What is the role of the health care system in reducing health inequalities in France?

Dominique Polton

Summary: As in other countries, there is evidence of substantial and increasing health inequalities in France, but thus far there has been no comprehensive policy aimed specifically at reducing them. Nonetheless, several policy developments have substantially improved financial accessibility to health care for the poor: universal coverage, exemption from co-payments, and subsidies to buy supplementary insurance. The strengthening of primary care and the implementation of programmes to reduce specific diseases and risk factors can also be viewed as steps in the right direction, although their impact has not been assessed in this respect. Concerns about health inequalities have also been growing in recent months, with several new reports commissioned by the Ministry of Health approaching the issue from different angles, including a newly released cancer plan. Further initiatives may also be expected following the forthcoming publication of a report of the High Committee of Public Health commissioned by the Government.

Keywords: health care, health inequalities, France, health policy

Extent of health inequalities in France
As in other countries, there is evidence of substantial and increasing health inequalities in France. For instance, within fifteen years from 1984 to 1999 although blue collar workers gained 3.5 years in life expectancy at age 35, white collar workers gained 4.5 years. Overall therefore the life expectancy gap between the two categories increased from six to seven years (see Table 1).¹

Initial attempts at international comparisons covering data collected early in the 1990s indicated that France, along with Finland, was an outlier in terms of differences in standardised mortality rates, but was at the average when health status was measured using self-assessment.² This somewhat ambiguous result remains consistent with recent evidence confirmed by more recent evidence from the Eurothine project.³

Table 1: Social inequalities in health in France

<table>
<thead>
<tr>
<th>Occupational class</th>
<th>Life expectancy at 35</th>
</tr>
</thead>
<tbody>
<tr>
<td>High officials, professionals</td>
<td>41.50</td>
</tr>
<tr>
<td>Intermediate non-manual</td>
<td>40.50</td>
</tr>
<tr>
<td>Agricultural workers</td>
<td>40.50</td>
</tr>
<tr>
<td>Independent workers</td>
<td>39.50</td>
</tr>
<tr>
<td>Lower officials</td>
<td>37.00</td>
</tr>
<tr>
<td>Manual workers</td>
<td>35.50</td>
</tr>
<tr>
<td>Non-active</td>
<td>27.50</td>
</tr>
<tr>
<td>Total</td>
<td>38.00</td>
</tr>
</tbody>
</table>

Source: Monteil C, Robert-Bobée I, 2005.¹

Growing concern
Health inequalities are a growing concern in France, but thus far there has been no global strategy and no comprehensive policy specifically aimed at reducing them. While academic research and empirical evidence continues to mount, these data have tended to remain solely in the academic domain. They have not been translated into clear recommendations to policy makers in terms of the strategy to reduce health inequalities.

Moreover, in France as in other countries, most of the research in the fields of social

 Dominique Polton is Economist, Caisse Nationale d’Assurance Maladie des Travailleurs Salari, Paris, France.
 Email: dominique.polton@cnamts.fr
epidemiology, public health or health economics is of the view that health care plays a minor role in the shaping of health inequalities. The community of public health scientists shares the view that health inequalities are rooted in global social inequalities, adverse living or working conditions and the life course accumulation of disadvantage. These adverse factors lead to greater exposure to material, psychosocial and behavioural risk factors in lower socioeconomic groups. As a result, there is little scientific debate on the contribution that the health care system could make to address this issue.

Several official reports on the issue of health inequalities have been published by a national advisory body, the High Committee on Public Health (Haut Comité de la Santé Publique), in the last fifteen years. In 1994, this newly created committee proposed the reduction of social inequalities in health as one of four medium-term objectives. There were also two intermediate objectives: first to improve living conditions and promote the social inclusion of very disadvantaged individuals, and second to improve their access to medical and social care.

The same committee published a report on the impact of poverty and precarious living conditions on health in 1998. The recommendations mainly focused on upstream policies to enhance social cohesion and reduce inequality in income, education or occupation but included also the extension of health insurance to achieve universality (which was not the case at that time), with easy access (to avoid non take up), a higher rate of reimbursement for the poorest part of the population (exemption of co-payments), and the organisation of the health care system with primary care at its cornerstone. The promotion of local initiatives and specific policies targeted at sub-populations, such as prisoners, pregnant women in deprived areas and children at risk in school-based settings were also advocated. Some of these recommendations were subsequently implemented.

This concern about health inequalities has again been growing in recent months and several new reports commissioned by the Ministry of Health have investigated this issue from different angles, such as looking at geographical inequalities in prevention or inequalities in cancer. The latter has already been translated into the cancer plan for 2009–2013. A new report advocating a broad and global strategy to tackle health inequalities should also be published imminently by the High Committee on Public Health.

**Implementation of policies related to the issue of health inequalities**

In the last decade, policies directly targeting health inequalities have focused on the poorest part of the population living in the most precarious conditions (i.e. the gradient dimension of the health inequalities issue is not considered globally as a target of policies), and have been directed mainly at facilitating access to health care.

However, other policies targeting the organisation of the delivery of care or specific risk factors or diseases are worthy of mention, since they may indirectly impact on health inequalities. In addition, some of these programmes now include a specific goal on health inequalities, as in the case of the cancer plan.

**Financial accessibility to health care for the poor: free supplementary coverage and subsidies to buy health insurance**

Universal coverage for all legal residents was achieved in 2000. Previously the basis of entitlement was employment status, but since January 2000, as part of the Universal Health Coverage Act (CMU), the small proportion of the population who previously had been excluded (and thus covered through social assistance provided by local communities) became entitled to public coverage on the basis of legal residence in France.

In addition to universal public health insurance by 2000 85% of the population had voluntary additional coverage. These voluntary health insurance (VHI) policies can be purchased through employers or on an individual basis and cover user charges that are not reimbursed by the public health insurance system (co-insurance, co-payments, difference between actual prices charged and official tariffs for dental prostheses and glasses). In total, VHI accounts for 13% of current expenditure on health care.

The CMU Act also addressed these copayments, by implementing free, means tested complementary coverage, covering an additional 7% (approximately four million) of the population. In practice, this means that the low income population is exempted from copayments. The maximum income for entitlement was set at about €600 per month, adjusted for household composition.

In 2004 the Act on Health Insurance Reform created an additional benefit: households whose income exceeded the ceiling by less than 20% became entitled to a subsidy to buy supplementary health insurance. The amount of the subsidy varies with age ranging from €100 for those individuals aged under twenty-five to €400 for individuals aged sixty or more. It is estimated that a further two million people could benefit from this scheme although the actual uptake rate has been much lower: in 2008 only 600,000 got the voucher while 450,000 effectively bought insurance.

**Assessment of these policies**

There is no doubt that the CMU has indeed improved financial accessibility to health care. Recent studies comparing CMU beneficiaries and the rest of the population for some specific conditions (for instance cardiovascular disease) show no difference in health care utilisation and no difference in quality of care (measured by the respect of clinical guidelines).

However if one considers the socio-economic gradient more globally, there is evidence of pro-rich inequity in access to specialist services. Even if this is true in all countries regardless of the organisation of the health care system, the differences are higher in France than in some other comparable countries (albeit less high for dental services) (See Figure 1). Moreover, there is a growing concern about the reluctance of some health care professionals to accept CMU beneficiaries.

It is not clear why the voucher system for those above the CMU income threshold has not achieved a high level of take up. It may be the case that the level of subsidy offered may be insufficient to attract individuals to join the scheme. However, surveys show that a significant portion of this population already have a supplemental insurance contract and could benefit from the subsidy at no cost.

**The organisation of the health care system and the role of general practitioners**

The French system has always been characterised by very easy access to health care (GP or specialists), total freedom of choice, and thus far no real rationing. The price paid for this is that it is an expensive system, probably less efficient than it could be, (albeit global comparisons are difficult: recent work for instance still puts France in first position when it comes to success in tackling avoidable mortality?)
When it equals zero, it indicates equity; when it is positive, it indicates pro-rich inequity; and when it is negative, it indicates pro-poor inequity.


and paying less attention to inequalities in access or health care use.

Nonetheless, compared to many other countries, the French system is weakly organised: until recently there was no need to be registered with a GP, while direct access to office-based specialists without referral was permitted. The 2004 Act on Health Insurance Reform implemented a new system of ‘soft’ voluntary gatekeeping: registration is non-compulsory but encouraged through financial incentives; the referring physician may be any physician (GP or specialist); direct access to specialists is still possible (but more costly); and the referring doctor is seen more as a record keeper rather than a gatekeeper.

90% of the eligible population has now registered, with 99% registering with a GP. This reform strengthens primary care and gives GPs explicit responsibility for the health of a population and for the global process of care. It is a foundation stone on which to build tools and incentives, including feedback of information on prescribing patterns, and the establishment of individual targets for screening, immunisation and efficient drug prescription. 2009 has seen the linking of financial incentives to the quality and efficiency of the process of care. It is still too soon to assess the impact of this reform. However, one result is the fact that differences in the quality of care (for the follow up of chronic patients or for screening) are now reported. Thus there is much more visibility allowing for public debate.

Public health plans and targeted interventions towards specific health problems

Some risk factors are more prevalent among lower socio-economic groups and thus contribute to inequalities in health outcomes. Although it does not guarantee a reduction of health inequalities, tackling these risk factors may improve the situation for the socioeconomic groups who are at most risk.

In this area quantitative targets have been formulated by the 2004 Public Health Act and different public health programmes have been implemented. Progress has been made for some indicators (tobacco use, average alcohol consumption) but in other areas the situation has not improved or in some cases even deteriorated (excessive alcohol consumption, obesity).

The recently published cancer plan for the period 2009–2013 explicitly includes the reduction of inequalities in cancer screening as one of its major targets. It is relevant, since in France cancer mortality is a driving force in the widening of health inequalities.

Conclusion

Health inequalities are a growing concern in France, but thus far there has been no comprehensive policy aimed specifically at reducing them. However, several policy developments have substantially improved financial accessibility to health care for the poor: universal coverage, exemption from co-payments, and subsidies to buy supplementary insurance. The strengthening of primary care and the implementation of programmes to reduce specific diseases and risk factors can also be viewed as steps in the right direction, although their impact has not been assessed in this respect.

Thus the issue of health inequalities appears to be gaining importance on the policy agenda at this time, as illustrated by the newly released cancer plan. Further initiatives may be taken following the forthcoming publication of a report of the High Committee of Public Health commissioned by the Government.

References