France's Healthcare System

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International comparisons

The 2000 WHO ranking of health systems, while strongly criticized, classified the French system as the world's best in terms of performance. Meanwhile, the Commonwealth Fund's 2014 ranking placed France at 9th out of 11 countries assessed, ahead of only Canada and the United States. The OECD also evaluates health systems, but without creating a rank order. It underlined some of the key strengths and weaknesses of the French system:

Strengths	Weakness
High life expectancy	Not enough prevention
High population coverage	Too much hospital-centrism and drugs consumption
High healthcare access	Not sufficiently community health services oriented

The 2015 public health law (Marisole Tourraine) emphasizes prevention with a focus on a few key areas: limiting binge drinking, reducing tobacco consumption, discouraging the promotion of excessive skinniness and decreasing junk food. It will also allow a supervised injection facility pilot.

Healthcare services

In France, primary care physicians (GPs) are mostly independent workers (60%) and are covered through medical public insurance (€23 user charge per consultation, no extra fees allowed). Specialists are generally hospital employees and part of their time is devoted to university teaching and research. Hospital employees can climb the competitive medical hierarchy until they gain the right to charge patients above the conventional fee of €28 in a private setting. When user charges exceed €35 per consultation for specialists, medical insurers will ask the doctor and the medical college about the ethics of doing so. The abundance of user charges and private practices raises concerns about equality.

Doctors can choose where they establish practice, causing problems with physician distribution around the country that will be worsened with the impending retirement of Baby Boomers in France.

About 2/3 of France's hospital beds are in public institutions and 1/3 are in private institutions. HAS (Haute Autorité de Santé) accredits hospitals on the basis of management and medical practices and must be assessed every 4 years. France does poorly at integrating social services and healthcare services, so care pathway approaches have been developed for certain populations (e.g. mental health, elderly).

A significant law passed in 2002 gave the right for patient representatives to sit in national and regional health strategy committees.

Health insurance in France

National health insurance was created in 1945 following the end up the Second World War. It was developed in response to high-risk workers (e.g. miners, farmers) who were concerned about the consequences of illness for themselves and their families. They created local funds, financed by employees and employer contributions, in order to pool risk. These local funds, called "*Mutuelles*", were non-profit entities independent from the public state, with worker representative sitting on the board of directors. Thus, French health insurance is based off the Bismarckian model (also found in German, Netherlands, and Belgium) in which healthcare is financed jointly by employees and employers through payroll deductions. About 20 years ago, France added a national tax on all incomes (not just worker incomes) to increase coverage and centralize governance.

Health insurance coverage is close to 100%. There are two levels of coverage – obligatory public health insurance (70% of total healthcare spending) and complementary private health insurance (20% of total healthcare spending). The remaining 10% of healthcare spending is paid for out-of-pocket.

Hospital care, GP and specialists consultations, investigations, physiotherapy, and pharmaceuticals are covered by public health insurance. However, user charges, private services, and uncovered services (e.g. optical, dental, psychologists, osteopaths) require complementary private health insurance for coverage. Significant inequities are created due to differences in access to complementary private health insurance and out-of-pocket payments. While most complementary private health insurers are non-profit *Mutuelles,* a small but growing segment are private for-profit corporations

In order to improve access to health insurance, the government created a universal health insurance (CMU - couverture maladie universelle) for those not covered by a *Mutuelle* such as the unemployed. CMU also includes complementary health insurance to cover user charges and other uninsured services for low-income individuals. However, those who do not meet the low-income threshold face challenges in paying user charges and for uninsured services. This leads to a "renunciation of care" for certain services such as dental and optical care.

For further information

- Commonwealth Fund International Profiles of Healthcare Systems: http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/jan/1802_mossialos_intl_profiles_2014_v7.pdf?la=en
- OECD Health at a Glance, 2015: http://www.oecd.org/health/health-systems/health-at-a-glance-19991312.htm