8 Conseil d'Analyse Economique; Brigitte Dormont, Pierre-Yves Geoffard & Jean Tirole, "Refonder l'assurance maladie" (2014) 12 Conseil d'Analyse Économique; Pierre-Yves Geoffard, "L'AMO ne suffit plus à garantir un accès aux soins sans barrière financière" (2016) 49 Regards 157.

52 Thomas C Buchmueller & Agnes Couffinhal, "Private health insurance in France" (2004) OECD Health Working Paper No 12.

private insurance market, where premiums are based on individual risk without considering ability to pay, and guarantees (services covered) vary as a function of the bargaining power of payers. Despite the regulations limiting risk selection, CHI prices set on the basis of health risk (age) without considering ability to pay are less equitable. Thus, while only 5 per cent of the population lacked CHI in 2014, the rate was 16 per cent for the unemployed and 12 per cent for individuals in the lowest income quintile, despite the existence of CMU-C and ACS (see fig. 9.4).⁵³ The quality of coverage (in terms of services offered) also varies widely across contracts and across income groups. Since the premiums increase with the generosity of the CHI contract, it is more difficult for low-income groups to access a good CHI contract. Moreover, collective contracts, which are always more advantageous because of the employer’s subsidy

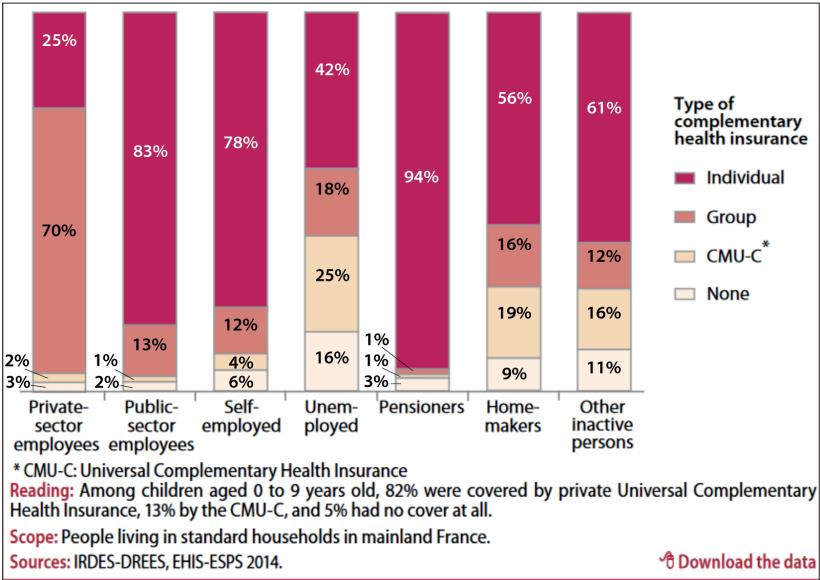


Figure 9.4. Distribution of CHI coverage in 2014, by employment status.

Source: Marc Perronnin & Alexis Louvel, *supra* note 51.

53 Marc Perronnin & Alexis Louvel, “Complementary Health Insurance in 2014: 5 per cent Had no Cover and 12% of the Poorest 20% of Households Had no Cover” (January 2018), online (PDF): *L’Institut de recherche et documentation en économie de la santé (IRDES)* <<https://www.irdes.fr/english/issues-in-health-economics/229-complementary-health-insurance-in-2014.pdf>>.

to the premium and concentration of low risks, are not accessible for the most precarious and sickest individuals, who are outside of the labour market. As a result, good CHI contracts with better price and coverage are more often subscribed by the wealthier. Despite owning lower-quality CHI contracts, on average, individuals with lower income spend proportionally more of their income on private health insurance: up to 10 per cent of household income.⁵⁴

Social inequalities in CHI coverage are particularly troubling given that the poorest individuals are often also the sickest.⁵⁵ Indeed, concentration of high out-of-pocket expenditures among those individuals with poor health status is a constant concern in France.⁵⁶ Although the reimbursement rates reflect the desire to better protect the sickest individuals (higher for hospital, lower for drugs), they do not cover all the financial risks associated with illness, which can be very high for some households. For example, in 2012, 1 per cent of the population paid an average of €4,971 per year for health care.⁵⁷ For certain benefits (especially dental care), which are only covered to a limited extent in the SHI package, out-of-pocket payments could be an important (especially for those who do not own CHI). However, studies show that out-of-pocket expenditure for health care covered in the SHI basket could also be a problem for patients with multiple, complex conditions, whether or not they benefit from the ALD scheme.⁵⁸ Individuals who have a chronic illness that are not enlisted for ALD can also face very high out-of-pocket payments.

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- 54 Bidénam Kambia-Chopin et al, "Les contrats complémentaires individuels: quel poids dans le budget des ménages?" (April 2008), online (PDF): *L'Institut de recherche et documentation en économie de la santé (IRDES)* <www.irdes.fr/Publications/Rapports2008/rap1701.pdf>; France, Ministères des solidarités et de la santé, *Assurance maladie et complémentaires santé: Comment contribuent-elles à la solidarité entre hauts et bas revenus?* by Florence Jusot et al, (France: DREES, 2017).
- 55 Lang et al, *supra* note 43; Cambois & Jusot, *supra* note 41; Goldberg et al, *supra* note 43.
- 56 Pierre-Yves Geoffard & Grégoire de Lagasnerie, "Réformer le système de remboursement pour les soins de ville, une analyse par microsimulation" (2012) 455 *Économie et statistique* 89; Franc & Pierre, *supra* note 15.
- 57 France, Ministères des solidarités et de la santé, *Haut Conseil pour l'avenir de l'assurance maladie. Rapport annuel 2012* (France: Haut Conseil pour l'avenir de l'assurance maladie, 2012).
- 58 Franc & Pierre, *supra* note 16; Dourgnon, Or & Sorasith, *supra* note 30; Geoffard & Lagasnerie, *supra* note 56.

The solution proposed by successive governments to this concern has been to increase CHI coverage for a larger part of the population, including with public subsidies. Nevertheless, publicly subsidized CHI schemes, which aim on one hand to improve the equity of access and on the other to control cost escalation, are also a source of two-tier treatment in the system. Patients who are part of public schemes (CMU-C, ACS) that do not allow extra-billing can face difficulties in getting an appointment with some physicians. While it is illegal to refuse a patient because of his/her insurance status, some sector 2 doctors could refuse recipients of CMU-C or ACS, using different pretexts.⁵⁹

5.3 Geographical Inequalities in Supply and Access

Notwithstanding the high level of human resources, the unequal geographical distribution of health workers, skewed to the well-off and city centres in urban areas, creates problems of access to care.

The “sacrosanct” principle of “freedom of installation”—that is, health care professionals can practice wherever they wish—results in an unequal distribution of health professionals across regions (see fig. 10.5).⁶⁰ The lack of specialists such as gynecologists, ophthalmologists, and anesthetists, as well as generalists in some areas, has become a serious policy concern in the past decade.⁶¹

While wait times for access to health care is generally considered as satisfactory (95 per cent of the French population can reach a primary-care doctor within fifteen minutes by car⁶² and 50 per cent of GP appointments are obtained within forty-eight hours), there are wide variations across regions.⁶³ Despite the overall high number of specialists, wait times for consulting a specialist became a concern in

59 Caroline Desprès, Stéphanie Guillaume & Pierre-Emmanuel Couralet, “Le refus de soins à l’égard des bénéficiaires de la Couverture maladie universelle complémentaire à Paris” (2009), online (PDF): CMU <www.cmu.fr/fichierutilisateur/fichiers/refus_soins_testing2009_rapport.pdf>.

60 Cour des Comptes, *supra* note 23.

61 Sylvie Castaigne & Yann Lasnier, “Les déserts médicaux” (2017) 27 Les avis du Conseil économique, social et environnemental.

62 Magali Coldefy, Laure Com-Ruelle & Véronique Lucas-Gabrielli, “Distances et temps d’accès aux soins en France métropolitaine” (April 2011), online (PDF): *L’Institut de recherche et documentation en économie de la santé (IRDES)* <www.irdes.fr/Publications/2011/Qes164.pdf>.

63 France, Ministères des solidarités et de la santé, *La moitié des rendez-vous sont obtenus en 2 jours chez le généraliste, en 52 jours chez l’ophtalmologiste* by Christelle

recent years. A recent survey suggests that there are important disparities between the specialties: the average appointment wait time was forty-four days for gynecologists, fifty days for cardiologists, and eighty days for ophthalmologists.⁶⁴ This survey also suggests that, with the notable exception of dermatologists and ophthalmologists, most patients could get an appointment within a week if their problem was urgent or new, while those for regular checkups often wait three to four months. Nevertheless, these averages hide very different situations between regions. A large number of territories, mostly semi-urban and rural, do not have enough specialists, while other areas have too many. For the three specialties above, the average wait time can exceed six months in some rural zones, on the peripheries of large cities, and in small- and medium-sized municipalities, where physician density is the lowest.⁶⁵ A few reports have also shown that, in specializations where there is a shortage of providers, access to physicians who do not extra-bill patients is particularly difficult. For instance, in Île-de-France, for some specialties (e.g., cardiologists, gastroenterologists, gynecologists, pulmonologists) the wait times to visit a specialist who respect SHI tariffs is nearly double that for those who extra-bill.⁶⁶

Several governments have tried to tackle the unequal geographic distribution of physicians and other health care professionals, but given the resistance from health care professionals, they mostly use financial incentives (tax incentives, financial provisions) to encourage physicians to set up practice in underserved areas. These instruments have had limited success in ensuring a fair distribution of human resources. But attempts to introduce quotas for controlling the further addition of doctors in oversupplied zones encounters strong resistance from physicians. More recently, encouraging group practice in primary care has been a lever for increasing the density of GPs in underserved areas, as well as for improving care coordination. Group practice appears to be more attractive for generalists than solo practice in rural or underserved areas.⁶⁷

Millien, Hélène Chaput & Marie Cavillon, *Études et Résultats*, No 1085 (France: Panoramas de la DREES, 2018).

64 *Ibid.*

65 *Ibid.*

66 Cour des Comptes, *supra* note 23.

67 Guillaume Chevillard et al, "Has the Diffusion of Primary Care Teams in France Improved Attraction and Retention of General Practitioners in Rural Areas?"

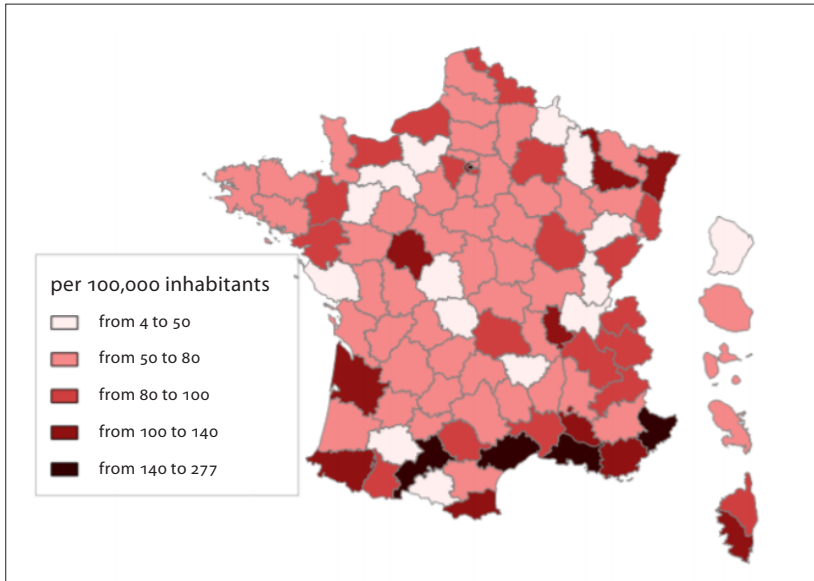


Figure 9.5. Density of specialists across French departments, 2016.

Source: Cour des Comptes, *supra* note 23.

6. Conclusion

The hybrid public-private model in France combines mandatory public insurance (SHI) with widespread (and increasingly mandatory and subsidized) private complementary insurance (CHI), covers effectively the entire French population for a comprehensive set of goods and services. The system requires patients to contribute to the cost of all services included in SHI, and relies heavily on private CHI to ensure access to care. The role of CHI is largely accepted by the public authorities, who have for decades encouraged the extension of CHI coverage, first to the lowest income groups, and gradually to the entire population. Given the increasing constraint on public resources, the private funding of basic health services via complementary insurance is considered as a necessity. However, the greater the entanglement and generalization of CHI, the greater the need for regulation and public intervention to counter the perverse effects of an unregulated insurance market, which is, by construction, less fair, not to mention the cost and complexity of multi-risk management.

Globally, France's experience suggests that reliance on private health insurance for financing essential health services is problematic for equity and solidarity in the system, as well as for cost containment. Complementary insurance is by nature based on contractual freedom, financed partly on the basis of risk without considering ability to pay, and variable in its guarantees. A number of public complementary schemes and regulatory measures were necessary over time to improve equitable access to care and to avoid a two-tier health care system. Therefore, the CHI market is closely controlled, via a mixture of regulatory measures and financial incentives, to reduce the difficulties that would otherwise face the sickest and the poorest in a competitive health insurance market. But pursuing a strategy to provide CHI for the entire population without controlling what is covered has proven to be problematic, both for ensuring equity of access and for cost-efficiency. Therefore, the content of CHI contracts are increasingly monitored and regulated in order to align them with public-sector objectives of controlling health care costs.

At the same time, the French model encourages plurality in health care provision, which relies on a mix of public and private providers. The high number of private hospitals funded by public insurance partly explains the relatively good results concerning waiting times, especially for elective surgery. Nevertheless, the high degree of autonomy (freedom of installation), together with dominant fee-for-service payment for health care providers, results in an unequal distribution of health professionals across regions, and creates problems of care coordination and access. To improve the efficiency and access to health care, new care models have been encouraged, with some promising results, which incentivize collaborative work in multidisciplinary group practices with alternative payment mechanisms.

Overall, the French model has some elements that can inspire the discussion on the role and place of private funding and provision in other countries facing public-budget pressures. The French experience suggests that privately provided health care can support a public health system, but the degree to which it creates a quality differential without endangering equity in access to care is heavily dependent on the way the private insurers and providers are managed, funded, and regulated. The elements of two-tier in France is mainly linked to the fact that there are profound inequalities in the distribution of

health professionals across the country, and that many physicians are allowed to extra-bill patients for providing essential services. In areas where access to a physician is difficult, private complementary insurance gives preferential access to those who own a better (more generous) CHI contract, one that covers high extra-billing costs.