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French Healthcare System

The French healthcare system is one of the most advanced but also most expensive in Europe. A major review of the health system in 1996 introduced new regulations aimed at limiting the growth of health expenditure. These regulations led to much tighter government controls of public and private hospitals, as well as ambulatory care services, to rationalize the supply of health care.

The provision of French healthcare is based on:

• A national statutory health insurance system, linked to employment and financed by employers and employees

• An until recently, essentially total freedom of patients to choose and use private and public health services without referral

The almost universal (99% of the population) national system of compulsory health insurance (assurance-maladie) was introduced in France as far back as 1946. Health insurance is paid through different schemes following the occupation of the individual. The largest scheme, le régime général or national health scheme, accounts for some 80% of the population, covering employees, their families and pensioners from agriculture, trade and industry. Contributions to the scheme are made through payroll deductions, with 12.8% of gross salaries being paid by the employer and 6.8% by the employee. In addition to the statutory health scheme, over 85% of the population chooses to make additional voluntary payments into supplementary sickness funds (mutuelles) or private insurance schemes to cover charges and services not reimbursable under the national scheme. It is nevertheless, interesting to note (from figures reported in 1993), that despite the various health insurances, as much as 19% of total national health expenditure was still being paid by the patient, one of the highest shares in Europe (WHO Highlights on Health in France, www.who.org).

Traditionally, patients have the freedom to choose from both private and public health services and to consult with any doctor or specialist at any time without referral. GPs provide a great share of the primary health care services (ambulatory care and house calls) and are paid on a fee-for-service basis usually according to a negotiated fee schedule although some doctors (30%) choose to set their own fees. Patients initially pay in full for their treatment and are later reimbursed by their insurance. The level of reimbursement follows a cost-sharing agreement with the insurance companies (ticket modérateur) and depends on the service provided and the needs of the patient: figures reported in 2002 indicate that a simple consultation is reimbursed at a rate of 70% (Bulletin d'Information de la Mutualite Sociale Agricole, No. 26, Aug-Sep 2002). Severely ill patients are exempt from personal contributions.

In principle, hospital care, both public and private, is paid for in a similar way with the patient paying the provider directly and seeking reimbursement from the insurance later. However, since the introduction in 1996 of a new system (tiers payant) whereby the hospital bills the insurance company directly, the patient in practice only pays the non-reimbursable sum (forfait hospitalier). With 1000 public hospitals, 750 private hospitals with a public utility function and 1400 private clinics under the Quantified National Objective (OQN), 13.5M hospitalizations were handled in the year 2000 (sourced from the French Ministry of Health).

An element of the modern computerized health system in France is the 'smartcard', introduced in March 1999, for claims transmission and reimbursement. The Vitale smartcard is a plastic card, carried by the insured, containing all relevant information about the person (name, social security number, date of birth, details on rights and benefits …).

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