

The National Health Insurance System In France

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Introduction

Over the past few decades, numerous attempts have been made to address the chaotic state of health insurance in the United States. A recurring theme in many of these discussions about health care has been the possibility of establishing a national health insurance system. Every time this issue has been raised, it has spawned a great deal of controversy. Many people have argued strenuously on both sides of the question. Advocates of a national health insurance system have argued that the implementation of such a system in the United States would provide comprehensive, affordable health care for all American citizens. Their arguments have been countered repeatedly by people who deny the viability of a national health insurance system. These individuals claim that the obstacles to establishing a national health care system in the United States are simply too large. They believe that America's powerful medical community would never permit the implementation of a system that would limit its revenue and that no one would be able to resolve issues such as how the system would be funded and who would be eligible for what type of care at what price.

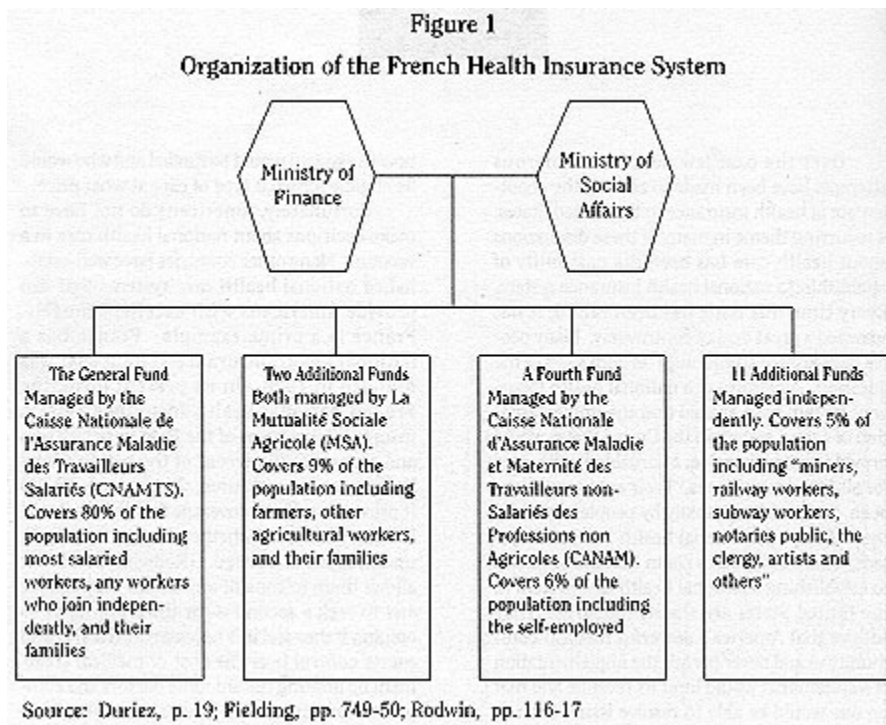
Fortunately, Americans do not have to make decisions about national health care in a vacuum. Many other countries have well-established national health care systems that can provide Americans with excellent models. France is a prime example. France has a national health insurance system that was founded in 1928. In its present form, the French national health insurance system insures 99.8 percent of the French population and covers 75-80 percent of the nation's total health care expenditures. (Duriez, pp. 19-21) It provides uniform coverage for all French citizens, regardless of whether they are employed, unemployed or retired. (Rodwin, p. 116) It allows them to consult any doctor they choose and to seek a second - or third or fourth - opinion if they feel it is necessary. (Vives) It also exerts control over the cost of medical treatment by limiting the amounts doctors and companies can charge for medical consultations, drugs, tests and apparatus. (Fielding, p. 751)

The French national health care system has tremendous potential as a model for Americans who are trying to formulate their own national health insurance system. The French experience is especially relevant to the American situation because, as Jonathan Fielding notes, "France has already faced, with varying levels of decisiveness, many [of the] challenges currently confronting the United States." (p. 748) Taking the successes and failures of the French national health insurance system into consideration could provide Americans with an extraordinary advantage in formulating their own system.

In this paper, I will explore the structure and function of the French national health insurance system. I will pay special attention to the overall organization of the French system, how it is funded, what quality of care it provides, which medical services it covers, and which procedures it fails to cover.

Structure of the French National Health Insurance System

The Ministry of Social Affairs and the Ministry of Finance oversee the French national health insurance system. These two ministries administer a series of regional and local national health care funds known as Sickness Insurance Funds (SIFs). Regional funds are the main organizational feature of the French system. The system is comprised of four main regional funds and a host of minor regional funds that provide insurance for different occupational segments of the French population. All of these funds, as well as the entities that manage them, the percent of the insured population they cover, and the type of workers they provide for, are detailed in Figure 1.



As can be observed in Figure 1, the main regional fund, the general fund, covers 80 percent of the French population, two additional agricultural funds cover nine percent of the population, a fourth fund for self-employed individuals covers six percent of the population, and eleven smaller funds cover the remaining five percent of the population. (Duriez, p. 19; Fielding, pp. 749-50; Rodwin, pp. 116-17)

Each regional fund oversees a series of local funds that are responsible for the daily administration of the health care system. According to Marc Duriez, the regional funds provide the following services: "overseeing the enrollment of the insured population, benefits, and prevention, public health and social programs in their district." (Duriez, p. 20; Rodwin, pp. 116-17)

Financing of the French National Health Insurance System

Every SIF is financed directly by employer and employee payroll contributions. These contributions are based on a percentage of every employee's salary and vary depending on the SIF involved and the employee's current employment status. The range of benefits the employee receives also depends upon these variables. (Fielding, p. 750) There are four main categories of workers for which significant differences in contributions and benefits are observed. These categories are as follows: currently employed (represented by members of the general fund), self-employed, retired, and unemployed individuals.

Inclusion in the major national health insurance fund, known as the general fund, requires employee

contributions of 6.8 percent and employer contributions of 12.8 percent of the employee's gross salary. Together, the employer/employee contributions amount to 19.6 percent of the employee's salary. This contribution is divided between health care funding (16 percent of gross salary) and unemployment insurance (3.6 percent of gross salary). The contribution entitles the employee and his or her family to the full range of benefits of both the health care and unemployment insurance systems. (Fielding, p. 750)

Self-employed individuals contribute a different percentage of their salaries to their national health insurance fund, known as CANAM, and are eligible for slightly different benefits than members of the general fund. Self-employed individuals contribute 12.8 percent of their gross salary to CANAM. Because self-employed individuals make only the employer contribution, the total percentage of their salary contributed to their SIF is 33 percent less than the percentage contributed by members of the general fund. As a result, self-employed individuals are not eligible for the full range of benefits normally provided by the French health care system. They receive fewer health care benefits and no salary continuation benefits. (Fielding, p. 750)

Retired people are in a completely different position than either currently employed or self-employed individuals. They contribute only 1.4 percent of their social security payments and 2.4 percent of their income from other pensions; however, they are not penalized for making small contributions. They continue to receive the full range of health insurance benefits that currently-employed members of their SIF receive. (Fielding, p. 750)

Unemployed individuals cease contributing to their SIF when they first become unemployed; however, the social security system picks up the slack and makes their contributions for them for a certain period of time. This length of time is calculated by using a complicated formula that takes into account the worker's age and the amount he or she has worked in the past. (Fielding, p. 750) For this length of time, their health insurance benefits remain unchanged. If this period of time runs out before they find a new job, unemployed individuals can either make the required contributions themselves or, if they fall below a minimum level of income, can request that their local government make the contributions for them. In these circumstances, the government would be obligated to make the insurance contributions. (Vives; Fielding, p. 750)

In theory, SIFs are self-sufficient. They should collect enough money through payroll contributions to pay for all of the health care expenditures incurred by their members each year. In reality, however, SIFs frequently run deficits. Some of these deficits are automatically paid off by subsidies from other, more prosperous SIFs; some are not. (Vives; Fielding, p. 750)

What the French National Health Insurance System Covers

The French national health insurance system reimburses patients for a wide range of medical services, including physician visits, prescription medications, hospitalization fees, medical tests and surgical procedures. Nearly all of these services require copayments. The size of the copayment required for a given service depends primarily on what ailment the patient suffers from and in which locale he or she is treated.

In most cases, individuals are reimbursed 60 percent for laboratory tests, 70 percent for physician visits and office consultations, and 75 percent for treatments at public hospitals. In certain circumstances, patients are reimbursed 100 percent for all expenses incurred. For example, no copayments are required for prenatal care, treatment of work-related injuries, care of the handicapped, care of veterans and military pensioners, or for the treatment of any disease that falls on a list of long, costly or otherwise defined sicknesses such as diabetes, cancer, AIDS, heart disease, transplantation, endstage renal disease,

and mental illness. In addition, all patients who are hospitalized in acute care facilities in excess of 31 days are reimbursed 100 percent for all expenses incurred after their thirty-first day in the hospital; however, these patients are required to pay a small "lodging fee" that generally falls between 55 and 75 francs (1 I- 15 U.S. dollars) a day. (Duriez, p. 27; Fielding, p. 752)

Similar guidelines govern the percentage of reimbursement for prescription drugs. Prescription medications are separated into three classes based on the urgency with which they are needed. Drugs are reimbursed either 100 percent, 70 percent, or 24 percent based on their classification. (Fielding, p. 750)

Supplementing National Health Insurance

The social security system covers an average of 75-80 percent of the total health care expenditures in France. The remaining 20-25 percent of health care expenditures can be paid for by the patient themselves, by mutual insurance companies, or by Aide Sociale, a government organization that pays the patient contributions for all French citizens that fall below a minimum level of income. (Vives; Duriez, p. 21; Fielding, pp. 750-51)

As of 1992, 87 percent of the French people had supplementary insurance to help pay for health care expenditures that were not covered by national health insurance. Supplementary insurance is provided by a variety of different organizations, ranging from mutual insurance companies to private insurance companies. It can be purchased on an individual basis or provided through employers. (Duriez, p. 21; Fielding, p. 750)

Mutual insurance companies provide supplementary insurance in much the same way that SIFs provide basic insurance. Each employee's contribution to a mutual insurance fund is calculated based on a fixed percentage of his or her wages. This percentage can be paid by the individual, by the employer, or by a combination of the two. (Duriez, p. 21; Fielding, pp. 750-51)

Not all French citizens carry supplementary insurance. Some individuals voluntarily choose not to; others simply cannot afford to make the additional insurance contributions it requires. Everyone who elects not to purchase supplemental insurance is responsible for paying his or her copayments, as well as any additional health care expenditures that are not covered by National Health Insurance, out of his or her pocket. Those who cannot afford supplemental insurance are not held responsible for these expenses; rather they are covered by Aide Sociale. (Vives)

Cost Containment Within the French National Health Insurance System

The French national health insurance system exerts careful control over medical service fees. The primary control mechanism that is used is the nationally negotiated fee schedule. The national fee schedule is essentially a list of the maximum amounts that can be charged for various medical services. It is re-negotiated every year by a committee comprised of representatives from the three major SIFs and the three major physicians unions. They are subject to the approval of the General Fund, at least one of the other major SIFS, at least one of the physicians unions, the Ministry of Finance and the Ministry of Social Security. Once the national fee schedule has been established, all hospitals, pharmacies, laboratories, any other treatment facilities, and most physicians in France are required by law to adhere to them. (Fielding, p. 751)

The only people who are permitted to charge fees in excess of the national fee schedules are tier-two physicians. In France, there are two tiers of physicians: tier-one physicians, who must adhere to the national fee schedule; and tier-two physicians, who are permitted to charge fees in excess of the national

fee schedule. In exchange for the privilege of charging higher fees, tier-two physicians sacrifice some of their health insurance benefits. Many physicians have taken advantage of the opportunity to join tier two because, for most physicians, the advantage of higher income greatly outweighs the disadvantage of lesser health care benefits. Tier two is now closed, and physicians are no longer able to join this tier; however, existing tier-two physicians are still permitted to charge fees in excess of the national fee schedule. (Duriez, pp. 28-29; Fielding, p. 751)

National health insurance does not cover any portion of a physician's fee that exceeds the national fee schedule. Any individual who consults a tier-two physician must either pay the additional charge herself or buy supplementary insurance to cover it. (Rodwin, P. 120)

The French National Health Insurance System's Deficit

In 1995, the French national health insurance system ran a deficit of 48 billion francs (approximately 9.6 billion U.S. dollars). (Vives) A large portion of this deficit can be attributed to two factors: the recent increase in unemployment across France and an aging population. Another sizable portion of this deficit can be attributed to abuses of the health insurance system. (Vives; Fielding, p. 752)

Problems Posed by Increased Unemployment and an Aging Population

Working individuals contribute a fixed percentage of their paychecks to the social security system. If they become unemployed, they cease contributing to social security; however, they retain all of their health care benefits. In this way, increased unemployment causes a decrease in the social security system's revenue at a time when the system's health care expenditures remain approximately constant. (Vives; Fielding, p. 752)

An aging population has the same effect on the social security system as increased unemployment. When individuals retire, they go from contributing either 12.8 percent or 19.6 percent of their salary to their SIF to contributing 1.7-2.4 percent of their retirement income; however, they continue to receive the same health care benefits. (Vives; Fielding, p. 752) This has the same effect as increased unemployment: the social security system's revenue decreases while its expenditures remain the same.

Many different solutions have been proposed to decrease the size of the national health insurance system's deficit. Most of these solutions have approached the problem from one of two angles: increasing the revenue of the social security system or decreasing the system's expenditures. Increasing revenue generally equates to the creation of new taxes or to an increase in the rate of the social security contribution. Decreasing expenditures usually translates into reducing demand by increasing co-payments or reducing supply by imposing fixed rates for services. In recent years, all of these approaches have been tried. (Fielding, p. 753)

The Minister of Social Security is responsible for restraining the growth of health care expenditures. This minister is appointed to serve an eighteen-month term and generally focuses on creating a plan that can be implemented within his or her term of service. Between 1975 and 1991, each successive Minister of Social Security proposed a plan to control health care costs, and the French government effected an average of one new plan every two years. All of these plans temporarily decreased health care expenditures; none of them had a lasting impact on the problem. (Fielding, pp. 752-53)

The main reason these plans failed to effect long-term changes in health care expenditures is that they were not unified; no "consistent economic ideology" lay behind them. (Fielding, p. 753) For the most part, these plans either increased copayments or limited the amount that could be charged for services.

Neither of these strategies proved to be effective for very long, but nothing else was tried. (Fielding, p. 753)

In order to reduce the national health insurance system's deficit, the problem needs to be approached from a new angle. It needs to be examined and evaluated by a person or group of people who will be appointed for more than a year and a half and will have time to become familiar with the problem, experiment with new solutions and get results. (Fielding, p. 753)

Problems Posed by Abuses of the Health Care System

Another way to reduce the deficit is to identify and eliminate costly abuses of the French health care system. In an interview with Alain-Baptiste Vives, the director of the Hopital de Roanne, I learned that "medical tourism" is one of the major forms of abuse. Under the current system, French citizens are permitted to consult as many doctors as they wish to consult for the treatment of the same problem. In some cases, this privilege is abused. Mr. Vives cited one case in which an elderly man consulted three specialists and obtained - and filled - three separate prescriptions. This is clearly a case in which the national health insurance system's money is being wasted. This man might well have benefitted from consulting three separate doctors; however, he could not possibly have benefitted from purchasing three times as much medicine as he needed and could realistically take. (Vives)

Abuses such as medical tourism will not be solved by eliminating the deficit; however, eliminating these abuses could go a long way toward alleviating the deficit.

Vives believes that medical tourism must be brought under control and can be brought under control without depriving people of the right to consult multiple doctors. He advocated one reform that is currently under consideration: giving each citizen a medical booklet to take to the doctor's office with her. Supposedly, if everyone were required to present this booklet to the doctor when they arrived at his office, the doctor could see how many other doctors, if any, the patient had consulted recently. If this reform is passed, it will enable doctors to identify people who are abusing the system, and hopefully, to bring these abuses under control. (Vives)

Immediacy of the Deficit Problem

The deficit that is incurred every year by the French national health insurance system is not simply a problem that must be dealt with at some point in the future; it is a problem that must be dealt with now.

In December of 1995, public-sector strikes paralyzed Paris. In her article, "Mon Frere, Can You Spare a Franc?" Robin Knight reported that "train services ground to a halt; the subway shut down; airports, schools and universities closed; 150,000 demonstrators clogged the streets; and mail deliveries dried up." (Knight, p. 48) The reason for these strikes? French Prime Minister Alain Juppé had proposed raising taxes and cutting social security benefits on programs such as pensions, health care, education, maternity and disability handouts. (Knight, p. 48) The French people clearly value these benefits, and they have proven that they will fight to keep them. But how can they keep a system that there is not enough money to support? If there is not enough money to support the French national health care system now, how will they possibly afford to maintain it after its budget has been slashed? The only possible answer is that health care spending must be brought under control. The deficit must be eliminated - without the benefit of increased tax revenue and possibly with a decrease in tax revenue.

It is important to remember that, even if France is having financial problems with its health insurance system, that does not mean that the United States should not emulate the French system. Regardless of

the current deficit, French health care expenditures are much lower than health care expenditures in the United States.

Some Comparisons Between the Health Care Systems in France and the United States

In their paper entitled "Health Care Under French National Health Insurance," Rodwin and Sandier identified four major differences between the health care systems of France and the United States. These differences are that the French system: covers a much higher percentage of the population, has lower rates for health care services, is characterized by more frequent use of health care services, and has a lower per capita spending than the United States. (Rodwin, p. 112) All of these points are highly significant and merit elucidation.

The French national health insurance system covers nearly every French citizen; it leaves only 0.2 percent of the population uninsured. The United States does not come close to matching this percentage; in the United States, 14.4 percent of the population is not covered by any form of health insurance. (Fielding, p. 749)

Service	Price/ Amount in France (in U.S. dollars)	Price/ Amount in U.S.	Year for Which Data is Available
Average price of a physician visit	\$18 for a generalist \$25 for a specialist	\$42	May 1992
Average cost of a hospital bed per day	\$172	\$590	1988
Average annual pre-tax physician salary	\$69,300	\$164,300	1990

Source: Rodwin, p. 119

The cost of health care is dramatically lower in France than it is in the United States. Table 1 provides some examples of the relative expense for different medical services in both countries. It is important to note that the disparity between health care prices in the two countries in no way reflects differences in the quality of medical services; French physicians are no less skilled than their American counterparts, and French treatments are no less effective than American treatments. Likewise, the lower physician salaries that prevail in France have not led to physician strikes, a lack of good doctors, or a shortage of medical school applicants.

The volume of medical services utilized is much greater in France than in the United States. The French visit doctors more frequently, are admitted to the hospital more often, and purchase more medicine than Americans. Table 2 compares the rates at which various medical services are used in both countries.

Table 2
Rates at Which Medical Services are Utilized:
France vs. the United States

Service	France	United States
Per Capita Number of Visits to a Physician	8.3	5.5
Per Capita Number of Visits to a Specialist	3.4	3.85
Per Capita Days of Hospitalizations	2.8	1.2
Rate at Which People Are Admitted for Inpatient Hospital Services	23.1%	13.4%
Average Number of Days Hospitalized for an Inpatient Service	12.3	8.3
Rate at Which People Are Admitted for Short-Stay Hospital Services	20.8%	12.4%
Average Number of Days Hospitalized in a Short-Stay Bed	7.0	6.4

Source: Rodwin, p. 114

From the above statistics, it is clear that French citizens visit doctors more frequently than Americans, are admitted to hospitals more frequently and remain in the hospital longer. In fact, the only category that showed a higher rate of use in the United States than in France was the per capita number of visits to a specialist - and that was undoubtedly a reflection of the fact that in France only 40 percent of physicians are specialists, while in the United States nearly 80 percent of physicians are specialists. (Easterbrook, p. 25)

Despite the fact that health services as a whole are utilized much more frequently in France than in the United States, France has a lower per capita spending than the United States. In 1992, for example, France spent approximately \$1,650 per person on health care, while America spent \$2,867 per person. (Easterbrook, p. 22) France also spent considerably less than the United States on total health care expenditures. Also in 1992 France spent 9.9 percent of its GDP on health care, while the corresponding figure in the United States was 13.4 percent. (Duriez, p. 34; Easterbrook, p. 22) Do these figures signify that the United States has a better health insurance system than the French, since after all Americans have invested much more money in their health care system than the French have in theirs? Quite simply, they do not. American health care is not superior to French health care. (Easterbrook, p. 22)

Conclusion

The French national health insurance system is composed of a series of regional and local sickness insurance funds. These funds are financed through employer and employee payroll contributions and provide affordable, high quality health care for nearly 100 percent of French citizens, regardless of whether they are employed, unemployed, self-employed, or retired. The French national health insurance system itself typically reimburses patients for 75-80 percent of their medical expenses. French citizens are able to purchase supplementary insurance in order to pay for the remaining 20-25 percent of their medical bills; if they cannot afford supplementary insurance, this percentage is usually covered by

Aide Sociale.

In France, the cost of medical services is kept low through the use of the national fee schedule, a register that establishes the amounts medical professionals can charge for services. Despite the low costs of medical services, the French national health insurance system frequently runs a deficit. This deficit is caused in part by increased unemployment, an aging population, and abuses such as medical tourism. Many possible solutions to these problems are currently under consideration, and many other solutions have already been tried; however, the deficit remains a very real problem for the French national health insurance system.

A brief comparison between health insurance in France and the United States reveals that health insurance in France covers a larger percentage of the population, provides more affordable health care services, sees health care services used more frequently than corresponding services in the United States, and has lower per capita spending than in the United States.

For many years, Americans have been playing with the idea of establishing a national health care system. According to Gregg Easterbrook 'author of the article "The National Health Care Phobia," at least 88 members of Congress and a majority of American citizens favor the establishment of a national health care system. Easterbrook also claims that "national health care is supposedly impossible in the United States." (p. 22) However, such a "national" health care system already has been implemented in one city in the United States - and has proven to be an unqualified success. This city is Rochester, New York.

For the past few decades, Rochester has operated a city-wide form of health insurance that combines elements of national health insurance with elements of market-driven medicine. Some benefits associated with this system are:

- * medical expenses that are 34 percent lower in Rochester than in the United States as a whole;
- * well-paid, self-employed physicians;
- * free choice of health care providers;
- * no waiting periods for medical procedures;
- * health insurance premiums that are the same for everyone, regardless of their personal situations;
- * health insurance that is not interrupted by a job change;
- * up-to-date medical technology.

Many of these benefits are familiar to us from national health care systems such as the French system. With establishment of a "national" health insurance system in Rochester, the main principles of national health insurance have proven to be efficacious in the United States, at least on a small scale. Maybe it is now time to try them out on a larger scale.

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