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Access to Health Care and Social Protection

L'accès aux soins de santé et la protection sociale

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Summary

In France, the access to healthcare has been conceived as a social right and is mainly managed through the coverage of the population by the National Health Insurance, which is a piece of the whole French social security scheme. This system was based on the so-called bismarckian model, which implies that it requires full employment and solid family links, as the insured persons are the workers and their dependents. This paper examines the typical problems that this system has to face as far as the right to healthcare is concerned. First, it addresses the need to introduce some universal coverage programs, in order to integrate the excluded population. Then, it addresses the issue of financial sustainability as the structural weakness of the French system – in which healthcare is still mainly provided by private practice physicians and governed by the principle of freedom – leads to conceive and implement complex forms of regulations between the State, the Social security institutions and the healthcare providers.

Résumé

En France, l'accès à la santé a été conçu comme un droit social et se trouve principalement organisé à travers la couverture de la population par l'assurance maladie, branche de la Sécurité sociale. Ce système est à l'origine fondé sur le modèle bismarckien des assurances sociales, ce qui suppose le plein emploi et de solides liens familiaux, dans la mesure où les personnes assurées sont les travailleurs et les personnes qui dépendent de ces derniers. Cet article examine les problèmes typiques auxquels le système français est confronté, en ce qui concerne l'accès aux soins de santé. Il montre tout d'abord qu'il a fallu y introduire un dispositif de couverture universelle, afin de couvrir les exclus du système d'assurance sociale. Ensuite, le texte aborde la question de la viabilité financière du système dont la faiblesse structurelle, qui tient au fait que les soins demeurent largement prodigués par les praticiens en activité libérale, conduit à concevoir et mettre en œuvre des formes de régulation fort complexes entre l'Etat, les organismes de sécurité sociale et les pourvoyeurs de soins.

Introduction

In France, the access to health care is founded on the recognition of a *right to health care*. More exactly and legally speaking, the Preamble of the Constitution of 27 October 1946 (para 11) states that: "The Nation guarantees to each one […] the protection of health". Actually, this provision recognizes the right to social and medical assistance which was progressively implemented since the XIXth century as well as it opens the door to a new generation of

economical and social rights which are supposed to be realized through the implementation of a general Social Security Scheme (created in 1945).

Basically, the right to health care requires an adequate system of healthcare (a certain amount of health services plus a high quality of service); it also commands the possibility for the whole population to have an access to the system (universal access).

In France, as in other European countries, the way to fit this requirement has been searched through the "socialization" of the access to healthcare. It means that the cost is sustained by the society and not (or scarcely) by the individuals. In this sense, the right to healthcare is a part of the European welfare State model.

Nevertheless, there are various ways to accommodate this right and to organize the "socialization". In some cases – in some countries (UK, Italy, Spain,…) – the citizens (meaning the residents) have a direct access to a National Health Service. In those cases the physicians, the medical staff, the public hospitals and the health centres are directly financed by the State (tax funding). In other countries (Germany, Belgium, France), the access to health care is managed through Social Insurance schemes (or "regimes") which are legally compulsory. In this case, each worker employed under a contract of employment or self employed must be affiliated to a Social Security (insurance) scheme. As a consequence, the employers and the employees have to pay salary based fees or contributions for each social risk legally covered by the Social Security Schemes[1]. Those risks are basically: sickness/maternity, invalidity, old age, unemployment.

So, in France, the access to healthcare is traditionally managed through the worker's rights towards the social insurance schemes dedicated to the sickness/maternity risk, ie the Social Health Insurance which is part of the French Social Security System[2]. This is the so-called "Bismarckian" model in which the social protection is mainly based on the participation to the labour market. In this sense, the social insurances (in France the Social Security) are an institution of the Labour market. This is why, though the healthcare system is placed under the control of the State authorities, the social insurances schemes are governed by representatives of the employers and of the employees at national level (employers' associations and workers' trade unions).

It has to be kept in mind that the social health insurance doesn't provide healthcare directly. It just finances it by reimbursing the medical expenses (medical consultation, medicines, healthcare at the hospital,…) to the patient who's entitled in the scheme. Moreover, in France, the system is based on the liberty to choose the doctor, the physician or the health centre which will provide the care. This poses a big problem as regards the financial issue. As people are free to access to healthcare and since the physicians are mostly "private practice" doctors (meaning that they act as independent workers), the consequence is that the medical consumption is sustained by the Social Insurance Schemes. Of course, there must be some limitations in order to keep the system safe and sustainable. Actually, the whole system is

[1] The financing of the whole social security system is supported by employers, employee contributions, and personal income taxes. The working population has twenty percent of their gross salary deducted at source to fund the social security system.

[2] We prefer to use the term of *social* health insurance rather than *public* health insurance because of the nature of this body: not a state body, but a private system, administrated by employers and employees representatives who act within a legal framework designed and controlled by the State.

regulated by various legal tools. In this paper, we'll focus on the relationships between the Social Security Institutions and the health centres.

1. The right to health care within the French welfare system

Certainly the goals of the founders of the French Social Security were to embody the right to healthcare in the Social security law: meaning that the whole population should be entitled directly or indirectly within the social insurance schemes. In this view, the role of social and medical assistance programs should have decreased progressively. Nevertheless, this is not how things went. Though the social security schemes play the main part in covering the population and financing the access to healthcare, they didn't achieve the goal of making the right to healthcare a real universal one. So the system had to be extended and complemented with techniques which belong to the social assistance world (law and philosophy).

1.1. The role of the social security schemes

1.1.1. The beneficiaries of the social health insurance

Originally, professional activity (employment and self employment) was the basis of the funding and benefits of the French public health insurance system. The main scheme (for employees) covers 80% of the population (about 46 millions insured persons). There are two additional schemes for the self employed and for agricultural workers. More recently, the system has been extended using other criteria so that people can be covered as residents if there not covered as workers (see below).

Nota: the "regimes" are distinct so the rights of the employees (the salaried workers) are not exactly the same as the self employed or the agricultural workers ones, towards the various social risks taken in charge by the Social Security. Nevertheless, as regards the sole access to healthcare issue, the rights of both categories are identical.

Within this system, either people are entitled to the coverage by the Social Health Insurance on the basis of *direct rights* or they are covered by *indirect rights*. The reason is that the system is "family-oriented".

- the affiliated worker (affiliation is compulsory) is entitled with direct rights[3];
- the affiliated worker's family members (widely speaking) are entitled with indirect rights: the wife/husband; the cohabiter (including the person of same sex provided he/she's passed a PACS)[4]; the children who are dependant; the person who's lived with the affiliated and who's been totally his dependant for at least 12 months; some other members of the affiliated person's family (parents, collaterals, ….) under certain conditions (living with the affiliated and caring at least two children dependants of the affiliated).

As regards the unemployed persons, if they're entitled to the Social Unemployment Insurance, they keep being insured by the Social Health Insurance just like during their former

[3] To be entitled to the reimbursement, the affiliated worker must have been employed and have contributed to the scheme during a certain time: 120 hours during 3 months (he'll then be entitled for 1 year) or 1200 hours/1 year (he'll be entitled for 2 years).

[4] A PACS is a civil union for domestic partnership.

employment period (no contribution required). If the unemployed is no or no longer entitled to the Social Unemployment insurance and if he was previously affiliated to the Social Health Insurance, his rights will be maintained during 12 months.

As regards the retired persons, they are fully covered by the Social Health Insurance (no contribution to the health insurance scheme required for the basic public pension).

1.1.2. **Scope and limits of the protection**

The Social Health Insurance covers a wide scope of healthcare, but those cares are not totally for free. The patients – ie the insured persons – are reimbursed for their health expenses for a certain amount. So the *social protection* based on the social insurance is limited and can be complemented by complementary insurance/private schemes.

a) The types of healthcare covered by the Social Health Insurance

According to the Social Security Code, the Social Health Insurance covers all healthcares which are considered as necessary to the beneficiaries. So it's up to the General Practitioner (GP) to decide which curative measures and treatments are necessary to recover health.

The legislation also establishes a list of typical healthcares that ought to be covered, but the list isn't a closed one (see art. L. 321-1 CSS):

- Medical expenses (medical consultations, surgery, medical biology examinations, expenses for a termination of pregnancy, …)
- Pharmaceutical expenses (medicines)
- Dental cares;
- Hospitalisation expenses
- Expenses for the physical re-education, the professional re-adaptation (after an accident, a disease);
- Pre marital examination (the health certificate has been suppressed by a 2007 Act)
- Some vaccination expenses (for certain categories of people)
- Transports expenses for medical reasons
- Some preventive healthcare (for instance dental examinations)

Nota: The local health insurance bodies not only reimburse those medical expenses; they also act autonomously as regards social action (aids for the persons in precarious situations[5]) and health prevention (vaccinations programs, examinations in order to prevent cancer, …).

b) The reimbursement and the patient's financial participation:

Nota: The Social Health Insurance reimburses a certain percentage of the "contractual fees" for healthcare, meaning the prices which have been fixed by a national agreement passed between unions of physicians and the social health insurance national board (see below).

An average of 70 percent of the cost of a visit to a family doctor or specialist is refunded. Reimbursements are on average of: 95 percent for a major surgery, 80 percent for minor surgery, 95 to 100 percent for pregnancy and childbirth, 70 percent for x-rays, routine dental

[5] Art. L. 262-1 Social Security Code.

care and nursing care at home. Reimbursements for prescribed medicines depend on the type of medication and range from 15% to 65%.

- Medical consultation: 70%
- Surgery: 80%. However, the patient has to pay a daily lump sum for the stay at the hospital (18 euros in the general public and private hospitals; 13,50 euros in psychiatric hospitals)
- Dental care: 70% for the "conservative dentistry". The dental prosthesis are reimbursed at 70% under a limit fixed by a "medical agreement" (for instance a dental crown is reimbursed at 70% on the basis of 107, 50 euros). Some dental cares, such as dental implants, are not considered as conservative dentistry and are not reimbursed at all by the Social Health Insurance (they can be reimbursed partially by some private health insurances).

So a part of the cost (percentage) of the medical acts (consultation, examinations, etc.) and of the medicine is left to the patient. This is the concept of "moderating ticket". This technique aims to limit the medical consumption. However, some patients can receive 100 percent coverage under certain conditions, such as having a chronic or acute medical condition (including cancer, insulin-dependent diabetes, heart disease…), requiring long-term care, having a long-standing condition, requiring a hospital stay of more than 30 days.

More recently, some reforms of the health insurance tended to increase the financial participation of the patients: Since 2005, the patient has to pay flat rate participation (contribution) for each medical consultation (1 euro); since 2008, people have to pay a fee on each medicine box (50 cents) and on each sanitary transport (2 euros); this extra fee which is not reimbursed (*franchise*) cannot exceed 50 euros/year for the affiliate.

c) <u>The role of the complementary insurance (private) schemes</u>

Because the Social Health Insurance doesn't cover 100% of the healthcare expenses, there is a room for private insurance complementary schemes. So people can voluntary contract either an individual health insurance or a collective one (those are corporate health insurance).

In France, such contracts can be offered by:

- Insurance companies;
- Mutual societies providing health insurance
- Non profit welfare organization managed by employers and union representatives

Those insurances cover totally or partially the part which is not covered by the Social Security. The complementary insurance schemes offer an extensive range of plans. The patient has to select the one that is best suited to his situation and needs to take into consideration his/her state of health, medical consumption, family, income and place of residence.

Since health expenditure is still growing in France, there has been ongoing concern about the deficit of the Social Security and governments have been inclined to reduce the level of reimbursement. As a result, more individuals are turning to the complementary schemes[6].

1.2. Extending the protection beyond the social insurance schemes

The weakness of the health insurance program as it was conceived in 1945 is that it supposes full employment as regards the labour market and family as the main social unit. It has to be said that this program never achieved a full coverage of the population (though were extended the "family" criteria in order to be entitled to indirect rights)[7]; moreover, during the late 1990's, the excluded population grew up constantly: long term unemployed people, people living on their own, an so on, ie categories of people which are not or no longer entitled to the Social Health Insurance. It made very clear that this population, even if it was entitled to medical assistance programs, suffered actually a lack of healthcare (especially dental care) by comparison with the rest of the society.

Was then pointed a failure of the principle of equal access to healthcare[8]. The Fight against exclusions Act 1998 reaffirmed the right to healthcare as a fundamental right of the person. This Act was followed by the 27 July 1999 Act that establishes the CMU (Universal Health Coverage) and the CMC (Complementary Health Coverage).

Recognizing the access to healthcare as a fundamental right implies other developments: should the migrants and especially the irregular migrants be excluded of the healthcare programs? The response of the French legal system was to organize an access to healthcare for this population based on medical assistance technique (the so-called State Medical Aid).

1.2.1. CMU and CMC: covering the excluded population

The major change results in the expansion to all legal residents, under the law of universal coverage called la *couverture maladie universelle* (universal health coverage). This doesn't mean that the reform substitutes new criteria (residence) to the former one (employment) in order to guarantee the right to healthcare to everyone. The Universal Health Coverage is a residual program which applies to the ones who are not entitled to the Social Health Insurance.

Actually, the legislation about the Universal Health Coverage implements two new techniques of coverage: the so-called "basic CMU" and the "complementary health coverage" (CMC). Those techniques (CMU and CMC) have to be distinguished: the goal of the basic CMU is to extend the Social Health Insurance and cover the uncovered persons while the goal of the CMC is to give an access to complementary schemes to the people on low income.

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[6] In 2007, about 93% of the population living in France was covered by a complementary health insurance (M. Garnero et M.-O. Rattier, "Les contrats les plus souscrits en complémentaire santé en 2007", Etudes et Résultats; DRESS, n° 698, août 2009).

[7] People not covered by the social health insurance by way of employment or family relationships with an affiliate could be covered by the "voluntary social insurance scheme". But not many people made this choice in the past.

[8] The major inequality came from the lack of complementary coverage: in 2000, 20% of the population had no complementary health insurance and the complementary schemes were strongly linked to the situation on the labour market (50% of the contracts were based on corporate plans). As a result, 38% of the unemployed, 28% of the non qualified blue collars and 23% of the retired workers had non complementary health insurance.

In 2008, there were about 2, 2 millions beneficiaries of the "basic CMU" and 4, 3 millions beneficiaries of the CMC.

As regards the funding:

The basic CMU is financed by the State and by the beneficiaries who have to pay a contribution (8% of their income). Nevertheless, people with low income (under 9020 euros per year for an individual) don't have to pay no contribution.

The CMC is funded though a "Fund for the Complementary Social Protection of the Universal Coverage sickness risk" (notice that the French legislation still uses the concept of sickness risk). This fund is a National public body financed by the Insurance Companies and other bodies which provide complementary or supplementary health coverage, plus a State contribution.

a) Basic CMU

Basic CMU helps anyone living in France who is not covered by another type of insurance get access to medical care and reimbursement of services and medication. People from all levels of income are entitled to it. They just have to justify living regularly and continuously in France (more than 3 months). The affiliation is not automatic and the person has to apply for it at the local Social Health Insurance bureau. The CMU is administrated by the local Social Health Insurance services (CPAM).

It covers part of the medical services for the legal resident and the people in his/ her household. It covers typically seventy percent of a doctor's visit. So in the basic universal health coverage, people are applied the usual "moderating ticket".

In order to control the health consumption, the legislation has established a "basket of healthcare services" which applies to the access to healthcare through the "CMU". Basically, the beneficiaries of the CMU have the same access to healthcare as the affiliates to the Social Health Insurance. Only certain categories of health products are access limited for the CMU beneficiaries: view glasses, some dental prosthesis and medical materials are covered under certain limits.

Nota: Beneficiaries of the *Minimum Income Allowance* (RSA) are automatically affiliated to the social security system. There are several requirements to qualify, but essentially every legal resident in France who earns less than a certain amount[9] is entitled to this financial social aid. As soon as they are affiliated, they are also entitled to the health coverage. Those individuals are entitled to a 100 percent reimbursement of medical and hospital costs.

b) Complementary Universal Health Coverage

Complementary CMU facilitates access to health care for people with low income[10] residing in France for more than three months, in a stable and uninterrupted manner. These individuals have 100% coverage without advance payment for the health services or medication (they are fully covered, no money upfront needed). The income of the individual´s household must not exceed a maximum amount. The spouse or the partner of the beneficiary as well as the

[9] 460 euros monthly for a single person living alone in 2010.
[10] About 630 euros per month for an individual living alone.

dependents under 25 years old is also included in this coverage. It is renewable on a yearly basis.

The beneficiary can choose the body (institution) which will administrate his rights. It can be:

- the local Social Health Insurance bureau;
- An insurance company;
- A mutual society providing health insurance
- A non profit welfare organization managed by employers and union representatives

Unlike the basic CMU, the Complementary Universal Health Coverage fully covers (100%):

- the medical consultations
- the medicines recognized by the Social Security;
- the laboratory/biological examinations
- the hospital fees (including the daily lump sum for the hospital stay) during the whole hospitalization

The beneficiaries don't have to pay the flat rate participation (1 euro) and the fees which were implemented in 2008.

However, the CMC covers under certain limits:

- Dental expenses, prosthesis, dental crowns, ...
- glasses frames (the "basic" view glasses are for free)
- other medical products and materials

Nota: the goal of the CMC is to provide low income people with healthcare total coverage. Nevertheless, remain excluded some working poor, ie persons whose income surpasses the limit to benefit from the CMC but which is down the poverty line. Those people can have their contributions or premiums to a complementary health insurance paid by the Social Funds of the local Health Insurance Services.

1.2.2. The right to health care for the irregular migrants (the State Medical Aid)

This medical aid (assistance) has been conceived for the foreigners who have been residing continuously in France for more than 3 months, who don't possess a residence permit and whose income is under the limit which applies for the access to the Complementary Universal Health Coverage[11]. The State medical aid also covers the beneficiary's dependents. The SMA is granted for 1 year (it can be re granted each year if the beneficiary has remained in France in the same conditions). The SMA is a state-funded scheme.

With the SMA, the beneficiary has an access to usual healthcare: medical consultations, hospitalisation and surgery, medicines, dental care, biological examinations, transports expenses for medical reasons, (…), ie all kinds of healthcare included in the social security law. The patient who wants to be granted has to ask for it at the local social health insurance bureau (even though the SMA is not included in the social health insurance coverage, it is administrated by the social health insurance services).

[11] This kind of medical assistance was created in 1999. In 2006, about 200 000 persons have benefited from it.

The beneficiary doesn't have to pay the charges for health care (100% coverage with no advance payment). He has a liberty to choose the physician or the health centre (applying regulated fees). The physicians, the hospitals are reimbursed by the social health insurance services (the State then has a debt towards it).

Nota: People who are not admitted to the SMA but who need emergency health care at the hospital can be cured for free. In this case, the charges and fees are fully paid by the Social Health Insurance.

First conclusion

Thanks to the Universal Health Coverage, the access to healthcare has been theoretically generalized to the whole population living in France. Is the system really efficient as regards its ability to manage a free or low cost access, especially for the low income workers or individuals? The average reimbursement rate for the health expenses is about 75% (this doesn't include the reimbursement from the complementary schemes). So one can conclude the social health insurance is still rather efficient from this point of view. However, this is a global data and the reality is more complex. On the one hand, the hospital care expenses remain almost fully covered by the social health insurance (90%); on the other hand, the doctor's visits (consultation in private offices) and medicines costs are getting less covered by the social health insurance (about 65%) which means a higher cost for the individuals and a wider room for the complementary health insurance schemes[12].

[12] From 1st January 2006, some 156 medicines lost their eligibility to reimbursement and others had their level reimbursement reduced (such as *veinotonic drugs* for the treatment of varicose veins).

2. Regulating the whole system and limiting the health expenditures

The social health insurance (for sickness and maternity) covers each year about 75% of the total health expenses. So the Social Security as an institution is the main financer of the medical consumption[13]. The sustainability of the system is therefore threatened by the habits of the patients and of the physicians towards medical consumption which has been on the non stop increasing way for years.

It has to be kept in mind that, in France, the role of the Social Security Institutions is not to manage and control the health policy, which is the role of the State. Their mission is only to protect the individuals against the social risks. However, the social security institutions have always been involved in the regulation of the system, in order to maintain its financial sustainability. So they first built some legal relationships with the medical sphere, in order to rule the medical fees. More recently, the 1996 Act (*ordonnance du 24 avril 1996*) about the funding of the Social Security, and the 2004 Act (*Loi du 13 août 2004*) about the Social Health Insurance have instituted a kind of a partnership between the State and the Social Health Insurance that aims at limiting the health expenditures.

2.1. The relationships between the social security institutions and the physicians

2.2.1. The medical agreements: ruling the fees

There is a paradox in the French system: the access to healthcare is socialized while the physicians are mostly private practice doctors. Moreover, the Social Health Insurance bodies are legally bound by the "fundamental principles of deontology" which are the freedom of practice and the professional and moral independence of the physicians, the liberty of choice of the physician (for the patient), the freedom of prescription (for the doctor), the professional secret, the direct payment of the medical fees by the patient.

Nevertheless it cannot be admitted that the social health insurance fully reimburses medical charges freely fixed by the physicians themselves. It'd surely threaten the health insurance financial sustainability. So, since the beginning (1945), the system has been regulated by collective bargaining between unions of physicians and the social health insurance board at national level, under control of the State. The objective is to reach tariff agreements so that the medical fees charged by the physicians and reimbursed by the health insurance are fixed.

Most of the physicians (about 97%) apply those agreements. Some of them only apply the agreed tariff (the so-called 1st sector) and it'll cost 23 euros for a general medical consultation. Others act under the agreement but are entitled to charge free medical fees. In this case (the so-called 2nd sector), they must fix the fees "reasonably" and the patients are reimbursed on the basis of the agreed tariff (23 euros). Only a few physicians act out of the agreement. They

[13] In 2007, 77% of the health care expenditures were paid by the Social Health Insurance, 13% by the complementary health insurances, 8, 5% by the patients themselves and 1, 5% by the State and the public local authorities.

can freely fix their fees and the patients are symbolically reimbursed (1 euro) for the consultation or the visit.

Even in sector 1, the physician can apply an additional fee, no reimbursed by the social health insurance. The right to charge additional fees is justified when the patient asks for a special service, such as visiting the doctor in time off, or so on.

2.2.2. Coordination and control

As it has been pointed out, one of the fundamental principles of the French system is, for the patient, the liberty of choice of the physician. As a consequence, the patient can visit any physician he wants, as often as he wants and keeps being entitled to the reimbursement by the social health insurance[14].

However, the Government decided to limit a bit this absolute freedom. In July 2005, a reform put in place a process of "coordinated care". Every affiliate to the social health insurance is required to appoint (designate) his/her own GP called "*médecin traitant*" (usual practitioner), so that this physician is registered at the local health insurance bureau as the one in charge of care of the patient[15]. This practitioner is in charge of coordinating the health cares for each of his patients. So now, the patient must visit first his/her usual practitioner. If he/she doesn't and chooses to consult another physician, the level of reimbursement from the social health insurance is decreased[16]. Moreover, if the patient directly consults a specialist (who's not his/her usual practitioner) he/she'll be charged an extra fee by the specialist. So those are kinds of penalties.

In case the usual practitioner is unavailable, the patient can consult another physician and inform his/her health insurance bureau, this does not affect his/her entitlement to reimbursement. The patient is free to change to another GP but has to report the change. The usual practitioner can send the patient to another physician (usually a specialist) if the situation requires it. This physician is called "correspondent doctor". With the authorization of the patient, this physician (the correspondent doctor) sends the relevant information to the usual practitioner in order to follow up and coordinate care.

2.3. New partnership between the State and the Social Security Institutions

2.3.1. The role of the State

The basic role of the State is to make sure that the whole population has an access to healthcare, either under the Social Health Insurance coverage or under medical assistance programs. The State is in charge of protecting patient's rights. It elaborates health policies and enforces them.

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[14] The patient doesn't need to be previously agreed by the social health insurance to be entitled to the reimbursement. However, in some cases and for some kinds of cares, a previous agreement is required (kinesitherapy, orthodontic dental cares, ...).This technique has been extended by the Social Security Funding Act 2008.

[15] The referring practitioner can be a GP or a specialist.

[16] From 70% to 30%.

In order to guarantee a correct access to healthcare and the sustainability of the system, the State regulates the prices (fees) of the medical acts and of the medicines are. According to the Social Security Code (art. L. 162-38), "The ministers in charge of the Economics, of Health and of Social Security can fix by a regulation the prices and the profit margins of the health products as well as the prices for the services covered by the social health insurance schemes".

As regards the hospital fees, they are fixed for each type of health centre or medical service:

For psychiatric care in psychiatric hospitals: 194, 90 euros (daily)
For medical care in the hospital: 828 euros (daily)
For surgery: 886 euros (daily)
The daily "hotel" charge for a hospital stay (*forfait journalier*) is 18 euros per day.

The State and the Regional Health authorities plan the size and numbers of hospitals. They decide on the amount and allocation of technical equipment (such as MRI, CT scans…). Through its agencies, the State organizes the supply of specialized wards and secures the provision of care.
In recent years, regional authorities have taken a growing role in policy-making and negotiation.

2.3.2. Some new tools for healthcare management

Times have changed. As the Social Security system founded in 1945 was exclusively funded by employers and employees salary-based contributions, it was managed by the *social partners* (representatives of the employers and of the employees) with an indirect State control. With the economical crisis of the 1970's and the increasing unemployment rates in the early 1990's, the funding was no longer guaranteed. So were introduced some taxes (CSG, CRDS) in order to make the Social Security funds sustainable. As a consequence, the French Parliament got empowered to discuss and vote those taxes. However, it was decided to keep this form of funding out of the State budget. So the Constitution had to be changed (*Loi Constitutionnelle du 22 février 1996)* and was created a new category of legislative tool within the French legal system: the Social Security Funding Acts. Since then, each year is voted and passed a Social Security Funding Act by the Parliament.

The Constitutional Act 1996 was followed by another Act passed on 24th April 1996 which explains the role and the content of the new tools. The Social Security Funding Acts have to "determine the general conditions for the financial balance of the Social Security" and, "as regards the income estimates, have to fix the expenses objectives". So the funding acts have to fix each year the so-called "National Objective for the Health Insurance Expenditures". This objective only deals with the expenses which are covered by the social health insurance.

Inside this global objective are designed the proper objectives for:

- The expenses for the medical consultations at doctor's private offices and for the prescriptions of drugs;
- The expenses for the health centres (the Social Security Funding Act for 2009 fixed an expense objective of 51 billion euros for the public and private hospitals, which is 3,2 % higher than the year before) ;

- The expenses of the medico social centres created and managed by the local health insurance bodies;
- The contribution to the expenses of the centres for disabled persons;
- Other kinds of expenses

Of course, this new legislative tool is not self sufficient. A new institutional frame was designed by the 1996 and 2004 Acts.

- At national level, are passed agreements between the State and the National Health Insurance Bodies for a pluriannual management of the objectives.
- At regional (local) level, were created new bodies (URCAM) in which are put together the boards of the various health insurance regimes (for employees, self employed and agricultural workers). Their mission is to coordinate at regional level the policy for sickness risk management, which implies a control of health expenditures, quality of healthcare and prevention.
- At regional level, were instituted (ordonn. 1996 and 13 August 2004 Act) new partnerships between the State and the Social Health National Insurance: both bodies participate in the Regional Hospital Agencies. Those (public) agencies are autonomous as regards finances and administration. Their mission is to define and to implement the regional policy for the supply of healthcare at the hospital. They also have to coordinate the activities of the public and private health centres, control the way they are managed and fix their resources. Since 1996, the financial resources of the hospitals are negotiated between the health centres heads and the regional hospital agencies. Before the creation of those agencies, there were two administrative regimes: the public hospitals were under budgetary control of the State; the private hospitals had to pass an agreement with the regional Health Insurance Bodies.

Conclusion

The financial issue has obviously to be taken into account within a discussion about the right to healthcare.

In 2008, the deficit of the whole Social Security System (including public pensions) was about 10 billions euros. In 2009, because of the economical crisis and the strong increase of the unemployment, the deficit was about 20 billions euros. Within this global negative result, the deficit of the sole Social Health Insurance was about 9, 4 billions euros.

Those results reveal the main weakness of the French system: in case of high rates of unemployment and unbalanced ratio between active and inactive population, the social insurances become seriously under-funded because of the lack of salary-based contributions (so they are refunded by the State which increases its own public debt).

Should personal income taxes (or other kind of taxes) substitute the traditional salary-based contributions in order to finance the whole system? Would this solution be better suited for a proper access to healthcare, meaning a real universal and equal access?
A “social VAT” is discussed. Some other European countries (Denmark in 1987, Germany in 2007) have implemented this technique. However, a political consensus hasn’t yet been reached in France on this subject.