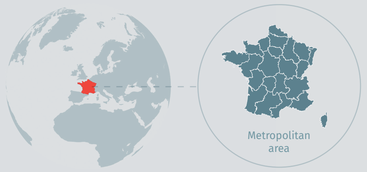
EVOLUTION OF UHC IN FRANCE

Countries learning from each other to achieve and maintain Universal Health Coverage (UHC)



Capital Paris 48°51'N 2°21'W
Official language French
Ethnic groups 93% French citizens
7% Foreign nationals
Area
• Total 640,679 km²
• Metropolitan France 551,695 km²

GENERAL INFORMATION

The French health care system has its origins in the Middle Ages, but since 1945 has been structured as part of a comprehensive social protection system that include maternity, family, occupational diseases, accidents at work and pensions.

Coverage of health risks has been continuously strengthened, harmonised and extended by increasing both the coverage of medical costs and the number of people covered. It has gradually acquired a universality that was completed in 2016 by a universal system of health care: Universal Health Protection (PUMA). This ambition makes the health sector one of the largest areas of public expenditure in France and an important economic sector. It accounts for 11% of GDP and employs one and a half million people.

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1898 - 1966

1898

Adoption of a law ensuring protection against industrial accidents for industrial workers.

1928

Adoption of a series of laws creating the first com-prehensive and compulsory system of social insurance (health, maternity, invalidity, old age, death insurance) for workers in industry and commerce.

1944

The National Council of the Resistance proposed in its programme a 'comprehensive social security plan aimed at ensuring a livelihood for all citizens in all cases where they are unable to secure such a livelihood through employment'.

1945

Passing of directives ensuring the creation of the social security system in France (man-agement by the social partners, financing by contributions paid by employers and employees) as well as the overhaul of the insurance system dating from the 1930s and the recognition of the complementary role of mutual funds.

1961

Law creating the sickness, maternity and disability insurance scheme for farmers.

1966

Creation of a health and maternity insurance for non-salaried workers in non-agricultural professions (artisans, traders, liberal professions).

HEALTH INSURANCE SCHEMES

Compulsory schemes:

They are characterised by compulsory membership and contribution liability and determine the range of reimbursable benefits and the reimbursement rates for care.

Private complementary schemes:

They offer coverage that varies according to the member's contract and are designed to cover health care expenses that are not covered by the compulsory scheme. If clients do not have complementary insurance provided by their employer, they can obtain it from a mutual health insurance fund, a provident fund or an insurance company.

1967 - 1978

1967

Reorganisation of the general social security system and financial separation of risks in three distinct branches (health, old age, family).

This financial separation is accompanied at institutional level by the creation of three national funds: The National Health Insurance Fund for Employees (CNAMTS), the National Retirement Insurance Fund for Employees (CNAVTS) and the National Fund for family allowances (CNAF).

The treasury management of the different branches is entrusted to the Central Agency for Social Security Organizations (ACOSS).

1978

Development of a special scheme for ministers of religion and members of religious congregations and creation of a personal insurance mechanism for the 'rest of the population'.

1990 - 1999

1990

Creation of the general social contribution (CSG).

This is paid on all income (employment income, replacement income, property income, investment income and gambling income).

1996

Adoption of the law reforming the Constitution of the Fifth Republic in order to create a new category of laws, such as social security financing laws (LFSS).

1997

Introduction of the Vitale card, which certifies entitlement to health insurance. It contains all the information necessary for reimbursement and simplifies access to care.

To prevent the cash advance from being an obstacle (especially for the poor), insured persons benefit from payment by third parties.

Introduction of a shared medical file (dossier medical partagé, DMP), which offers a digital health record that maintains and secures health care information on treatments, test results, allergies, etc. The file may only be shared with the health care professionals chosen by the patient.

1999

Establishment of the state-funded Universal Medical Coverage (CMU) scheme for low-income groups.

2004 - 2018

2004

Adoption of the law on the reform of health insurance (promotion of generic drugs, aid for the acquisition of additional cover, empowerment of socially insured persons by creating a flat rate of 1 euro).

2006

Establishment of the Social Security Scheme for self-employed persons grouping together health insurance plans and old age insurance plans for liberal professions, industrialists, craftsmen and traders.

2009

The Hospital, Patient, Health and Territory Act (HPST) creates regional health agencies (ARS) and sets new rules for the governance of health establishments.

Each ARS adopts the national policy of France and adapts it to the demographic, epidemiological or geographical specificities of its region by drawing up regional health programmes (PRS), which include regional prevention plans, plans for organising outpatient and inpatient care, regional health and social organisation plans for the elderly or people in need of care, people with disabilities or people who are financially insecure.

2016

Implementation of Universal Health Protection (PUMA: protection universelle mal-adie). All persons legally residing in France are entitled to coverage of their health expenses. The health insurance reimbursement rate averages 76.8%.

Drafting of the law on the modernisation of the French healthcare system, which provides for the general introduction of third-party payment (exemption from advance payment) for all insured persons by 2017.

2018

The social security scheme for the self-employed is merged with the general social security system.

REMAINING CHARGE FOR THE HOUSEHOLD:

7%
of global health spending.

2019

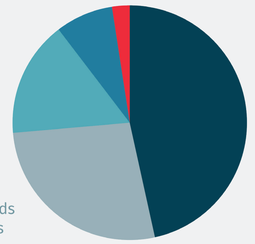
100%

Gradual implementation of 100% health coverage.

HEALTH FINANCING IN FRANCE

The French system has essentially been based for more than twenty years on the national objective of spending on health insurance (ONDAM), set by social security financing laws. It specifies an overall spending target to control health spending and only tracks health expenses financed by health insurances. Close monitoring of expenditure and regulatory instruments was established in 2010. The state and social security systems are financed by a mixture of social contributions and taxes.

CONSUMPTION OF HEALTH CARE AND MEDICAL GOODS (CSBM) IN 2018



- 46.4% Hospital care
- 27% Urban care
- 16.1% Medicines
- 7.9% Other medical goods
- 2.5% Sanitary transports

OUTLOOK - REMAINING CHALLENGES

- Promotion of the establishment of doctors, development of telemedical services and opening of multidisciplinary health facilities in less-favoured areas to reduce imbalances in the distribution of care provision.
- Expansion and strenghtening of synergies between all actors in the health care system to respond to profound changes in society (increasing ageing, chronic diseases, etc.) and the rising costs of medicines and health technologies.
- Development of measures to promote healthy behaviour, early detection of certain diseases in risk groups and major vaccination campaigns. - Improvement of coherence between public policies

For reference, please visit: https://p4h.world/en/france | Maps are an approximation of actual country borders.

This card was created in friendly collaboration with Mr. Jean-Yves Hocquet – Legal Affairs Department, Ministry of Solidarity and Health / Ministry of Labour