

France: nation and world 1



Achieving universal health coverage in France: policy reforms and the challenge of inequalities

Olivier Nay, Sophie Béjean, Daniel Benamouzig, Henri Bergeron, Patrick Castel, Bruno Ventelou

Since 1945, the provision of health care in France has been grounded in a social conception promoting universalism and equality. The French health-care system is based on compulsory social insurance funded by social contributions, co-administered by workers' and employers' organisations under State control and driven by highly redistributive financial transfers. This system is described frequently as the French model. In this paper, the first in *The Lancet's Series on France*, we challenge conventional wisdom about health care in France. First, we focus on policy and institutional transformations that have affected deeply the governance of health care over past decades. We argue that the health system rests on a diversity of institutions, policy mechanisms, and health actors, while its governance has been marked by the reinforcement of national regulation under the aegis of the State. Second, we suggest the redistributive mechanisms of the health insurance system are impeded by social inequalities in health, which remain major hindrances to achieving objectives of justice and solidarity associated with the conception of health care in France.

Introduction

Since the end of World War 2 in 1945, the French health-care system has evolved as a social project driven by two great principles: universalism and equality. The extension of health insurance coverage over seven decades has made it possible to guarantee everyone access to the minimum of health care. The health insurance system is based on a redistributive philosophy intended to match households' financial contributions to their ability to pay and to guarantee individuals on low income access to good quality coverage.

The social model of health is a feature of the French experience. Its aim is to promote justice and solidarity while ensuring high-quality health care. The French model, as it is often called, is based on a national system of health insurance funded by employee and employer social contributions and co-administered by workers' and employers' organisations under State supervision. This model has inspired national reforms in developing countries, supported by French international health assistance, as discussed in the second paper in *The Lancet's Series on France*.¹ It is set apart most often from other European health protection systems in a reductionist opposition between Bismarckian and Beveridgean social insurance systems.

Here, we show that it is difficult to relegate health governance in France to an institutional archetype. The French system not only relies on various policy mechanisms and health actors but also has been transformed profoundly over the past two decades. Changes have affected health financing, health-care provision, and monitoring of national health strategies. These changes have been a result of public administration reforms and reorganisation of labour, management, and government bodies involved in health insurance. The role of State institutions in regulating the health-care system has grown throughout these successive reforms.

The French experience also shows that the objectives of universality and equality cannot be met simply by continuously extending health insurance coverage: they also need public efforts to reduce social inequalities in health effectively. Although institutional mechanisms guarantee solidarity in health-care funding, substantial social disparities continue to maintain inequalities in social groups' access to care. Similar to most developed countries with comparable institutional capacity, the French system—although generous in its principles—still has difficulty reaching its egalitarian objectives. Many determinants of social inequalities in health lie outside the health-care system—eg, education, social class, and living and working conditions.

Here, we first discuss how the French health-care system relies on a diversity of institutions, policy mechanisms, and health actors. State-driven reinforcement of national regulations has been extensive in the past two decades. Second, we focus on redistributive aspects of the French health-care system. We address both funding mechanisms and key factors that might impede the social model of health. We show how some social determinants are major obstacles to meeting the objectives of universality and equality in access to health care.

French health-care governance: institutional change and policy reforms

Historically, the French health-care insurance and delivery system is one that involves State institutions, non-profit groups, and the private sector. Beginning in the 1990s, government regulation played an increasing part in the French system without, however, centralising it. First, local participants retain substantial autonomy: health-care professionals have much freedom in their work and are involved in the governance of hospitals and other health-care facilities; patients have the freedom to choose how they access the health-care system. Second,

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This is the first in a *Series* of two papers about France

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institutional diversity is maintained and local co-ordination among providers and payers remains insufficient. Nowadays, State reinforcement in its supervision of the health system takes on complex, even hybrid, forms. It relies on introducing governmental rules drawn from company management techniques and on what is known as the new public management.² The Ministry of Health and health regulatory agencies also promote prevention programmes to make individuals more responsible for dealing with their health risks—eg, smoking,³ alcohol,⁴ and obesity.⁵

Panel 1: Main health reforms in France since 1945

1945

Creation of the *Sécurité Sociale* (Social Security Act)

1958

Major hospital reform; setting the civil servant status for doctors working in public hospitals and creating teaching hospitals

1967

Creation of specific risk-related funds, managing health, retirement, and family benefits; management of such funds is given to representatives of both employers and employees

1970

Act #70-1318, establishing policy methods for rationalising and balancing health-care delivery across French regions (*carte sanitaire*) and authorising clustering of hospitals

1984

Funding reform for public hospitals; global budgeting

1991

Act #91-748, establishing policy methods for rationalising and balancing health-care delivery across French regions (*schémas d'organisation sanitaire*) and making compulsory the development of strategic planning for hospitals (*projets d'établissement*)

1996

Legislative decrees (*ordonnances Juppé*), striving to increase control mechanisms on health expenditure and creating regional hospital agencies (*agences régionales de l'hospitalisation* [ARH]) in charge of health-care organisation, control, and monitoring

2002

Loi Kouchner for the rights of patients and representatives of patients

2004

Law #2004-810, reorganising (among others) the health insurance governance system; and law #2004-806, developing public health policies

2005

Reform of hospital architecture and governance; implementation of prospective payment system (*tarification à l'activité*)

2009

Law *Hôpital, patients, santé, territoire*; creation of regional health agencies (*agences régionale de la santé* [ARS]), merging ARH and social security regional bureaux; measures fostering coordination of health-care providers and reinforcing the gatekeeper role of general practitioners (family doctors) in the care pathway

2015

Loi Touraine (panel 2)

Institutional diversity in the French health system

In France, hospitals developed most considerably from the 19th century. Moreover, in 1893, as assistance laws were passed in Europe, the Third Republic decided to guarantee access to health-care facilities to poor people. Concurrently, collective or private insurance schemes (*sociétés de secours mutuel*, *caisses syndicales*, and *caisses patronales*) were launched.⁶ However, one might judge that first attempts to establish a system covering health-care costs in France date back to statutes that set up the first compulsory social insurance, enacted in 1928 and 1930. Nonetheless, resistance by private practitioners limited implementation. Only at the end of World War 2 did a new plan emerge. The National Council of the Resistance, which comprised representatives of all political parties, from Communists to Gaullists, set up a complete social insurance system covering health care, workplace accidents, old age, and family benefits.^{6,7} Since 1945, the French health-care system has expanded gradually, broadening the population's solidarity-based coverage through other compulsory funds. In 1945, the general social insurance system (*régime général de la sécurité sociale*, hereafter called the general fund) and its health insurance fund (hereafter, the general health insurance fund) were established for the private sector. Several specific funds were added subsequently, most importantly, the social insurance fund for farmers and agricultural workers in 1961 (*mutualité sociale agricole*) and the national fund for professionals and independent workers in 1966 (now the *régime social des indépendants*). Nowadays, around 15 of these funds coexist (eg, for civil servants, students, the armed forces, seamen, members of the National Assembly, and authorised private-practice doctors). In France, employer and employee payroll taxes fund this mandatory coverage. Trade unions and employers' organisations (the social partners) administer health insurance funds jointly and equally. The universality of the solidarity-based coverage was enhanced in 1999 with a system of free access to care. Populations previously excluded from the standard services were included in the general fund and covered by universal basic health insurance (*couverture maladie universelle de base* [CMU]). Subsequently, free universal complementary health insurance was launched to cover co-payments not reimbursed by the compulsory insurance. These notable advances in the compulsory health insurance system frequently took place during exceptional historic occasions or relied on special legal processes—ie, decrees (*ordonnances*) in 1945, 1958, 1967, and 1996, which are legislative texts the government introduces to bypass medical professions' power and lobbying (panel 1).^{8,9}

Nonetheless, this historic movement, making health insurance universal in France, has not led to the institutionalisation of a State-controlled health-care system, either for health insurance (especially supplementary) or for health-care provision. Despite its affinities with the Bismarckian model,¹⁰ the French model is singular. It has been characterised since 1945 by its

diarchic leadership: the joint (ie, employers and employees) compulsory health insurance system manages private medicine, whereas the Ministry of Health manages public hospitals and public health programmes. More generally, the French system combines public, non-profit, and private institutions and mechanisms and is characterised traditionally by its diversity. It is noteworthy that implementation of health-care laws and policies in overseas departments and territories varies.¹¹

Although the French system is not national, by contrast with the British and Scandinavian health systems, it nonetheless grants a major role to State institutions in the areas of health insurance and health-care provision. The public sector's role in organising health is considerable, not only in the training of doctors (general practitioners and specialists) but also in the health care that public hospitals offer (eg, regional university hospitals, regional hospitals, and local hospitals). From 1950 to 1990, decisions to expand the public care on offer boosted the number of public hospital beds from 350 000 to 580 000; nowadays, they account for 65% of the total.

The French system is not based on market regulation, by contrast with the US system. Nonetheless, it gives market players a large role. In health insurance, for example, many private complementary plans bolster the compulsory system and, nowadays, have a key role in funding the primary care associated with minor risks. A dense network of private clinics provides a substantial share of the health care on offer, specialising in specific diseases and treatments, particularly surgery, with a 45·5% market share in 2010. Also, particularly in outpatient care, the French system is characterised by a large private (self-employed) sector, which accounts for nearly 20% of national health-care costs and to which the French population turn first when sick, for these are their primary-care doctors.

The French health-care system has a large non-profit sector: the *mutuelles* are key players in the complementary insurance business. They defend the principle of solidarity among their subscribers and do not link premiums to subscribers' health risks. To the extent possible, they also avoid selection according to risks. Non-profit health-care institutions are plentiful, providing nearly 60 000 beds in 2010. They are funded in a manner similar to public hospitals, although private law governs their accounting procedures. Profits are not distributed to shareholders, as in purely private hospitals, but are reinvested in the facility. Nearly all these facilities are committed officially to upholding French values of equality: every individual has an equal right of access to care and to its continuity and permanence (table, figure 1; appendix p 1).

First efforts to coordinate the provision of care in France began in the 1970s. For nearly three decades after that, health maps were the main national method for State-controlled planning of hospital capacity and distribution of health facilities and equipment throughout the country. Since 1977, public agencies have coordinated health-care provision in France. Nowadays, regional health agencies

Panel 2: Touraine's law

Touraine's law on public health was adopted on April 14, 2015. It focuses on access to health care and prevention as top priorities of the national health agenda.

The law extends health prevention actions in the areas of food, hygiene, sexuality, and risk behaviours (eg, smoking, alcohol), including through the development of school educational programmes targeting young populations aged 15–24 years. Touraine's law also facilitates access to emergency contraception without restrictions for young women.

The law plans to disseminate the third-party payment management system (*système du tiers-payant*) as a way to reduce financial barriers in access to health care, particularly for the poorest populations. Third-party payment allows patients not to advance medical expenses. After having been implemented in pharmacies in the past decade, this payment scheme is planned to be extended to medical consultations: practitioners will be paid directly by social security and supplementary health insurance.

Touraine's law authorises class actions for medical disputes. Patients will be able to collectively sue companies when they are victims of accidents, particularly those related to the use of medicinal products.

The law also aims to expand public access to health-related information. It establishes a public service for health information, open to citizens. Touraine's law also plans to set a national health data system that will bring together major medical administrative databases—eg, reimbursement of medical expenses, length of hospital stays, health facilities for people with disabilities, data for risks factors leading to premature death. It intends to open these databases to non-governmental organisations and associations, health industries, complementary private insurance, and research centres.

A controversial measure entails plans to trial harm-reduction programmes through legalised drug use centres, over a period of 6 years. These centres will be used exclusively for especially vulnerable drug addicts, under the supervision of health professionals, with the aim to reduce related infectious diseases (such as HIV and hepatitis) while decreasing drug consumption through education.

are tasked with adapting national policies developed by the Ministry of Health to every region's specific characteristics. Accordingly, they coordinate public health strategies that combine preventive and care components through regional health programmes; they draw up *schémas régionaux d'organisation des soins* (regional health-care organisation plans), which replaced the *carte sanitaire* (health map) in 1991, as methods for health planning. The regional agencies are supposed to ensure resources are managed coherently and to guarantee equal access to high-quality health care. Empowering regional health agencies represents a crucial shift in the French health-care organisation. Although agencies enjoy a degree of autonomy, their directors are appointed and managed at a distance by the Ministry of Health. Institutional coordination remains especially difficult because of the multiplicity of stakeholders—their concerns and the interests they defend. Coordination and continuity of care between private practitioners and public hospitals remain an endemic problem.

Nationally, governance of health insurance and health policies is equally complex. The diversity of compulsory and complementary plans complicates management of the social protection of health. The ongoing back-drop of union elections prevents strong leadership in joint organisations. Moreover, negotiations among

See Online for appendix

	Public sector	Non-profit sector	For-profit sector
Health-care organisations	University affiliated hospitals (CHU, CHR), general hospitals (CHG)	Cancer centres, mutualist clinics, and health centres	Clinics, private medical offices, and medical groups
Patient selection	No	No	Yes
Specific activities	Research and teaching, transplants, antenatal diagnostics	None (cancer treatment remains an important activity)	None
Number of centres	947	700	1047
Number of beds	258 156	57 717	98 522
Number of ambulatory places	38 862	11 778	14 512
Overall market shares	60.6%	8.5%	30.9%
Surgical market shares	45.8%	8.6%	45.5%
Status of doctors	Civil servants,* salaried (public) employees, casual workers	Salaried (private) employees*	Salaried (private) employees and self-employed
Number of doctors	94 877	16 838	41 843

Data for 2011 taken from references 12 and 13. CHU=centre hospitalier universitaire. CHR=centre hospitalier régional. CHG=centre hospitalier général. *Doctors who work as employees in public and non-profit sectors do have the right to work as private practitioners, so they can get a complement of income, which can be substantial. Those who work in university hospitals (CHU) can hold an academic status (eg, professor of university), which also provides a substantial additional income.

Table: Main characteristics of French health-care facilities

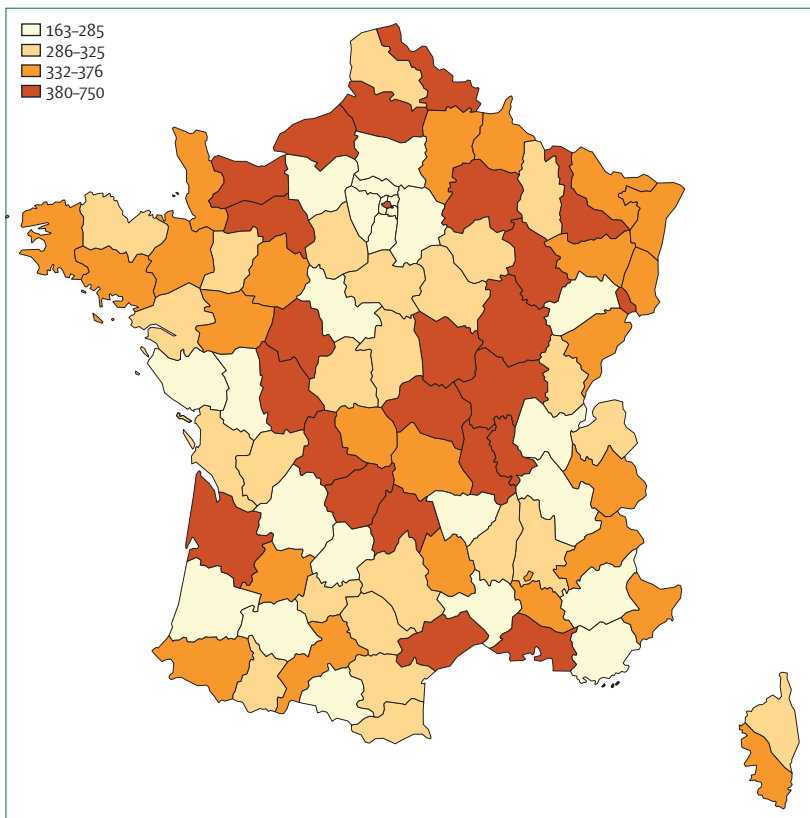


Figure 1: Distribution of acute care hospital beds in France, 2012

Data are the number of acute care hospital beds per 100 000 population. Data are taken from Eco-Santé France.

For Eco-Santé France see <http://www.ecosante.fr>

organisations that manage health insurance, doctors' unions, and hospitals can degenerate, with various stakeholders incapable of reaching an agreement.^{6,9}

The mixed nature of the French system is propitious, allowing diverse funding modes and medical practices to coexist. This diversity grants freedom to professionals and patients; however, it also makes national regulation complex and fragmented.

The State's enhanced regulation capacities

Over the past two decades, policy reforms have enhanced the State's capacity to regulate the health sector. It exerts more direct control over various segments of the system, which medical professionals had previously regulated with independence. Nonetheless, increased bureaucratic centralisation has not followed this move, and the French system continues to be polycentric. This augmented control is paradoxical. Undertaken with neo-managerial reforms lauding decentralised regulation and autonomy of health-care professionals and other stakeholders, it leverages methods borrowed from the private sector to govern and manage at a distance.¹⁴ The State's regulatory involvement is clear in the domain of health insurance, affecting a scheme that has granted a central role to social partners since 1945. Initially, the central government developed methods for regulating budgets, in particular by defining indicative budgets that foresaw restricted resource levels. In 1996, the French Parliament gained the power to define budgetary rules and the ceiling of increases to health-care expenditure. Thus, laws were enacted to authorise the annual budget for the entire social insurance system. The role of parliamentary institutions expanded, as the growing number of health-related bills shows. France also elected to change how health-care costs are funded. Besides the classic compulsory contributions levied on wages, the *contribution sociale généralisée* (CSG, in which *généralisée* means revenues from capital are also taxed) is paid to the fiscal administration as a public insurance tax. Indeed,

France, with the CSG, has departed from a traditional social insurance system towards a tax-based funding system, which relies on State fiscal administration to obtain the financial resources. This evolution contrasts with the situation of countries with tax-based systems where politicians are calling for social insurance models.

The State has also defined the minimal insurance guarantees to be covered not only by compulsory insurance but also by the chiefly private complementary plans. For historic reasons, such complementary guarantees were accorded automatically to residents of the three eastern districts that Germany governed from 1870 to 1919, known as Alsace-Moselle. In 1999, universal basic health insurance offered the poorest populations other minimal guarantees. Finally, in 2015, a new set of minimal guarantees was set for all salaried workers. Over these decades, the ability of public authorities to define health insurance coverage increased substantially.

Progressive reinforcement of the State's role in health insurance has led to changes in the governance of the social insurance system. Although formally preserving the historic diarchy between the Ministry of Health and the health insurance administration, a 2004 statute instituted a different shared governance by uniting the group of compulsory funds (creation of the *union nationale des caisses d'assurance maladie* [UNCAM]) and the for-profit and not-for-profit complementary plans. The legislature has attributed unprecedented responsibility in this organisation to a government-appointed director. This person has uncommon formal powers and is sometimes regarded as a junior health minister. These powers include regulating health insurance financing and costs and organising and coordinating care—eg, of patients with diabetes or those being discharged from hospital.

The State's enhanced role in organising care is also manifest in the new instruments and procedures developed to regulate the hospital sector. The launch in 1996 of regional hospital agencies (*agences régionales de l'hospitalisation* [ARH]), and their later change into regional health agencies (*agences régionales de la santé* [ARS]), eventually strengthened the central government's influence, although they were often presented as a devolution of power. The regional agencies, whose scope of responsibility was broadened in 2009 to include non-hospital care and social medicine, constitute an intermediate echelon between the Ministry of Health and local health professionals. Created under the guise of modernising public health policy, these agencies merged the regional and local offices of the Ministry of Health and the health insurance funds to improve regional coordination in providing care. Instead of respecting the principle of autonomy that guided the founding of these regulatory agencies, these reforms in fact helped the Ministry of Health regain control of the hospital sector. The increasing reliance on managerial methods and economic inducements is sometimes interpreted as a surreptitious form of liberalisation or privatisation of the health-care

system (appendix p 2).¹⁵ In fact, however, these new modes of health regulation benefit ministerial bureaucracy most,¹⁶ mainly by continued convergence of the private hospital sector into the regulatory system of public hospitals. In 1991, the private sector was included in regional health planning and, therefore, in regional health resources programming. In 1997, private hospitals became subject to the same standards of assessment and certification as those in the public sector, under the supervision of a national technical agency. Since 2008, the same prepayment financing rules have been imposed on establishments in the public sector (for medical, surgical, and obstetric services only) and private sector. Both the public and private sectors have also been engaged in the same quality assessment procedures, already envisioned as a supplementary funding mechanism.¹⁷ In 2009, hospital directors were made more clearly subordinate to the regional agencies. At the same time, however, their power within their hospitals was reinforced, to the detriment of local decision-making bodies in which, traditionally, medical professionals had played a primary part. Relationships between central government ministries, agencies, and hospitals are, in principle, contractual—an administrative idea guided by the new public management. In practice, however, such changes reinforce a hierarchical administration deeply rooted in French bureaucratic culture. The use of quality indicators exemplifies this trend. Although such indicators were set up to empower patients and give them a chance to choose better hospitals, the national policy implemented turned out to be a rather formal and bureaucratic exercise, reinforcing the role of national and regional levels on hospitals.

Less State regulatory intervention takes place in non-hospital care. The medical profession has succeeded, until now, in preserving its right to direct payment by patients, based on procedures done; the health insurance fund then reimburses the patient. This form of payment is traditionally considered a guarantee of the freedom for private doctors to practise and for patients to choose and bear economic responsibility. Doctors' unions have succeeded also in preserving the right to collective bargaining, granted in 1970 by the health insurance fund nationally, despite frequent conflict. These periodic negotiations determine the fees that doctors can charge their patients, who are then reimbursed by the health insurance fund.¹⁸ However, since 2004, this fund has been placed under the supervision of a State high-ranking official, and new procedures have reduced the autonomy of health-care professionals. Doctors have had to agree to top up their fees, which depends solely on payment for performance, with a flat-rate payment that the health insurance fund calculates according to various performance indicators. Many health-care professionals, including pharmacists and nurses, are now paid directly by the fund for the reimbursable portion of the care via a third-party payer mechanism; the patient no longer needs to prepay and await reimbursement. Since the

Touraine Law, adopted on April 14, 2015 (panel 2), doctors must comply with this third-party payment scheme. These changes in how the health insurance fund pays for care have changed the direct relationship between health-care professionals and patients—a key principle enshrined in the 1927 Charter of Private Medicine.

Moreover, State regulation of public health has been reinforced.^{19,20} The AIDS epidemic revealed the poverty of these institutions and the ineffectiveness of French public health policy. Subsequently, resources grew, stimulated by European programmes and the need to respond to a series of health crises—eg, bovine spongiform encephalopathy in 1996.²¹ National (and European) technical agencies were created to strengthen health security and safety in pharmaceutical drugs, food, and the environment.²² At the same time, diverse agencies or independent authorities acquired jurisdiction in the regulation of health care; among them are the National Agency for Health Accreditation and Evaluation in 1997, replaced in 2004 by the High Authority for Health, and the National Agency for Drug Safety. Supposedly more reactive and more open to stakeholders than the traditional civil service administration, these French agencies have reproduced and even strengthened bureaucratic characteristics. The requirements of transparency promote the formalism of more numerous technical standards, while their organisations constitute a new hierarchical level within the administration. Moreover, the jurisdictions of these agencies overlap and change constantly (appendix pp 3, 4).²

Increased State regulation of the health sector is a result of several factors: the national and regional agencies network; the convergence of the public and private hospital systems; the expanded relations between non-hospital and hospital medicine; and the increase in State-regulated control of health insurance funds.

Institutional polycentrism and coordination challenges

The effects of the strengthened State role on the French health-care system are not clear. In some respects, they take on paradoxical forms. First, the movement towards increased State regulation has not eliminated the diversity of schemes and public and private operators. The general health insurance fund maintains a high level of coverage through the various compulsory schemes and the considerable financial participation of non-State operators (non-profit and private insurance) in health-care funding. These complementary insurance plans apply particularly to routine care, notably the types of treatment that compulsory health insurance reimburses poorly but that can represent a substantial expense for households (eg, orthodontics and ophthalmology). Some complementary insurance plans also offer limited coverage for alternative medicines (eg, osteopathy and homeopathy). The current restructuring of the health-care system has not modified fundamentally the balance between the public and private sectors in the health-care supply. The private sector has preserved a substantial market share of hospital care (particularly

surgery) and private practitioners still provide almost all primary care. Most ambulatory pharmacies and biological laboratories also are private.

Policy reforms do not necessarily produce better coordination between funding institutions and care providers. On the contrary, public decision makers, researchers, and health-care professionals agree that inadequate coordination in the health-care system remains a key problem in current reforms.²³ For example, elderly people or individuals with disabilities are generally entitled to multiple sources of coverage that can be complex for the patients to manage.²⁴ Similarly, the absence of coordination between information systems linking the different non-profit complementary insurance providers to the compulsory system tends to impede rapid reimbursement of patients. For health research, France does not have a body akin to the US National Institutes of Health to oversee public research funding. Many experts have underscored the dispersion of funding and programmes among the Ministry of Health, the Ministry of Research, social protection bodies, national research organisations (including the National Institute for Health and Medical Research [INSERM]), public health institutions (such as the Institut Pasteur), and other public health agencies and institutes (notably, the National Cancer Institute; the National Agency for Food Safety, the Environment and Labour; and the National Institute for Prevention and Health Education). In 2009, efforts to coordinate their activity led to the creation of a national research alliance in life sciences and health, the AVIESAN alliance, which INSERM chairs. Beyond its mandate to spearhead research, the alliance is engaged in coordinating health research programmes to an extent unprecedented in France. By its scale and its intentions, this process can be compared to the UK National Health Service's research and development programme, developed from 1994 under the supervision of Michael Peckham, which led to the founding of the National Institute for Health Research (NIHR) in 2006.

The inadequacy of institutional coordination is more flagrant still in the provision of care. Successive reforms have introduced new coordination, typically added on to previous systems and compounding organisational complexity. Moreover, although coverage is estimated to have improved, geographical disparities persist (eg, between metropolitan and overseas territories),¹¹ in addition to inequalities in access to care and prevention. The freedom of private practitioners to choose where they practise has not been called into question, despite attempts at reform involving doctors' unions, doctors, and medical students. Nowadays, this policy of geographical balance in the availability of primary care is being implemented with extreme caution. It entails slow readjustments in the number of students admitted to different medical schools every year and financial incentives to set up practice in areas with scant medical resources.²⁵ Looking forward, these areas of poor medical coverage are an increasing concern, particularly in rural territories. Coercive

measures to spur the employment of doctors in these areas are viewed as inadequate. Public authorities have supported creation of around 800 cross-disciplinary *maisons de santé* (medical health centres) to provide care, both in urban and in more deprived rural areas (figure 2).

Enhancing the role of primary care has been a major theme of recent reforms, through creation of care networks and nursing homes and experimentation with different pay schemes for doctors (eg, as employees or with bonuses associated with public health projects). These reforms deal simultaneously with issues of geographical access to care, coordination among health-care professionals, and support for public health activities (eg, prevention, screening). Evaluations are underway, but attempts to include more general practitioners in care networks have, thus far, achieved little success.^{26,27}

Yet another prominent aspect of lack of coordination entails information systems linking care providers. In 2004, a law was passed to promote the digitalisation and centralisation of all patients' medical records, to facilitate information exchange. This initiative has faced multiple delays, and integration of information systems between health-care professionals and hospitals remains minimal. Despite regulatory attempts intended to streamline the health-care pathway, the care actually provided remains largely the product of an informal work organisation driven by professional logic.

The coherence of prevention policies and health education is still sparse. Despite the important role of State institutions,²⁸ non-profit associations and private operators are part of the many players in this domain. Henceforth, in key areas (eg, alcohol and tobacco consumption, and obesity), the primary goal of prevention policies has been to influence individual behaviour rather than target structural causes. Current health prevention measures put the onus on individuals to reduce at-risk practices by changing their habits and lifestyle.²⁹ They emphasise individual responsibility and autonomy, because patients are provided with information and health education, and continue to benefit from the broad coverage for their health expenses.

As we have seen, the French health-care system has undergone gradual transformation in recent decades, leading to reinforced State oversight and evaluation capacities and a loss of power for social partners in governing the health insurance system. Medical professionals and patients still benefit from autonomy and freedom of choice. This dichotomy partly explains extant coordination challenges. Yet, the health insurance system continues to fulfil the redistributive goal that its founders assigned to it in 1945.

Health coverage in France: redistributive effects and social determinants

Countries such as France that have chosen universal health coverage face two major economic questions. First, a macroeconomic question: how much does

universal access cost? Second, a microeconomic question: what is the net result of health insurance on family budgets? In other words, what is the cost–benefit balance of health insurance per individual or per household living in France and insured? The question of health insurance in France has always been linked to discussions about its redistributive nature on the one hand, and the social inequalities in health on the other. The French system—with its principles of access to care and its funding methods—aims to promote equality of access among citizens. But the facts show that social inequalities in health outcomes continue and seem to be getting worse, particularly for specific diseases such as obesity and cancer.³⁰ Is this a sign the French system is failing to reach its egalitarian objectives, or that policy has not succeeded in fully measuring the myriad causes of social inequalities in health, which arise before the health-care system comes into play?

Macroeconomics and socialised funding of health-care costs

France has one of the highest health-care outlays in the world. In 2012, with annual per person expenditure of €3650 (US\$4288), France ranked third for health-care costs among large countries in the Organisation for Economic Co-Operation and Development (OECD), as a proportion

For OECD data see
<http://stats.oecd.org>

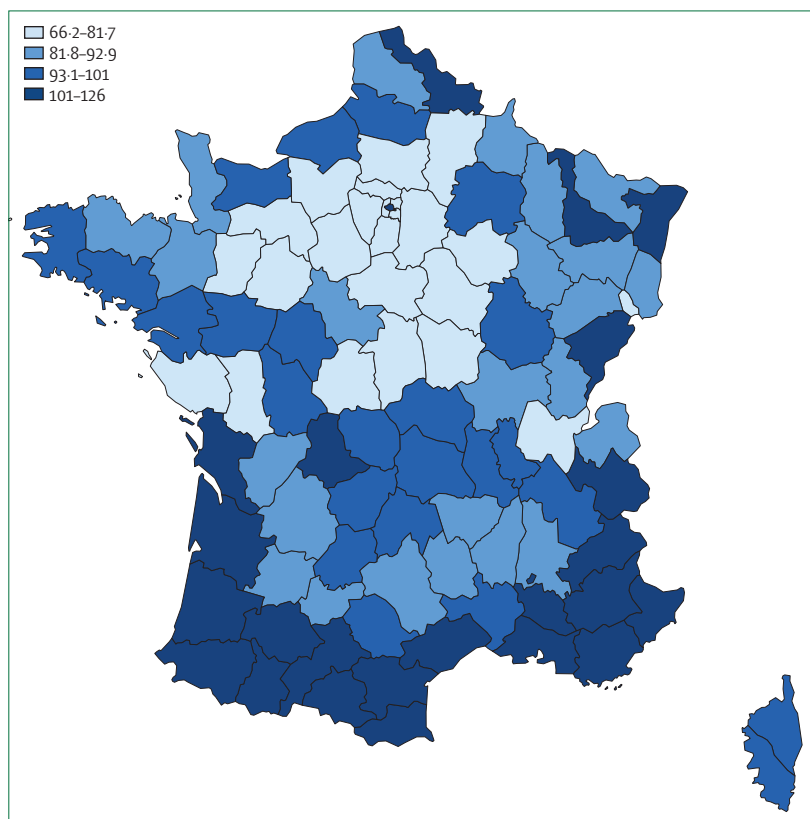


Figure 2: Geographical density of general practitioners, 2012

Data are the number of general practitioners per 100 000 population. Data are taken from Eco-Santé France.

For *Sécurité sociale* data see <http://www.securite-sociale.fr>

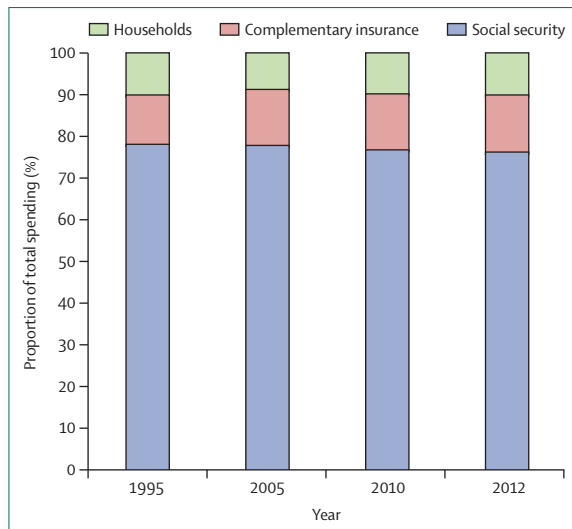


Figure 3: Evolution in distribution of health expenditure, 1995–2012
Data are taken from reference 12.

of gross domestic product (GDP; 11.6%), trailing only the USA (16.9%) and the Netherlands (11.8%). Nonetheless, this percentage is close to those of other European countries (Germany, 11.3%; Belgium, 10.9%) or OECD members (Canada, 10.9%). Similarly, when we look at the proportion of total health-care costs represented by public expenditure, France is indistinguishable from other countries (with the exception of the USA): in 2012, public spending for health care represented 77.4% in France, 76.8% in Germany, 75.2% in Belgium, 70.1% in Canada, and 85.8% in the Netherlands. These figures contrast sharply with the percentage in the USA, which was only 47.6% in 2012. This difference testifies to the fundamental differences in ways of funding health care. In France, private insurance companies or non-profits (*mutuelles*) supplement compulsory health insurance coverage funded by public contributions (figure 3).

In that light, health costs seem to be well covered in France: 92% of these costs were reimbursed to French patients (compared with 87% in Germany, 79.6% in Belgium, 85% in Canada, and 88% in the USA). Only the Netherlands had slightly higher coverage at 94%, according to the OECD. These findings show the French system is one of the most comprehensive, with only 8% of out-of-pocket spending. Nonetheless, the overall rate of 92% and, within this figure, the relative proportions of compulsory public insurance and private insurance vary according to the person and the disease. Generally, public health insurance provides 100% coverage for expensive chronic diseases, which mainly affect elderly people (eg, diabetes, cancer, or cardiovascular diseases). The private sector, on the other hand, covers costs associated with auxiliary services, regarded as low risk (eg, dental, optical, and minor diseases). Because public insurance specialises in major diseases and exempts patients from co-payments for them, the overall reimbursement rate

has remained stable for the past decade, even though rates are sometimes reduced for specific types of care (eg, drugs with poor therapeutic efficacy). Population ageing leads to an increasing proportion of people benefiting from 100% coverage for chronic diseases, thus maintaining the volume of public health spending.

Year after year, governments face a public insurance deficit (€17 billion in 2012, or 0.8% of GDP, according to *Sécurité sociale*). Health-care costs are growing at a rate faster than the French GDP, which is the tax base for revenue allocated to financing the social insurance funds. In fact, the deficit results mainly from France's weak economic growth. The health insurance accounts would have been balanced since the beginning of the century had GDP grown by an annual rate of 2–3%.³¹ Thus, low growth during 2000–10 has required the French Government to shoulder this deficit.

Microeconomics and a redistributive funding system

Coverage of health-care costs and funding vary considerably by income level. When we divide the French population into income deciles (D1 the poorest; D10 the richest; figure 4), we see a clear trend in the distribution among public insurance, complementary insurance, and out-of-pocket spending for households. The poorest groups benefit fully from the different public coverage schemes: for households in the lowest decile of the population, the compulsory system and the free complementary plan cover nearly 90% of costs of care. Conversely, wealthier individuals use more of the types of care the public funds do not cover as well. For them, the public fund covers on average less than 70% of their costs. This difference between rich and poor populations does not result solely from the qualitatively different health-care consumption of the wealthier segments of the population. Two or three low-income deciles contain a high proportion of elderly people who have retired, have modest pensions, and typically, because of their age, suffer from long-term chronic diseases that exonerate them from co-payments. For example, the D2 decile represents the peak in health-care consumption, associated with a high reimbursement rate (figure 4B).

Analysis of contributions to the health insurance system also reveals substantial variations according to income. Figure 4 shows the contributions and the benefits from the health insurance system of French residents. The national average for contributions to the two types of insurances was €5190 in 2008. Contributions to national health insurance are clearly progressive because of the taxation policy, yet the private system is almost flat as the rates charged are rarely based on household income (figure 4A). However, the level of reimbursement paid by the public health insurance fund remains globally flat among income deciles (figure 4B).

This comparison of payments to and reimbursements from the public system highlights the important redistributive effect of the French health insurance system. The

main mechanism of redistribution is coming from asymmetry between contributions and reimbursements, from wealthier individuals towards poor populations. The French system is more redistributive than schemes in which contributions are determined on the basis of a lower risk of disease. To understand this transfer, socioeconomic and epidemiological factors must be examined together. Since poor people are sick more often compared with wealthier individuals, a natural redistributive effect occurs that is favourable to them—the direct effect of horizontal redistribution between healthy and ill that is intrinsic to all health insurance systems. But more detailed analyses show that the redistributive character of the system persists when this socioeconomic epidemiological effect is removed.³² There is vertical redistribution, even after adjustment for horizontal redistribution (from healthy to sick) that intervenes consecutively to the socioeconomic gradient in health.

This redistributive effect is an important dimension of the health insurance system in France. It is much stronger than in education, for example, for which the social balance between contribution levels and programme benefits remains low, as the poorest families use fewer public education services.³³ International comparisons show the French health insurance system is one of the three most redistributive systems among OECD countries, particularly because of the strong progressiveness of its contribution levels compared with other countries.³⁴ In 2000, the creation of a specific system of access to care for the poorest people in France—the CMU—accentuated further this redistribution process. For the poorest populations, the CMU represents a shift from employment-based coverage to one based on residence. The most disadvantaged groups now have access at the same time to public insurance (with no conditions other than residence) and free complementary health insurance.

Overall, the combination of public insurance and private insurance (private insurance being redistributive but completing the services abandoned by the public system) makes it possible to fit the real price paid by every individual to their ability to pay. More precisely, out-of-pocket spending for health care ranges from 4% for households in deciles D1, D2, and D3 to 13% for the richest decile (D10).

The French system nonetheless has deficiencies. More than 20% of members of population categories entitled to the free complementary universal system do not use it (non-take-up). Moreover, this system, which is based on a poverty criterion, displaces the problem towards the less poor, but still very low-income categories, for which this complementary insurance is not free.³⁵ Some types of care are not included as reimbursed expenses, including preventive care, some vaccines, and preventive dental care, which leaves substantial out-of-pocket charges that are obstacles to access to care. Finally, observing redistributive transfers promoting access to care for people most in need at any given moment provides no

information on situations these individuals might face throughout their entire lives. Premature mortality recorded in the poorest populations (appendix p 5) could mean that the system, redistributive in a cross-sectional view, is much less so over an entire lifecycle: if people in different income groups do not have the same lifespan, their ability to capture redistributive transfers is not, in fact, the same in an intertemporal perspective.

Are social inequalities in health a French paradox or universal phenomenon?

The French system of funding theoretically should create the best conditions for equitable access to health, through its dual mechanism of vertical (favourable to the poorest groups) and horizontal (favourable to the populations most vulnerable to the risk of disease) redistribution. Nonetheless, a qualitative observation of health-care use shows important differences among social groups, after adjustment for their health needs (ie, age, sex). The principle of horizontal equity states that every individual should receive care according to his or her health needs. Many empirical studies show that use of health care differs by social group.³⁶

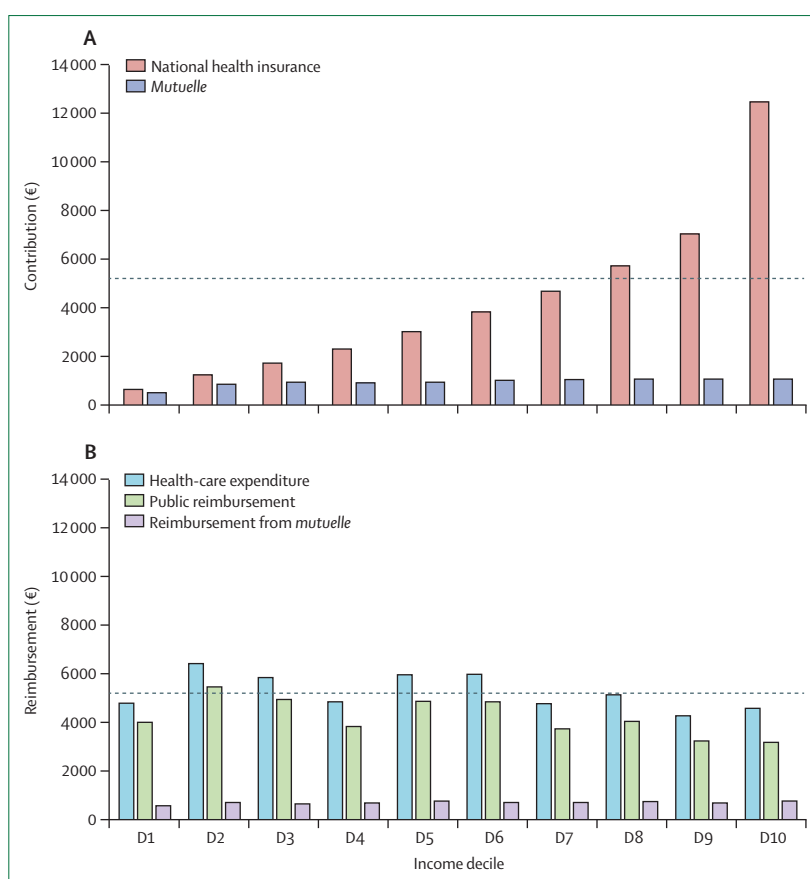


Figure 4: Contributions to health insurance and reimbursements made, by income
Data taken from reference 32. Income deciles are from D1 (poorest) to D10 (richest). Dotted line depicts the national average for contributions to the two types of insurance, which was €5190 in 2008. (A) Contributions made by households to insurance schemes. (B) Reimbursements made to households from insurance schemes.

In France, differences in use of health care among social groups have been recorded. Analyses measuring odds ratios associated with different income levels show that after controlling for age, sex, and health status, substantial differences exist among social groups for specialist care: the wealthiest half of the population see specialists twice as frequently as do the poorest 25%.³⁷ Similar reports abound for preventive care, particularly screening programmes, even though some are free (eg, colonoscopy, mammography, eye examinations). Moreover, social health inequalities might increase along with medical innovations because the richest proportion of the population benefits more quickly from the latest techniques.³⁸

Nonetheless, international comparisons show that social inequalities in access to care are a nearly universal phenomenon. Among comparable OECD countries, France is located at the median.³⁹ A comparative analysis of health-care systems shows that both the organisation of care and the principles applied for funding the health-care system are important factors that affect inequalities in health-care use. National (or universal) health systems succeed better at reducing differences in access to care than do employment-based systems, partly because that care is free and because general practitioners, as the referring doctors, filter access to care. From this perspective, changes made to the organisation of the French system to reinforce the role of primary care and screening access to the system—through institutionalisation of general practitioners as referring doctors for patients—will help reduce these inequalities.⁴⁰

Social inequalities in health outcomes remain important. Figure 5 shows how life expectancy differs by *département* and sex. At age 35 years, the life expectancy of a male manual worker is 6.3 years less than that of a male senior executive (3 years less for women; appendix p 5). Furthermore, men who have no secondary school diploma are 2.5 times more likely to die before the age of 65 years than are men who attended higher education institutions (1.9 for women; appendix p 6). Of note, in 2003, the gap between manual workers and executives was a bit narrower (5.7 years difference), suggesting an increase—or at least a perpetuation—of social inequalities in death rates (appendix p 6). Some morbidity variables also show a social gradient: the frequency of depressive episodes in the general population is 9%, compared with 16% among unemployed people and those not in the labour force.⁴¹ Cancer is the most studied disease in relation to social disparities in health, and large inequalities have been noted among men with cancer, particularly for malignant disease of the upper respiratory tract. Such inequalities increased between 1968 and 1981 among men and remained stable thereafter. Social inequalities were less pronounced among women, but were still seen for lung, uterine, and stomach cancers.⁴²

Social inequalities in health outcomes have been analysed widely.⁴³ In France, as in other countries, social factors play a part well before considerations of access to

the health-care system come into play (appendix pp 5, 6). Every social position corresponds to a particular combination of resources and risk factors. The determinants of health inequalities can be classified in several categories: biological determinants, which are in principle independent of the social situation, although links have been shown between epigenetic markers and embryonic and fetal life;⁴⁴ behavioural determinants (eg, smoking, alcohol, diet, and physical activity), themselves affected by social and occupational positions; environmental determinants associated with living (eg, habitat) or working conditions (eg, drudgery, exposure to pollutants);⁴⁵ and socioeconomic conditions of society as a whole (eg, social stratification, income, training, and work). The most disadvantaged social categories accumulate all these risk factors. Even psychosocial risks and stress at work affect the lowest occupational and social categories more frequently or more strongly compared with the highest occupational and social categories.⁴⁶

Health inequalities by ethnic group or race are studied rarely in France since gathering ethnic and racial statistics is forbidden by law. However, the health of people who have immigrated to France is generally less good than that of the native-born French population:⁴⁷ an immigrant is at higher risk of reporting poor health than is a native French person (crude odds ratio 1.5); the age-matched and sex-matched risk is higher (odds ratio 1.74). The economic and social conditions of people who have immigrated to France partly account for these inequalities. However, beyond these factors, analysis of differences according to country of origin seems to show that the level of development of the country of origin also has a long-term effect on the health of immigrants.

The influx of migrants fleeing war is another challenge that French and European health systems have to face. In some French cities (eg, Paris and Calais), health service access points in hospitals for people living in precarious conditions (*permanences d'accès aux soins de santé pour les personnes précaires*) are overwhelmed and cannot respond adequately to migrants' needs. Although the epidemic risk of tropical and infectious diseases is low, disorders related to precarious living conditions (eg, gastroenteritis and tuberculosis) cannot be ignored.

Existing studies on health in France do not compare the health status of homeless people to the rest of the population (appendix pp 7, 8). However, some surveys focusing on disadvantaged groups show that homelessness is a factor that can worsen health conditions. For instance, among beneficiaries of temporary accommodations or hot meal distribution, 16% of homeless people declare poor or very poor health versus 3% of people with stable accommodation. Differences in proportions are significant for all diseases, but they are especially high for migraines, respiratory diseases, accidents, or diet-related diseases. These survey findings show that the longer the duration of homelessness, the poorer health becomes. Infectious diseases such as tuberculosis are starting to reappear in

homeless populations: tuberculosis is more prevalent in people who are homeless than in those with stable housing (120 cases per 100 000 vs 4·3 cases per 100 000).

Addressing the root causes of social inequalities in health

Social inequalities in health depend principally on the circumstances in which people are born, grow up, live, work, and age.⁴⁸ In turn, health conditions can affect an individual's social situation, particularly when chronic disease affects their work.⁴⁹ Redistribution mechanisms cannot compensate for the cumulative effects of these major social factors that act ahead of and independently from the health-care system.⁵⁰ Since the social insurance system began, French policy has focused on addressing financial barriers to health and has succeeded at achieving formal equality in access to health care. There have been some pronounced successes in controlling risk behaviours linked with social determinants. For example, mortality from alcoholic diseases has fallen strikingly, with 13 500 fewer deaths in 2012 compared with 1982 (according to the *Centre d'épidémiologie sur les causes médicales de décès* [CePiDC]). France has also taken strong measures on smoking (eg, tobacco taxation, smoking ban in public places) that will have an effect on mortality from tobacco-related diseases in the next 10 years. Furthermore, France has implemented policies aimed at attacking the root causes of social inequalities in health outcomes. The Public Health Act of 2004 was a turning point. In 2009, launching a second Cancer Plan, France placed inequalities at the heart of its public health policy. In 2012, the current President of France, François Hollande, reaffirmed this priority with the Third Cancer Plan and Touraine's Law.⁵¹ Implementation is far from simple. Directing prevention policies towards vulnerable populations can be counterproductive: if policies contribute to stigmatising these populations they risk increasing inequalities further, as shown by studies of public action against smoking and obesity.⁵²

Equality of access to care through vertical and horizontal redistribution strives to enable the social insurance system to correct what it can. The social solidarity the French system instituted has had a positive effect on living conditions in general and on health. Compared with the British health-care system, the French system is far from reaching its target of reducing those inequalities attributable to inherited social circumstances on which the system can act.⁵³ However, this objective should not be abandoned: it remains a necessary, albeit insufficient, condition for reducing inequalities.⁵⁴ Better equality in access to health care has a positive effect on the quality of life of the poorest populations.⁵⁵ Reducing social inequalities in health may well make society as a whole stronger.⁵⁶

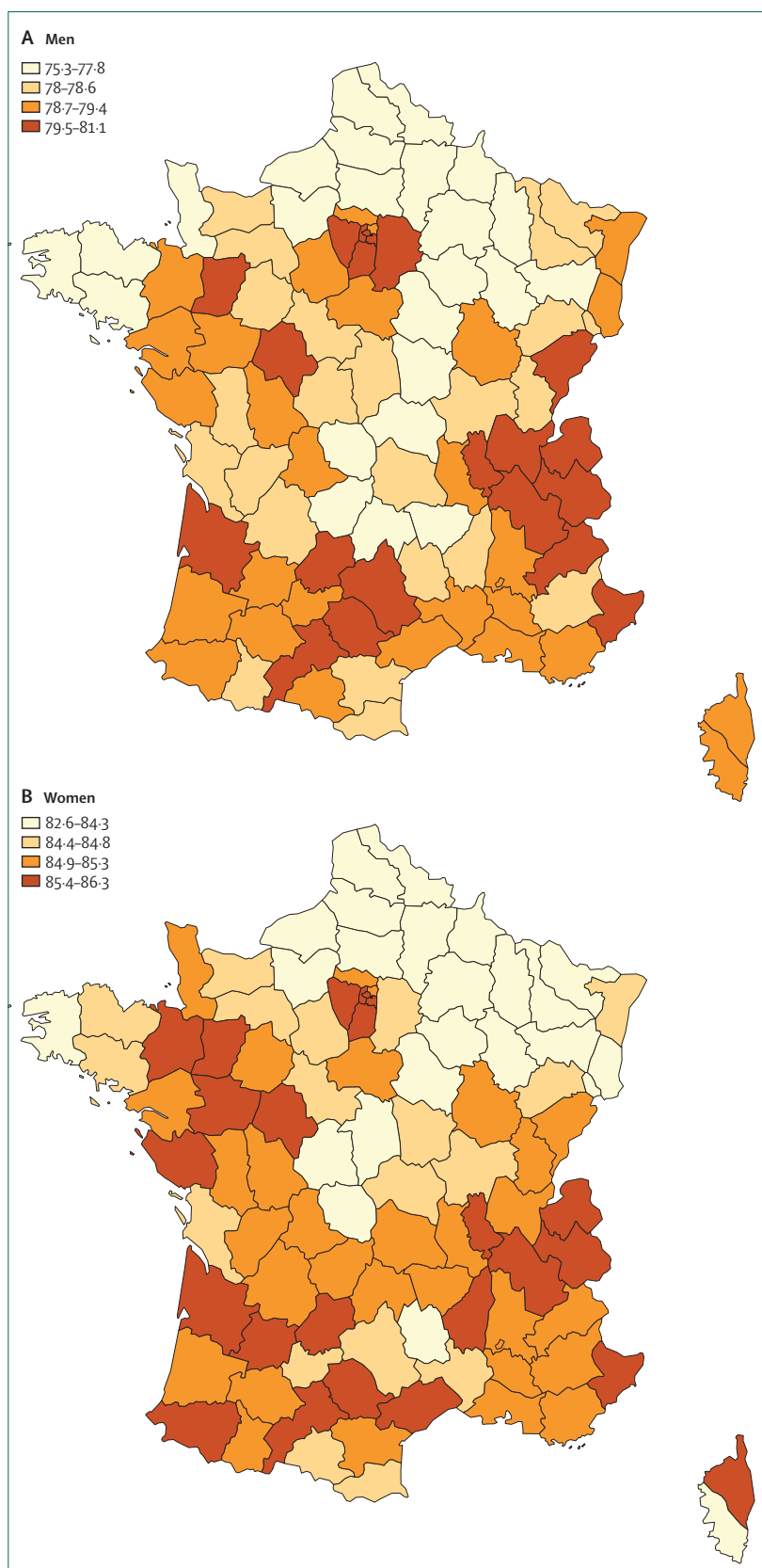


Figure 5: Life expectancy at birth, 2013

Data are life expectancy at birth (years). Data are taken from Eco-Santé France.

For CePIDC data see <http://www.cepidc.inserm.fr>

Panel 3: Key points

The French health system promotes the principle of health-care insurance based on a redistributive funding model. It includes, in particular, a specific system of free access to care for very poor people.

The French health-care system features a high level of institutional diversity: a centralised public regulatory authority, coexisting with a mix of public, non-profit, and private health insurance providers and hospitals, together with a large sector of self-employed doctors for the provision of primary care.

This institutional mix guarantees nearly universal coverage of the French population and sharply reduces financial barriers to access for poor populations—all at a reasonable total cost (11.6% of gross domestic product).

This institutional heterogeneity allows both health-care professionals and patients a high degree of freedom. It also increases the complexity of the regulation mechanisms for both social security and health-care provision.

Over the past two decades, government institutions have strengthened substantially their role regulating the health-care system, through the development of oversight and monitoring mechanisms in three domains: the governance of health insurance; the organisation of health-care provision; and public health.

In such a hybrid system, coordination among multiple health providers and decision makers can be difficult and could lead to a waste of resources. Improved coordination is needed in the areas of health insurance funding, information sharing (among health-care providers), health research, health-care delivery services, prevention policies, and health education programmes.

The French health-care system is one of the most redistributive among countries in the Organisation for Economic Co-operation and Development, particularly because of the strongly progressive nature of payroll taxes. It combines horizontal redistribution (for those most exposed to health problems) with elements of vertical redistribution (for the poorest populations) through the automatic application of sliding scales based on income.

In the domain of health insurance, numerous private complementary plans augment the compulsory system and have a key role in funding the primary care associated with minor risks.

As in many high-income countries, health inequalities depend, in particular, on socioeconomic factors (eg, social category, access to employment, income, and educational level). These determinants are added to the behavioural and environmental risk factors that affect the most disadvantaged populations.

The goal of reducing social inequalities in health has not yet been met. Although the most recent public health laws focus more directly on non-monetary sources of health inequalities, some socioeconomic determinants maintain unequal access to several categories of care (eg, specialists, dentistry, and eye care and glasses). The mechanisms of redistribution cannot compensate for the cumulative effects of these major social factors that act ahead and independently of the health-care system.

Since the very origin of the social insurance system, French policy has relied strongly on dealing with financial barriers. It is only more recently that France has implemented policies aimed at addressing the root causes of social inequalities in health.

Challenges in the next decade

The French health-care system will confront various challenges in its governance in the next 10 years. Most important will be to reorganise a system built after World War 2 on one central pillar, the public hospital, which implicated doctors in regulating the health-care system. The increasing prevalence of chronic diseases among an ageing population calls for a new transversal scheme joining hospital services with ambulatory and social care. This shift must be tackled in the context of stricter budget restrictions and costly medical advances. The founding values of the French health-care system, which find strong popular support, are under pressure: nowadays, combining high quality in health services and social equality in health seems necessary but hardly sustainable without institutional reforms. This tense equation needs new forms of governance that coordinate a wide range of actors, interests, and stakeholders at different territorial levels. Beyond economic and medical issues, France has to face a new democratic challenge. Parliament's increasing role, and new forms of participation of patients' and citizen's

organisations, prove that a more inclusive health-care system is likely to gradually replace the sector's traditional regulation, which has given professional medical associations an important influence to negotiate successive health reforms. This shift could reorganise the health-care sector at a more rapid pace over the coming years.

Beyond the issue of governance, the French health-care system risks evolving into a socially fragmenting two-tier system. Increasing socioeconomic inequalities combined with efforts by health professionals to flee the public system's harsh budgetary constraints might reinforce gradually a high quality, high price, no waiting, private health-care sector. Growth in the number of protest movements, grounded in 1992 European legislation abolishing France's social security monopoly and that seek to avoid social security contributions, could reinforce this trend. Economic globalisation, moreover, permits the wealthiest segments of society to offshore their income and, thus, escape French solidarity contributions. An increasing share of ambulatory-care doctors—and sometimes hospital doctors working for

public institutions—charge prices above regulated fees, which indicates that the risk of fragmentation is real. The French Government's response has been to officialise these practices and to render conditional and set limits to these fee surcharges (the surcharge must remain below 150% of the regulated fee). This social split is already a reality in some public services. The fight against fragmentation in the health-care system is the battle France must not lose.

Meanwhile, the most disadvantaged populations and the lower middle class are less eager to seek health care, which is an important challenge to universal access to health in the next decade. Touraine's law (panel 2) plans to generalise the third-party payment scheme for private medical consultations, thereby extending a system already in place for the delivery of prescriptions. Reducing health disparities in the population, however, cannot be met only through financial incentives, because health inequalities result from social and professional factors distinct from the health-care system. The fight against the health divide requires public health policies that fully integrate such factors. Tomorrow, the wealthiest individuals and households will have easy access to high-technology, personalised, and even predictive medicine. For the most disadvantaged groups, and to a large extent the lower middle class, health policies will have to not only act on behavioural, environmental, and professional risk factors but also set up ambitious health education and prevention programmes. One of the subsequent challenges will also be to make high-technology medicine accessible to all.

Concluding remarks

Four main lessons can be drawn from the evolution of the French health-care system over past decades (panel 3). First, health insurance coverage remains broad and redistributive in France by comparison with other OECD countries. Insurance has an important role in social cohesion. More broadly, access to basic health care is recognised as a fundamental human right: good health is an essential element of freedom. Health has been judged for a century a public good for which the government is responsible.

Second, State health regulatory institutions have gradually become leading players in regulation of health insurance and health-care provision. Key institutional features of the French system—the traditional dualistic balance between employment and government institutions and the territorial autonomy of public and private health-care providers—are increasingly less prominent. However, at this time, both patients and doctors maintain high levels of autonomy.

Third, institutional fragmentation and lack of coordination remain serious policy challenges for effective health-care services. For policy makers, these challenges justified stricter accountability and surveillance mechanisms through State regulatory

agencies and geographical and budgetary planning. At the same time, development of quasi-market regulatory methods has made possible the wider application of the principles of result-based management and the use of incentive mechanisms—eg, payments for performance, remuneration for public health objectives, and activity-based financing.

Finally, redistribution does not have merely a social or moral aim: it also improves health nationally. Nonetheless, in France, as in most high-income countries, the redistributive system still does not provide an effective response to social inequalities in health. It befalls the French Government to develop more effective policies targeting the causes of these inequalities. Public policies must target areas outside the health-care system to combat these inequalities. France has started to shift towards such policies, as shown by health-related laws enacted since 2004. Nonetheless, the austerity policies that successive French Governments have applied in the continuing aftermath of the deep economic and financial recession of the late 2000s has slowed progress toward these objectives. State institutions are not disengaging from the health-care system: their financial commitment continues. Economic policies to boost labour market flexibility and reduce social expenses, however, have a harmful effect on unemployment and poverty—both important health determinants. Developing a sustainable system that allows for effective policies to redress health inequalities is going to depend in large part on political choices.

Contributors

All authors contributed to writing of the report.

Declaration of interests

We declare no competing interests.

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