

Case study 2

Couverture maladie universelle: reaching the poorest in France

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“Between 10% and 15% of my patients are in a situation of financial insecurity,” explains Dr Gilles de Saint-Amand, a general practitioner in a rural area. “There is no doubt that some of them are genuinely marginalized; they had difficulty obtaining treatment but now, thanks to *couverture maladie universelle* [CMU – universal health insurance], it’s easier for them to consult me. From a health point of view, this is clearly an advantage, while, from an administrative point of view, the procedures have been considerably simplified.” For social workers, CMU is also an advantage. “Since it was introduced,” explains Annie Dunant, a child care nurse in a state-run maternal and child health centre, “when we have to deal with children with health problems, it’s much easier for us to urge the parents to bring them to see a doctor, because we know this won’t cause them financial problems.”

Universal health insurance was introduced in France on 1 January 2000. The principle behind it is to offer every person resident in France basic medical cover, with additional cover available to people whose incomes are below a given ceiling. The aim is to offer “health insurance for all”, in order to give everyone equal access to health care.

In France, access to health insurance is based on a system of social security contributions by salaried employees and workers. This gives them and their families the right to partial reimbursement of their health expenses (basic cover). Patients are free to choose and consult their self-employed doctor (a general practitioner or a specialist): they pay the doctor for the consultation and are then partially reimbursed by the health insurance scheme. The same arrangement applies to drugs, for which patients pay pharmacists and are then reimbursed. A proportion of these health costs (known as the

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“co-payment”) must be paid by the patients themselves, unless they take out a contract with a private insurance company or mutual association (*mutuelle*), which offers products that reimburse all or part of these costs. In 2000, 80–85% of the population had taken out additional cover that reimbursed them for at least part of their health care costs. This system gives a good proportion of the population satisfactory access to health care, but others are still excluded.

Before CMU, one measure was already in place: free medical aid, managed by the regional government (*département*) in France. Up to 1992, benefits were awarded to the very poor on request, each time they needed treatment. This system created inequities: not only did people in need have to apply each time they had a health problem, but they were also treated very differently from one *département* to another.

As of 1992, requests were still submitted to the administrative services of the *département*, but they were handled in cooperation with the local offices of the national health insurance fund (*caisses primaires d'assurance maladie*, CPAM). People in financial difficulties had to apply to the services of the local government authority (in the *département*) to obtain an entitlement for 1 year, for them and their families, rather than “one-off” aid. This was progress of a sort, but the problem of inequity between the *départements* persisted.

Moreover, the extent of poverty was increasing. According to sociologist Olivier Quérrouil, a technical adviser to the CMU fund and a former adviser to the interministerial task force on the guaranteed minimum wage:

Between the 1960s, when 50% of the population were covered by social insurance, and the 1980s, when the figure had risen to 98%, we saw the total success of the social security system. But the existence of that last 2% was untenable. First, because this was unacceptable from a humanitarian point of view and, second, because we ended up with a system in which 60 million people's rights to health insurance had to be verified in order to reveal the 2% who were not entitled to coverage.

Since the health insurance system was established, entitlements have been extended to the families of workers (the beneficiaries), and a personal insurance scheme has been set up for people who do not contribute through their

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workplace, but the system is still based on contributions. In the 1980s, we hoped to achieve full employment and thus health insurance coverage for all. But this did not happen. Between 1993 and 1998, the number of people in receipt of medical aid tripled (from 1 million to 3 million, or 5% of the population). It was no longer possible to go on talking about “residual vulnerable groups”. The social security system, which had become ever more generalized since its inception in 1945, had to respond to this problem, and a succession of political leaders began to seek solutions.

In 1997, a study carried out by the Health Economics Research Centre (*Centre de Recherche d'Etude et de Documentation en Economie de la Santé*, CREDES) highlighted inequalities in access to health care. Some 600 000 people did not have access to social security. In addition, 16% of the population did not have supplementary cover. Many of them did not seek treatment because they could not afford their share of the health costs.

The problem was aggravated by outpatient treatment being reimbursed under the basic coverage scheme at a lower rate (60–70%) than that of hospital treatment (80–95%). The result was that people who could not afford to seek treatment at an early stage, by consulting a doctor, hesitated to do so. As Etienne Caniard, Vice-President of the French National Federation of Mutual Insurance Companies, points out:

This shows that the basic health insurance scheme was not enough to guarantee access to care. This led to a question for Martine Aubry, the then Minister of Employment and Solidarity: in order to ensure equal access to treatment, would the system have to be reorganized in accordance with the resources available? Her answer was no, and she opted for a specific system whose primary philosophy is to avoid stigmatizing the least well off.

A revolutionary Act

In 1999, Parliament adopted an Act that set up CMU as an integral part of a broader act on measures against social exclusion. It has three components. The first component establishes basic CMU for all, with no contributions required from people with an income below a certain level (see Box 1). In other words, any person properly resident in France, who does not contribute through his or her employment and who is not a beneficiary, is automatically affiliated with the social security system. Another major innovation is that the burden of proof of entitlement is on the health

Box 1. Who is entitled to CMU?

CMU and supplementary CMU are available free of charge, provided an income ceiling is not exceeded. This ceiling was revised in February 2002. It is now €562 (US \$489) per month for a single person, €843 (US \$733) for a couple or a single parent with a child, €1011 (US \$879) for three people, €1180 (US \$1026) for four and €225 (US \$196) per additional person. This entitlement is awarded for one year, renewable after review of the insured person's situation. Since February 2002, people who no longer come under this arrangement, because their situation has changed, none the less continue to benefit from dispensation with regard to meeting medical expenses. Also, since that date, people whose income is in the band of up to 10% over the ceiling for benefiting from supplementary CMU are entitled to assistance amounting to €115 (US \$100) in order to take out supplementary cover with an insurer or mutual association. The contracts proposed by insurers or mutual associations guarantee them the same rates of reimbursement as supplementary CMU.

Source: CMU Fund.

insurance fund rather than the individual. People over 16 years of age can therefore join a fund with documents merely proving their residence and identity. People with no fixed abode must be registered with a recognized body in order to receive benefits. The local office of the insurance fund can question people and can ask for additional evidence that they do not come under a scheme for employed people, but they will be automatically entitled to basic coverage for one year. Subsequently, depending on their income, they will be required (or not required) to contribute to this system of basic coverage.

The second component of the Act is the establishment of supplementary CMU. Below a certain income ceiling, people receive this supplementary insurance free of charge, which meets health costs within the limit laid down by the social security system. This supplementary insurance covers the cost of co-payments, a daily tariff for non-medical inpatient costs (€10.67 or US \$9.28 per day), dental prostheses and spectacles (up to a limit of €396 or US \$345 per two-year period).¹²

¹² Full reimbursement of dental prostheses was introduced at the beginning of 2002. Initially, reimbursement of optical appliances and dental prostheses was limited to €396 (US \$345) per two-year period. This ceiling now remains only for optical appliances.

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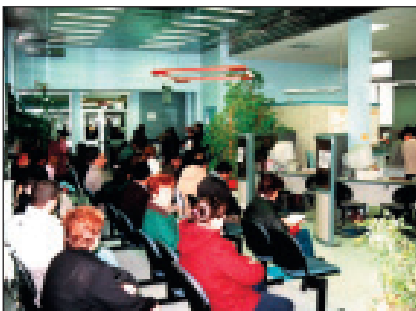
Doctors consulted by patients covered by CMU, however, make a commitment not to exceed the baseline rates laid down by agreement between the National Health Insurance Fund for Salaried Employees (*Caisse Nationale d'Assurance Maladie des Travailleurs Salariés*, CNAMTS), the Government and the medical associations. They may not set their own fees. Supplementary CMU is granted each time for a one-year period.

Individuals have a free choice of their supplementary insurer – which may be the health insurance fund itself, a private insurance company or a mutual association – from a list given to them when they register with the primary fund. If people choose a body other than the health insurance fund, the advantage is that they will be able, provided they do not exceed the CMU income limits, to take up a preferential offer of supplementary insurance (at a cost of €229 or US \$199 per year) after they leave the scheme. One essential point is that the CMU scheme does away with advance payments. Patients do not pay their doctor or the hospital; instead, the latter are reimbursed directly by the insurance funds and supplementary insurance bodies.

Finally, the third component of the Act relates to amendment of the arrangements for state medical aid. This is aimed at people in France whose



In January 2000, the "revolutionary Act" created a very large response. Many people were keen to register for CMU.



status is unclear but whose income is lower than the same ceiling used for CMU. Approximately 100 000 people are affected. They can submit a request for cover to the local health insurance fund office, to local or regional welfare service departments, or through nongovernmental organizations and charitable bodies. This component gives free access to hospital treatment for all, and to general practitioner care for people who have been in France for over three years (see Box 2).

The Act provides for rapid implementation of these measures, since it came into force on 1 January 2000. In the few months after the Act was passed in July 1999, the various bodies charged with operating CMU had to organize themselves to handle the recipients of this new service.

With regard to financing, a fund has been set up to finance the supplementary CMU scheme. Resources come from an allocation from the state budget and through contributions from complementary bodies (insurance companies and mutual associations), calculated on the basis of 1.75% of their turnover. In 2000, the fund's budget was €1047 million (US \$911 million). In 2002, it was due to rise to €1120 million (US \$975 million). When insured people choose primary insurers as their provider of supplementary insurance, their expenditure is fully reimbursed by this fund. If, however, they choose a mutual association or an insurance company, these bodies have their contribution to the CMU fund reduced by €228.67 (US \$199) per person registered per year. This sum, which is claimed to correspond to the average expenditure per person incurred by supplementary insurers, does not cover the management costs of the bodies that have agreed to insure them. Estimates show that the average annual health expenditure must be revised upwards to approximately €244 or US \$212 per person in 2001. Supplementary insurers are currently calling for an increase in their deduction or, indeed, full reimbursement of their costs, as is the case for the primary insurers. "There is a great deal of work to be done on the ground to reach out to people who could benefit from CMU but are not aware of it," notes Caniard. "This work could be done by mutual groups, in collaboration with welfare associations, but this would require additional resources."

A cultural shift?

"Introducing CMU has been a real cultural shift, at all levels," notes Marc Schlüsselhuber, the Director responsible for access to care at the

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At the end of 2001, 120 000 people were in receipt of government medical aid (GMA), 70% of whom lived in the region of Ile de France (Paris and the surrounding area) and 44% in Paris itself. This aid is targeted at people whose status is "irregular" in one way or another. Not only is it "generous", it is a response to a public health problem. "Many of these people," explains Yves Carcenac, Inspector General of Social Affairs, "were developing communicable diseases, especially tuberculosis, but were afraid of being identified when they applied for treatment." One specific characteristic of this population is that it is especially difficult to assess how many people are involved. Since GMA was introduced, however, and after a slow start due to a certain degree of suspicion, 10 000–12 000 new people have been signing up every three months. Aid is granted mainly on the basis of a statement by the recipients describing their situation. Its introduction, however, has been more difficult than that of CMU, as is noted in a report issued by the General Inspectorate of Social Affairs (*Inspection Générale des Affaires Sociales*, IGAS). One reason for the difficulty is that the population concerned was not given enough information: one of the main channels for disseminating information was humanitarian organizations, since the government services have made no arrangements to do so. Another reason is that some primary insurance funds arranged for only one reception facility per region, which had the effect of stigmatizing these people who, according to the spirit of the law, should be able to "lose themselves" in the mass of insured people. The fact that access to general practitioner care is restricted to people who have been in France for more than three years creates complex situations. On the one hand, it is difficult for people in an irregular situation to prove that they have been in the country; on the other hand, it paradoxically "rewards" those people who remain in an irregular situation for longer periods of time. Finally, the IGAS report notes that budgetary management by the Government is "causing concern". For instance, the cost of €60 million (US \$52 million) provided for in the 2002 budget had already reached a level of €145 million (US \$126 million) in 2001.

Box 2. Medical aid to people whose status is "irregular"

Source: IGAS.

Seine-Saint-Denis primary health insurance fund. In this region close to Paris, which is severely affected by problems of poverty, the number of potential beneficiaries of supplementary CMU was initially estimated at 200 000. At the beginning of 2002, 146 650 people were entitled to benefits, after a peak of 177 000 in June 2001. In the first six months of the scheme, 87 000 people registered. Schlüsselhuber recounts:

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For local insurance funds like us, we had to move from doing administrative work and applying mathematical formulae to carrying out a social role. The staff had to be convinced that, in the future, we would have a role to play in tackling poverty. As soon as the scheme was set up, we were inundated with applications. We had had a few months to prepare ourselves, 130 people were mobilized to tackle this issue, and we recruited about a hundred young people.

One of the main changes is that the insurance funds now have to prove people's entitlements, instead of the reverse. Schlüsselhuber recalls:

On 3 January 2002, a young man arrived to join the scheme. He had no job, he was in the process of applying for the guaranteed minimum income and he seemed to be in a "regular" situation. We therefore registered him automatically, without supporting documents. Clearly, we will ask for these documents at a later date and check his entitlements, but for us, as a civil service department, this was completely new.

Schlüsselhuber sees the same innovative approach for government medical aid: "In practical terms, when someone whose status is irregular comes to join the scheme, we try to ask them for all the supporting documents they can provide. But at the outset, especially in their cases, we have to be satisfied with statements made by them." In this *département*, GMA has meant that the number of people of irregular status who receive free medical care has risen from 3000 to 13 000. Schlüsselhuber continues:

We know that there are still people who do not dare to register because they're afraid that their illegal status will be discovered, but information about this new entitlement to social welfare coverage is gradually spreading.

CMU has improved the image of the health insurance system. The primary health insurance fund is now taking action against poverty. In Seine-Saint-Denis today, we are cooperating with the *département's* social workers, for instance by notifying them of people who have been refused CMU cover because their income is above the ceiling, so that they can be tracked and helped under other schemes. We are developing preventive action in households, associations and town halls, and we are offering a telephone hotline. In fact, we have re-established our dialogue with insured members of the public. Now we really have the impression of contributing something more

than just reimbursement. CMU is a system that requires everyone, throughout the whole process, to become involved in action aimed at strengthening solidarity.

Generally speaking, the introduction of CMU has completely changed the way in which primary health insurance funds operate. A study¹³ carried out by the Directorate for Research and Statistical Evaluation (*Direction de la Recherche, des Etudes, de l'Evaluation et des Statistiques*, DREES) at the Ministry of Employment and Solidarity highlights the difficulty of setting up a reception facility that is “normal”, in order not to stigmatize recipients of CMU, yet is also capable of responding appropriately to these particular cases. Initially, some local health insurance funds were not able to offer reception facilities to CMU beneficiaries on an equal footing with those of other insured people and had to make special arrangements. The deadline for registering for supplementary CMU, which by law must not be more than two months, has also created problems in some offices that faced technical problems when the system was set up.

In some places, waiting times at primary insurance fund offices have been avoided by making use of voluntary help, obtaining the support of mutual associations and insurance companies, and setting up reception facilities in hospitals, town halls and poor districts.

Recipients: 7.8% of the population

Almost two years later, on 30 September 2001, 1.2 million people were in receipt of basic CMU, according to the DREES study,¹⁴ while 4.7 million people or 7.8% of the population were covered by supplementary CMU. The number of recipients peaked in June 2001, at 5.3 million. This may be explained by the Act having provided for an automatic entitlement to CMU for people previously entitled to medical aid. The situation of some of these people, however, has changed, or they have not requested renewal because they have no need of care. Others can benefit from medical aid in a *département* where the income ceiling was higher than that for CMU.

¹³ BOISGUERIN, B. *Les bénéficiaires de la couverture maladie universelle au 30 septembre 2001*. Paris, Direction de la Recherche, des Etudes, de l'Evaluation et des Statistiques, 2002 (Etudes et Résultats, No. 158).

¹⁴ Ibid.

A young and female population

Another DREES study¹⁵ in November 2000 defined the target populations more accurately. Recipients of CMU are primarily women (55%) and young people (39% are under 20). Some 6% are over 60 and, among people of working age (20–59 years), 40% are unemployed. In 26% of cases, the reference person (that is, the person in the family who is registered for CMU and through whom the other members receive cover) is employed. Finally, 36% of recipients are in a household where the reference person is a worker, and 27% are in one where he or she is an employee. In 30% of the cases, the socioprofessional categories of reference persons are not defined, either because they have never worked or because they are inactive or are housewives.

Two years on, reimbursement figures serve as the main tool for assessing the health impact of introducing CMU. Statistics compiled by CNAMTS show that, in 2000, the health expenses of people covered by supplementary CMU amounted to 70% of the costs incurred by those insured under other schemes. By the beginning of 2001, however, the corresponding figure had risen to 85%. This may be explained by the target population for CMU being younger and thus in better health. While the health costs of people covered by supplementary CMU are lower than those of other insured people, they are initially focused more on primary care (general practitioners, drug costs) and seem to be growing gradually closer to the health consumption patterns of the population as a whole.

At the end of 2000, a study of a sample of beneficiaries showed that one in every two people covered by CMU said that, before joining the scheme, they had not proceeded with at least one treatment for financial reasons. This mainly concerned treatments that were poorly reimbursed by basic social security, such as dental care (31%), optical care (25%), dental prostheses (19%) and specialist consultations (10%). Since the introduction of CMU, 65% of those sampled said they had sought at least one of the treatments they had previously not taken up. Two thirds had “caught up” by initiating dental or pharmaceutical treatment and by consulting general practitioners or specialists. With regard to dental prostheses and optical care, only 40% of people had caught up with treatment previously

¹⁵ BOISGUERIN, B. & GISSOT, C. *L'accès aux soins des bénéficiaires de la CMU. Résultats d'une enquête réalisée en novembre 2000*. Paris, Direction de la Recherche, des Etudes, de l'Évaluation et des Statistiques, 2000 (Etudes et Résultats, No. 152).

abandoned. This may be explained by the existence of a ceiling on expenditure of €396 (US \$345) per two-year period. Abolition of the ceiling for dental care at the start of 2002 should help to enable people covered under CMU to initiate this treatment.

Another indicator of the effectiveness of CMU is the fall in attendance at health care centres operated by humanitarian organizations. These bodies were very much involved in discussions about introducing the Act and its enabling legislation, and they continue to closely monitor the impact of CMU and to refer their patients to the primary health insurance fund offices. “We are seeing a clear fall in the number of patients in our centres, since they now have easier access to general practitioners or hospital treatment,” notes Nathalie Simonot of Médecins du Monde. “Some centres in small towns have even closed down. There is still a problem of information, however, and we believe that many people who are entitled to CMU are not aware of the fact.” The same observation comes from the National Union of Private Health and Social Work Agencies (*Union Nationale Interfédérale des Oeuvres et Organismes Privés Sanitaires et Sociaux*, UNIOPSS), which notes a marked fall in attendance at health care centres. Nevertheless, it stresses the lack of information available to people who do not take the initiative of asking for it, as well as to the most severely excluded social groups, towards whom outreach activities must be directed if they are to be encouraged to take up the services available.

A major step forward in social terms

“Universal health insurance is a major step forward in social terms”, concluded a recent IGAS report.¹⁶ Yves Carcenac, co-author of the report with Evelyne Liouville, notes that:

Equal access to treatment, regardless of a person’s place of residence, and a single counter in the offices of local social security services seem to be generating a spirit of neutrality that was not always evident in the previous system. It’s still too early to clearly see a health impact, but we know that the measures taken under this Act, in particular the fact that people no longer have to meet their health costs “up front”, really makes for easier access to health care, and it seems that we are moving towards harmonization with the rest of the population.

¹⁶ CARCENAC, Y. & LIOUVILLE, E. *Première évaluation de l’application de la loi du 27 juillet 1999 portant création d’une couverture maladie universelle*. Paris, Ministère de l’Emploi et de la Solidarité, 2001 (Rapport No. 2001, 112).

Centralization at the national level, however, raises new problems. One that government offices are facing is the problem of control. “It’s the corollary of the spirit of trust embodied in the Act,” explains Carcenac. “We trust people by agreeing to base our action on their statements. The corollary is that we can check what they say. At the beginning, we were in a start-up phase. Today the CMU system has reached cruising speed, and steps must be taken to organize these checks.”

Another difficulty is that health professionals, on whom the operation of the CMU system partly depends (because they agree not to exceed the charges agreed), do not always “play the game”. Some of them, the IGAS report notes, refuse treatment to people covered under CMU, refuse to waive charges up front, or charge additional fees. One of the main reasons put forward is that some funds take a long time to pay out. These delays are not general, however, and they mainly concern doctors who do not have computers and who send in their claims for reimbursement by mail, rather than electronically. Other doctors, especially some dental surgeons, do not accept the rates laid down for payment of treatment. Instances of refusal to give treatment are relatively isolated, however, and the CMU system has greatly simplified administrative procedures.

The main criticism of the CMU system, however, concerns the “threshold effect”. People whose incomes are above the ceiling entitling them to CMU, even by €1, find themselves back in a precarious situation without the access to care that they had before CMU was introduced. Some people who are in receipt of allowances, such as isolated elderly people receiving the minimum old age pension or the disabled person’s allowance, have an income that is slightly above the ceiling, so they do not benefit from supplementary CMU. Compared with the estimated cost of health expenses per person for the supplementary CMU scheme (€238 or US \$207), the rate of contribution to a supplementary insurance policy is much higher for an equivalent sum insured. In addition, a dozen or so *départements* have set the ceiling for access to government medical aid higher than that for CMU. In theory this could mean that CMU downgrades them by preventing them from benefiting from this aid, but in practice successive postponements decided on by the Government – in order to avoid people who benefited from government medical aid having to make too sudden a change to a new situation without supplementary assistance – have meant that they did not have to leave the scheme until the end of 2001 or early 2002. Measures

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giving support for subscribing to supplementary cover, which should be in place in 2002, will help them continue to receive care.

This is the next bridge to cross in the French health system's efforts to tackle poverty. The CMU scheme has made it possible to cover the health costs of a very large proportion of the poorest people. The only group left comprises those with incomes above the threshold that would entitle them to CMU.

For their part, the humanitarian organizations are proposing that, on the one hand, the income ceiling for CMU should be raised and that, on the other hand, regressive income-linked assistance should be introduced to help people with their contributions for supplementary cover. "If the supplementary insurance bodies want to maintain their monopoly," points out Jean-Claude Boulard, a Member of Parliament and one of the people involved in drafting the CMU Act in 1999, "they will have to come up with a system of modulated contributions starting at the CMU cut-off point." The IGAS report has studied various scenarios, ranging from raising the income ceiling to introducing benefits payable when people leave the CMU scheme. Ultimately, it has adopted the introduction of benefits, a move endorsed by the Government, which considers that raising the ceiling would be too costly and would only shift the problem of the threshold effect.

Despite some start-up difficulties and the emergence of the problem of a threshold effect, CMU none the less embodies undoubted progress, both for beneficiaries and for those involved in the health system. "The special feature of this Act," conclude Carcenac & Liouville, "is that, in addition to having been introduced under efficient conditions and to facilitating access to care for the least well off, it has also created a new frame of mind among most of those involved: people all have their hearts set on making it work at their level. Now, we have to consolidate." Further evaluations of the Act are planned at two-year intervals, which should allow the system to be fine-tuned if necessary.