World Health Organization

European Region

Can people afford to pay for health care?

New evidence on financial protection in France

Damien Bricard

France

WHO Barcelona Office for Health Systems Financing

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Abstract

This review is part of a series of country-based studies generating new evidence on financial protection – affordable access to health care – in health systems in Europe. Catastrophic health spending is lower in France than in many other European Union (EU) countries, but unmet need for dental care is above the EU average and both outcomes are marked by significant income inequality. Catastrophic health spending is heavily concentrated in the poorest fifth of households and mainly driven by out-of-pocket payments for outpatient medicines, medical products and outpatient care. This is likely to reflect widespread, heavy and complex user charges (co-payments) for publicly financed health care, including substantial balance billing for medical products and outpatient care. Complementary health insurance (CHI) covering user charges covers around 95% of the population and improves financial protection for most people due to sustained Government efforts to secure free or subsidized access to CHI for people with very low incomes. However, CHI does not fully address the problems caused by user charges: households with the lowest incomes are the least likely to have any form of CHI and CHI is a highly regressive way of financing the health system. It also involves significant transaction and financial costs for the Government and employers. Since 2019 the Government has taken steps to reduce balance billing for medical products. Building on this, the Government can use public resources more efficiently by reducing user charges and limiting the health system's reliance on CHI – for example, exempting households with low incomes and people with chronic conditions from all co-payments; introducing an income-based cap on all co-payments; further limiting balance billing; and reducing the regressivity of CHI.

Keywords

FRANCE
HEALTH CARE FINANCING
HEALTH EXPENDITURES
HEALTH SERVICES ACCESSIBILITY
FINANCING, PERSONAL
POVERTY
UNIVERSAL COVERAGE

About the series

This series of country-based reviews monitors financial protection in European health systems. Financial protection – ensuring access to health care is affordable for everyone – is central to universal health coverage (UHC) and a core dimension of health system performance.

What is the policy issue? Out-of-pocket payments can create a financial barrier to access, resulting in unmet need, and lead to *financial hardship* for people using health services. People experience financial hardship when out-of-pocket payments – formal and informal payments made at the point of using any health care good or service – are large in relation to a household's ability to pay. Out-of-pocket payments may not be a problem if they are small or paid by people who can afford them, but even small out-of-pocket payments can cause financial hardship for poor people and those who have to pay for long-term treatment such as medicines for chronic illness. Where health systems fail to provide adequate financial protection, people may not have enough money to pay for health care or to meet other basic needs. As a result, lack of financial protection can undermine health, deepen poverty and exacerbate inequalities. Because all health systems involve a degree of out-of-pocket payment, unmet need and financial hardship can occur in any country.

How do country reviews assess financial protection? Each review is based on analysis of common indicators used to monitor financial protection: the share of people foregoing health care due to cost (*unmet need*) and the share of households experiencing financial hardship caused by out-of-pocket payments (*impoverishing and catastrophic health spending*). These indicators are generated using household survey data.

Why is monitoring financial protection useful? The reviews identify the health system factors that strengthen and undermine financial protection; highlight implications for policy; and draw attention to areas that require further analysis. The overall aim of the series is to provide policy-makers and others with robust, context-specific and actionable evidence that they can use to move towards UHC.

How are the reviews produced? Each review is produced by one or more country experts in collaboration with the WHO Barcelona Office for Health Systems Financing, part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe. To facilitate international comparison, the reviews follow a standard template, draw on similar sources of data and use the same equity-sensitive methods. Every review is subject to external peer review. Results are also shared with countries through a consultation process held jointly by WHO

headquarters and the WHO Regional Office for Europe. The country consultation includes regional and global financial protection indicators. See UHC watch[1] for more information on methods and indicators.

What is the basis for WHO's work on financial protection in Europe? Financial protection is a Sustainable Development Goal, part of the European Pillar of Social Rights and at the heart of the European Programme of Work, 2020–2025 – "United Action for Better Health in Europe" – the WHO Regional Office for Europe's strategic framework. Through the European Programme of Work, WHO supports national authorities to reduce financial hardship and unmet need for health services (including medicines) by identifying gaps in health coverage and redesigning coverage policy to address these gaps. The Tallinn Charter: Health Systems for Health and Wealth and resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region include a commitment to work towards a Europe free of impoverishing out-of-pocket payments. Other regional and global resolutions call on WHO to provide Member States with tools and support for monitoring financial protection, including policy analysis and recommendations.

Comments and suggestions for improving the series are most welcome and can be sent to euhsf@who.int.

1. UHC watch [online database]. Copenhagen: WHO Regional Office for Europe (https://apps.who.int/dhis2/uhcwatch, accessed 7 March 2024).

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Tracking progress on affordable access to health care in Europe and central Asia

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Short film about UHC watch

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Abbreviations

ACS	*aide au paiement d'une complémentaire santé* [complementary health insurance payment assistance]
AME	*aide médicale de l'État* [State medical aid]
CHI	complementary health insurance
CMU	*Couverture Maladie Universelle* [universal health coverage]
CMU-C	*Couverture Maladie Universelle* Complémentaire [complementary universal health coverage]
CSG	*Contribution Social Généralisée* [General Social Contribution]
CSS	*Complémentaire Santé Solidaire* [free or low-cost complementary health insurance programme]
EHIS	European Health Interview Survey
EU	European Union
EU14	EU Member States before 1 May 2004 and as of 1 February 2020
EU27	EU Member States as of 1 February 2020
EU-SILC	EU Statistics on Income and Living Conditions
GDP	gross domestic product
GP	general practitioner
HAS	*Haute Autorité de Santé* [High Health Authority]
INSEE	*Institut National de la Statistique et des Études Économiques* [Institute for Research and Information in Health Economics]
OECD	Organisation for Economic Co-operation and Development
PUMA	*Protection Universelle Maladie* [universal health protection]
SHI	social health insurance
SMR	*service médical rendu* [rendered medical service]
UNCAM	*Union Nationale des Caisses d'Assurance Maladie* [National Union of Health Insurance Funds]
VAT	value-added tax

Countries

ALB	Albania
ARM	Armenia
AUT	Austria
BEL	Belgium
BIH	Bosnia and Herzegovina
BUL	Bulgaria
CRO	Croatia
CYP	Cyprus
CZH	Czechia
DEN	Denmark
DEU	Germany
EST	Estonia
FIN	Finland
FRA	France
GEO	Georgia
GRE	Greece
HUN	Hungary
IRE	Ireland
ISR	Israel
ITA	Italy
LTU	Lithuania
LUX	Luxembourg
LVA	Latvia
MAT	Malta
MDA	Republic of Moldova
MKD	North Macedonia
MNE	Montenegro
NET	Netherlands (Kingdom of the)
POL	Poland
POR	Portugal
ROM	Romania
SPA	Spain
SRB	Serbia
SVK	Slovakia
SVN	Slovenia
SWE	Sweden
SWI	Switzerland
TUR	Türkiye
UKR	Ukraine
UNK	United Kingdom

Executive summary

This review assesses the extent to which people in France experience financial hardship when they use health care. It covers the period from 2011 to 2024 using data from household budget surveys from 2011 and 2017 (the latest available year), data on unmet need for health services up to 2022 (the latest available year) and information on coverage policy (population coverage, service coverage and user charges) up to March 2024.

The review's main findings are as follows.

- In 2017 1.4% of households were impoverished or further impoverished after out-of-pocket payments and 2.1% of households experienced catastrophic health spending.[2] The incidence of catastrophic health spending is lower in France than in many European Union (EU) countries, in line with France's very low reliance on out-of-pocket payments to finance the health system.

- The incidence of catastrophic health spending is much higher than the national average (2%) in the poorest fifth of the population (9%) and in households headed by unemployed people (10%), other inactive people (8%) and single parents (5%).

- Almost 90% of all households with catastrophic health spending are in the poorest fifth of the population (consumption quintile). In the poorest quintile, catastrophic health spending is mainly driven by out-of-pocket payments for outpatient medicines, medical products (things like hearing aids, dentures and glasses) and outpatient care.

- Although unmet need for health care (caused by cost, distance or waiting time) was close to the EU average in 2022, unmet need for dental care (for the same reasons) was well above the EU average. Income inequality in unmet need was significant, especially for dental care.

Three features of coverage policy that are likely to strengthen financial protection in France offer examples of good practice for other countries.

- The basis for entitlement to social health insurance (SHI) benefits does not depend on payment of contributions (since the *Couverture Maladie Universelle* [universal health coverage] reform in 2000) and is individual, automatic and permanent (since the *Protection Universelle Maladie* [universal health protection] reform in 2016), meaning all legal residents are covered, including people with precarious jobs.

2. The household budget survey in France is usually only carried out every five years. Although it has not been carried out since 2017, analysis of financial hardship using survey data for 2011 and 2017 provide valuable information on patterns and trends over time. The next household budget survey is due to be carried out in 2026.

- Undocumented migrants with low incomes who have been in France for at least 90 days have free access to very similar benefits as legal residents, and without user charges, through the *aide médicale de l'État* (AME) [State medical aid] scheme. However, many people face administrative barriers that prevent them from enrolling in the AME scheme.

- People with any of 32 specified *affections de longue durée* [chronic conditions] are exempt from the *ticket modérateur* [percentage co-payments], although only for treatment of those conditions. People with these conditions represent around 18% of the population in France and are regular users of health care, which increases their risk of incurring catastrophic health spending.

The factors that are likely to undermine financial protection, particularly for households with low incomes, include the following weaknesses in coverage policy.

- User charges (co-payments) are widespread, heavy and complex. France is one of the very few countries that applies user charges to all types of health care, including primary care visits and emergency visits. It is also unusual in maintaining retrospective reimbursement for health care. The *ticket modérateur* [percentage co-payments] are widely applied and can lead to financial uncertainty for households when there are multiple goods or services with differing prices – for example, medicines, medical products and inpatient care. Balance billing is permitted in some outpatient and inpatient settings and accounts for almost all out-of-pocket payments for medical products and around half of out-of-pocket payments for outpatient visits.

- Although there are mechanisms to protect people from user charges – for example, exemptions and caps – these mechanisms are not sufficiently protective. People with low incomes and chronic conditions are not exempt from all co-payments, there is no overall cap on co-payments for anyone and existing caps for fixed co-payments are not linked to income, so they offer more protection to richer than poorer households.

- The SHI benefits package is relatively comprehensive but less generous for dental care, which may explain why unmet need for dental care was above the EU average in 2022 and marked by significant income inequality.

Complementary health insurance (CHI) covering SHI user charges plays an important role in the health system. It covers around 95% of the population and improves financial protection for most people due to sustained Government efforts to make access to CHI more affordable for everyone, and especially for households with very low incomes through the *Couverture Maladie Universelle Complémentaire* (CMU-C) [complementary universal health coverage] scheme (free CHI) and the *aide au paiement d'une complémentaire santé* (ACS) [complementary health insurance payment assistance] scheme (subsidized CHI). CHI does not fully address the problems caused by user charges, however, for several reasons.

- People in the poorest quintile are much less likely to have any form of CHI (11% had no CHI in 2017 compared to 4.5% on average). When they are covered, they are less likely to have good quality CHI.

- The thresholds for accessing CMU-C and ACS (now *Complémentaire Santé Solidaire* (CSS) [free or low-cost complementary health insurance]) do not benefit enough low-income households because they are set at a low level. People also experience administrative barriers to take-up; as a result, CSS only covers around 70% of the eligible population and the remaining 30% are unable to benefit from exemptions from user charges that target CSS beneficiaries.

- CHI is a highly regressive way of financing the health system, imposing a heavy financial burden on the poorer half of the population. In 2017 CHI premiums accounted for 6% of the household budget in the two poorest quintiles, compared to only 2.5% in the richest quintile.

Relying so heavily on CHI to provide financial protection also involves significant transaction and financial costs for the Government and employers.

Since 2000 the Government has taken important steps to strengthen financial protection, initially focusing on improving access to SHI and CHI and, more recently, focusing on reducing balance billing for medical products for dental care, optical care and hearing aids through the *100% Santé* [100% health] reform phased in between 2019 and 2021.

Building on this, the Government can do more to reduce unmet need and financial hardship, particularly for households with lower incomes and people with chronic conditions, and to limit the health system's reliance on CHI.

Public resources for health can be used more efficiently if they are directed towards reducing co-payments, including balance billing, by:

- exempting CSS beneficiaries and people with *affections de longue durée* [chronic conditions] from all co-payments, so that they no longer need CHI;
- setting an annual cap on all co-payments for the whole population and linking it to household income, so that it is more protective for people with lower incomes; and
- taking other steps to reduce financial uncertainty, increase transparency and enhance access – for example, limiting balance billing for all types of health care, replacing the *ticket modérateur* [percentage co-payments] with low, fixed co-payments and phasing out retrospective reimbursement.

At the same time, the Government can take steps to reduce the regressivity of CHI by:

- simplifying and automating administrative procedures to prevent households from losing CSS coverage from one year to another;
- setting monthly contributions low enough to encourage much greater take-up among people already eligible for CSS;
- reviewing the thresholds for receiving free or subsidized CHI (CSS) to see if they are high enough to cover all those at risk of poverty or social exclusion; and
- linking subsidies for CHI for Government and private-sector employees to income, so that these subsidies are limited to (or at least significantly more generous for) people with lower incomes.

The Government can also improve the coverage of dental care, to reduce income inequalities in unmet need for this type of care, and improve access to AME for undocumented migrants by simplifying and automating administrative procedures.

In addition to reducing financial hardship and unmet need, these measures would make the health system less complex and more transparent, fair and resilient.

1. Introduction

This review assesses the extent to which people in France experience financial hardship when they use health care. It covers the period from 2011 to 2023 using data from household budget surveys from 2011 and 2017 (the latest available year), data on unmet need for health services up to 2022 (the latest available year) and information on coverage policy (population coverage, service coverage and user charges) up to December 2023.

Research shows that financial hardship is more likely to occur when public spending on health is low relative to gross domestic product (GDP) and out-of-pocket payments account for a relatively high share of total spending on health (Xu et al., 2003; Xu et al., 2007; WHO, 2010; WHO Regional Office for Europe, 2019; WHO Regional Office for Europe, 2023). Increases in public spending or reductions in out-of-pocket payments are not in themselves guarantees of better financial protection, however. Policy choices are also important.

The French health system is organized through a social health insurance (SHI) scheme involving several non-competing funds. Entitlement to SHI benefits is based on legal residence (not on payment of contributions), with all funds offering the same relatively comprehensive benefits package. Although user charges (co-payments) are applied to most SHI benefits, including primary care visits and hospital admissions, about 95% of the population has complementary health insurance (CHI) to cover these co-payments. This unusually high level of CHI coverage reflects decades of Government intervention and investment, including the provision of free and heavily subsidized CHI for people with very low incomes. In 2021 CHI accounted for 12% of current spending on health (WHO, 2023). As a result of relatively high levels of public spending on health and spending through CHI, France has one of the lowest levels of out-of-pocket payments as a share of current spending on health in the European Union (EU) – around 9% in 2021 compared to a EU27[3] average of 19% and an EU14[4] average of 16% (WHO, 2023).

In the last two decades the Government has increased user charges but has also implemented a range of policies to promote affordable access to health care, starting in 2000 with a change in the basis for entitlement to publicly financed health coverage from employment and payment of contributions to residence and the introduction of free CHI for people with very low incomes.

This review is the first in-depth analysis of financial protection in France. Previous research has been limited in part due to the difficulty of identifying the extent to which out-of-pocket payments are subsequently reimbursed by the SHI scheme or CHI. Earlier studies using different methods from this study (Yerramilli et al., 2018) have found that France offers a good level of financial protection compared to other countries (Arsenijevic et al., 2016; Baird, 2016a; 2016b) and linked this finding to CHI coverage (WHO, 2010; Franc & Pierre, 2015).

The review is structured as follows. Section 2 sets out the analytical approach and sources of data used to measure financial protection. Section 3 provides a brief overview of coverage policy. Sections 4 and 5 present the results of the statistical analysis, with a focus on out-of-pocket

3. EU Member States as of 1 February 2020.

4. EU Member States before 1 May 2004 and as of 1 February 2020: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands (Kingdom of the), Portugal, Spain and Sweden.

payments in Section 4 and financial protection in Section 5 (covering both financial hardship and unmet need). Section 6 provides a discussion of the results of the financial protection analysis and identifies factors that strengthen and undermine financial protection. Section 7 highlights implications for policy.

2. Methods

This section summarizes the study's analytical approach and main data sources. More detailed information can be found on the Methods page of UHC watch (WHO Regional Office for Europe, 2024).

The analysis of financial protection in this study is based on an approach developed by the WHO Regional Office for Europe (Cylus, Thomson & Evetovits, 2018; WHO Regional Office for Europe, 2019), building on established methods of measuring financial protection (Wagstaff & van Doorslaer, 2003; Xu et al., 2003).

2.1 Financial hardship linked to out-of-pocket payments

Financial hardship is measured using two main indicators: impoverishing and catastrophic health spending. Table 1 summarizes the key dimensions of each indicator.

Table 1. Key dimensions of catastrophic and impoverishing spending on health

	Impoverishing health spending
Definition	The share of households *impoverished or further impoverished after out-of-pocket payments*
Poverty line	A *basic needs line*, calculated as the average amount spent on food, housing (rent) and utilities (water, electricity and fuel used for cooking and heating) by households between the 25th and 35th percentiles of the household consumption distribution who report any spending on each item, respectively, adjusted for household size and composition using Organisation for Economic Co-operation and Development (OECD) equivalence scales; these households are selected based on the assumption that they are able to meet, but not necessarily exceed, basic needs for food, housing and utilities; this standard amount is also used to define a household's *capacity to pay for health care* (see below)
Poverty dimensions captured	The share of households further impoverished, impoverished and at *risk of impoverishment after out-of-pocket payments* and the share of households not at risk of impoverishment after out-of-pocket payments; a household is impoverished if its total consumption falls below the basic needs line after out-of-pocket payments; further impoverished if its total consumption is below the basic needs line before out-of-pocket payments; and at risk of impoverishment if its total consumption after out-of-pocket payments comes within 120% of the basic needs line
Disaggregation	Results can be disaggregated into household *quintiles* by consumption and by other factors where relevant
Data source	Microdata from national *household budget surveys*
	Catastrophic health spending
Definition	The share of households with out-of-pocket payments that are greater than 40% of household capacity to pay for health care. This includes all households who are impoverished after out-of-pocket payments (because they no longer have any capacity to pay) and further impoverished (because they have no capacity to pay before or after out-of-pocket payments).
Numerator	Out-of-pocket payments
Denominator	A household's capacity to pay for health care is defined as total household consumption minus a standard amount to cover basic needs; the standard amount is calculated as the average amount spent on food, housing and utilities by households between the 25th and 35th percentiles of the household consumption distribution, as described above; this standard amount is also used as a *poverty line* (basic needs line) to measure impoverishing health spending
Disaggregation	Results are disaggregated into household quintiles by consumption per person using OECD equivalence scales; disaggregation by place of residence (urban–rural), age of the head of the household, household composition and other factors is included where relevant
Data source	Microdata from national household budget surveys

Note: see the Glossary provided by UHC watch for definitions of words in italics (WHO Regional office for Europe, 2024).

Source: WHO Regional Office for Europe (2019).

Financial hardship indicators are generated by analysing data from household budget surveys. This study analyses anonymized microdata from the *Budget des Familles* [household budget survey] carried out by the *Institut National de la Statistique et des Études Économiques* (INSEE) [French National Institute of Statistics and Economic Studies] every five years and most recently in 2011 and 2017. Analysis is limited to metropolitan France. The data sample consisted of 10 342 households in 2011 (a response rate of 67.1%) and 12 081 in 2017 (58.4%).

Measuring out-of-pocket payments in the French health system is complicated by the fact that many health services are subject to retrospective reimbursement by the SHI scheme rather than being provided as a benefit in kind (this is known as *tiers payant* [third party payment]); in contrast, almost all other EU countries provide all health care as a benefit in kind. This means that people first have to pay providers out-of-pocket for some covered health services – outpatient primary care and specialist visits, for example – and are then reimbursed (partially or in full) by the SHI scheme. In addition, a significant share of out-of-pocket payments in the form of user charges for SHI benefits are subsequently reimbursed by CHI.

In 2011 the household budget survey was changed to enable a more accurate assessment of out-of-pocket payments. The questionnaire makes it possible to distinguish between payments that are subsequently reimbursed by SHI and CHI and those that are not. As a result, the 2011 and 2017 waves of the survey are not comparable to earlier waves (1995 to 2006).

All currency units are presented in euros.

2.2 Unmet need for health care

Unmet need for health care due to cost, distance and waiting time (health system factors) is measured using data from European or national surveys (Box 1).

Box 1. Unmet need for health care

Unmet need is defined as instances in which people need health services but do not receive the care they need because of access barriers. Self-reported data on unmet need should be interpreted with caution, especially across countries. However, analysis has found a positive relationship between unmet need and a subsequent deterioration in health (Gibson et al., 2019) and between unmet need and the out-of-pocket payment share of current spending on health (Chaupain-Guillot & Guillot, 2014), which suggests that unmet need can be a useful indicator of affordable access to health care.

Every year EU Member States collect data on unmet need for health care (medical examination or treatment) and dental care (dental examination or treatment) through EU Statistics on Income and Living Conditions (EU-SILC) (Eurostat, 2024a. EU Member States also collect data on unmet need through the European Health Interview Survey (EHIS), carried out every 5–6 years (Eurostat, 2024b). The third wave of this survey was launched in 2019. Whereas EU-SILC typically provides information on unmet need as a share of the population, EHIS provides information on unmet need among people reporting a need for health care. EHIS also asks households about unmet need for prescribed medicines.

Financial protection analysis that does not account for unmet need could be misleading. A country may have a relatively low incidence of catastrophic health spending because many people face barriers to access and are unable to use the health services they need. Conversely, reforms that increase the use of health care can increase people's out-of-pocket payments – through, for example, user charges – if protective policies are not in place; in such instances, reforms might improve access to health care but at the same time increase financial hardship.

Source: WHO Regional Office for Europe (2019).

3. Coverage policy

This section briefly describes the governance and dimensions of publicly financed health coverage – population coverage, service coverage and user charges (co-payments) – and reviews the role played by CHI.

Legal residents are guaranteed access to publicly financed health services through a **SHI scheme** financed by employer contributions, an earmarked income tax (*Contribution Sociale Généralisée* (CSG) [general social contribution]) and transfers from the Government budget. The SHI scheme is managed by three funds and covers around 98% of the population. There is a general scheme covering 88% of the population (employees and, since 2018, self-employed people), a scheme for farmers and agricultural employees covering 10% of the population and special schemes for specific professions such as the military and notaries. All schemes together form the *Union Nationale des Caisses d'Assurance Maladie* (UNCAM) [National Union of Health Insurance Funds]. UNCAM defines the SHI benefits package and agrees prices with health care providers.

Alongside this, **CHI covering user charges (co-payments) for SHI benefits** plays an important role in the health system. CHI is provided by private entities on a mandatory basis for employees in the private sector (mandatory since 2016) and on a voluntary basis for the rest of the population. It covers around 96% of the population (Fouquet, 2020). The Government pays for CHI for people with a very low income (*Couverture Maladie Universelle Complémentaire* (CMU-C) [complementary universal health coverage] and subsidizes the cost of CHI for people with a low income (*aide au paiement d'une complémentaire santé* (ACS) [complementary health insurance payment assistance]). In 2019 the system was simplified through the creation of *Complémentaire Santé Solidaire* (CSS) [free or low-cost complementary health insurance programme], which allows these two groups to benefit from the same publicly financed CHI coverage, free of charge for people with a very low income (formerly CMU-C) and with a payment for others (formerly ACS).

There have been many reforms to health coverage in the last two decades. Key changes to coverage policy are summarized in Table 2.

Table 2. Changes to coverage policy, 2000–2024

Source: author.

Year	Month	Change	Health services targeted	Population group targeted
2000	January	A new law (CMU) changes the basis for entitlement from employment and payment of contributions to legal residence	All health services	People entitled to SHI benefits
2000	January	Introduction of means-tested access to free CHI (CMU-C) covering user charges for SHI benefits	All health services	Low-income households covered by the SHI scheme
2003	September	84 medicines with low therapeutic value delisted	Prescribed medicines	People entitled to SHI benefits
2005	January	Introduction of means-tested vouchers for subsidized access to CHI (ACS)	All health services	Low-income households covered by the SHI scheme
2005	January	Referral system strengthened through the introduction of a *médecin traitant* [preferred doctor] for referral to a specialist	Doctor visits (general practitioner (GP) or specialist)	People covered by the SHI scheme
2005	January	New fixed co-payments introduced, with an annual cap on these co-payments	Doctor visits and diagnostic tests	People covered by the SHI scheme (except people covered by CMU-C)
2005	January	Introduction of tax benefits for insurers who offer so-called "solidarity contracts" or "responsible contracts"	All health services	People with CHI
2006	January	282 medicines with low therapeutic value delisted	Prescribed medicines	People entitled to SHI benefits
2008	January	89 medicines with low therapeutic value delisted	Prescribed medicines	People entitled to SHI benefits
2008	January	New fixed co-payments introduced, with an annual cap on these co-payments	Outpatient medicines, paramedical services, medical transportation	People covered by the SHI scheme (except people covered by CMU-C)
2010	April	*Ticket modérateur* [percentage co-payments] for 150 medicines increased from 65% to 85%	Prescribed medicines	People entitled to SHI benefits
2011	October	26 medicines with low therapeutic value delisted	Prescribed medicines	People entitled to SHI benefits
2013	July	Sector 2 providers cannot balance bill ACS beneficiaries	Outpatient care	People covered ACS
2013	June	The National Inter-professional Agreement reform requires all employers in the private sector to provide subsidized CHI to employees with effect from 2016; employers must cover at least 50% of an employee's CHI premium and offer cover equal to or greater than a "basic" contract (implemented in January 2016)	All health services	Employees in the private sector
2014	January	The Social Security Financing Act, effective from January 2014, requires CHI companies to report the amount and composition of administrative costs as a percentage of premiums to enhance the transparency and comparability of CHI contracts.	All health services	People with CHI
2015	April	Responsible contracts must comply with additional obligations including the capping of reimbursements for optical care and for the extra fees of the physicians who have not signed an "access to health care" contract.	All health services	People with CHI
2015	April	Insurers are not allowed to cap the number of days for which the fixed co-payment for inpatient care (forfait hospitalier) is reimbursed per hospital stay.	Inpatient care	People with CHI
2015	July	ACS beneficiaries have to obtain their contract from a list of eligible providers selected by a public tender. Each provider's bid has to include three predefined coverage options	All health services	People with CHI
2015	July	ACS beneficiaries cannot be balance-billed by Sector 2 providers and they benefit from third-party payment. They are exempt from the fixed co-payments at the point of service and can decline mandatory coverage by the employer	All health services	People with ACS

Table 2. Contd

Year	Month	Change	Health services targeted	Population group targeted
2016	January	A new law *Protection Universelle Maladie* (PUMA) [universal health protection] replaces CMU and grants all legal residents an individual, automatic and continuous right to health care, without the need for administrative formalities when circumstances change	All health services	People entitled to SHI benefits
2016	January	CHI becomes compulsory for private sector workers	All health services	Employees in the private sector
2018	January	Fixed co-payments for inpatient stays increased from €18 to €20 per day	Inpatient care	People covered by the SHI scheme
2019	November	CMU-C and ACS modified to become CSS	All health services	Low-income households covered by the SHI scheme
2019-2021	From January 2019 to January 2021	The *100% Santé* reform improves SHI and CHI coverage of selected medical products for dental care, optical care and hearing aids and caps the retail price of these medical products; CSS beneficiaries and people with CHI no longer have to pay anything out of pocket for these products	Dental care, optical care and hearing aids	People covered by the SHI scheme
2022	January	Co-payment for emergency care changed to a single, fixed co-payment per visit to an emergency department, regardless of the type of care received (*forfait patient urgence* [emergency care package]) of €19.61. Previously the co-payment was calculated based on the services provided.	Emergency care	People covered by the SHI scheme
2022	January	The Government provides all public sector employees with a subsidy of €15 a month for CHI; the subsidy is set to rise to 50% of the CHI premium from 2024 and up to 2026 at the latest, matching the minimum share to be paid by employers in the private sector	All health services	Public employees
2023	August	*Ticket modérateur* [percentage co-payments] increased to 45% (up from 35%) for scheduled transportation	Medical transportation	People covered by the SHI scheme
2023	October	*Ticket modérateur* [percentage co-payments] increased to 40% (up from 30%)	Dental care	People covered by the SHI scheme
2023	November	The tariff for a consultation increased to €26.50 (up from €25)	Outpatient care (GPs in Sector 1)	People covered by the SHI scheme
2024	March	Fixed co-payments double for medicines (€1 per package, up from €0.50), procedures for a medical auxiliary (€1, up from €0.50) and medical transportation (€4, up from €2); the daily cap doubles for auxiliaries (€4, up from €2) and medical transportations (€8, up from €4)	Outpatient medicines, paramedical services, medical transportation	People covered by the SHI scheme

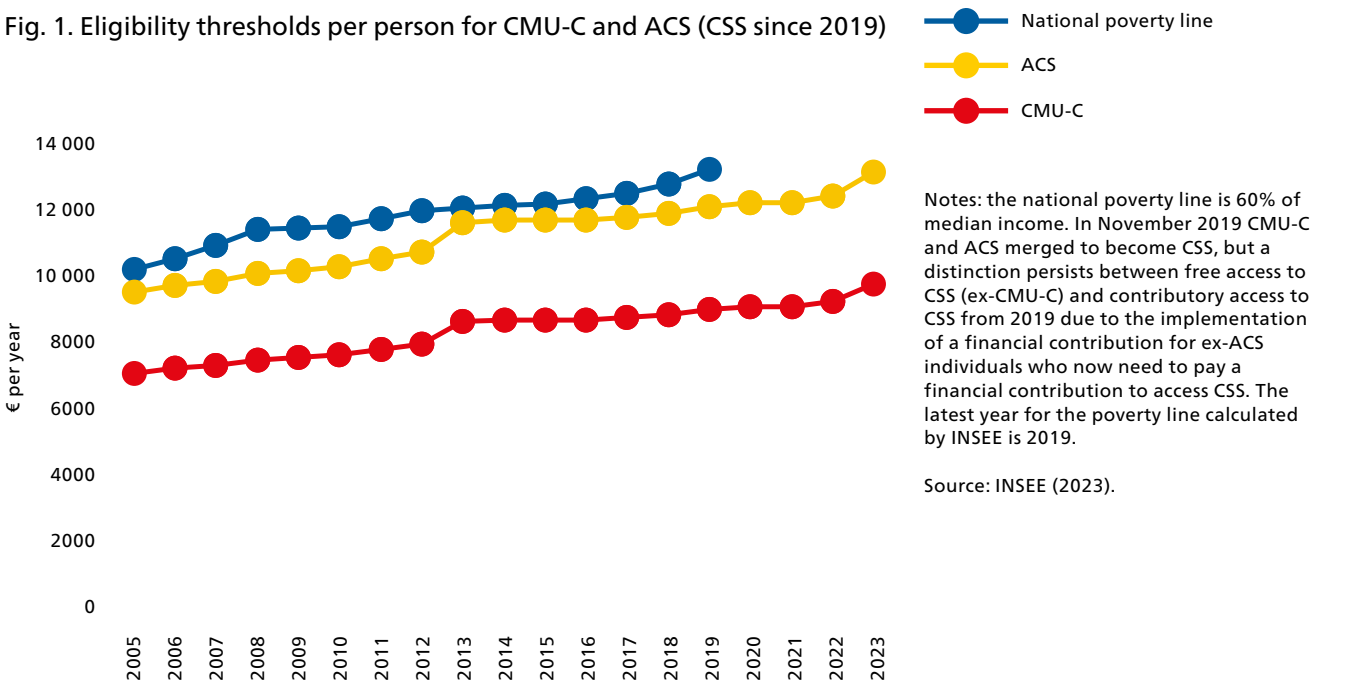
3.1 Population coverage

Entitlement to SHI benefits is based on legal residence (unlike in most countries with SHI schemes). In 2000 the law on *Couverture Maladie Universelle*, (CMU) [universal health coverage] changed the basis for entitlement from employment and payment of contributions to legal residence (see Box 2). Under CMU, dependent children and spouses were entitled to SHI benefits through the affiliation of a covered parent or spouse. In 2016 a new law – PUMA – granted all residents an individual, automatic and continuous right to health care, without the need for administrative formalities when circumstances change. PUMA entitles children aged 16 and over and dependent spouses to be covered in their own right.

People in an irregular situation – for example, undocumented migrants – can benefit from free access to health care through the *aide médicale de l'État* (AME) [State medical aid] scheme if they have been living in France for a continuous period of at least three months (this condition does not apply to children) and have an annual income of less than €9571 (for a single person) in 2023 (Fig.1). AME beneficiaries have access to more or less the same SHI benefits as legal residents (only thermal treatment, fertility treatment and medicines with low medical value are excluded from their entitlements) without user charges. People who are not eligible for AME (those in France for less than three months or above the income threshold) can only access emergency care.

In 2019 AME covered just over 300 000 people – only around half of all those who are eligible to benefit (Jusot et al., 2019; Wittwer et al. 2019). Low take up may reflect administrative barriers to enrolment: AME beneficiaries need to prove the amount of time they have been living in France and their income and must re-apply for the benefit each year.

Fig. 1. Eligibility thresholds per person for CMU-C and ACS (CSS since 2019)



Notes: the national poverty line is 60% of median income. In November 2019 CMU-C and ACS merged to become CSS, but a distinction persists between free access to CSS (ex-CMU-C) and contributory access to CSS from 2019 due to the implementation of a financial contribution for ex-ACS individuals who now need to pay a financial contribution to access CSS. The latest year for the poverty line calculated by INSEE is 2019.

Source: INSEE (2023).

Box 2. How France broke the link between entitlement to SHI benefits and payment of contributions by changing the basis for entitlement to residence

In 2000 France changed the basis for entitlement to SHI benefits from employment and payment of contributions to legal residence, under a new system known as CMU. The reform was driven by concerns about the growing number of young people who were not entitled to health insurance due to rising unemployment and other factors. In 2016 CMU was replaced by PUMA, which grants all legal residents an individual, automatic and continuous right to health care, without the need for administrative formalities when a person's circumstances change.

The SHI scheme has also broadened its revenue base. In 1991, provoked by concerns (subsequently justified) that social security financed exclusively through employment would not be sustainable in the future, the Government introduced a new tax on income – the CSG – to finance family allowances. The CSG was extended to old age pensions in 1993, sickness benefits in 1997 and SHI in 1998. It is levied on all sources of income, including income from wages, benefits, investments, property and gambling, with lower rates for income from benefits and higher rates for income from property and gambling.

Close to 40% of SHI revenue now comes from this earmarked income tax. Over time the CSG has replaced employee contributions for SHI, which fell from 32% of SHI revenue in 1999 to 3% in 2000 and were abolished in 2018. In 2019 employers' social contributions were reduced from 13% to 7% for salaries of less than 2.5 times the minimum income. To make up for this reduction, the share of value-added tax (VAT) transferred from the Government budget to finance health care increased sharply, from 0.3% of VAT revenue in 2018 to 23.1% in 2019.

Revenues from the CSG, employer contributions and other taxes are pooled by the SHI scheme and used to purchase a single benefits package for anyone who has been living in France legally and continuously for at least three months.

Source: author, adapted from Chevreul et al (2015) and WHO Regional Office for Europe (2023).

3.2 Service coverage

The SHI scheme offers a single, national benefits package covering a relatively comprehensive range of services including outpatient care provided by GPs, dentists and specialists; diagnostics tests and other paramedical services; inpatient care; prescription medicines and other covered medical products and equipment; health care related transportation; and home care. To be eligible for coverage, health services must be provided or prescribed by a doctor, dentist or midwife and dispensed by health care professionals or organizations recognized by the SHI scheme.

The benefits package is defined through an explicit positive list of covered services, medicines and medical products (known as *Liste des Produits et Prestations remboursables*). A negative list defines excluded medical procedures (for example, chiropractic care and cosmetic surgery).

Coverage and pricing decisions for procedures, medicines and medical products covered by the SHI scheme are defined at the national level by the Ministry of Health and the SHI scheme based on proposals from the Transparency Committee of the *Haute Autorité de Santé* (HAS) [High Health Authority] and ad hoc committees. Before adding items to the benefits package the HAS Commission for Economic Evaluation and Public Health requests an economic evaluation. Interventions are assessed by the Transparency Commission, which assigns a therapeutic value to medicines (known as *service médical rendu* (SMR) [rendered medical service]) and medical products and procedures (known as *service attendu* [expected service]). Medicines are classified into four categories according to their effectiveness (SMR level) and UNCAM assigns a coverage level for each category: major (100% of the tariff covered), important SMR (65%), moderate SMR (30%) and low SMR (15%). Between 2002 and 2011 public authorities delisted around 486 medicines in the low SMR category to contain costs (see Table 2) (Pichetti & Sermet, 2011).

The SHI scheme does not cover services provided by psychologists, dieticians or osteopaths and, since January 2021, homeopathic products. Since January 2022, however, people with mild to moderate mental disorders are covered for up to eight consultations a year with a psychologist upon prescription by a physician.

SHI coverage of **dental care, optical care (glasses and contact lenses) and hearing aids** is also limited, although recent reforms have aimed to make these types of care more affordable. For example, all dental care is subject to heavy user charges in the form of the *ticket modérateur* [percentage co-payments] (see below), periodontal treatment is limited to older adults and access to dental prosthetics is also limited (Winkelmann, Gómez Rossi & van Ginneken, 2022).

Many outpatient services (dental care, general and specialised outpatient care and care provided by midwives) are subject to retrospective reimbursement by the SHI scheme rather than being provided as a benefit in kind (this is known as *tiers payant* [third party payment]), except for patients with CMUC and ACS (since July 2015) and patients with certain *affections de longue durée* [chronic conditions] and maternity for the relevant treatments (since January 2017) This means that people first have to pay providers out-of-pocket for covered health services and are then reimbursed (partially or in full) by the SHI scheme. Only three countries in Europe allow retrospective reimbursement for publicly financed health care – Belgium, France and Luxembourg – and Belgium and France are trying to reduce it (Bouckaert, Maertens de Noordhout & Van de Voorde, 2023; WHO Regional Office for Europe, 2023).

A referral to specialist care is not a requirement. However, people are encouraged to designate a *médecin traitant*, typically a GP, to be their first point of contact during an episode of care and to provide referrals to specialists. Those who do not have a *médecin traitant* or self-refer to

a specialist must pay higher user charges than those referred by their *médecin traitant* (Dourgnon & Naiditch, 2010; Dumontet et al., 2017).

Access to health professionals and paramedical services is limited in some areas due to major disparities in the distribution of GPs and specialists (Vergier, 2016; Legendre et al., 2019 and Legendre, 2020). In 2018 6% of the population was considered to be living in an area with an insufficient number of GPs (Legendre et al., 2019). Lack of professionals is mainly a problem in rural areas, which are often called medical deserts (Chevillard & Mousquès, 2018).

Waiting times are an issue for specialists in ophthalmology, dermatology, cardiology, gynaecology and rheumatology, for whom waiting times are more than two months on average (Millien, Chaput & Cavillon, 2018).

3.3 User charges (co-payments)

User charges are applied to almost all SHI benefits, including primary care visits and hospital admissions (see Table 3). However, about 95% of the French population has CHI to cover these co-payments (see section 3.1.4).

Two main types of co-payments are applied: the *ticket modérateur* [percentage co-payments] and fixed co-payments introduced in 2005 and 2008.

The *ticket modérateur* [percentage co-payments] varies by type of health care, adherence to referral (for specialist visits) and therapeutic effectiveness (for outpatient medicines: 0% for highly effective medicines and between 15% and 100% for other medicines).

Fixed co-payments are in four broad groups:

- €1 for each doctor visit (GP and specialist) and diagnostic test, up to an annual cap of €50 (since 2005); there are discussions about doubling the fixed co-payment for doctor visits in 2024);
- €19.61 for an emergency visit; people with any of 32 specified *affections de longue durée* [chronic conditions] or with work-related injuries pay a reduced co-payment of €8.49 per visit;
- outpatient medicines (€1 per package), paramedical services (€1 per service up to a daily limit of €4) and medical transportation (€4 per journey up to a daily limit of €8), up to a separate annual cap of €50 (since 2008); so-called responsible CHI contracts do not cover these two groups of fixed co-payments (see section 3.4); and
- €18 per inpatient care day (since 1983), increased to €20 in 2018.

Balance billing is permitted for some doctors and dentists in outpatient settings; doctors in contracted private hospitals; and medical products such as crowns, bridges and dentures, glasses and contact lenses and hearing aids, as follows:

- doctors belonging to a list called "Sector 2" are allowed to charge higher than the agreed tariff for SHI benefits; in 2018 around 10% of GPs and 47% of specialists were on the Sector 2 list, with balance billing accounting for a larger share of specialist fees than GP fees (DREES, 2019);

- dental care is subject to balance billing for providers in Sector 2 and medical products; and

- medical products are subject to the *ticket modérateur* [percentage co-payments] of 40% of the tariff of reimbursement by the SHI scheme and people have to pay any difference between the tariff and the retail price; because medical products are not subject to price limits, this results in significant balance billing.

The following mechanisms have been put in place to regulate or limit balance billing.

- Balance billing for doctor visits has not been permitted for people with CMU (since 2000) or for people with ACS (since 2013).

- Since 2015, responsible contracts must comply with a cap on the coverage of balance billing when the doctor has not adhered to the "access to care contract" (a contract in which they commit not to increase the average level of balance billing and the share of activity subject to balance billing in exchange for partial coverage of their social security contribution).

- The *100% Santé* reform launched in 2019 aims to restrict balance billing for selected medical products (hearing aids, glasses and dental prostheses) for CSS beneficiaries and people covered by a so-called "responsible" CHI contract. The reform started to reduce out-of-pocket payments for medical products for this group of people by increasing Government tariffs (to reduce co-payments) and capping retail prices for a basic set of medical products (to prevent balance billing). In 2021 these policy changes were fully implemented, so all medical products are now available without balance billing – in other words, people should not have to pay more than 40% of the SHI tariff for this selection of medical products and should not incur any out-of-pocket payments after reimbursement by CHI. However, providers can still offer people medical products not included in the selection.

Extra billing is permitted for some services in hospitals.

Exemptions, caps and **CHI** are used to protect people from co-payments.

The following are exempt from co-payments.

- **People:** CMU-C and ACS beneficiaries (now CSS) and children up to 18 years are exempt from fixed co-payments. CMU-C and ACS beneficiaries (now CSS) are exempt from balance billing.

- **Services:** people with any of 32 specified *affections de longue durée* [chronic conditions] are exempt from the *ticket modérateur* [percentage co-payments], but only for treatment of those conditions. The list of conditions includes anaemia, cancer, chronic obstructive pulmonary disease, coronary heart disease, cystic fibrosis, dementia, diabetes,

epilepsy, haemophilia, heart failure, HIV infection, kidney disease, leprosy, liver disease, long-term psychiatric conditions, multiple sclerosis, organ transplant, paraplegia, Parkinson's disease, rheumatoid polyarthritis, schistosomiasis, stroke, tuberculosis and ulcerative colitis. In 2017 12 million people (18% of the population) had one of these specified chronic conditions and these conditions accounted for almost 60% of spending on health submitted for reimbursement (Adjerad & Courtejoie, 2021).

There is no overall cap on co-payments. Fixed co-payments are subject to daily caps (depending on the type of service) and two annual caps, both set at €50 a year. There is a cap on the *ticket modérateur* [percentage co-payments] for inpatient care after 30 consecutive days of inpatient care stay, but it is not an annual cap. None of these caps is linked to household income.

CHI plays a large role in protecting people from the *ticket modérateur* [percentage co-payments] for SHI benefits and is discussed in detail in the next section.

Table 3. User charges for publicly financed health services, 2024

Source: author.

Service area	Type and level of user charge	Exemptions	Cap
Outpatient care			
GP and specialist visits	*Ticket moderáteur* [percentage co-payments]: 30% for a doctor visit Fixed co-payment: €1 per visit up to a daily cap of €4 for visits to the same doctor Balance billing permitted for doctors in Sector 2	People with any of 32 *affections de longue durée* [chronic conditions] are exempt from the ticket modérateur [percentage co-payments] for treatment of those conditions only CMU-C and ACS beneficiaries (now CSS) and children up to 18 years are exempt from fixed co-payments CMU-C and ACS beneficiaries (now CSS) are exempt from balance billing for doctor visits Since 2019 balance billing for a basic selection of medical products is capped for CMU-C beneficiaries (now CSS) and people with a "responsible" CHI contract; this applies to medical products for dental care (crowns, bridges and dentures), optical care (glasses) and hearing aids (see Table 2 for the *100% Santé* reform)	No overall cap and no cap on the *ticket modérateur* [percentage co-payments] Daliy cap of €4 for fixed co-payments for outpatient primary care visits to the same doctor, €4 for paramedical services and €8 for for medical transportation Annual cap of €50 for fixed co-payments for doctor visits and diagnostic tests and a separate annual cap of €50 for fixed co-payments for medicines, paramedical services and medical transportation
Dental visits	*Ticket moderáteur* [percentage co-payments]: 40% for a dentist visit Balance billing permitted for dentists in Sector 2		
Medicines	*Ticket moderáteur* [percentage co-payments]: 0% for highly effective medicines (major SMR) and 35% (important SMR), 70% (moderate SMR) or 85% (low SMR) for other medicines Fixed co-payment: €0.50 per package		
Diagnostic tests and other paramedical services	*Ticket moderáteur* [percentage co-payments]: 40% for paramedical services and diagnostic tests; 45% for scheduled medical transportation Fixed co-payment: €1 for a diagnostic test and €4 for medical transportation and €1 for paramedical services		
Medical products	*Ticket moderáteur* [percentage co-payments]: 40% for medical products, including crowns, bridges and dentures in dental care Balance billing permitted but restricted since the *100% Santé* reform		
Emergency visits	Fixed co-payment: €19.61 per visit (*forfait patient urgence*) People with any of 32 specified *affections de longue durée* [chronic conditions] or with work-related injuries: €8.49 per visit	Newborns in the first 30 days Maternity care from the last four months of pregnancy until 12 days postpartum Recipients of a disability pension and beneficiaries after an accident at work or an occupational disease with a disability of at least two thirds Military pensioners	No

Table 3. contd

Service area	Type and level of user charge	Exemptions	Cap
Inpatient care			
Inpatient care	People have to pay the highest of the following two amounts computed over the length of the stay: • *ticket moderáteur* [percentage co-payments]: 20% of the total bill • fixed co-payment: €20 per day in hospital (€15 in psychiatric facilities) Balance billing is permitted for physician services in public and private hospitals Extra billing is permitted in public and private hospitals for more comfortable accommodation (e.g. a single room, telephone, television etc.)	People with any of 32 *affections de longue durée* [chronic conditions] are exempt from the ticket modérateur [percentage co-payments] for treatment of those conditions only Maternity care in the last four months of pregnancy until 12 days postpartum; newborns in the first 30 days; occupational injuries; children with disabilities under the age of 20 living in institutions; and military pensioners Exempt from the *ticket modérateur* [percentage co-payments] only: a person hospitalized for therapeutic or diagnostic procedures with a tariff over €120 (a fixed co-payment of €24 is applied instead of the ticket modérateur [percentage co-payments]; this fee does not apply to diagnostic imaging, emergency transport or transport between care facilities and applies only once per hospital stay) and hospitalization above 30 consecutive days (100% coverage begins on the thirty-first day) Extra billing is exempt if the need for additional comfort is medically justified	No overall cap If the *ticket modérateur* [percentage co-payments] is higher than the fixed co-payment calculated over the whole stay then only the *ticket modérateur* [percentage co-payments] applies and the fixed co-payment applies only once for the last day Cap per inpatient stay on the *ticket modérateur* [percentage co-payments] after 30 consecutive days in hospitals; the cap does not apply to balance billing or extra billing

3.4 The role of CHI

CHI plays a substantial complementary role in the health system in France, mainly covering co-payments and balance billing for SHI benefits. In 2019 CHI covered 96% of the population and in 2021 it accounted for 13% of current spending on health (Pierre & Rochereau, 2022; WHO, 2024).

CHI is provided mainly by not-for-profit, employment-based mutual associations or provident institutions but also by commercial (for profit) entities. The majority of CHI contracts are purchased by individuals (51% of the population), followed by group contracts (38%) and CMU-C (7%) (Fouquet, 2020).

The exceptionally high take up of CHI in France reflects decades of effort by the Government to ensure that CHI is accessible and affordable (Franc & Couffinhal, 2020). The following paragraphs summarize three key public policy strategies to promote the take-up of CHI.

Free or subsidized CHI for people with low incomes

- In 2000 the Government introduced free access to CHI (CMU-C) for people with a very low income. In 2004 it introduced subsidized CHI (ACS) for people with a low income who were not eligible for CMU-C. Unfortunately, neither of these schemes has managed to achieve high levels of take up. In 2021 about 7.2 million people benefited from CMU-C and ACS, but it is estimated that almost 10 million were eligible (Blanchon et al., 2021). Low take-up might be due to lack of information for users or complex administrative procedures as people need to apply every year and prove their income (Franc & Couffinhal, 2020).

- At the end of 2019 CMU-C and ACS were modified to become a new scheme with a simplified approach (CSS): people are offered a single contract, still free for those eligible for CMU-C and those eligible for ACS can now benefit from the same coverage as CMU-C by paying a monthly contribution of €8 for a person aged under 30 years up to €30 for a person aged 70 or over. In 2023 the annual income thresholds for a single person to be eligible for CSS were €9719 (free CSS) and €13 120 (subsidized contributory CSS) in the previous 12 months. This is lower than the national poverty line of €13 224 in 2019 (60% of median income). Over time annual income thresholds to access CSS have always been below the national poverty line and have increased on a par with it (see Fig. 1).

Mandatory CHI for employed people

In 2013 the Government introduced a requirement for all **employers in the private sector** (the National Inter-professional Agreement reform) to provide subsidized CHI to all employees no later than 1 January 2016. Employers must cover at least 50% of an employee's CHI premium and offer cover equal to or greater than a "basic" contract; the rest of the premium is paid by the employee. The same law also improved the portability of CHI contracts for people who lose their job; these people can now keep their CHI contract for up to 12 months after the end of their employment contract. The reform mainly resulted in a transfer of individual contracts to group contracts rather than significantly increasing the share of the population covered by CHI (Pierre & Jusot, 2017). The share of private-sector employees covered by a group contract rose from 75% before the reform to 84% in 2017 (Lapinte & Perronnin, 2018), mainly benefiting employees with precarious jobs (Fouquet, 2020). Analysis has found that higher-earning employees generally benefit from more generous CHI coverage, both in terms of the scope of services covered and the extent of the employer subsidy (Perronnin & Raynaud, 2020).

For **public employees**, a separate reform introduced in 2022 set a Government subsidy of €15 a month for CHI. The subsidy is set to rise to 50% of the CHI premium in 2024, matching the minimum share to be paid by employers in the private sector.

Regulation of CHI premiums and benefits

CHI premiums and benefits have typically differed significantly across people, but they are increasingly regulated. In 2005 the Government introduced tax benefits for insurers who offer so-called solidarity or responsible contracts and several waves of contract regulation were put in place from there. These "solidarity" and "responsible" contracts now account for around 95% of all CHI contracts.

- **Solidarity CHI contracts** do not link access to CHI or CHI premiums to health status.

- **Responsible CHI contracts** should fully cover the *ticket modérateur* [percentage co-payments] (except in the case of self-referral for specialist visits, to respect the referral system) and fixed co-payments for inpatient stays and emergency care (but should not cover fixed co-payments for outpatient care. The coverage of balance billing is also limited to encourage providers not to increase prices.

- In 2019 the Government introduced the ***100% Santé*** reform, which aimed to restrict balance billing for selected medical products for dental care, optical care and hearing aids so that by 2021 100% of the cost would be covered jointly through the SHI scheme and CHI for all CSS and CHI beneficiaries, meaning that they no longer incur any out-of-pocket payments for these products. To maintain freedom of choice, people can still opt for medical products with prices that are not capped.

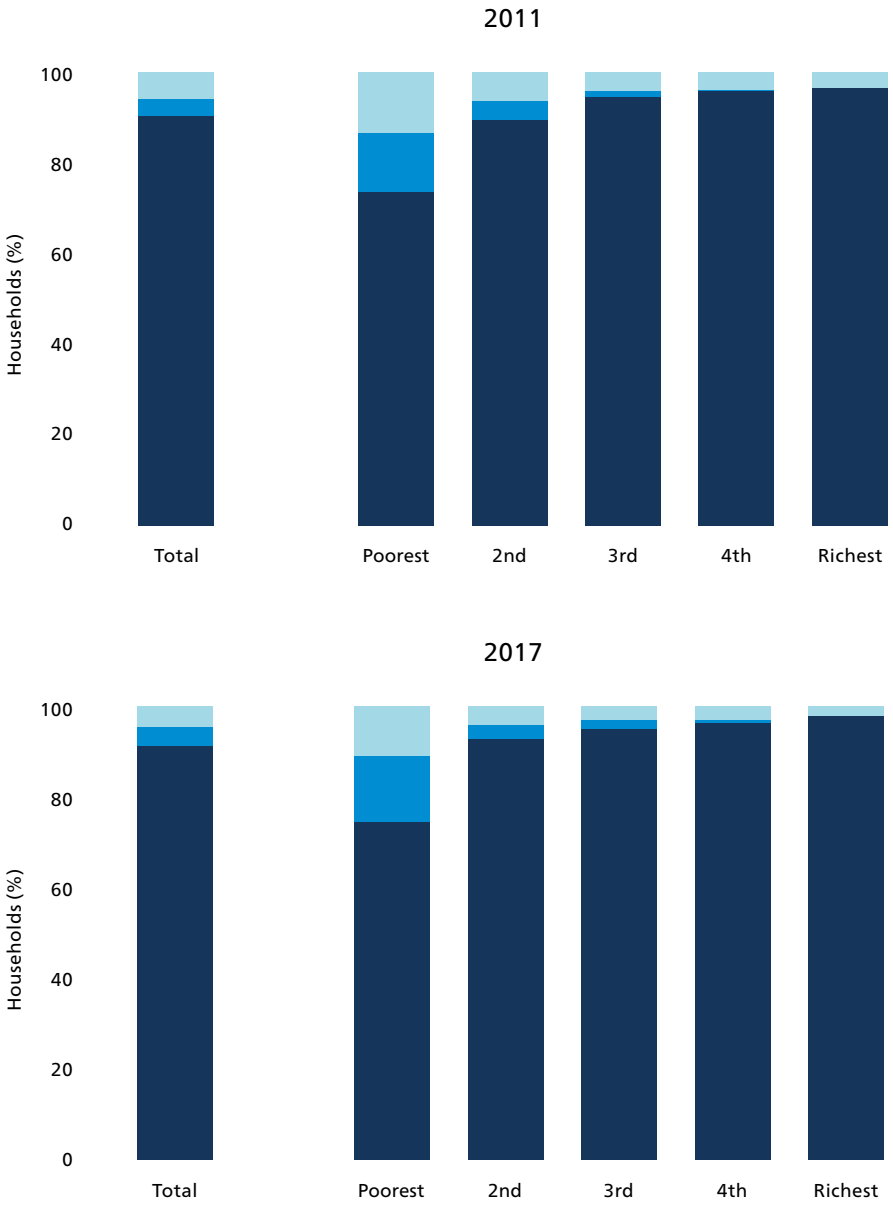
In spite of these sustained public policy efforts, CHI still does not cover all households and lack of CHI coverage is much higher among poorer than richer households. Data from the household budget survey indicate that just over 95% of households were covered by some form of CHI in 2017, up slightly from 94% in 2011 (Fig. 2). In both years there are significant differences in CHI coverage across consumption quintiles. On average 4.5% of households did not have any form of CHI in 2017, but this share ranged from 2% in the richest quintile to 11% in the poorest quintile (Fig. 2), reflecting low levels of take-up of CMU-C and ACS, but also a problem of affordability for those above the eligibility thresholds.

The share of households with CMU-C was slightly higher in 2017 than in 2011 (by 0.6 percentage points). Not surprisingly, the share of households with CMU-C is much higher in the poorest (15%), second (3%) and third (2%) quintiles than in the two richest quintiles.

Household budget survey data indicate that households without any form of CHI are most likely to be headed by younger people, unemployed people and other inactive people and is most common in single-parent households (Fig. 3). Between 2011 and 2017 the share of households without any form of CHI fell, probably reflecting the increase in eligibility thresholds for CMU-C and ACS, the requirement for private-sector employers to subsidize CHI for employees and efforts to increase the portability of CHI contracts.

Table 4 highlights the main gaps in publicly financed coverage and indicates the role of CHI in filling these gaps.

Fig. 2. Breakdown of households by CHI status and consumption quintile



Notes: ACS is included in the CHI category. Quintiles are based on per person consumption adjusted for household size and composition using OECD equivalence scales.

Source: author, based on household budget survey data.

Fig. 3. Share of households without CHI or CMU-C by age, economic activity and household composition

Source: author, based on household budget survey data.

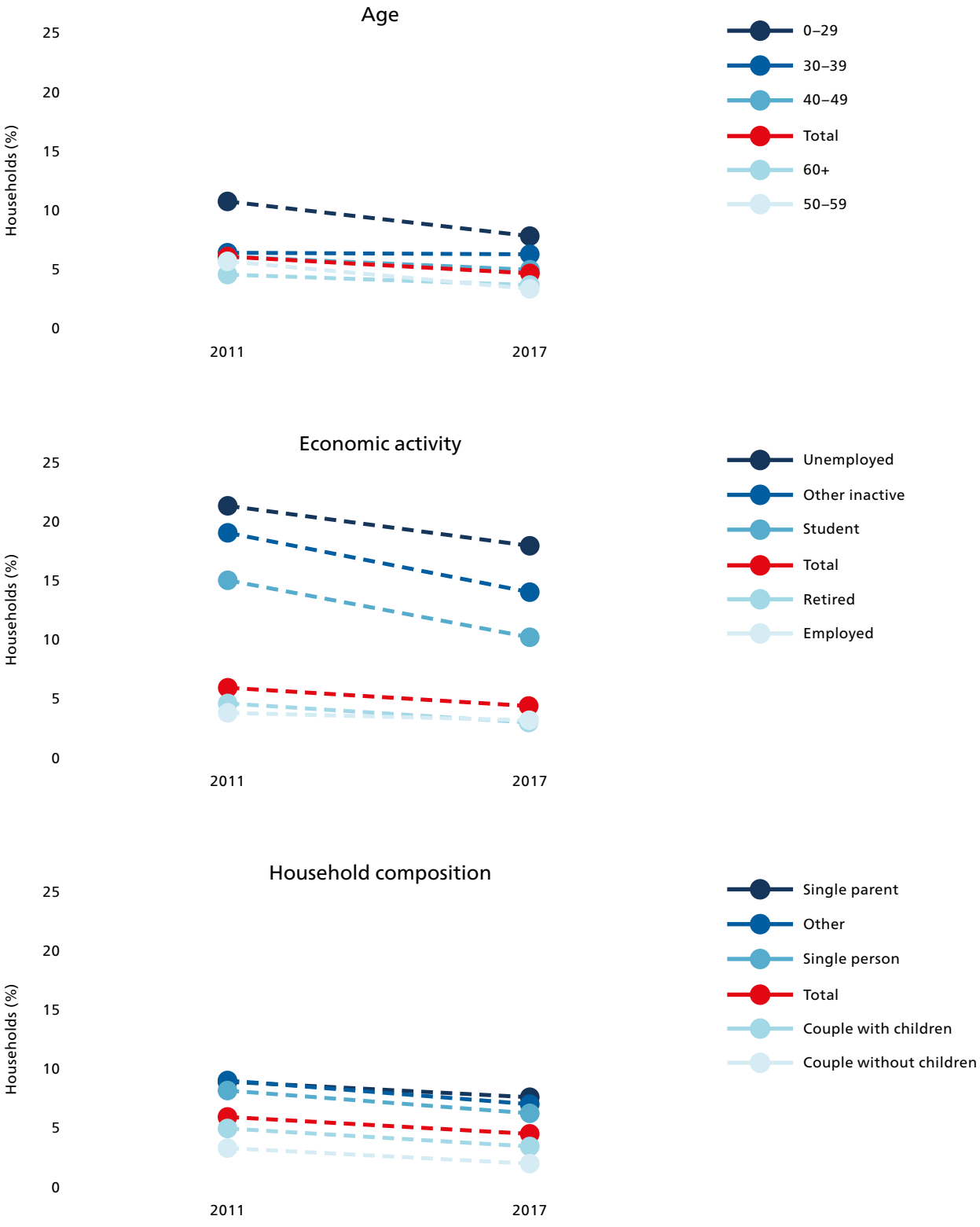


Table 4. Main gaps in coverage

Source: author.

	Main gaps in publicly financed coverage	Are these gaps covered by CHI?
Population coverage	Undocumented migrants are excluded from the SHI scheme but can benefit from free access to health care through AME if they have been in France for at least three months and have an annual income of less than €9571 (for a single person). People living in France for less than three months can access emergency care only.	No.
Service coverage	Some medical goods and services are less well-covered by the SHI scheme – particularly dental care and medical products such as glasses and hearing aids.	To a limited extent: coverage for these medical goods and services largely depends on the quality of CHI contracts. Since 2021 CHI contracts have had to offer a minimum level of coverage of dental care, glasses and hearing aids without out-of-pocket payments (*100% Santé* reform).
User charges (co-payments)	User charges are applied to all types of health care, mainly in the form of the *ticket modérateur* [percentage co-payments]. There is no cap on the *ticket modérateur* [percentage co-payments]; caps on fixed co-payments are not linked to household income. Balance billing is permitted for some GPs and specialists (in Sector 2), dental care and medical products such as optical care (glasses and contact lenses) and hearing aids; it is also permitted for physician services in SHI-contracted private hospitals. Extra billing is permitted in public hospitals and private hospitals (e.g. supplements for more comfortable accommodation).	To a large extent: CHI covers the *ticket modérateur* [percentage co-payments], although so-called responsible CHI contracts do not cover fixed co-payments for outpatient care and only more expensive CHI contracts cover balance billing for doctors, dental care and medical products such as glasses and hearing aids. However, CHI does not fully address the problems caused by user charges: households with the lowest incomes are the least likely to have any form of CHI and CHI is a highly regressive way of financing the health system.

3.5 Summary

The basis for entitlement to publicly financed health care has some highly protective features: entitlement to SHI benefits is based on legal residence rather than payment of contributions (since the CMU reform in 2000); legal residents have an individual and permanent right to SHI coverage (since the PUMA reform in 2016); and undocumented migrants with low incomes who have been in France for more than 90 days are entitled to very similar benefits to legal residents through the AME scheme.

The SHI scheme offers a single, national benefits package covering a relatively comprehensive range of services. Although coverage of dental care, optical care and hearing aids is less generous, recent reforms (*100% Santé*) have tried to address this by ensuring that selected medical products are fully covered by SHI and CHI for most of the population.

Access to health professionals and paramedical services is limited in some areas due to major disparities in the distribution of GPs and specialists. Waiting times are an issue for some specialised doctors.

Unlike in most other EU countries, retrospective reimbursement is still maintained in outpatient care.

A complex system of user charges is applied to all types of health care, with heavy use of the *ticket modérateur* [percentage co-payments] and balance billing. Extra billing is permitted in private hospitals. There are partial exemptions from co-payments: people with very low incomes (CSS beneficiaries, see below) and all children are exempt from fixed co-payments only, while 32 *affections de longue durée* [chronic conditions] are exempt from the *ticket modérateur* [percentage co-payments] for those conditions only. Although there are some caps on fixed co-payments, these are not linked to income and there is no overall cap on co-payments.

CHI covers user charges (co-payments and some balance billing) for SHI benefits and covers around 96% of the population. The Government provides free CHI for people with a very low income (CMU-C) and subsidizes the cost of CHI through ACS. Since 2019 the system has been simplified: the CSS scheme allows these two groups of people to benefit from the same publicly financed CHI coverage, free of charge for former CMU-C beneficiaries and through the payment of contributions for former ACS beneficiaries. CHI take up is much lower in poorer quintiles, reflecting low take up of CSS, a CSS eligibility threshold that is too low and financial difficulties in accessing CHI for people above the CSS eligibility threshold.

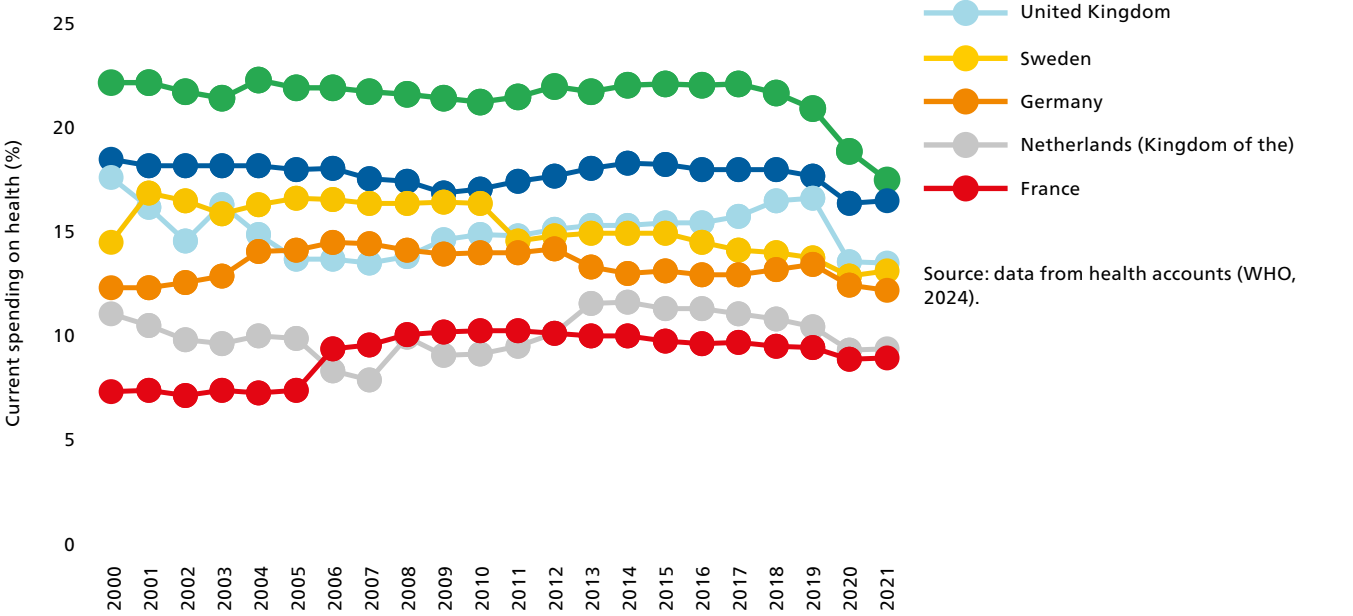
4. Household spending on health

The first part of this section uses data from national health accounts to present patterns in public and private spending on health. The second and third parts use household budget survey data to review out-of-pocket payments (the formal and informal payments made by people at the time of using any good or service delivered in the health system) and household spending on CHI premiums. The fourth part considers the role of informal payments.

4.1 Public and private spending on health

Data from national health accounts indicate that France has the lowest level of out-of-pocket payments as a share of current spending on health in Europe: 9% in 2021 compared to an EU14 average of 16% and an EU27 average of 19% (Fig. 4).

Fig. 4. Out-of-pocket payments as a share of current spending on health, France and selected countries



Source: data from health accounts (WHO, 2024).

Low reliance on out-of-pocket payments partly reflects relatively high levels of public spending on health. In 2021 public spending on health accounted for 9% of GDP in France, similar to Austria, Denmark and Sweden but lower than Germany (Fig. 5). The health share of the Government budget grew to 15.7% in 2021, up from 13.5% in 2000 and on a par with the EU14 average, but it remains significantly smaller than in these peer countries (17–20%) (Fig. 6). Public spending on health has increased over time but much more slowly since 2010 (Fig. 7). There was a higher than usual increase in 2020 in response to the coronavirus disease (COVID-19) pandemic.

Fig. 5. Public spending on health and GDP per person in EU14 countries, 2021

Notes: public spending on health is defined here as revenue from the government budget and SHI contributions. France is shown in red. The figure excludes Ireland and Luxembourg because they are outliers in terms of GDP per person and the Netherlands (Kingdom of the) because the Dutch data on public spending on health are not internationally comparable.

Source: data from health accounts (WHO, 2024).

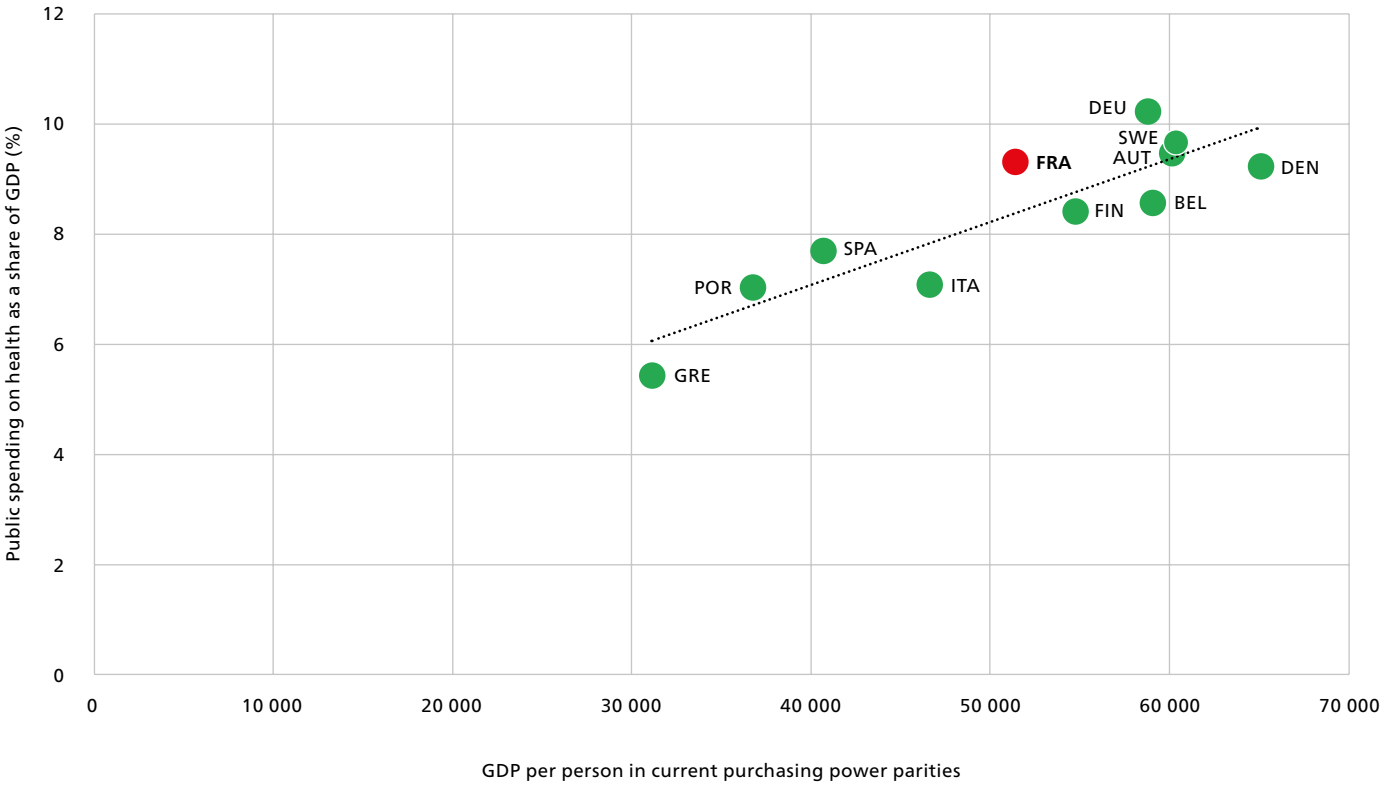
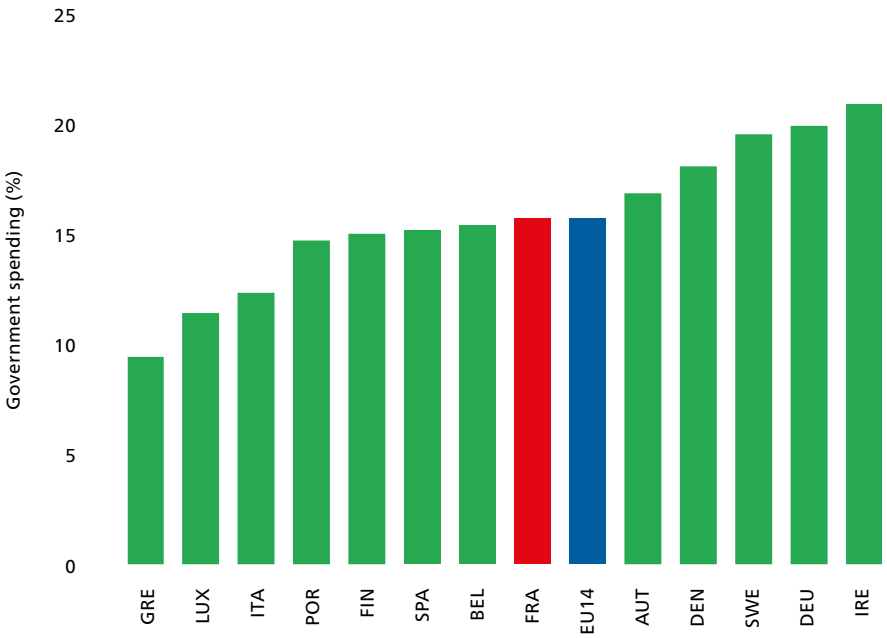


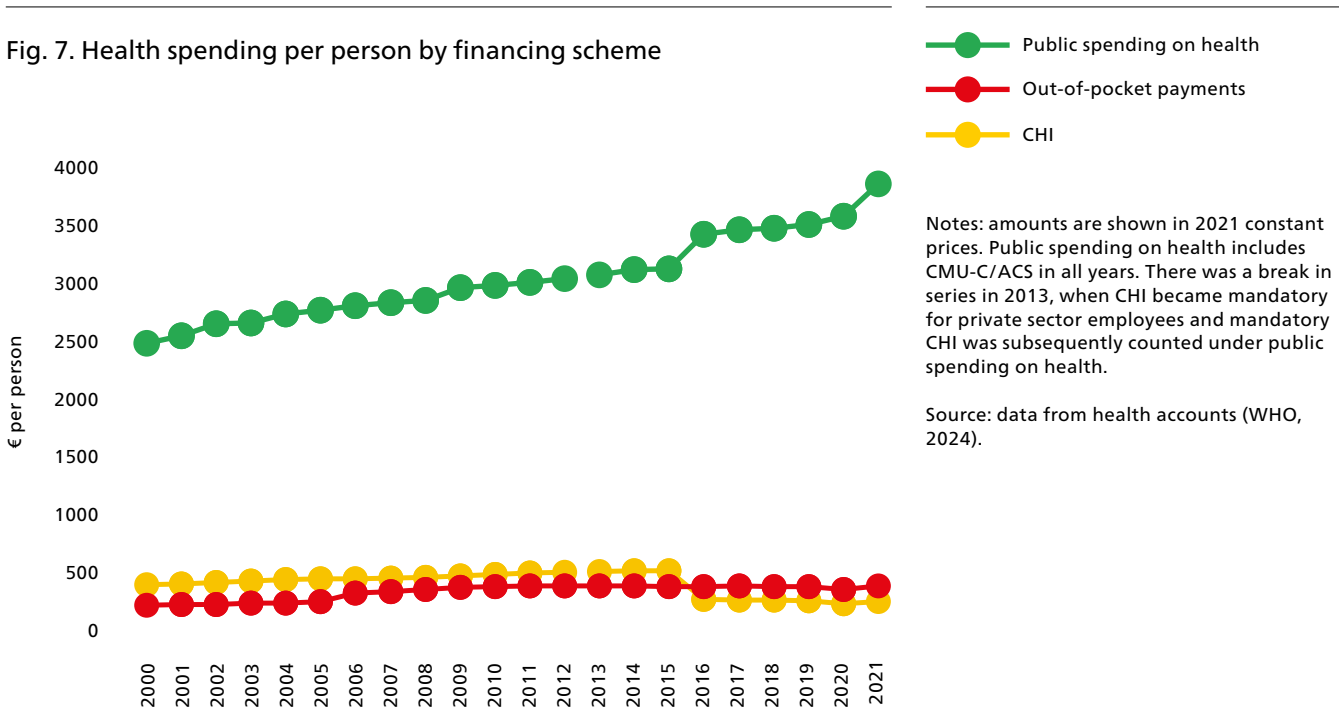
Fig. 6. Public spending on health as a share of the Government budget in EU14 countries, 2021



Notes: public spending on health is defined here as revenue from the Government budget and SHI contributions. The figure excludes the Netherlands (Kingdom of the) because of lack of comparability of the data on public spending on health.

Source: data from health accounts (WHO, 2024).

Fig. 7. Health spending per person by financing scheme



Notes: amounts are shown in 2021 constant prices. Public spending on health includes CMU-C/ACS in all years. There was a break in series in 2013, when CHI became mandatory for private sector employees and mandatory CHI was subsequently counted under public spending on health.

Source: data from health accounts (WHO, 2024).

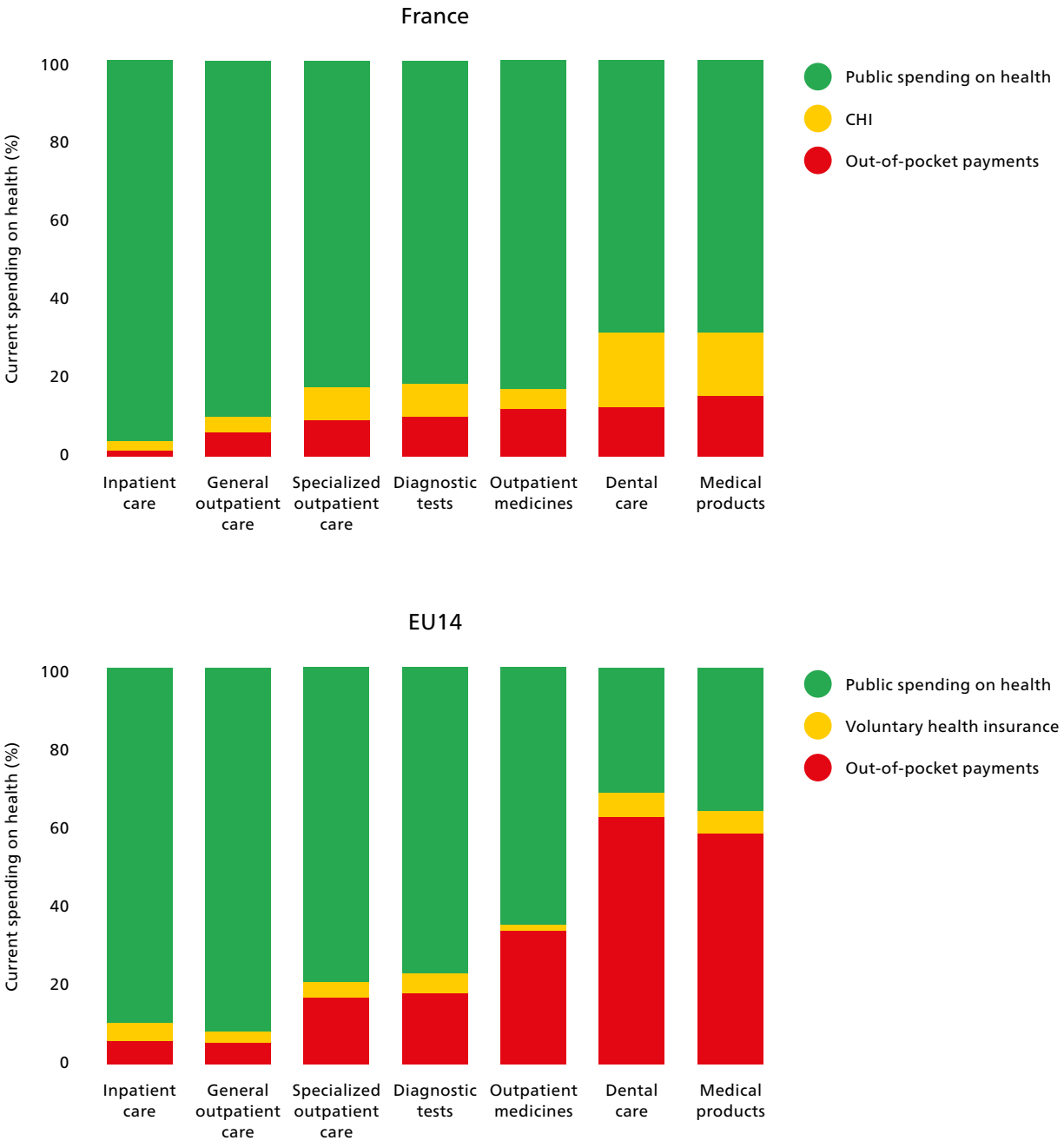
Low reliance on out-of-pocket payments also reflects unusually high levels of spending through CHI, which accounted for 13% of current spending on health in 2021 compared to an EU27 average of around 4% (WHO, 2024). The only other EU countries with similar shares are Ireland (10%) and Slovenia (12%). Note that since 2016, when CHI became compulsory for employees in private companies, around half of all spending through CHI is counted as compulsory in national accounts and international databases, which complicates international comparison of voluntary health insurance and public spending on health. The figure of 13% includes spending through both voluntary and compulsory CHI in France. Fig. 7 shows the change in CHI classification from 2013. Before 2013 CHI spending per person was higher than out-of-pocket payments per person but since then it is below out-of-pocket payments per person.

Out-of-pocket payments per person increased from 2005 to 2010, stabilized then fell slightly from 2011 (see Fig. 7). The sharp increase in 2006 is due to the introduction of new fixed co-payments in 2005, a reduction in coverage of the least effective medicines and the introduction of the *médecin traitant* referral system (see Table 2), which imposed higher co-payments on people visiting specialists without a referral. Out-of-pocket payments per person continued to increase in the following years due to measures aimed at reducing the social security deficit, including the introduction of a second wave of new fixed co-payments in 2008, reaching a peak in 2010. Since 2011, out-of-pocket payments have decreased, mainly due to the growing share of people who are exempt from co-payments for treatment of 32 *affections de longue durée* [chronic conditions] (Grangier, 2018) (see section 3.3 for details).

Broken down by type of care, the out-of-pocket payment share of current spending on health is highest for medical products, dental care and outpatient medicines (Fig. 8). Over time, however, the out-of-pocket payment share has fallen for these services, especially for medical products, reflecting CHI's growing role in covering this type of care (data not shown).

Fig.8. Breakdown of current spending on health by type of service and financing agent, France and EU14, 2021

Source: data from national health accounts (OECD, 2024).

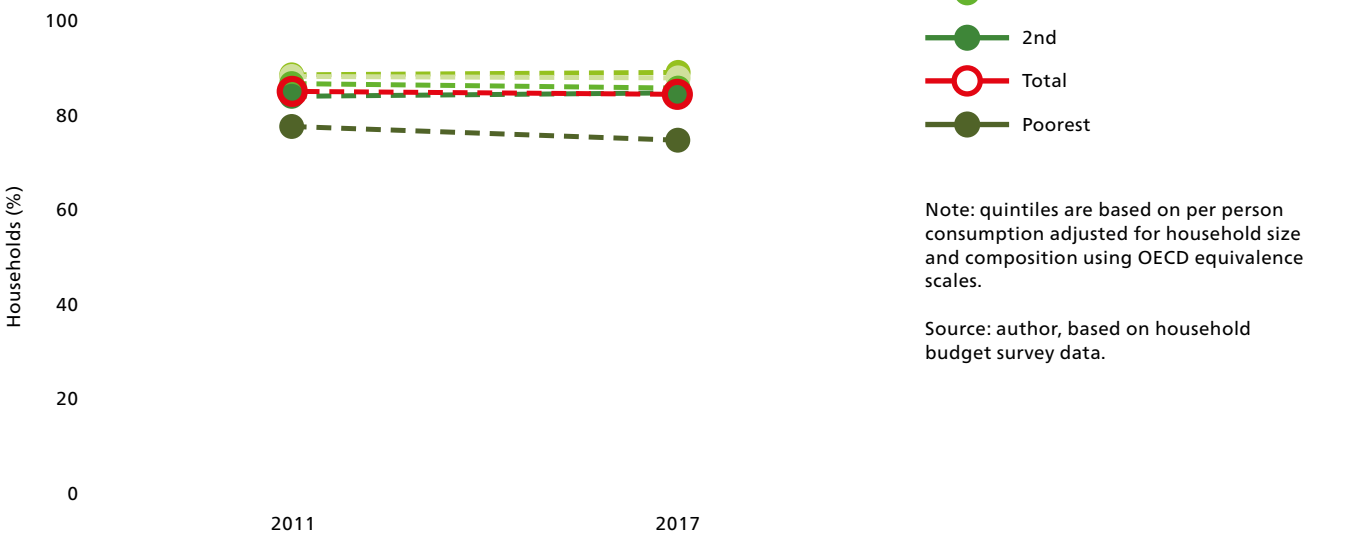


4.2 Out-of-pocket payments

In 2011 and 2017 about 85% of households reported out-of-pocket payments. Households in the poorest consumption quintile were least likely to report out-of-pocket payments in both years (Fig. 9).

In the poorest quintile households covered by CMU-C were much less likely to report out-of-pocket payments than households with or without CHI (Fig. 10). This could reflect the fact that households with CMU-C or ACS are exempt from fixed co-payments for SHI benefits, in contrast to households with or without CHI (see Table 3). It could also indicate unmet need for health care in this group of very poor households.

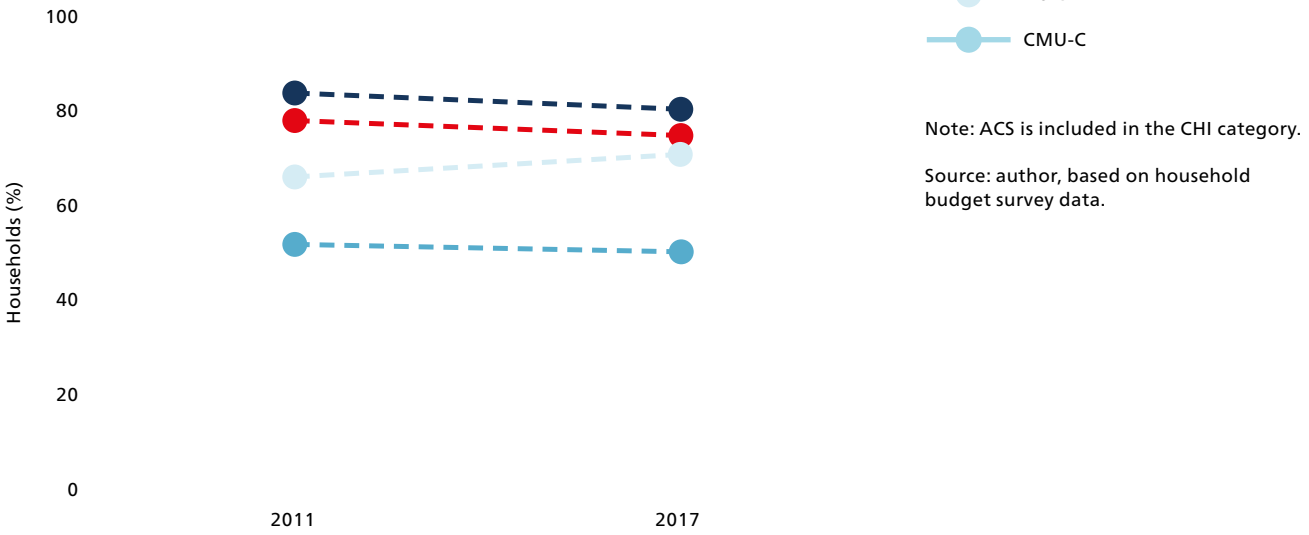
Fig. 9. Share of households with out-of-pocket payments by consumption quintile



Note: quintiles are based on per person consumption adjusted for household size and composition using OECD equivalence scales.

Source: author, based on household budget survey data.

Fig. 10. Share of households with out-of-pocket payments in the poorest consumption quintile by CHI status



Note: ACS is included in the CHI category.

Source: author, based on household budget survey data.

The average amount spent out of pocket per person was €237 in 2017, ranging from €92 in the poorest quintile to €457 in the richest (Fig. 11). The average amount increased over time in the three richest quintiles and fell in the two poorest quintiles.

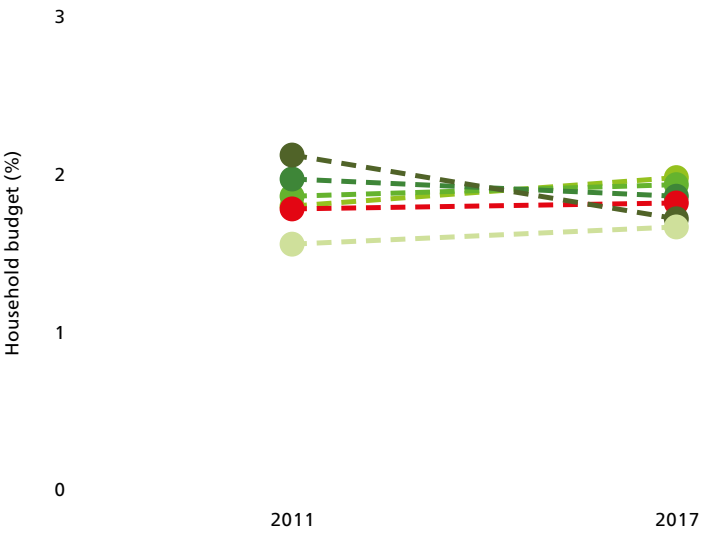
In 2017 out-of-pocket payments accounted for 1.8% of total household spending (the household budget) on average (Fig. 12). Out-of-pocket payments in the poorest quintile accounted for a similar share of the household budget compared to the richest quintile (both at 1.7%). Between 2011 and 2017 this share decreased sharply in the poorest and second quintiles and increased slightly in the other quintiles, making the distribution of out-of-pocket payments less regressive in 2017 than in 2011.

Fig. 11. Annual out-of-pocket spending on health care per person by consumption quintile

Note: amounts are shown in real terms (base year 2020).

Source: author, based on household budget survey data.

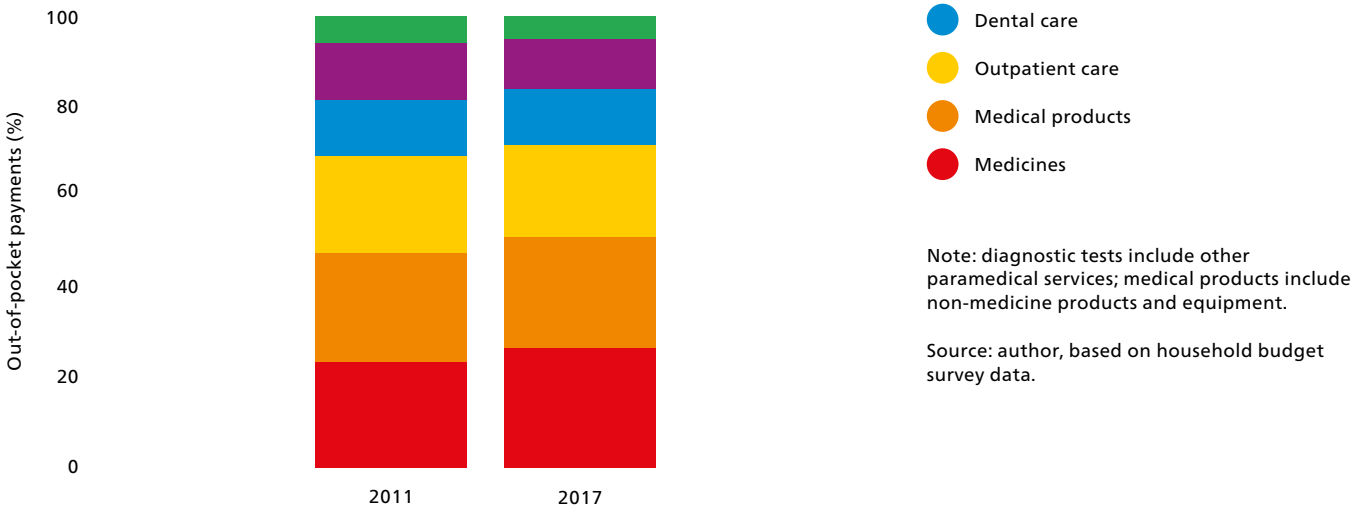
Fig. 12. Out-of-pocket payments for health care as a share of total household spending by consumption quintile



Source: author, based on household budget survey data.

Outpatient medicines accounted for the largest share of out-of-pocket payments in 2017 (27%), followed by medical products (25%) and outpatient care (20%) (Fig. 13). The outpatient medicines share grew slightly over time.

Fig. 13. Breakdown of out-of-pocket spending by type of health care

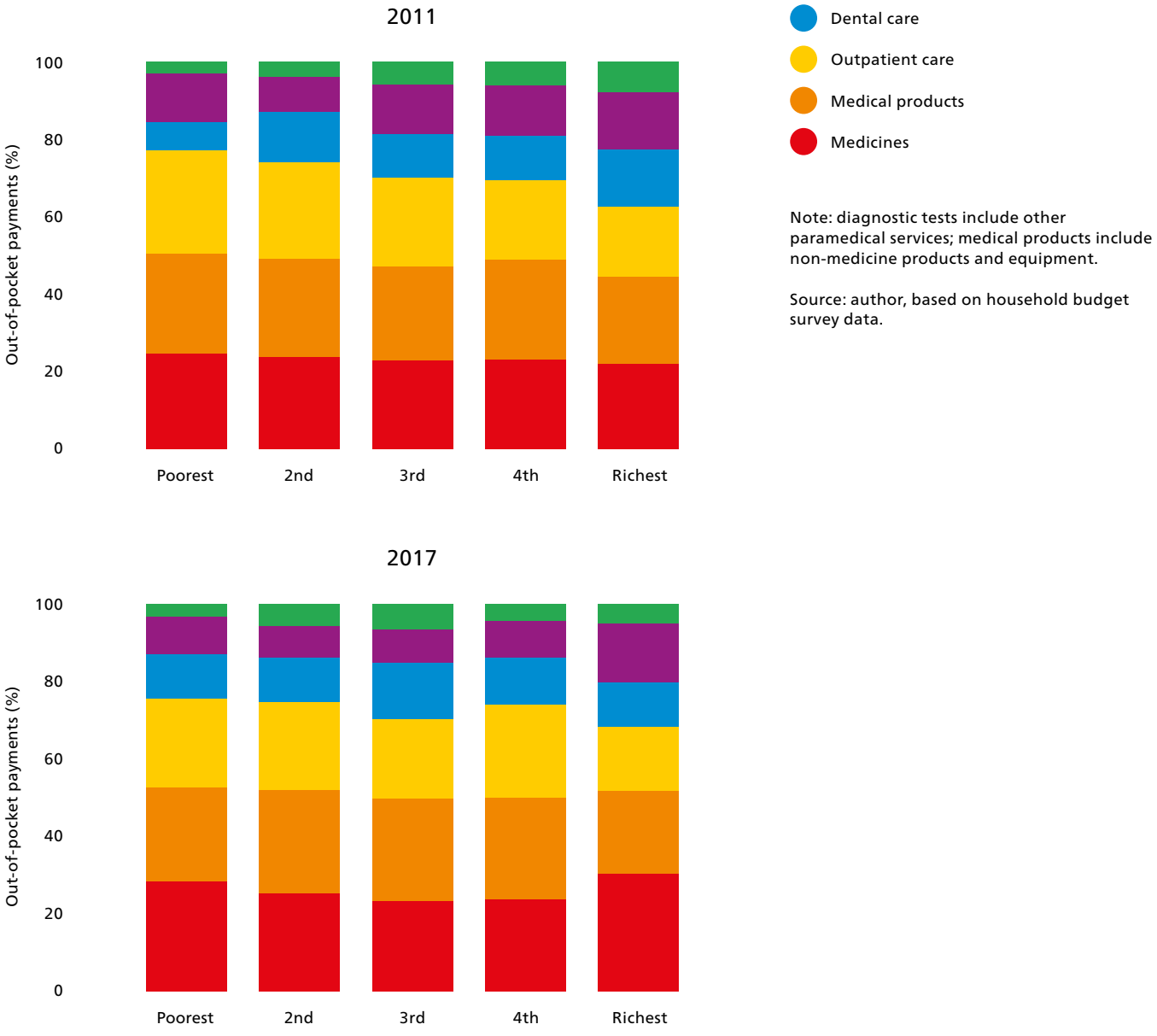


Note: diagnostic tests include other paramedical services; medical products include non-medicine products and equipment.

Source: author, based on household budget survey data.

In 2011 the poorest quintiles devoted a larger share of out-of-pocket payments to outpatient medicines, medical products and outpatient care than richer quintiles, but in 2017 these differences were more muted (Fig. 14). In 2017 the richest quintile spent a larger share on dental care than poorer quintiles (Fig. 14).

Fig. 14. Breakdown of total out-of-pocket spending by type of health care and consumption quintile

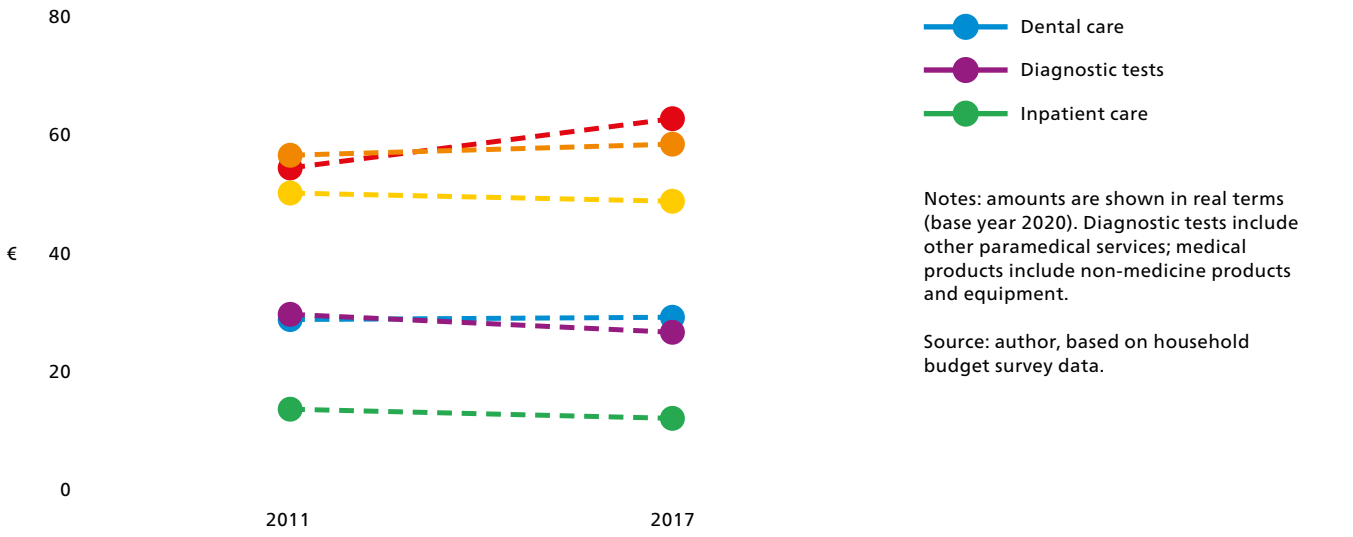


Note: diagnostic tests include other paramedical services; medical products include non-medicine products and equipment.

Source: author, based on household budget survey data.

Spending per person on outpatient medicines and medical products increased between 2011 and 2017 (Fig. 15). The increase in spending on outpatient medicines was mainly driven by higher spending in the richest quintile, while the spending on outpatient medicines, medical products and outpatient care for the poorest quintiles decreased (data not shown).

Fig. 15. Annual out-of-pocket spending on health care per person by type of health care



Notes: amounts are shown in real terms (base year 2020). Diagnostic tests include other paramedical services; medical products include non-medicine products and equipment.

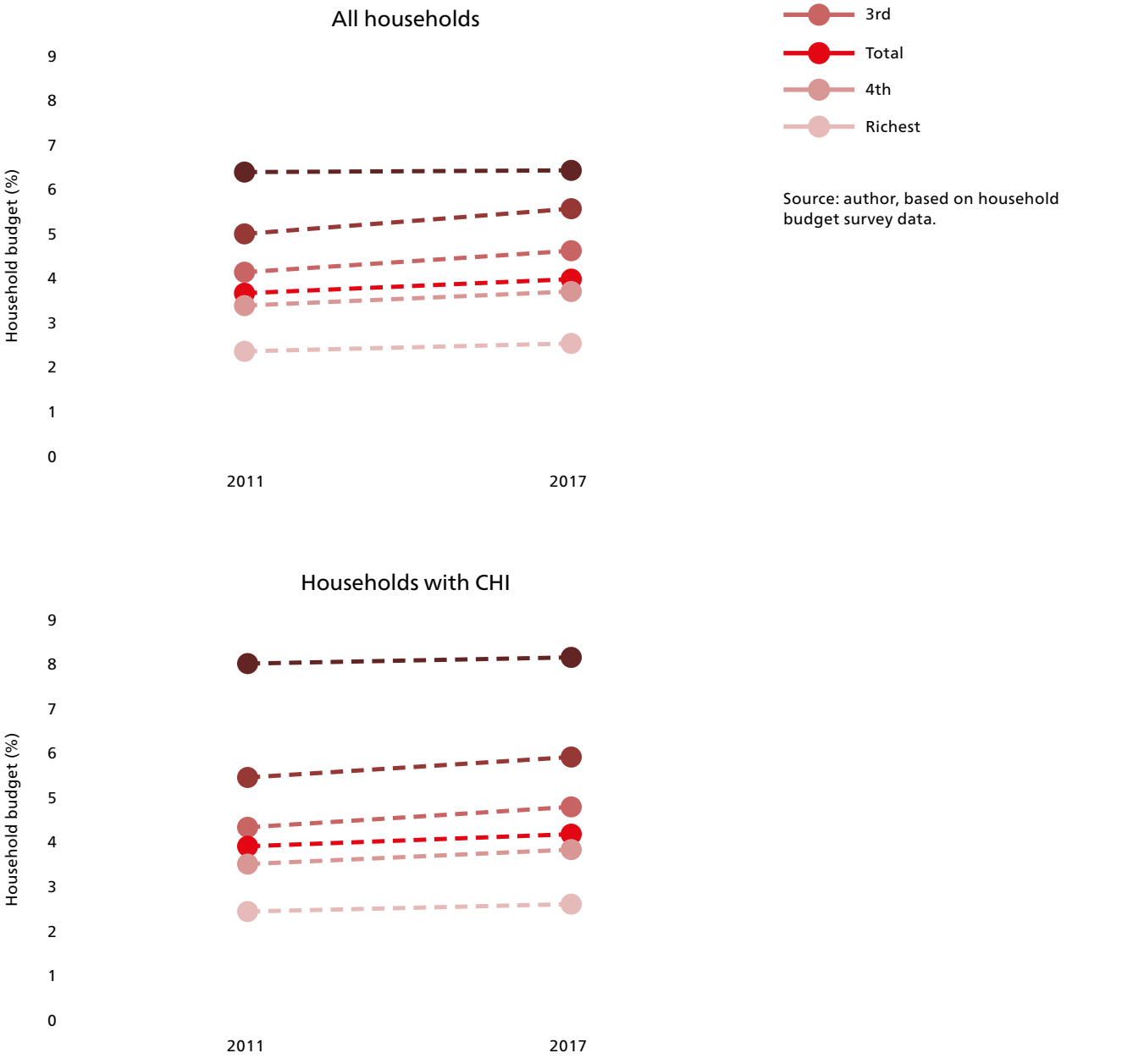
Source: author, based on household budget survey data.

4.3 CHI premiums

Households spend much more on CHI premiums than out-of-pocket payments. CHI premiums accounted for 4% of the household consumption on average in 2017 (just over 4% in households with CHI) (Fig. 16) – more than double the share spent on out-of-pocket payments (1.8%) (Fig. 12).

The distribution of spending on CHI premiums is highly regressive. In both years it was highest in the poorest quintile, accounting for 6.4% of the household consumption on average in 2017 (compared to 1.7% spent on out-of-pocket payments) and rising to 8.2% among households with CHI (Fig. 16). It was lowest in the richest quintile, for whom it accounted for 2.5% on average (compared to 1.7% spent on out-of-pocket payments) and 2.6% among households with CHI (Fig. 16). Taken together, CHI premiums and out-of-pocket payments account for 8% of household consumption in the poorest quintile in 2017, compared to only 4% in the richest quintile (Fig. 12 and Fig. 16).

Fig. 16. Household spending on CHI as a share of total household spending by consumption quintile

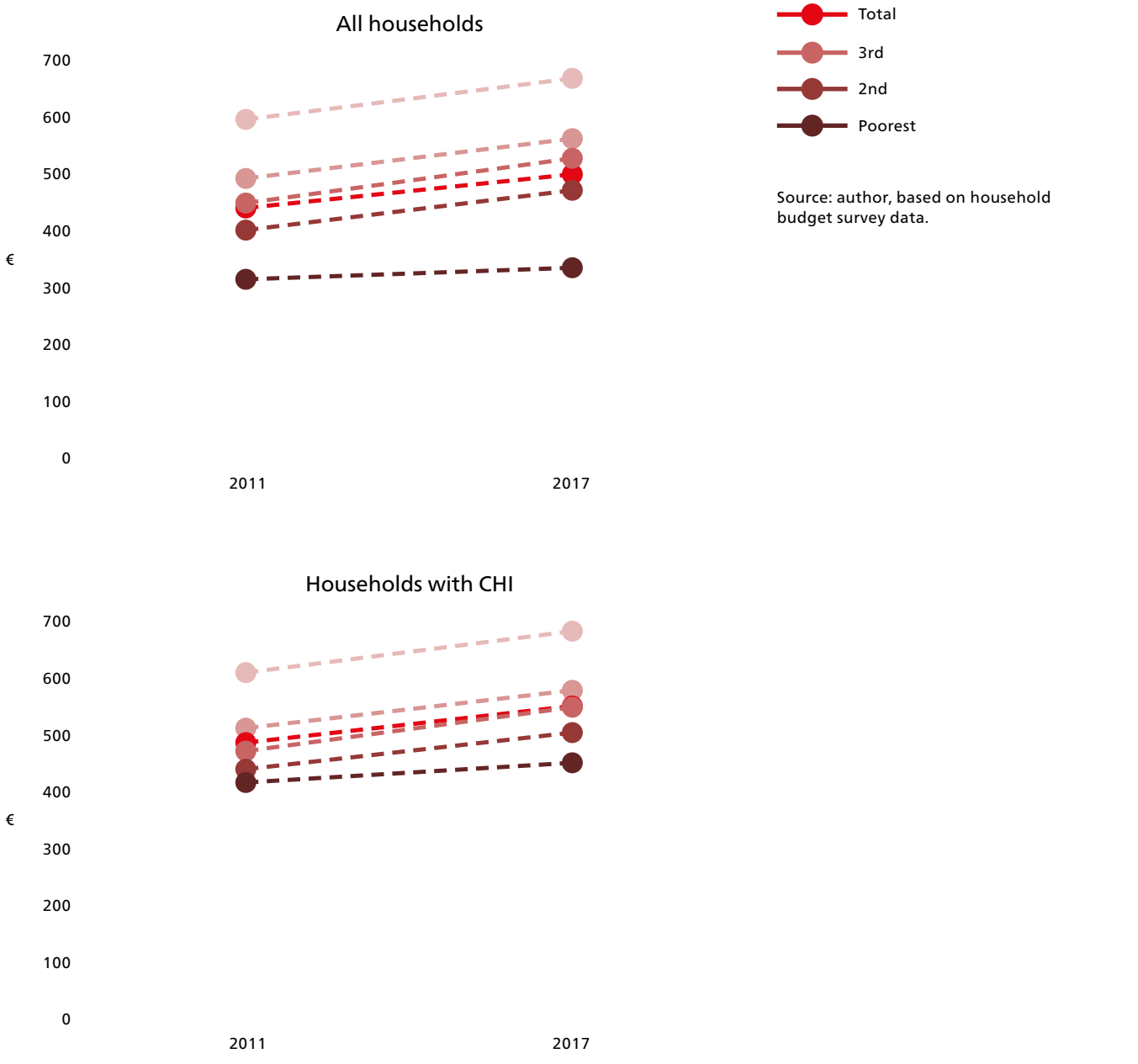


Source: author, based on household budget survey data.

Among households with CHI, the share of the household budget spent on CHI premiums increased slightly between 2011 and 2017 in all quintiles, but the increase was smallest in the poorest quintile (Fig. 16).

The average amount spent on CHI premiums per person was €500 in 2017, ranging from €334 in the poorest quintile to €669 in the richest (Fig. 17). For households with CHI the average amount is slightly higher compared to those of all households although for the poorest quintile it is notably higher (€449). The average amount increased over time in all quintiles.

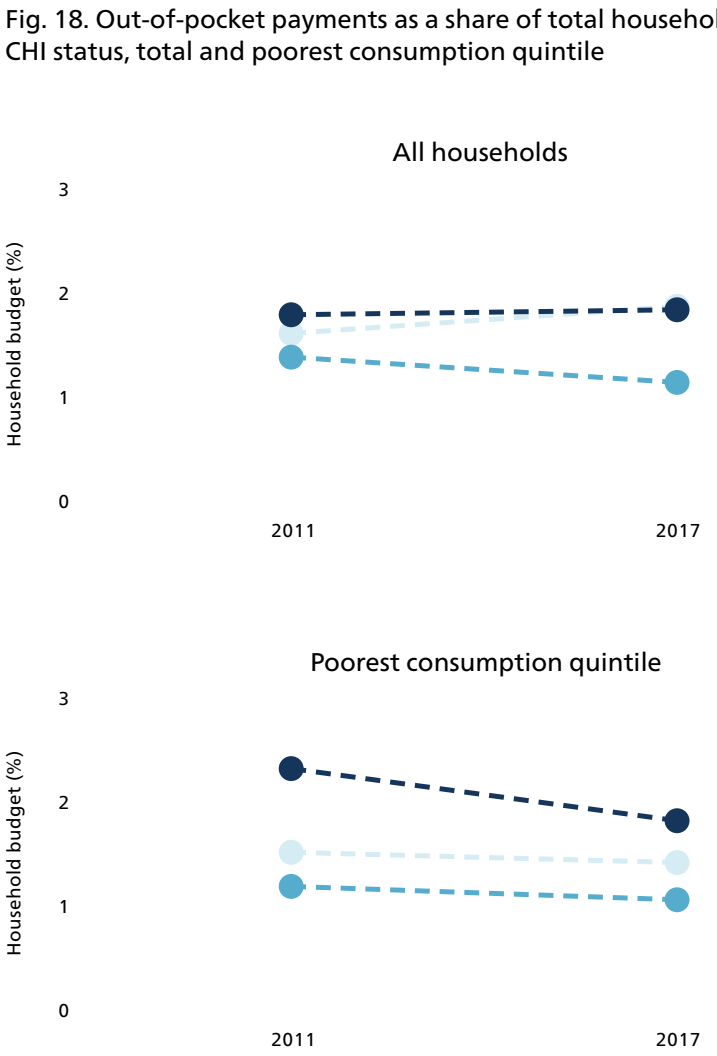
Fig. 17. Annual spending on CHI premiums per person by consumption quintile



Source: author, based on household budget survey data.

Being covered by CMU-C reduces out-of-pocket payments as a share of the household budget. In 2017 households in the poorest quintile with CMU-C spent 1.1% of their budget on out-of-pocket payments, compared to 1.7% for all households in this quintile (Fig. 18 and Fig. 12).

Fig. 18. Out-of-pocket payments as a share of total household spending by CHI status, total and poorest consumption quintile



CHI
No CHI
CMU-C

Note: ACS is included in the CHI category.

Source: author, based on household budget survey data.

4.4 Informal payments

The 2023 Eurobarometer survey on corruption found that 3% of respondents in France reported having made an informal payment for health care, on a par with the EU average (European Commission, 2023). Informal payments are not considered to be a major issue in France, however.

4.5 Summary

Data from national health accounts indicate that France has the lowest level of out-of-pocket payments as a share of current spending on health in the EU: 9% in 2021 compared to an EU14 average of 16% and EU27 average of 19%.

This partly reflects relatively high levels of public spending on health as a share of GDP – similar to Austria, Denmark and Sweden in 2021 but lower than Germany. The share of the Government budget allocated to health in 2021 (16%) was on a par with the EU14 average but significantly lower than in these peer countries (17–20%).

It also reflects unusually high levels of spending through CHI, which accounted for 12% of current spending on health in 2021 compared to an EU27 average of around 4% (WHO, 2024). The only other EU countries with similar shares are Ireland (10%) and Slovenia (12%).

The share of current spending on health financed through out-of-pocket payments in 2021 is highest for medical products, dental care and outpatient medicines.

Household budget survey data show that the richest households spend five times as much as the poorest households out of pocket. However, as a share of total household spending (the household budget), out-of-pocket payments are relatively evenly distributed across all households, amounting to just under 2% on average in 2017.

Outpatient medicines account for the largest share of out-of-pocket payments (27% in 2017), followed by medical products (25%) and outpatient care (20%), with little variation across quintiles.

Households spend much more of their budget on CHI premiums than on out-of-pocket payments on average (4% vs 2% in 2017). Spending on CHI premiums is highly regressive, accounting for 6.4% of a household's budget in the poorest quintile compared to only 2.5% in the richest. Being covered by CMU-C or ACS reduces the out-of-pocket payment share of household budgets.

Informal payments are not considered to be a major issue in France.

5. Financial protection

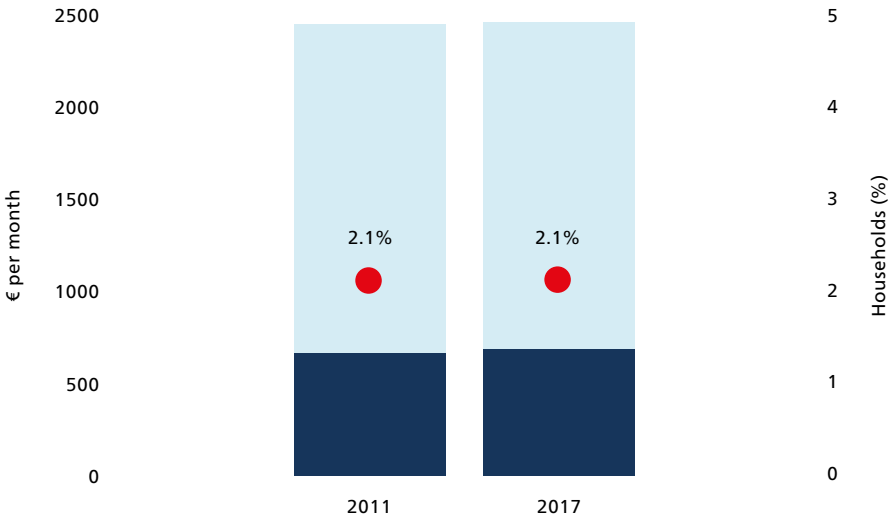
This section uses data from the French household budget survey to assess the extent to which out-of-pocket payments result in financial hardship for households who use health services. It looks at household capacity to pay for health care, the relationship between out-of-pocket spending on health and poverty – impoverishing health spending – and the incidence, distribution and drivers of catastrophic health spending. The section also draws on other survey data to assess unmet need for health services.

5.1 Household capacity to pay for health care

Household capacity to pay for health care is what is left of a household's budget after spending on basic needs. In this study basic needs are defined as the average cost of spending on food, housing and utilities (water, electricity and fuel) among a relatively poor part of the French population (households between the 25th to 35th percentiles of the consumption distribution), adjusted for household size and composition. In 2017 the monthly cost of meeting these basic needs (the basic needs line) was €685 which was very low compared to France's monthly national poverty line of €1015 in 2017 (60% of median income).

On average household capacity to pay for health care and the cost of meeting basic needs did not change during the study period, despite economic upheaval in the years following the global financial crisis of 2008 (Fig. 19). The share of households living below the basic needs line also remained stable over time (2%) (Fig. 19). This reflects the important role social policies played in stabilizing household income as the Government redistributed income to poor households via social protection benefits and social transfers (Beffy, Clerc & Thévenot, 2014). Although unemployment grew rapidly during the study period, rising from 7% in 2008 to 10% in 2015 (Eurostat, 2024c), the share of people at risk of poverty or social exclusion did not increase much on average and fell substantially among older people (Fig. 20). Poverty levels are generally low in France compared to other EU countries (data not shown) (Eurostat, 2024d).

Fig. 19. Changes in the cost of meeting basic needs, capacity to pay and the share of households living below the basic needs line



Average household capacity to pay

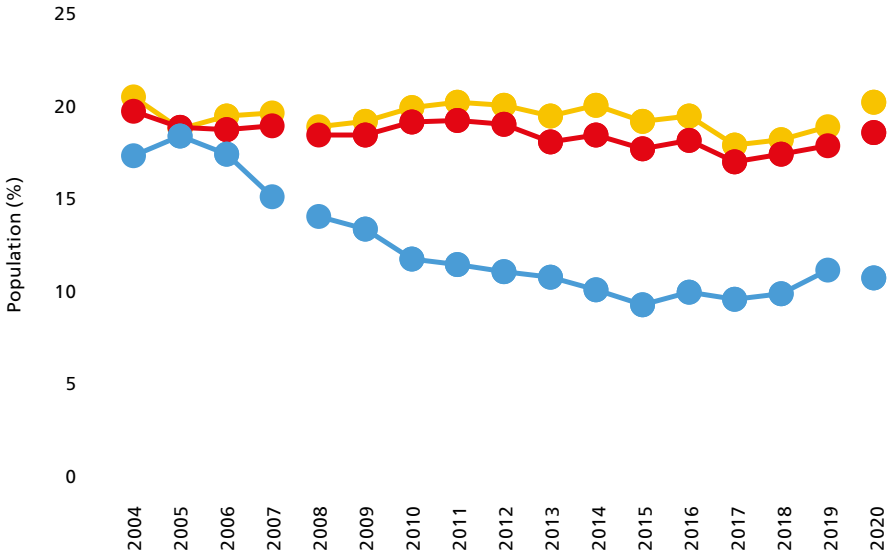
Cost of meeting basic needs

Share of households living below the basic needs line (%)

Notes: amounts are shown in real terms (base year 2020). Capacity to pay is measured as a household's consumption minus a normative (standard) amount to cover basic needs such as food, housing and utilities.

Source: author, based on household budget survey data.

Fig. 20. Share of the population at risk of poverty or social exclusion by age



16–64

Total

65+

Note: break in time series in 2008 and 2020.

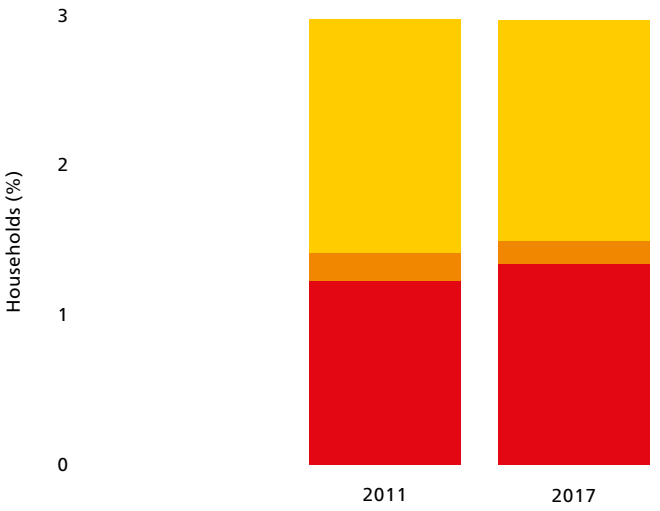
Source: Eurostat (2024d).

5.2 Financial hardship

How many households experience financial hardship?

Impoverishing health spending is defined in this study as out-of-pocket payments that push people into poverty or deepen their poverty. In 2017 1.4% of households were impoverished or further impoverished after out-of-pocket payments (Fig. 21). The share of further impoverished households rose slightly over time.

Fig. 21. Share of households at risk of impoverishment after out-of-pocket payments



At risk of impoverishment
Impoverished
Further impoverished

Note: a household is impoverished if its total spending falls below the basic needs line after out-of-pocket payments; further impoverished if its total spending is below the basic needs line before out-of-pocket payments; and at risk of impoverishment if its total spending after out-of-pocket payments comes within 120% of the basic needs line.

Source: author, based on household budget survey data.

Households with catastrophic health spending are defined in this study as those who spend more than 40% of their capacity to pay for health care. In 2017 2.1% of households – around 800 000 people – experienced catastrophic spending, a similar share to 2011 (Fig. 22).

The incidence of catastrophic health spending is lower in France than in many EU countries, but it is higher than in Ireland, Slovenia, Spain and the United Kingdom, even though those countries rely more heavily than France on out-of-pocket payments (WHO, 2023; Fig. 23).

Fig. 22. Share of households with catastrophic health spending

Source: author, based on household budget survey data.

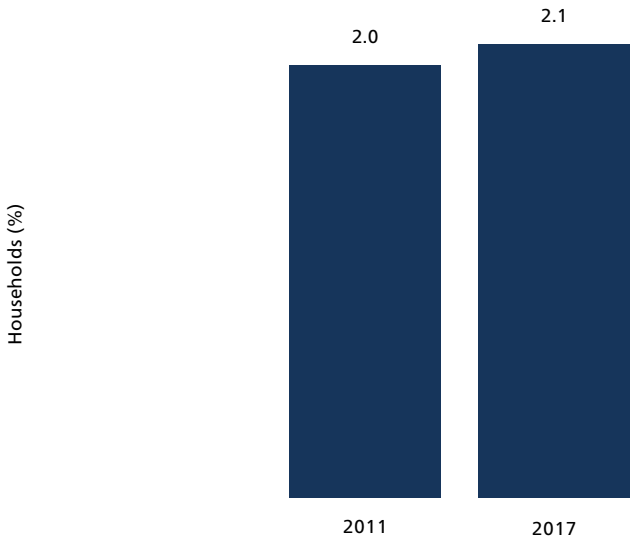
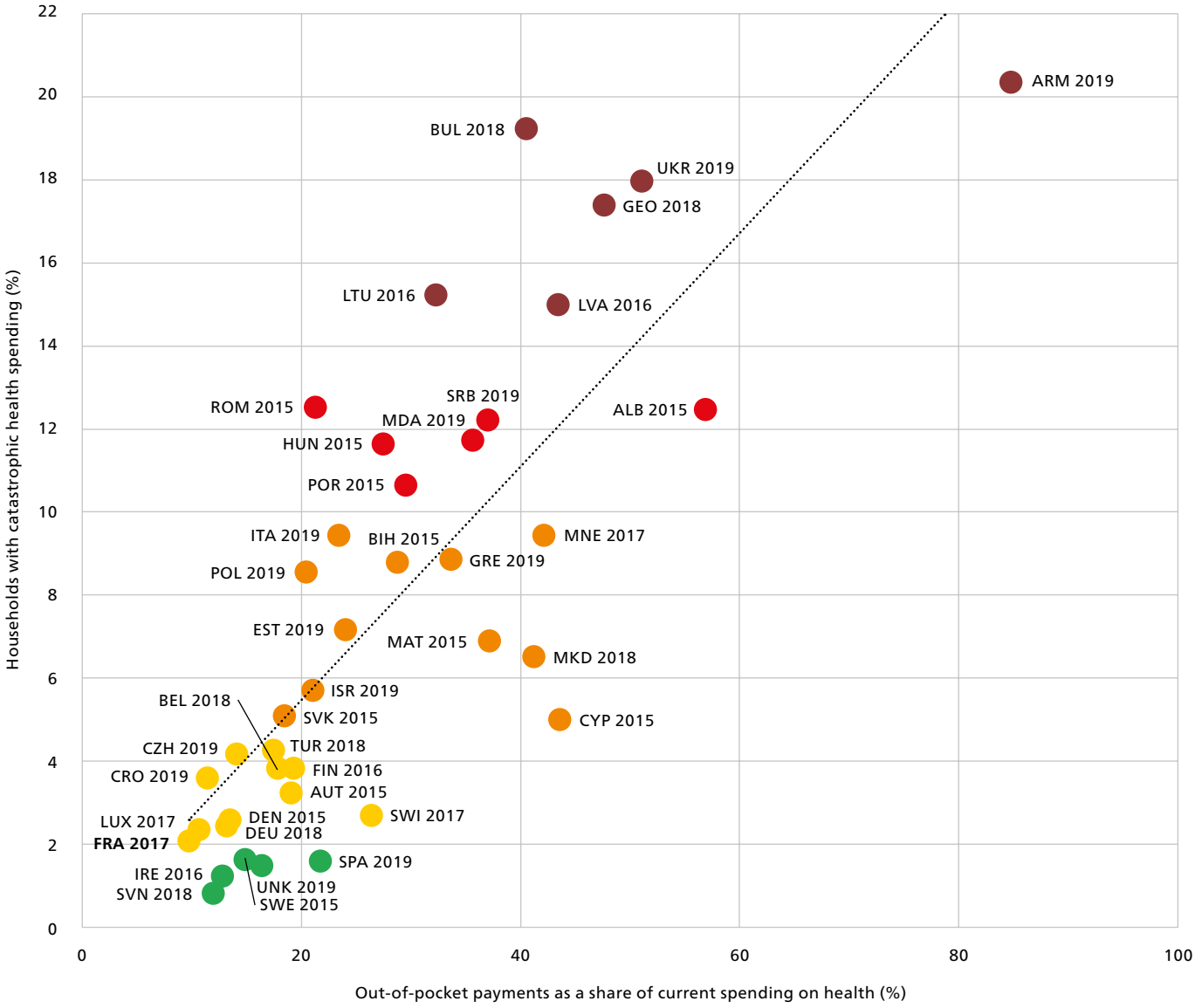


Fig. 23. Households with catastrophic health spending and out-of-pocket payments as a share of current spending on health in the WHO European Region, 2019 or latest available year before COVID-19

Notes: data on catastrophic health spending and out-of-pocket payments are for the same year. Dots are coloured by the incidence of catastrophic health spending: green < 2%, yellow < 5%, orange < 10%, red < 15%, dark red above 15%. The list of country codes used here can be found in the Abbreviations.

Source: data on catastrophic health spending from UHC watch (WHO Regional Office for Europe, 2024); and data on out-of-pocket payments from WHO (2024).



Who experiences financial hardship?

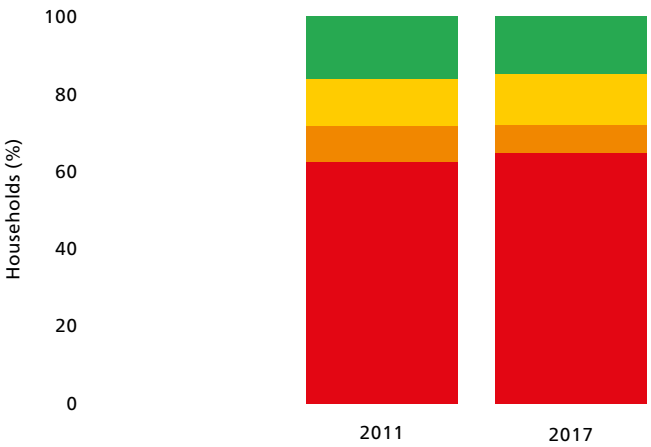
Most households with catastrophic health spending are further impoverished, impoverished or at risk of impoverishment after out-of-pocket payments (Fig. 24).

Households experiencing catastrophic health spending are heavily concentrated in the poorest consumption quintile (Fig. 25). Around 9% of households in the poorest quintile experienced catastrophic spending in 2017, compared to 0.2% in the richest. Catastrophic incidence is also high among households headed by unemployed people (10%), other inactive people (8%) and single parents (5%) (data not shown). Between 2011 and 2017 the share of households with catastrophic health spending increased slightly, mainly in households headed by unemployed people, single parent families and people aged 50–59. This can be partly explained by changes in the poorest quintile, with rising unemployment in the years after the financial crisis and a sharp decrease in in the risk of poverty or social exclusion among older people (see Fig. 20).

Among households with catastrophic health spending, the average amount spent on health as a share of total household spending rises progressively with income (data not shown). In 2017 households who were further impoverished spent 1.7% of their budget on health care, down from 2.3% in 2011. This is similar to the average share of household budgets spent on health – 1.8% (see Fig. 12).

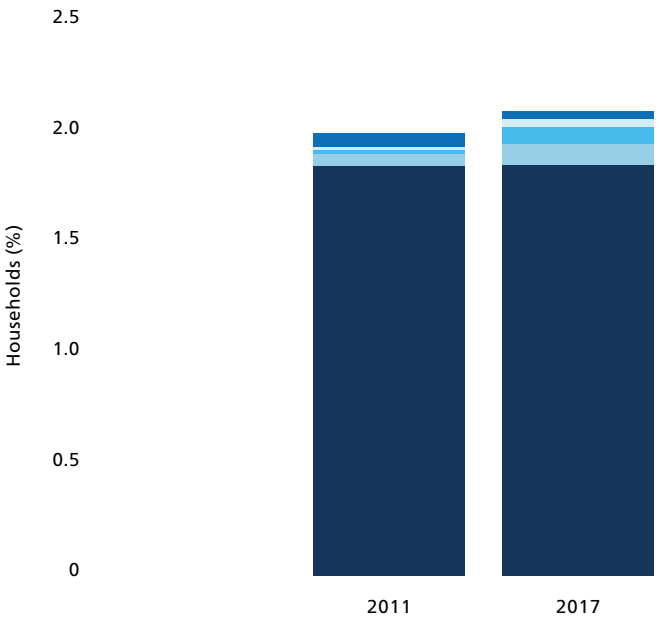
CHI has a strong influence on the incidence of catastrophic health spending. In the poorest quintile catastrophic incidence is much lower in households with CHI (6%) than those with CMU-C (15%) or without CHI (22%) (Fig. 26). This clearly indicates that while CMU-C plays an important role in protecting poor households from financial hardship, it is less protective than CHI.

Fig. 24. Breakdown of households with catastrophic health spending by risk of impoverishment



Source: author, based on household budget survey data.

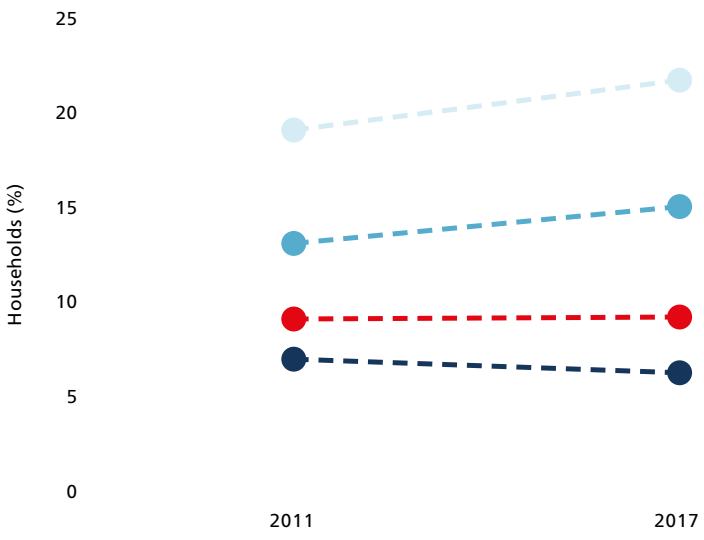
Fig. 25. Share of households with catastrophic health spending by consumption quintile



Note: quintiles are based on per person consumption adjusted for household size and composition using OECD equivalence scales.

Source: author, based on household budget survey data.

Fig. 26. Share of households in the poorest consumption quintile with catastrophic health spending by CHI status



Note: ACS is included in the CHI category.

Source: author, based on household budget survey data.

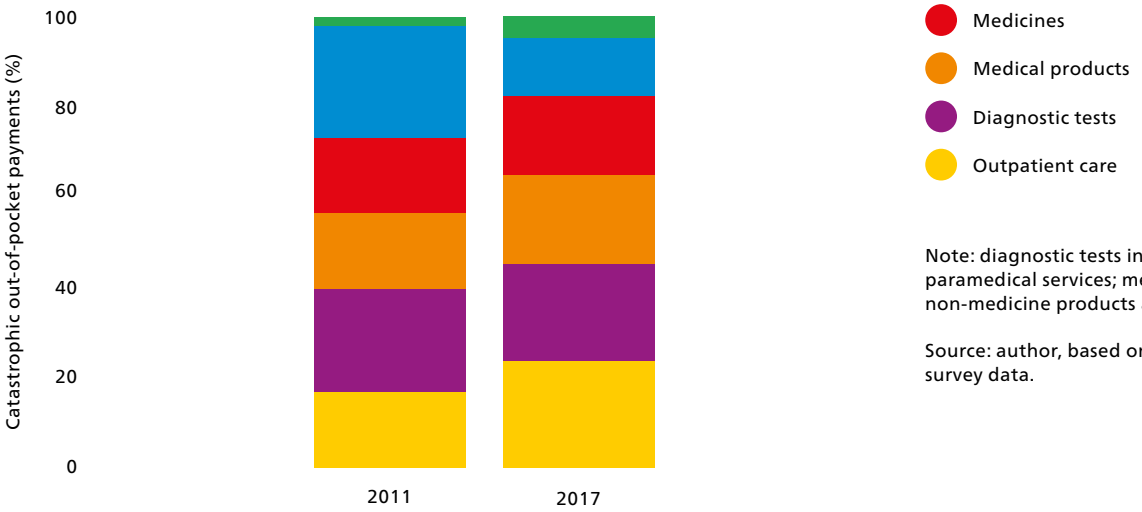
Which health services are responsible for financial hardship?

In 2017 catastrophic health spending was driven mainly by outpatient care (24%), followed by diagnostic tests (21%) and medical products (20%) (Fig. 27). Between 2011 and 2017 the shares spent on outpatient care and inpatient care grew, while the dental care share fell.

In the poorest quintile catastrophic spending is mainly driven by outpatient medicines (28%), followed by medical products (26%) and diagnostic tests (21%) (Fig. 28). Between 2011 and 2017 there was an increase in the dental care share and a decrease in the outpatient care share.

Looking at the poorest quintile by CHI status, CHI coverage seems to protect more against catastrophic spending on outpatient medicines, medical products and outpatient care compared to CMU-C coverage or not having CHI (Fig. 29). In these last two categories there is much less spending on dental care than in households with CHI, reflecting unmet need (see below).

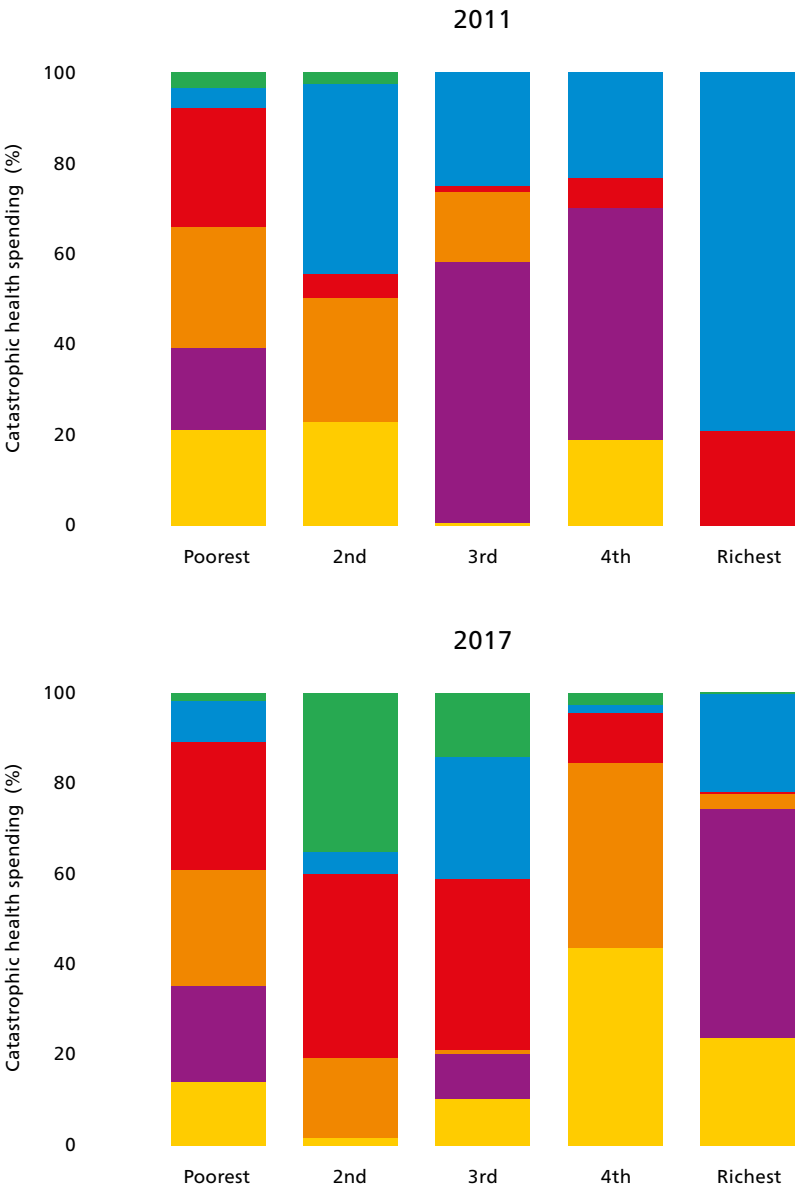
Fig. 27. Breakdown of catastrophic health spending by type of health care



Note: diagnostic tests include other paramedical services; medical products include non-medicine products and equipment.

Source: author, based on household budget survey data.

Fig. 28. Breakdown of catastrophic health spending by type of health care and consumption quintile

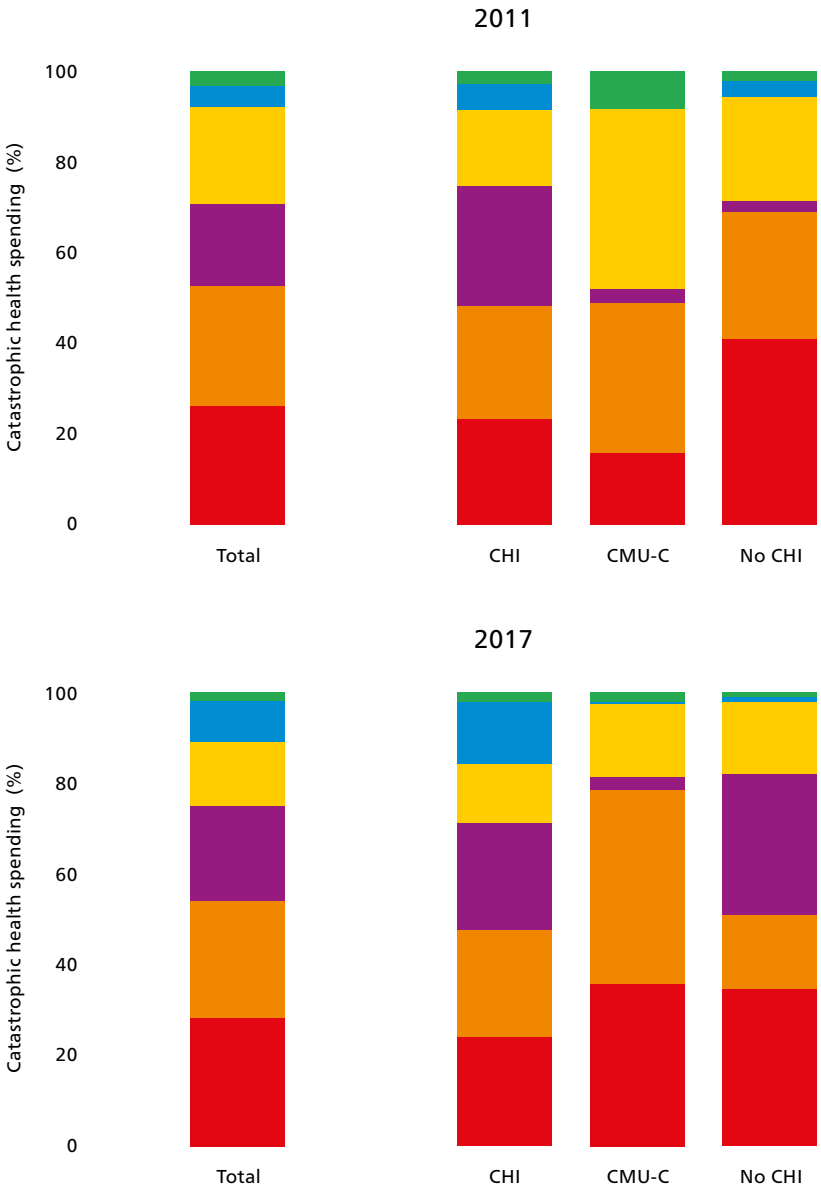


Inpatient care
Dental care
Medicines
Medical products
Diagnostic tests
Outpatient care

Note: the breakdown for richer quintiles should be interpreted with caution due to the small numbers involved.

Source: author, based on household budget survey data.

Fig. 29. Breakdown of catastrophic health spending in the poorest consumption quintile by type of health care and CHI status



Inpatient care
Dental care
Outpatient care
Diagnostic tests
Medical products
Medicines

Note: diagnostic tests include other paramedical services; medical products include non-medicine products and equipment.

Source: author, based on household budget survey data.

5.3 Unmet need for health care

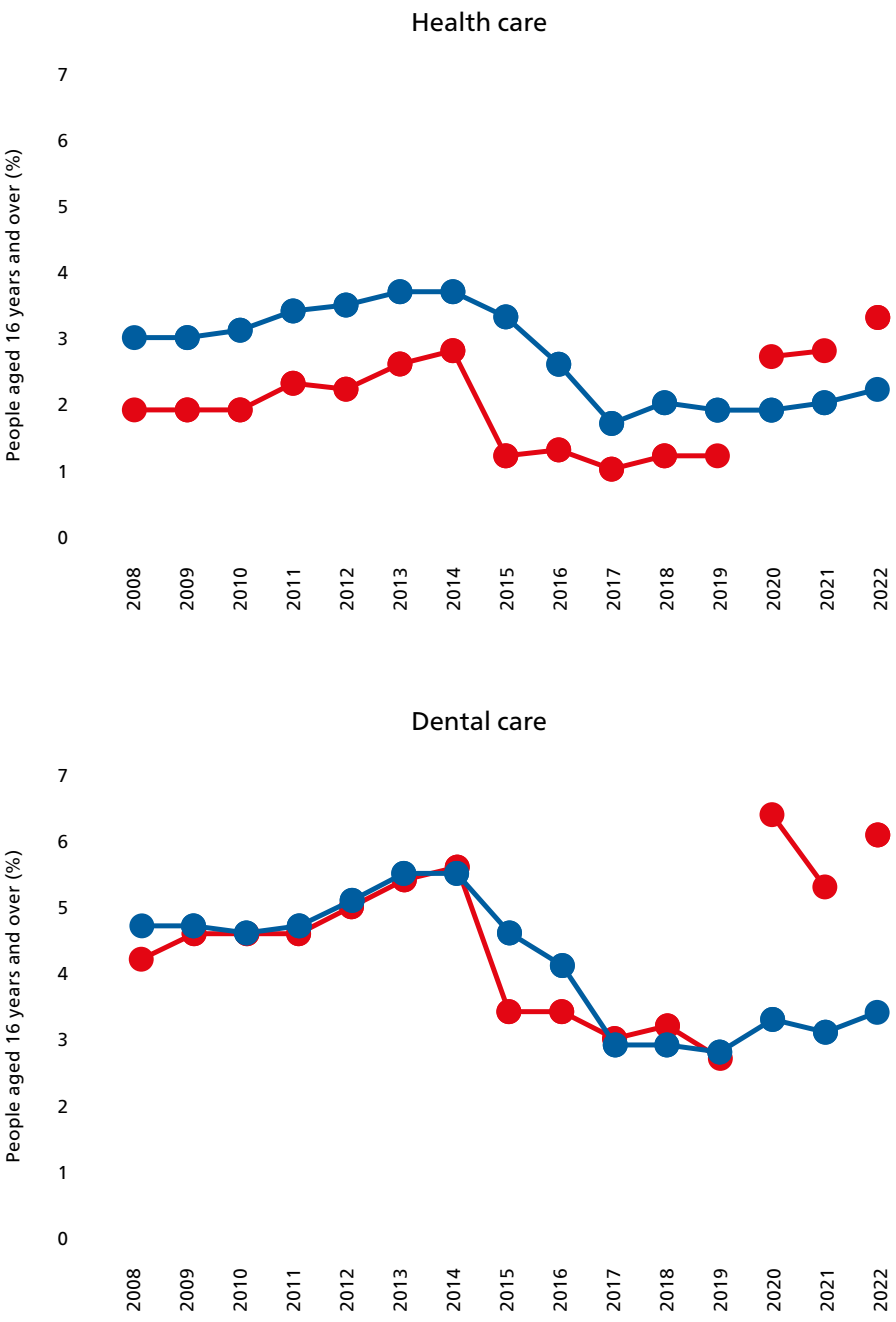
Studies have documented socioeconomic inequalities in doctor and dentist visits, with high levels of income inequality in specialist visits and cancer screening (Doorslaer, Koolman & Jones, 2004; Jusot, Or & Sirven, 2012; Devaux & de Looper, 2012; Devaux, 2015). Households with low incomes, manual workers and people with CMU-C have a higher probability of reporting foregone care than others (Feral-Pierssens et al., 2020)

Data on unmet need (see Box 1) due to cost, distance or waiting time show that in 2021 unmet need for health care and dental care in France was above the EU average (Fig. 30). Unmet need for dental care is higher than unmet need for health care. Unmet need for both health care and dental care increased between 2008 and 2014. From 2015, unmet need for health care has remained relatively stable while unmet need for dental care fell.

There is significant income inequality in unmet need for both types of care. In 2022 the poorest quintile had around four times the level of unmet need for health care and dental care compared to the richest quintile. Income inequality increased between 2008 and 2014 and has fallen sharply since 2015, especially for dental care (Fig. 31). These results might reflect inequality in the geographical distribution of health professionals and financial constraints for the poorest quintiles (for example, out-of-pocket payments for dental care not covered by SHI or CHI).

EHIS data on unmet need for health care, dental care and prescribed medicines show that on average, unmet need is the highest for dental care. There is income inequality for all three types of care, with unmet need being consistently higher than average in the poorest income quintile (Fig. 32).

Fig. 30. Self-reported unmet need for health care and dental care due to cost, distance and waiting time, EU and France

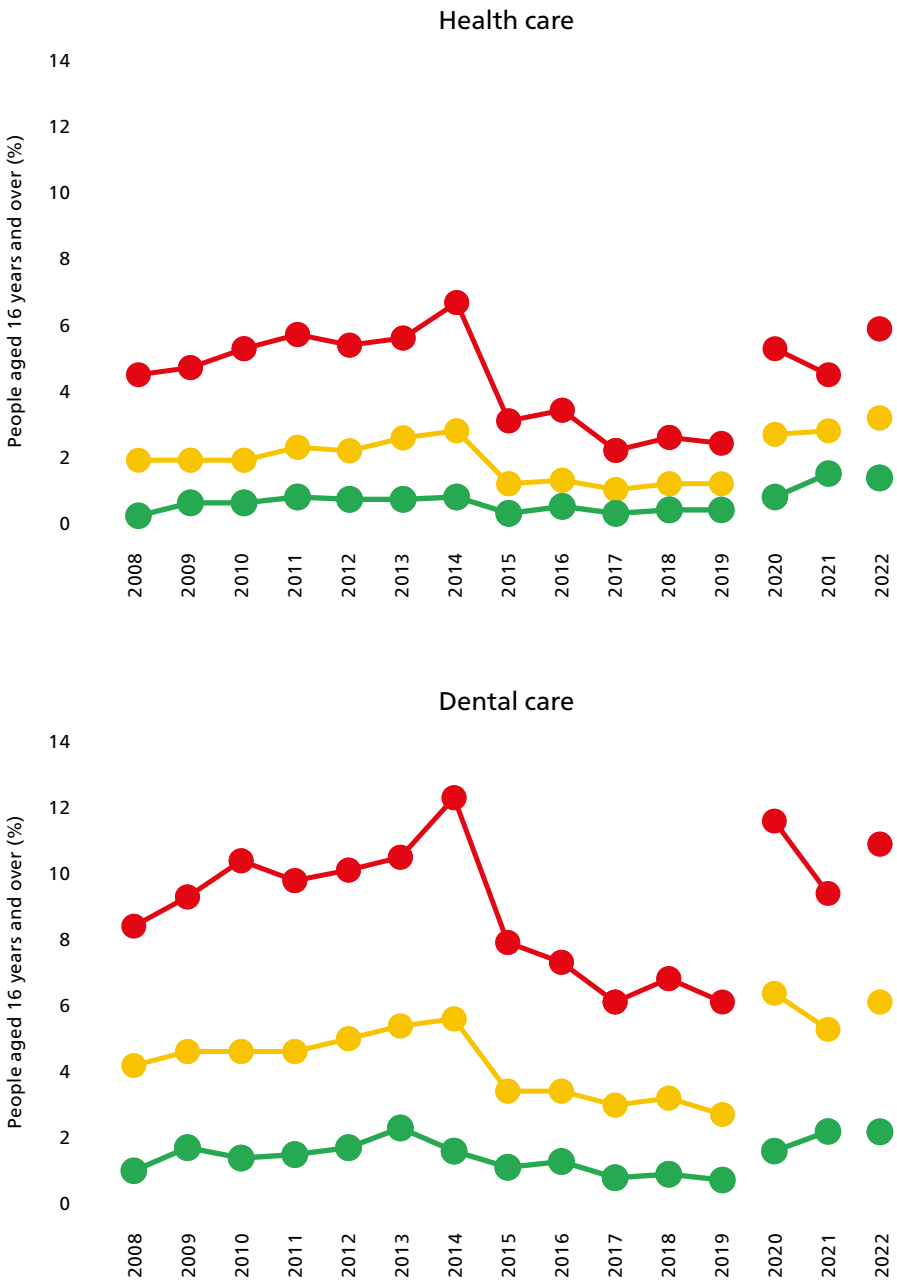


France
EU

Notes: for France there is a break in time series in 2020 and 2022. Data for the EU up to 2020 include the United Kingdom.

Source: EU-SILC data from Eurostat (2024a).

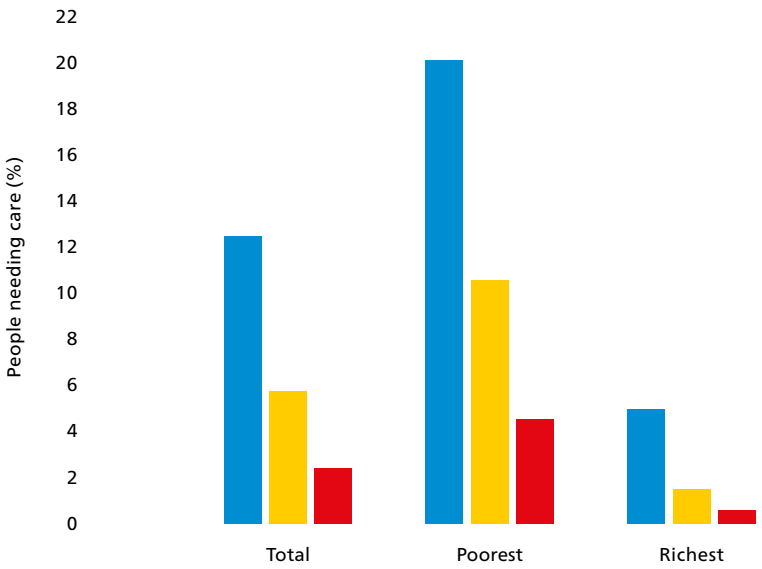
Fig. 31. Income inequality in unmet need for health care and dental care due to cost, distance and waiting time



Note: break in time series in 2020 and 2022.

Source: EU-SILC data from Eurostat (2024a).

Fig. 32. Self-reported unmet need due to cost by type of care and income, 2019



Notes: data from EHIS for unmet need in France are not comparable to other EU countries due to differences in the questionnaire. People needing care refers to people aged 15–64 years. Poorest and richest refer to income quintiles.

Source: EHIS data from Eurostat (2024b).

5.4 Summary

The incidence of catastrophic health spending is lower in France than in many EU countries, but higher than in some countries that rely more on out-of-pocket payments to finance the health system such as Ireland, Spain and the United Kingdom.

In 2017 1.4% of households were impoverished or further impoverished after out-of-pocket payments (a slight increase compared to 2011) and 2.1% of households experienced catastrophic health spending (almost the same as in 2011).

Catastrophic health spending is heavily concentrated among households with low incomes. In 2017 close to 90% of households with catastrophic spending were in the poorest quintile (compared to 0.2% in the richest). The incidence of catastrophic spending was highest among households in the poorest quintile (9%) and those headed by unemployed people (10%), other inactive people (8%) and single parents (5%).

In the poorest quintile, catastrophic health spending is mainly driven by outpatient medicines, medical products and diagnostic tests. Outpatient care also plays a role in driving catastrophic spending in the two richest quintiles.

Although unmet need for health care was close to the EU average in 2021, unmet need for dental care was above the EU average. Income inequality in unmet need was significant, especially for dental care.

6. Factors that strengthen and undermine financial protection

This section considers factors within the health system that may be responsible for financial hardship caused by out-of-pocket payments in France and which may explain the trend over time.

6.1 Coverage policy

Coverage policy in France has important strengths, particularly when it comes to population coverage.

Unusually for a country with an SHI scheme, **the basis for entitlement to SHI benefits is legal residence rather than payment of contributions** (see Box 1). France broke the link between entitlement to SHI benefits and payment of contributions in 2000 (CMU) and removed administrative barriers to SHI coverage in 2016 by giving all legal residents aged over 16, including dependent children and spouses, an individual and permanent right to SHI benefits (PUMA). When entitlement is linked to payment of contributions, countries often struggle to cover all legal residents, especially people with precarious jobs, so the French reforms are a good example for other countries with SHI schemes to follow.

Undocumented migrants with low incomes who have been in France for at least 90 days have access to more or less the same SHI benefits as legal residents (through AME, described in section 3.1) and, in addition, do not have to pay any user charges at all for covered services. A weakness of the AME scheme is that it only covers around half of all those who are eligible to benefit, probably due to administrative barriers to enrolment: AME beneficiaries need to prove their income and the amount of time they have been living in France and must re-apply for the benefit each year.

People with any of 32 specified *affections de longue durée* [chronic conditions] are exempt from the *ticket modérateur* [percentage co-payments] (although only for treatment of those conditions). People with these conditions represent around 18% of the population in France and are regular users of health care, which increases their risk of incurring catastrophic health spending.

Gaps in coverage remain, however. Although the SHI benefits package is relatively comprehensive, it is more limited for dental care. There are weaknesses in the design of user charges policy, particularly for medical products. While most people have some form of CHI covering user charges, unequal access to CHI continues to be a challenge, which is why the design of user charges matters.

These issues help to explain why:

- financial hardship and unmet need are heavily concentrated in households with the lowest incomes (see Fig. 25);

- catastrophic health spending in these households is mainly driven by out-of-pocket payments for outpatient medicines and medical products (see Fig. 28); in contrast, dental care is a smaller than average driver of catastrophic health spending in these households; and

- unmet need is much higher for dental care than health care and there is significant income inequality in unmet need for both types of care (see Fig. 31).

Weaknesses in the design of user charges (co-payments)

Weaknesses in the design of user charges can be summarized as follows: heavy user charges, mostly in the form of the ticket modérateur [percentage co-payments], are applied to all types of health care; balance billing is allowed; and although there are mechanisms to protect people from user charges –exemptions and caps – these mechanisms are not sufficiently protective.

France is one of the very few countries in Europe that applies user charges to all types of health care, including primary care visits and emergency visits. It is also unusual in maintaining retrospective reimbursement for health care.

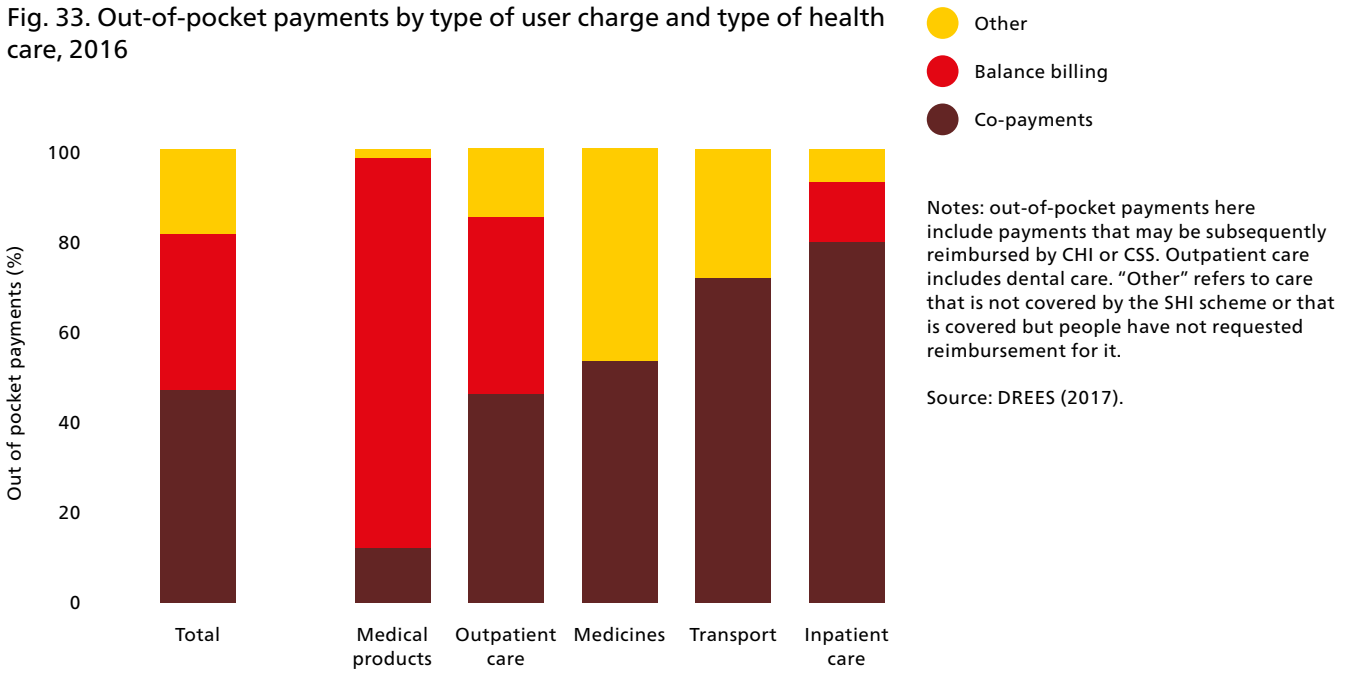
There is heavy use of the *ticket modérateur* [percentage co-payments], which can lead to financial uncertainty for households when there are multiple goods or services with differing prices – for example, medicines, medical products and inpatient care.

Exemptions from co-payments are limited. CSS beneficiaries and all children are exempt from fixed co-payments only, while *32 affections de longue durée* [chronic conditions] (see section 3.3) are exempt from the *ticket modérateur* [percentage co-payments] for the treatment of those conditions only.

There is no overall cap on all co-payments. Although there are annual caps on some fixed co-payments, these are not linked to income, which means that they offer more protection to richer households than poorer households.

Balance billing is widespread and particularly pervasive for medical products and outpatient care. It is allowed for outpatient visits (doctors in Sector 2), some inpatient care (physician services in private hospitals) and medical products. Fig. 33 shows that in 2016 balance billing accounted for 34% of all out-of-pocket payments on average, rising to 40% for outpatient care and 86% for medical products. Since 2019 the *100% Santé* reform has attempted to reduce balance billing for a selection of medical products for dental care (crowns, bridges and dentures), optical care (glasses) and hearing aids for CSS and CHI beneficiaries by increasing SHI coverage and controlling prices. It is not possible to see the impact of this reform on catastrophic health spending because post-2017 household budget survey data are not yet available, but the incidence of unmet need for dental care fell in 2021 (see Fig. 31), which could be due to the reform.

Fig. 33. Out-of-pocket payments by type of user charge and type of health care, 2016



Notes: out-of-pocket payments here include payments that may be subsequently reimbursed by CHI or CSS. Outpatient care includes dental care. "Other" refers to care that is not covered by the SHI scheme or that is covered but people have not requested reimbursement for it.

Source: DREES (2017).

Unequal access to CHI continues to be a challenge

CHI is the main mechanism protecting people from user charges. In the last two decades the Government has invested heavily in making access to CHI affordable for everyone, and especially for households with very low incomes through CMU-C and ACS (CSS since 2019). As a result, household budget survey data suggest that CMU-C is protective: in 2017 households with CMU-C spent less of their total consumption (budget) on out-of-pocket payments (1%) than other households in the poorest quintile (1.7%) (see Fig. 18).

Challenges remain, however, and can be summarized as follows: people with low incomes are less likely to have any form of CHI or good quality CHI; very few poor households benefit from CMU-C and ACS (now CSS); most poor households rely on CHI, which means they are still exposed to user charges; CMU-C is not protective enough; and CHI is a very regressive way of financing health care.

People with low incomes are less likely to have any form of CHI or good quality CHI. On average around 5% of the population did not have any form of CHI in 2017, rising to 11% in the poorest quintile (see Fig. 2). Even among those who do have CHI, the quality and affordability of CHI coverage tends to be lower for people with lower incomes. As a result, CHI does not fully address the problems caused by user charges.

Very few households with low incomes benefit from CMU-C or ACS (now CSS). Only 15% of households in the poorest quintile have CMU-C (see Fig. 2) which could be for two reasons. First, the eligibility threshold for CMU-C

is below the national poverty line (see Fig. 1). The replacement of CMU-C and ACS with CSS at the end of 2019 (see section 3.4) aimed to improve the affordability of CHI by extending CMU-C, but the threshold remains below the national poverty line. Second, take-up of CMU-C and ACS is very low, probably due to the administrative burden of having to re-apply every year and provide proof of income (France & Couffinhal, 2020). In 2021 about 7.2 million people benefited from CMU-C, but it is estimated that almost 10 million were eligible (Blanchon et al., 2021).

Most households with low incomes rely on CHI, which means they are still exposed to user charges. Nearly 75% of households in the poorest quintile rely on CHI for protection. Unlike CSS beneficiaries, they are not exempt from balance billing for doctor visits or from fixed co-payments.

CMU-C does not seem to be as protective as CHI. In the poorest quintile, the incidence of catastrophic health spending varies substantially by CHI coverage status, rising from 6% among households with CHI to 15% among those with CMU-C and 22% among those with no CHI (see Fig. 26).

CHI is a highly regressive way of financing health care. In 2017 CHI premiums accounted for 6.4% of household consumption in the poorest quintile and 5.6% in the second quintile, compared to only 2.5% in the richest quintile (see Fig. 16). This is in addition to the 1.7% that households in the poorest and richest quintile were spending through out-of-pocket payments (see Fig. 12). Although CHI is an effective protection mechanism for most people in France, it comes with a significant financial burden for households in the poorest quintiles.

CHI also involves significant transaction and financial costs for the Government and employers, adding to the complexity of coverage policy.

The study's findings indicate that while the French health system provides relatively strong financial protection, and in spite of sustained Government efforts to make CHI affordable for everyone, more needs to be done to reduce financial hardship and unmet need for households with low incomes – in particular, to protect them from out-of-pocket payments for medical products and outpatient prescribed medicines. The *100% Santé* reform phased in between 2019 and 2021 appears to be an important step towards reducing balance billing for medical products and may be behind the reduction in unmet need for dental care in 2021 (see Fig. 31), but it is not yet possible to assess its impact on financial hardship.

6.2 Summary

Two key features of coverage policy are likely to enhance financial protection for people with low incomes and offer examples of good practice for other countries. First, the basis for entitlement to SHI benefits does not depend on payment of contributions (since the CMU reform in 2000) and is individual and permanent (since the PUMA reform in 2016), meaning all legal residents are covered, including people with precarious jobs. Second, undocumented migrants with low incomes who have been in France for 90 days have free access to very similar benefits as legal residents, and without user charges, through the AME scheme. However, many people face administrative barriers that prevent them from enrolling in the AME scheme.

The factors that undermine financial protection, with a disproportionate impact on poorer households, include the following weaknesses in coverage policy.

- User charges (co-payments) are widespread, heavy and complex. France is one of the very few countries that applies user charges to all types of health care, including primary care visits and emergency visits. It is also unusual in maintaining retrospective reimbursement for health care. The *ticket modérateur* [percentage co-payments] are widely applied and can lead to financial uncertainty for households when there are multiple goods or services with differing prices – for example, medicines, medical products and inpatient care. Balance billing is permitted in some outpatient and inpatient settings and accounts for almost all out-of-pocket payments for medical products and around half of out-of-pocket payments for outpatient visits.

- Although there are mechanisms to protect people from user charges – for example, exemptions and caps – these mechanisms are not sufficiently protective. People with low incomes and chronic conditions are not exempt from all co-payments, there is no overall cap on co-payments for anyone and existing caps for fixed co-payments are not linked to income, so they offer more protection to richer than poorer households.

- The SHI benefits package is relatively comprehensive but less generous for dental care, which may explain why unmet need for dental care was well above the EU average in 2022 and marked by significant income inequality.

CHI covering user charges improves financial protection for most people thanks to sustained Government efforts to make access to CHI affordable for everyone, and especially for households with very low incomes through CMU-C and ACS (now CSS). Challenges remain, however, and can be summarized as follows:

- CHI does not fully address the problems caused by user charges because people with low incomes are less likely to have any form of CHI and, when covered, they are less likely to have good quality CHI.

- The thresholds for accessing CMU-C and ACS (now CSS) do not benefit enough low-income households because they are set at a low level. People also experience administrative barriers to take-up, meaning eligible households cannot benefit from policies to protect CSS beneficiaries from user charges.

- CHI is a very regressive way of financing the health system, imposing a heavy financial burden on the poorer half of the population. In 2017 CHI premiums accounted for 6% of the household budget in the two poorest quintiles, compared to only 2.5% in the richest quintile.

7 Implications for policy

Financial hardship caused by out-of-pocket payments is lower in France than in many EU countries (2% of households in 2017, the latest year of data available) but higher than in some countries that rely more on out-of-pocket payments to finance the health system such as Ireland and Spain.

Catastrophic health spending is heavily concentrated among households with low incomes, unemployed people, other inactive people and single parents. Close to 90% of households with catastrophic spending are in the poorest consumption quintile and 72% are impoverished or further impoverished after out-of-pocket payments.

In the poorest households, catastrophic health spending is mainly driven by outpatient medicines, medical products and diagnostic tests. Outpatient care also plays a role in driving catastrophic spending in the two richest quintiles.

Although unmet need for health care is close to the EU average, unmet need for dental care was above the EU average in 2022. Income inequality in unmet need is significant, especially for dental care.

These findings reflect strengths in coverage policy. The de-linking of entitlement to SHI benefits from payment of contributions (through CMU and PUMA), the provision of very similar benefits to undocumented migrants with low incomes who have been in France for more than 90 days (through AME) and the exemption from the *ticket modérateur* [percentage co-payments] for people with *affections de longue durée* [chronic conditions] are examples of good practice for other countries. However, many undocumented migrants face administrative barriers that prevent them from enrolling in the AME scheme.

However, substantial income inequality in financial hardship and unmet need for dental care reflects weaknesses in coverage policy. Although the SHI benefits package is relatively comprehensive, it is more limited for dental care. The mechanisms in place to protect people from widespread and heavy user charges (including balance billing) are not sufficiently protective. CHI covering user charges improves financial protection for most people, but gaps persist – unequal access to CHI continues to be a challenge for many households with low incomes and CHI is a highly regressive way of financing the health system, imposing a heavy financial burden on the poorer half of the population.

Since 2000 the Government of France has taken important steps to strengthen financial protection, initially focusing on improving access to SHI and CHI and, more recently, focusing on reducing balance billing for medical products including for dental care, optical care and hearing aids through the *100% Santé* reform phased in between 2019 and 2021.

Building on this, the Government can do more to reduce unmet need and financial hardship, particularly for households with lower incomes and people with *affections de longue durée* [chronic conditions], and to limit the health system's reliance on CHI.

Public resources for health can be used more efficiently if they are directed towards reducing co-payments, including balance billing, by:

- exempting CSS beneficiaries and people with specific *affections de longue durée* [chronic conditions] from all co-payments, so that they no longer need CHI;
- setting an annual cap on all co-payments for the whole population and linking it to household income, so that it is more protective for people with lower incomes; and
- taking other steps to reduce financial uncertainty, increase transparency and enhance access – for example, limiting balance billing for all types of health care, replacing the *ticket modérateur* [percentage co-payments] with low, fixed co-payments and phasing out retrospective reimbursement.

At the same time, the Government can take steps to reduce the regressivity of CHI by:

- simplifying and automating administrative procedures to prevent households from losing CSS coverage from one year to another;
- setting monthly contributions low enough to encourage much greater take-up among people already eligible for CSS;
- reviewing the thresholds for receiving free or subsidized CHI (CSS) to see if they are high enough to cover all those at risk of poverty or social exclusion; and
- linking subsidies for CHI for Government and private-sector employees to income, so that these subsidies are limited to (or at least significantly more generous for) people with lower incomes.

The Government can also improve the coverage of dental care, to reduce income inequality in unmet need for this type of care, and improve access to AME for undocumented migrants by simplifying and automating administrative procedures.

In addition to reducing financial hardship and unmet need, these measures would make the health system less complex and more transparent, fair and resilient.

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