

History of the Universal Disease Cover (*Couverture Maladie Universelle*)

Catherine Dumont-Fourchard
Ministère de la Santé et des Solidarités

Health care expenditure amounts to 10.14% of GDP in France.

Medical services in France are provided by public institutions (hospitals), private institutions (private hospitals: *cliniques*) and private providers (doctors and other para-medical professionals).

Medical density is relatively high although national distribution is uneven: in 2003, France had 3.4 doctors per 1000 inhabitants.

Hospital expenses amount for 44.4% of the total care consumption, 26.9% of the expenses are generated by health professionals and 21.1% by the prescription of drugs.

The organisation of the health insurance system is rather complex but the principle of employment based coverage still exists.

The general scheme (*régime général*) delivers 85% of the benefits and covers private sector employees as well as different categories of people who were not originally covered by a scheme such as students and war veterans.

A variety of small special schemes cover different categories of workers (railway employees, seamen...).

Two other schemes cover people working in the agricultural sector and entrepreneurs, tradesmen and artisans.

The basic regulations of the social security system cover only a part of the medical care costs. In 2005, 77.5% of the medical care costs and medical goods were covered by social security, 12.9% by additional insurance and 8.7% had to be paid directly by the persons themselves. Different situations of medical care are covered:

- 92.5% of hospital care
- 65.7% for the providers of ambulant care (general practitioner etc.)
- 61.9% for medical goods (drugs, prosthesis...)

This shows that the additional insurance's coverage is nearly insignificant in hospital but determinant for other cares, particularly in areas such as dental and optical care and more generally in first aid areas.

Under this condition, the authorities cannot take any further interest in the possibility for the population to be insured by the additional insurance.

It is indispensable that the authorities intervene in order to avoid leaving an important part of the population without additional coverage, especially those who do not have the means to acquire additional coverage, with the respective social and health consequences.

1. History of the Universal Disease Cover (CMU)

For a long time, ensuring the medical follow up of the most vulnerable has really mattered to France.

Before the set up of Universal disease coverage (CMU), the most vulnerable used to use the state medical help, which in the nineties saw its field of intervention consisting of more and more services in order to cover the whole health expenses refunded by social security.

In 1999, 3.3 millions of people were insured by this device. However, the intervention of many actors (local communities, sickness insurance, state...) caused difficulties.

Therefore, it was decided to simplify the device by entrusting its responsibility to the state and its management to local organisation of health insurance.

The 27/07/1999 law which gave birth to the CMU includes three topics:

- It allows people who live in France to take advantage of health insurance if they are not insured otherwise. Today this device affects around 1.5 million people.
- It allows people whose incomes are lower than a ceiling (around 580€ per person), to have a complementary insurance to take care of 100% of the whole health expenses if they are refundable by the French social security. Today, this device includes around 4.8 million people.
- It creates a State medical help for health expenses of foreigners in illegal situation. Today, this device includes 170,000 people.

Persons benefiting from the CMU are exempt for the co-payment and have not to pay fees in advance (health professionals and institutions are directly paid by the health insurance funds).

Since 2000 this device barely evolved. The 13/08/2004 law has come to complete the device by creating a help to the acquisition of complementary health insurance for people whose resources are equal to the ceiling of CMU + 20%. The amount of this help is currently 100 EUR for one person between 0 and 25 years old, 200 EUR between 25 and 60 years old, and 400 EUR for those above 60 years old. These amounts represent between 30 to 50% of the costs of insurance contracts.

Today there are around 4.8 million people who benefit from supplementary CMU. These figures remain the same since the creation of the device. The recipients of CMU are younger than other social insured. 44% of the population is less than 20 years old against 25% of mainstream population. Women are also more present in this population (53.6% of manpower).

The localisation of recipients of CMU tells of geographical inequalities with an important concentration in the most disadvantaged areas: Seine Saint Denis, Provence, Alpes, Côte d'Azur, Réunion, and overseas territories.

With respect to the acquisition of additional coverage of people, the device is increasing. Now the number of people concerned is very far from those estimated: 235 000 recipients versus 2 millions people estimated. There are many actions for communication to let this device be known and to reach people involved.

2. Financial analysis

Rapidly analysing the structure of the expenditures of people benefiting from CMU, we realise that for the percentage of people covered by 100% for a long time, affectation is more important for the recipients of CMU than for those of other insurances (+3%). This shows that people benefiting from CMU are in worse health than others. The care expenditures which were done in town are below those of other insured people. Nevertheless hospital expenditures are higher. By 2002, a recipient of CMU spent 2,133 EUR in care while an average insured spent 1,700 EUR, this is 25% less. But this difference is only about hospital expenditures.

Besides, people who benefit from CMU rather meet general practitioners than specialists compared to the rest of the population. The average amount of prescriptions is also less important for those people than for others.

In broad outlines we can say that CMU involves two kinds of groups:

- People who are in a situation of precariousness therefore presenting the characteristics of precarious people for what is health: dangerous behaviour, no prevention, resort to hospital treatments, people with severe and lasting pathologies.
- Very modest couples with children: 17% of the children under 10 benefit from CMU. In terms of redistribution we can say that CMU plays a prominent part since these families can access treatments without any major consequences over other expenditures.

3. Principal difficulties

There are two kinds:

- Those who do not need this device.
- The population targeted by CMU is around 6 millions. Only 4.8 millions are recipients. Some analyses were done in order to explain this situation.

There are 3 reasons

- The lack of information. The person concerned has never heard of this device.
- The fear of stigmatisation. The potential recipients are embarrassed by this situation.
- Carelessness & dissocialisation for a part of the most precarious, especially the recipients of RMI – “*Revenu minimum d’insertion*” (welfare benefit).

The local organisations of social insurance in charge of management have to learn as social allowance office did, to find systematically the rights of the insured people.

This non-appeal is more stressed with the potential recipients of the help to acquire a complementary health insurance. There too, many actions of communication are in progress towards the involved audience.

Refusal of care

Since a few years, some practitioners have been refusing to handle recipients of CMU. Those refusals are hard to evaluate. Several inquiries have been done on too limited samples to draw conclusions on a national level.

However, refusal of treatment is a reality. It mainly concerns dentists and specialists who practise free prices, which cannot be applied to CMU's recipients. An inquiry made in Val de Marne region showed that the rate of refusals by specialists could reach 41%.

Faced with that situation, the ministry of health has wished decisions to be taken:

- Recall of obligations falling to practitioners and statistical follow up of refusal of care.
- Broadcasting of information to the recipients of CMU on their rights.
- Exhortation to choose a principal practitioner (mediator practitioner).
- Easy access to the rights (social insurance card given in short notice).
- Systematic complains in case of observation of treatment refusal.

The CMU is 7 years old. Its setting-up made it possible for all to benefit from a disease coverage. In a context when CMU receivers are sicker than the average population particularly because of their financial situation, inquiries have shown that the CMU made it possible to limit the lack of recourse to care for financial reasons. The system still needs to be improved in order for all people who potentially need coverage to have real access to care and prevent some doctors to refuse them care service for financial or organisational reasons.