The french health care system

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ABSTRACT: The French health care system is a model of national health insurance (NHI) that provides health care coverage to all legal residents. It is an example of public social security and private health care financing, combined with a public-private mix in the provision of health care services. The French health care system reflects three underlying political values: liberalism, pluralism and solidarity. This article provides a brief overview of how French NHI evolved since World War II; its financing health care organization and coverage; and most importantly, its overall performance.

Introduction.

The French health care system is a model of national health insurance (NHI) that provides health care coverage to all legal residents. It is not an example of socialized medicine, e.g. Cuba. It is not an example of a national health service, as in the United Kingdom, nor is it an instance of a government-run health care system like the United States Veterans Health Administration. French NHI, in contrast, is an example of public, social security and private health care financing, combined with a public-private mix in the provision of health care services.

The French health care system reflects three underlying political values (Rodwin, 1981):

1. liberalism, in the sense of giving patients free choice of doctors and hospitals;
2. pluralism, in offering diverse health care delivery options ranging from private fee-for-service practice, health centers and outpatient hospital consultations for ambulatory care, through a range of public, non-profit and for-profit hospitals;
3. solidarity, in the sense of having those with greater wealth and better health finance services for those who are less well-off and in poorer health.

In practice, the French health system represents a delicate balance between NHI and private fee-for-service practice – *la médecine libérale* (Rodwin, 2003; Rodwin and LePen, 2004; Steffen, 2010). The tensions involved in achieving universalism, respecting liberalism and meeting the challenge of rising inequalities are often highlighted in attempting to characterize the distinguishing features of French NHI (Nay et. al. 2016; Steffen 2016). Also, the question of whether the system is sustainable, recurs with regularity (Rodwin and contributors, 2006).

In this article, I provide a brief overview of how French NHI evolved since World War II; its financing, health care organization and coverage; and most importantly, its overall performance.

Evolution, coverage, financing and organization

Evolution: French NHI evolved in stages and in response to demands for extension of coverage. Following its original passage, in 1928, the NHI program covered salaried workers in industry and commerce whose wages were under a low ceiling (Galant, 1955). In 1945, NHI was extended to all industrial and commercial workers and their families, irrespective of wage levels. The extension of coverage took the rest of the century to complete. In 1961, farmers and agricultural workers were covered; in 1966, independent professionals were brought into the system; in 1974 another law proclaimed that NHI should be universal. It wasn't until January 2000 that comprehensive first-dollar health insurance coverage was granted to the remaining uninsured population, on the basis of residence in France (Boisguerin, 2002).

NHI forms an integral part of France's Social Security system, which is typically referred to by means of an agrarian metaphor, as a set of three sprouting branches: 1) pensions; 2) family allowances; 3) health insurance and workplace accident coverage (Damon and Ferras, 2015). The first two are managed by a single national fund whereas the third branch is run by three main NHI funds: for Salaried Workers (CNAMTS); for farmers and agricultural workers (MSA); and for independent Professionals (RSI) (Bras and Tabuteau, 2015). In addition, there are eleven smaller funds for specific occupations and their dependents, each defending their "rightfully earned" entitlements. The CNAMTS covers 86 percent of legal residents in France which includes salaried workers, those recently brought into the system because they were uninsured, and the beneficiaries of seven of the smaller funds administered by CNAMTS.

All NHI funds are legally private organizations responsible for the provision of a public service. In practice, they are quasi-public organizations supervised by the government Ministry that oversees French Social Security. The main NHI funds have a network of local

and regional funds that process reimbursement checks for health care providers and/or patients, look out for fraud and abuse, and provide a range of customer services for their beneficiaries.

Coverage and Benefits: French NHI covers services ranging from hospital care, outpatient services, prescription drugs (including homeopathic products), spa treatments, nursing home care, cash benefits, and to a lesser extent, dental and vision care. Small differences in coverage remain among different NHI funds. Smaller funds with older, higher-risk populations, e.g. farmers, agricultural workers and miners, are subsidized by the CNAMTS, as well as by the state, on grounds of what is termed "demographic compensation." Retirees and the unemployed are automatically covered by funds according to their occupational categories.

Financing: As of 2016, public health care expenditures accounted for 79 percent of total health care spending (DRESS, 2016). Private voluntary health insurance (VHI) accounted for another 13 percent and out-of-pocket payments around 8 percent. Of the total public portion, social security payroll taxes accounted for 64 percent of the total. The remainder was financed by a national income tax on all earnings, including dividends and interest from capital (16%), revenues from a tax on tobacco, alcohol, the pharmaceutical industry and private voluntary health insurance (VHI) (12%), state subsidies (2%) and contributions from other branches of social security (6%).

Health Care Organization: Liberalism is correctly invoked as underpinning the medical profession's attachment to cost-sharing and selected elements of *la médecine libérale* (private fee-for-service practice): selection of the physician by the patient, freedom for physicians to practice wherever they choose. Likewise, the diverse forms of practice in ambulatory care – private office-based arrangements that still prevail, along with growing numbers of health care centers and hospital-based consultations – reflect the importance of pluralism in French medical practice. As for hospitals, most acute beds are public (two-thirds), with the remaining third consisting of private beds divided among commercial for-profit and private not-for profit, usually affiliated with the public hospital service.

Performance

The French health care system is worthy of attention from health policymakers worldwide, for three reasons. First, France is among those countries that enjoy the highest levels of population health among wealthy nations. Second, France ranks #1 among OECD nations on an important indicator of health system performance – avoidable mortality. Third, the French have easy access to primary health care, as well as specialty services, at less than half the per capita cost (Table 1) of what is spent in the U.S.

Population health status

Health systems are often compared and ranked, based on their population's health status. Insofar as access to public health services and medical care can significantly improve a population's health, this is a good starting point in evaluating a health system.

Whether one compares life expectancy at birth, life expectancy at 65 years, infant mortality rates, or years of life lost due to premature death, France performs better than the U.S. (Table 1). France is also noted for having the highest longevity for women, after Japan.

These indicators, however, are not sufficient for assessing the system's performance, because they reflect many other important determinants of health, e.g. poverty rates (Figs. 1-2); other socio-economic disparities; maternal and child health programs; work and family policies; and nutrition. Although the U.S. spends more on health care as a share of GDP, than any other nation, France spends a significantly higher share of its GDP on social service programs, particularly on family support and employment training programs (Fig. 3). An important hypothesis to investigate is whether France's government spending on these programs contributes to the population's impressive population health status.

Health system indicators

France's claim to fame with respect to health system performance is its top ranking among wealthy OECD nations, based on its success in averting deaths from a range of curable cancers, pneumonia, ischemic heart disease, maternal deaths in childbirth, and a host of other causes of mortality considered to be "amenable to health care interventions." Avoidable mortality (AM) attempts to capture the extent to which deaths under the age of 75 years would *not* have occurred, had the population benefitted from access to effective disease prevention programs, primary care, as well as specialty services.

Based on a comparison of avoidable mortality among 19 OECD nations, France has the lowest rate (ranks #1) and the U.S. has the highest rate (ranks #19) (Nolte and McKee, 2008). Moreover, between 1999-2007, the percentage decline in AM in France (27.7%) was higher than in the U.S. (18.5%) (Nolte and McKee, 2012). Based on these findings, Nolte and McKee estimate that if the U.S. were to achieve levels of AM of the three top-performing countries (France, Japan and Australia), about 101,000 deaths could be avoided.

An exclusive focus on AM does not allow one to disentangle the consequences of poor access to disease prevention versus primary or specialty health care services. Thus, it is useful to consider other indicators that capture the consequences of barriers in access to primary and specialty care (Gusmano and Rodwin, 2010). The first is well-established – hospital discharges for ambulatory care sensitive conditions (ACSC). It measures hospitalizations for exacerbations of conditions (e.g. asthma, diabetes, and hypertension) that are less costly and less painful to treat in community-based medical settings (Milman, 1993). The Agency for Healthcare Research and Quality (AHRQ) currently devotes part of its efforts to tracking access to primary care by examining rates of ACSC. Likewise, the Commonwealth Fund monitors ACSC as a measure of access across states. The second indicator is less well known. It concerns access to specialized cardiac care for those patients who require revascularization – coronary artery bypass surgery or angioplasty.

Comparative analysis of ACSC rates in the U.S. and France indicates that the U.S. rate is almost twice that of France, whether one examines national-level data or compares New York City and Paris. This demonstrates that access to primary care is significantly worse in the U.S. than in France, leading to many more hospitalizations that could be avoided if our health care system were improved (Gusmano, Rodwin Weisz, 2013; Gusmano, Rodwin, Weisz, 2014). With respect to cardiac services, contrary to conventional views that the U.S. makes available greater access to

life-saving medical technologies than other nations, after adjusting for the fact that the French have less heart disease than Americans, it appears that the rate of revascularization in the U.S. is not as high as in France – neither for adults (35-64 years) nor for older persons (65+) (Gusmano et. al. 2007). This supports the claim that the French health care system provides relatively easy access to specialized health care services.

Along with access to primary and specialty care, there is another important dimension of health system performance that merits attention – satisfaction with the health care system as reported in comparative surveys not only of the adult population, but also by chronically ill patients and physicians. Although comparisons of

TABLE 1. BASIC INDICATORS: FRANCE, U.S., GERMANY, NETHERLANDS, SPAIN, UNITED KINGDOM (2013-2016)

	France	United States	Germany	Netherlands	Spain	United Kingdom
Demographic and economic characteristics						
Total population	66,760,000 (2016)	323,127,500 (2016)	82,175,700 (2016)	16,979,100 (2016)	46,445,800 (2016)	65,382,600 (2016)
Percent of population >65 yr of age	17.9 (2013)	14.5 (2014)	21.4 (2014)	17.1 (2013)	18.3 (2014)	17.3 (2014)
Gross domestic product (GDP) per capita ($)	41,364.40 (2016)	57,591.20 (2016)	48,947.10 (2016)	50,539.60 (2016)	36,317.70 (2016)	42,622.20 (2016)
Health care system						
Heath care expenditures as percent of GDP	11.0 (2016)	17.2 (2016)	11.3 (2016)	10.5 (2016)	9.0 (2016)	9.7 (2016)
Per capita health expenditures in $PPPs	4,600.4 (2016)	9,892.3 (2016)	5,550.6 (2016)	5,385.4 (2016)	3,248.4 (2016)	4,192.5 (2016)
Public expenditures on health as % of GDP	8.7 (2016)	8.5 (2016)	9.5 (2016)	8.5 (2016)	6.3 (2016)	7.7 (2016)
Practicing physicians per 1,000 population	3.3 (2015)	2.6 (2014)	4.1 (2015)	3.3 (2013)	3.9 (2015)	2.8 (2015)
Physician consultations per capita	6.3 (2014)	4.0 (2011)	10.0 (2015)	8.2 (2015)	7.6 (2014)	5.0 (2009)
Average length of stay in hospitals (Acute Care)	5.7 (2014)	5.5 (2014)	7.6 (2015)	6.2 (2015)	5.9 (2015)	6.0 (2015)
Acute care beds per 1,000 population	4.1 (2015)	2.5 (2014)	6.1 (2015)	3.6 (2013)	2.4 (2015)	--
Health status						
Infant deaths per 1,000 live births	3.7(2015)	5.8 (2014)	3.3 (2015)	3.3 (2015)	2.7 (2015)	3.9 (2015)
Maternal deaths per 100,000 live births	5.1 (2014)	12.7 (2007)	3.3 (2015)	3.5 (2015)	3.6 (2015)	4.5 (2015)
Life expectancy at birth	82.4 (2015)	78.8 (2015)	80.7 (2015)	81.6 (2015)	83.0 (2015)	81.0 (2015)
Female Life expectancy at 65 yrs	23.5 (2015)	20.6 (2015)	21.0 (2015)	21.1 (2015)	23.0 (2015)	20.8 (2015)
Male Life expectancy at 65yrs	19.4 (2015)	18.0 (2015)	17.9 (2015)	18.4 (2015)	19.0 (2015)	18.6 (2015)
Female Life expectancy at 80 yrs of age	11.4 (2015)	9.8 (2015)	9.4 (2015)	9.6 (2015)	10.7 (2015)	9.5 (2015)
Male Life expectancy at 80 yrs of age	9.2 (2015)	8.4 (2015)	8.1 (2015)	8.1 (2015)	8.8 (2015)	8.4 (2015)
Years of life lost per 100,000 population due to death before 70 yrs of age	3,130.4 (2013)	4,610.7 (2014)	2,880.1 (2014)	2,540.0 (2014)	2,397.9 (2014)	2,995.8 (2013)

Source: OECD Health Data. Data in this Table were assembled by Ekemini Isaiah

consumer satisfaction are often inconsistent, there was evidence in 2007-8 across Europe, that France was first among those nations with the highest rates of consumer satisfaction (HI Europe, 2007). In June 2008, Harris Interactive, France 24 and the International Tribune collaborated on a survey that placed France at the top with 55 percent of respondents "satisfied" in contrast to the 28 % in the U.S. (HI, 2008).

Results of the 2008 Commonwealth Fund International Survey of Sicker Adults are consistent with these positive views of the French health system (Schoen, 2008). For example, with regard to "overall health system" assessments, sicker French patients (41%), along with their Dutch counterparts (42%), had among the highest rates of persons who felt that "only minor changes (were) needed."

Beyond measuring satisfaction, a number of other questions in the Commonwealth Fund Survey provide further evidence that the French have relatively easy access to health care. For example, on the question of medical homes – "do you have a doctor you usually see" – 99% of sicker adults, in France, answered "yes." Finally, the percent of sicker adults with out-of-pocket expenses over $1000, in the past year, was among the lowest in France (5%).

French policymakers assume that their NHI system is a realistic compromise between Britain's national health service, which they believe requires too much rationing and offers insufficient choice, and the mosaic of subsystems in the U.S., which they consider socially irresponsible because of the large share of the population that remains uninsured, under-insured or even forced to declare bankruptcy after a serious episode of illness.

Lessons from the French health system

Health systems cannot be transplanted from one country to another; nor should they be. Looking abroad, at best, can inform policy debates at home. Beyond France's impressive population health status and health care system performance, there are some distinctive features of the system that raise important questions for health policy, in general.

1. **There is no choice of insurance plan for standardized benefits**: The French health system differs from most other European health systems in its strong resistance to the most recent wave of reform efforts that have sought to introduce a dose of competition and market forces within a social context that maintains its commitment to national solidarity (Oliver, et. al., 2005). In France, American nostrums of unleashing market forces under the banner of "consumer-directed health care," and selective contracting by private health insurers, have gained little traction (Rodwin and LePen, 2004). French NHI does not allow a choice among health-insurance plans for the essential benefits covered under the program. Nor does it allow local health-insurance funds to engage in selective contracts with "preferred providers." The competition occurs among health care providers, not among the small number of insurers to which beneficiaries are assigned based on their occupation.
2. **All insurers reimburse providers according to nationally set rates**: In France, all insurers pay the same price for hospital services. Likewise, all physicians receive the same reimbursement under a national fee schedule that is negotiated every year. Approximately one-quarter of all physicians (12% of general practitioners) have opted for what is called "sector 2" and are entitled to balance bill their patients, i.e. to set fees above the national fee schedule. In these cases, physicians lose their own health insurance benefits and must pay for their own insurance like all others who are self-employed. Health centers and public hospital outpatient departments (where the most prestigious specialists work) may only charge patients national rates.
3. **There are no physician gate-keepers**: French NHI allows patients the freedom to consult general practitioners, specialists and hospitals of their own choosing. There are no restricted networks, no concept of out-of-network surcharges. Since 2005, policymakers have imposed a soft gate-keeping system by requiring French residents to sign up with a primary care doctor (*médecin traitant*). It is still easy, subject to a slightly higher co-insurance payment, to have direct access to a specialist without a referral (Dourgnon and Naiditch, 2010).
4. **There is extensive co-insurance and voluntary health insurance coverage**: In France, co-insurance (the so-called *ticket modérateur*), remains a component of the reimbursement system. Almost the entire population choose from a wide range of VHI products covering portions of co-insurance, extra-billing and supplementary benefits beyond the basic plan (mainly dental and optometry services). Most of the remaining population has free voluntary health insurance provided by the NHI fund or the government.
5. **Sicker patients have better insurance coverage**: In France, when patients become severely ill, their health insurance coverage improves. Although co-insurance and direct payment are symbolically an important part of French NHI, patients are exempted both when: 1) expenditures exceed approximately $100 per month; 2) hospital stays exceed 30 days; 3) patients suffer from serious, debilitating or chronic illness (e.g. cancer, heart disease, diabetes…); or 4) patient income is below a minimum ceiling, thereby qualifying them for exemption from co-insurance payments.
6. **Parliament sets annual health care expenditure targets**: All of the features noted above operate within a system in which Parliament approves an annual health care expenditure target for the coming year. This includes spending targets for specific components of health care (hospitals, community-based physician services and other sub-sectors). If hospitals and physicians exceed their targets by billing for higher than the projected volume of services, prices are negotiated downward the following year.

Biography

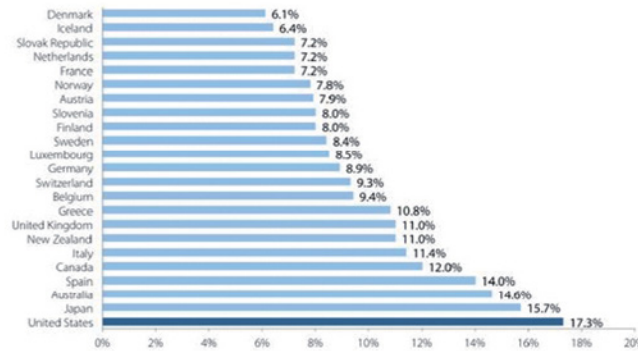
Victor G. Rodwin is Professor of Health Policy and Management, Wagner School of Public Service, New York University (NYU) and Co-Director (with Michael Gusmano) of the World Cities Project, a collaborative venture that studies health systems and population aging among, and within, New York, Paris, London, Tokyo and Hong Kong.

FIGURE 1

U.S. Poverty Rates Higher, Safety Net Weaker than in Peer Countries

Economic Policy Institute, Issue Brief, 7/24/2012

Relative poverty rate in the United States and selected OECD countries, late 2000s



Note: The relative poverty rate is defined here as the share of individuals living in households with income below half of household-size-adjusted median income. Poverty rates are based on income after taxes and transfers.

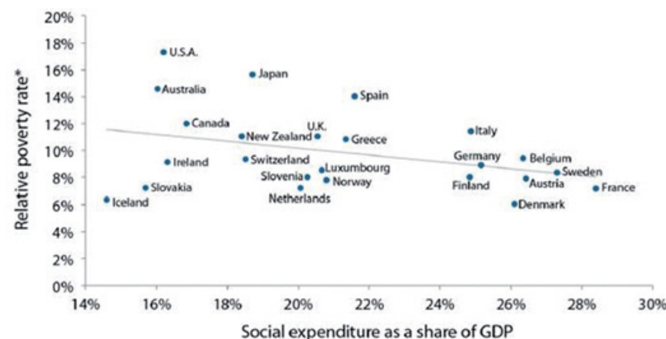
Source: Authors' analysis of Organisation for Economic Co-operation and Development *Stat Extracts* (data group labelled "late 2000s")

FIGURE 2

U.S. Poverty Rates Higher, Safety Net Weaker than in Peer Countries

Economic Policy Institute, Issue Brief, 7/24/2012

Social expenditure and relative poverty rates in selected OECD countries, late 2000s



* The relative poverty rate is the share of individuals with income below half of household-size-adjusted median income. Poverty rates are based on income after taxes and transfers.

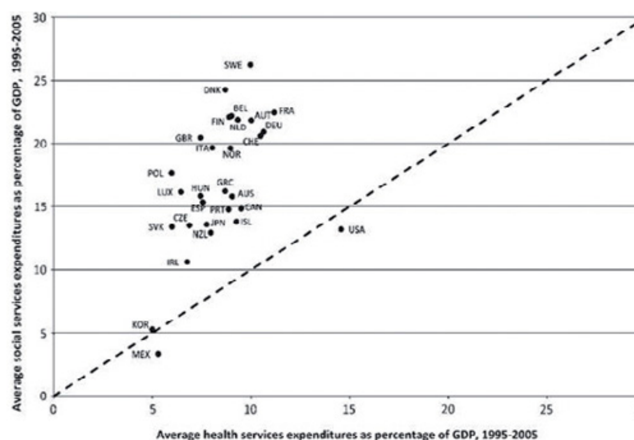
Note: Social expenditure is government expenditure on social programs, such as Social Security and Medicare in the United States. The equation for the trend line is $y = -0.2559x + 0.1528$ and the $R^2 = 0.1266$.

Source: Authors' analysis of Organisation for Economic Co-operation and Development *Stat Extracts* (data group labelled "late 2000s")

FIGURE 3

Health and social services expenditures: associations with health outcomes

Figure 2 Average social-services expenditures versus average health-services expenditures as percentages of gross domestic product (GDP) from 1995 to 2005, by country. *Social services expenditures Hungary are missing for 1995–1998, and for Portugal for 2005; health-services expenditure data are missing for the Slovak Republic for 1995–1996. Source: *OECD Health Data 2009* (accessed June 2009); *OECD Social Expenditure Dataset* (accessed December 2009); authors' calculations.



Bradley EH, Elkins BR, Herrin J, *et al. BMJ Qual Saf* (2011). doi:10.1136/bmjqs.2010.048363

FIGURE 4

In Amenable Mortality – Deaths Avoidable through Health Care – Progress in U.S. Lags that of 3 European Countries

Nolte, E. and M. McKee. *Health Affairs.* 2012; 31(9):2114-2122.

Age-Standardized Mortality Rates From Selected Causes In Four Countries, 1999 And 2006/2007

	Mortality rates per 100,000 people ages 0–74, 2006/2007				Percent change from 1999 to 2006/2007			
Country	Amenable causes	Heart disease (50%)	Other causes	All causes	Amenable causes	Heart disease (50%)	Other causes	All causes
MEN								
France	60.97	13.67	326.96	401.60	27.7	30.7	16.9	19.2
Germany	90.29	30.45	286.32	407.05	24.3	33.2	15.3	19.0
UK	91.27	34.47	253.76	379.51	36.9	41.7	8.4	21.1
US	106.90	37.18	328.20	472.26	18.5	32.6	8.8	13.6
WOMEN								
France	49.39	2.84	126.88	179.10	23.4	37.9	11.2	15.5
Germany	65.87	9.23	133.06	208.15	22.7	37.9	11.3	16.8
UK	74.14	10.82	153.81	238.76	31.9	47.8	6.0	18.6
US	84.50	14.52	191.47	290.49	17.5	35.8	6.1	11.7

SOURCE Authors' calculations based on data from the World Health Organization mortality database (Note 15 in text) and Centers for Disease Control and Prevention vital statistics data (Note 16 in text). **NOTES** Data for Germany for 2007 were not available; we used data for 2006 instead. As explained in the text, we assumed that 50 percent of deaths from heart disease were amenable deaths. Numbers may not sum to the total because of rounding.

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