The “Health Benefit Basket” in France

The French health insurance system, a mix of explicit and implicit regulations, offers wide-ranging reimbursement in the fields of preventive, curative, rehabilitative, and palliative care. The present analysis of the health benefit basket in France is being carried out during a period of reforms. This contribution describes the structure of the statutory health insurance system, followed by a description of the entitlements and benefits and of the actors involved in the decision-making process with its criteria for services of curative care, HCl. Finally, we analyze the main changes which may affect the health basket in France.

The structure of the French statutory health insurance system

The financial management of health care in France is undertaken mainly by the statutory health insurance system as a branch of the wider social security system. The health insurance system's current structure is based on its founding text, the Ordinance of 4 October 1945 and subsequent legislative measures. This system has covered the entire population of France since 1 January 2000 when the Couverture Maladie Universelle (CMU, Universal Health Coverage Act) extended basic health insurance cover to all legal residents of France. The French statutory health insurance system is a compulsory scheme and covers all households regardless of health status, income, number of persons, etc. It provides a somewhat uniform field of reimbursement, with the “basket of goods and ser-

vices” covered by the insurance funds being identical for all the statutory schemes with the reimbursement rate being the same for the three main insurance schemes since 2000. The exceptions are the Alsace-Moselle region's local scheme and certain public sector schemes [1]. Membership in one of the health insurance funds of the statutory health insurance depends on the profession of each person. In the context of the CMU, however, participation depends on legal residence in France and on the level of income. Any dependants of the insured person are also covered by his/her health insurance.

The three main health insurance schemes are as follows: (a) The General Scheme (Régime général) covers employees in commerce and industry and their families (about 84% of the population) as well as persons receiving CMU, estimated in late 2003 at about 1,500,000 person (2.4% of the population) [2]. (b) The Agricultural Scheme (Mutualité sociale agricole) covers farmers and agricultural employees and their families (about 7.2% of the population). (c) The Scheme for the Non-agricultural Self-Employed (CANAM) covers craftsmen and self-employed persons, including self-employed professionals such as lawyers (about 5% of the population). Another ten work-related schemes cover specific sections of the population.

Statutory health insurance funds three-quarters of the health expenditure and therefore leaves considerable scope for complementary sources of funding. An estimated 85% of the population have complementary health insurance. Taking in-

to account recipients of Couverture Maladie Universelle Complémentaire (Complementary Universal Health Coverage 6% of the population), about 91% of the French population are covered by the complementary health insurance scheme, which covers the same health basket as the statutory schemes and not other goods and services [3]. The most important benefit catalogues for France and their underlying criteria are displayed in ■ **Tables 1 and 2** while the following sections are confined to curative health care services.

Organizational structure and actors involved in the definition of the benefit basket for curative services

In France the general conditions of the reimbursement system are established by law. Health benefit catalogues are drawn up at national level with the whole range of goods and services reimbursed by the statutory scheme being specified in Article L.321-1 of the Social Security Code (SSC) [4]. The reimbursement of goods and services depends on their inclusion in positive lists, according to Articles L.162-1-7, L.162-17, and L. 165-1 of the SSC. Until 2004 positive lists were officially enforced by ministerial orders detailing the inclusion of new goods and services. Ministers made their decisions upon the advice of ad hoc scientific commissions and agencies, for example, the National Agency for Accreditation and Evaluation in Health Care (ANAES). The inclusion of all the listed procedures depends on ANAES advice which considers

Table 1

Catalogues and implicit regulation

	GBR	CCAM	NGAP	LSAC ATU	Med. dev.	NABM	Sp. reg.
HC.1 Curative care services							
1. Inpatient curative care	+	+	-	-	-	-	-
2. Day-patient curative care	+	+	-	-	-	-	-
3. Outpatient curative care	+		-	-	-	-	-
3.1. Basic medical and diagnostic services	+	+	-	-	-	-	-
3.2. Outpatient dental care	+	+	-	-	-	-	-
3.3. All other specialized health care	+	+	-	-	-	-	-
3.4. All other outpatient curative care (paramedical)	-	-	+	-	-	-	-
3.5. Services of curative home care	+	-	+	-	-	-	-
HC.2 Services of rehabilitative care							
1. Inpatient rehabilitative care	+	-	-	-	-	-	+
2. Day cases of rehabilitative care	+	-	-	-	-	-	+
3. Outpatient rehabilitative care	+	-	+	-	-	-	-
4. Services of rehabilitative home care	+	-	+	-	-	-	+
HC.3 Services of long-term nursing care							
1. Inpatient long-term nursing care	+	-	-	-	-	-	+
2. Day cases of long-term nursing care	+	-	-	-	-	-	+
3. Long-term nursing care: home care	+	-	+	-	-	-	-
HC.4 Ancillary health care services							
1. Medical analysis laboratory	+	-	-	-	-	+	-
2. Diagnostic imaging	+	+	-	-	-	-	-
3. Patient transport and emergency rescue	+	-	-	-	-	-	+
HC.5 Medical goods dispensed to outpatients							
1. Prescribed medicines	+	-	-	+	-	-	-
2. Other medical nondurables	+	-	-	-	+	-	-
3. Therapeutic devices and other medical durables	+	-	-	-	+	-	-
HC.6 Prevention and public health services	-	-	-	-	-	-	+

GBR General Benefit Regulation, CCAM list of physicians' and dentists' technical procedures, NGAP list of physicians' consultations and other health professionals' activity, LSAC ATU positive lists of drugs, Med. dev. positive lists of medical devices, NABM positive lists NABM biology procedure, Sp. reg. specific regulation

the effectiveness and/or safety of these procedures and the conditions under which they need to be performed.

Reimbursement is legal only when goods or services are provided in an appropriate medical context. Reimbursement for all goods and all paramedical procedures depends on the provision of a prescription, which serves as confirmation of the necessity of such goods and services. For some types of treatment, such as physiotherapy and spa treatment, the prescription from a physician does not provide the needed status for reimbursement. Coverage by statutory health insurance is subject to the prior authorization (*entente préalable*) of the physicians advising the health insurance funds, after examination of the patient's case history and a possible interviewing of the patient.

According to Article L.322-2 of the SSC, the insured person's copayment is fixed by a decision of Union Nationale des Caisses d'Assurance Maladie (UNCAM, National Union of Health Insurance Funds) within rate limits defined by a Council of State decree. The copayment can be either a percentage of the charges or a lump sum. The patient's contribution to the total cost of treatment varies according to the type of treatment, being higher for outpatient care and drugs compared to hospital treatment. The copayment must be paid by the insured person or, where applicable, by their complementary health insurance fund.

Council of State decrees also define copayment exemption conditions (Article L.322-3 of the SSC). The most important exemptions are linked to the health status,

especially in the case of one person suffering from one of 30 specified long-term illnesses, for example, diabetes, AIDS, cancer, and psychiatric illness, and if the patient is suffering from one or several incapacitating diseases. Other health status-based exemptions concern, for example, disabled persons under the age of 20 years and pregnant women during the final 4 months of pregnancy.

The health benefit basket is explicitly defined by positive lists of goods for both the public and the private sectors. Positive lists only apply to services delivered by private sector professionals in their own practices or in private for-profit hospitals. Conversely, services dispensed in public hospitals or private not-for-profit hospitals were mainly the subject of implicit definition since they were paid for by a global bud-

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Abstract

The French “Health Benefit Basket” is defined principally by positive lists of reimbursed goods and services; however, global budget-financed hospital-delivered services are more implicitly defined. The range of reimbursable curative care services is defined by two coexisting positive lists/fee schedules: the Classification Commune des Actes Médicaux (CCAM) and the Nomenclature Générale des Actes Professionnels (NGAP). The National Union of Health Insurance Funds has been updating these positive lists since August 2004, with the main criterion for inclusion being the proposed procedure’s effectiveness. This is assessed by the newly created High Health authority (replacing the former ANAES). In addition, complementary health insurers are consulted in the inclusion process due to their important role in French healthcare financing.

Keywords

Health benefit plans · Health services · Health priorities · National health programs · France

get, which means in practice that basically every dispensed service was reimbursed. The situation is currently undergoing an important reform.

HC1 services qualifying for reimbursement by the health insurance system include: (a) inpatient care and treatment in public or private healthcare institutions; (b) outpatient care provided by general practitioners, specialists, dentists, and midwives; and (c) diagnostic services and care prescribed by physicians and performed by laboratories and paramedical professionals, such as nurses, physiotherapists and speech therapists.

In July 2005, two health benefit catalogues for curative services exist: (a) The Classification Commune des Actes Médicaux (CCAM), which revises the previous medical services catalogue, has been adopted in 2005 with its application still only partial [5]. (b) The general fee schedule (Nomenclature Générale des Actes Professionnels, NGAP), which is the medical procedures positive list for health professionals in private practice, in their own surgeries and consulting rooms and in private-for-profit hospitals, remains in force until the CCAM is fully implemented.

Inpatient curative service

The Social Security Act of 18 December 2003 (Loi de financement de la sécurité sociale, LFSS) changed the inpatient acute care funding rules, but implementation is still in progress. The situation will continue to change during the next few years for at least two reasons. Firstly, the positive list for physicians’ procedures, the CCAM, applies to both private and public hospitals (Article 162-1-7 of the SSC), which had not been the case before. Secondly, the implementation of the per-case payment reform that will lead to the result of both sectors being brought into line. These situations before and after the reforms of 2004–2005 are shown in **Table 3**.

As seen in **Table 3**, there has been no positive list to define reimbursable services in public and in private not-for-profit hospitals, in which inpatient services were regulated by implicit coverage. However, the implementation of the per-case payment system will simplify the situation as all medical, surgery and obstetrics ser-

vices in all hospitals will be included in it. The reform will also change the remuneration schemes of inpatient and outpatient care. Services provided in inpatient or outpatient acute care will be financed through a payment-per-case system. This is based on a diagnosis-related group type of classification of 700 Groupes Homogènes de Malades (GHM), considering comorbidities. A nationally fixed tariff (Groupe Homogène de Séjours, GHS, Homogeneous Group of Stays) is applied to each GHM [6]. Outpatient procedures will be paid on a fee-for-service basis, and organ retrieval and emergency services by annual lump sum payments. This payment system also includes earmarked funding (Missions d’intérêt général et Aide à la contractualisation, MIGAC) to finance other activities, such as research and education, but also certain healthcare activities promoted by contracts between hospitals and regional health agencies. The new GHS payment system has been in operation since 1 March 2005 for private-for-profit hospitals. Procedures carried out by physicians are always paid separately and directly to the physicians concerned on a fee-for-service basis, while in public hospitals, tariffs include specialists’ salaries. Since July 2005, the CCAM is used as the general fee schedule and can be considered as the positive list for private for hospitals. Health insurance funds will not finance any stay if one of these procedures does not apply. CCAM is currently available only for technical procedures such as surgery, medical imaging, and radiotherapy performed by physicians. Paramedical services, including, physiotherapy, which are linked to inpatient medical procedures, are reimbursed only if they are an essential part of the medical treatment. Regarding the definition of the health basket, the rules for day-case patient care are the same as those applicable to inpatient care. GHS tariffs refer to day hospital treatment.

Outpatient curative care

Patients who need health care have until now been free to choose which physician to consult and have also been allowed to refer themselves to specialists. Only few general practitioners have begun playing the role of gatekeepers, although a few of

Table 2

Benefit-defining laws/decrees, catalogues and implicit regulation

	GBR	CCAM, NGAP	LSAC ATU	Med. dev.	NABM	Sp. reg.
Legal status: law, decree	Law	UNCAM decision	Ministerial order	Ministerial order	UNCAM decision	Administrative document
Decision maker	Parliament	UNCAM, on the advice of HAS and UNOC	Ministers of health and social security, on the advice of the Transparency Commission	Ministers of health and social security on the advice of the ad hoc Commission	UNCAM, on the advice of HAS and UNOC	
Original purpose: entitlements, reimbursement, target setting	• Reimbursement • Tariffs	• Positive list • Fee schedule	• Positive list • Prices or reference prices	• Positive list • Reference prices	• Positive list • Fee schedule	Positive list
Positive-negative definition of wwbenefits	Positive	Positive	Positive	Positive	Positive	Positive
Degree of explicitness ^a	3 (except inpatient care: 1)	3	3	3	3	2 or 3
If itemized: goods/procedures only; linked to indications	Mainly goods and procedures; linked to indications	Procedures, sometimes linked to indications	Pharmaceutical products, linked to indications	Goods linked to indications	Procedures linked to indications	Mainly indications
Updating	–	Regularly	Regularly	Regularly	Regularly	–

GBR General Benefit Regulation, CCAM list of physicians' and dentists' technical procedures, NGAP list of physicians' consultations and other health professionals' activity, LSAC ATU positive lists of drugs, Med. dev. positive lists of medical devices, NABM positive lists NABM biology procedure, Sp. reg. specific regulation
^a 1, "all necessary"; 2, "areas of care"; 3 "items"

Table 3

Definition of benefit catalogues for inpatient care

Before 2004–2005	After 2004–2005
Funding rules depend upon hospital status: PH and PNFPH, vs. PFPH	New funding rules making the basket more explicit
Range of reimbursed medical procedures defined at least for PFPH but not for other services, e.g., nursing care	Same list of medical procedures for both private and public hospitals (Article 162-1-7 of the SSC),
No positive list for PH, an implicit coverage for all services in PH and PNFPH mainly financed by the global budget	Same prospective per-case payment system for PH and PFPH for all medical, surgery and obstetrics services, based on DRG-type classification of GHS, but tariffs still differ from PH to PFPH.
Basket of reimbursable drugs defined for PH and PFPH	Basket of reimbursable drugs defined for PH and PFPH

PH public hospital, PNFPH private non-for-profit hospital, PFPH private-for-profit hospital, DRG diagnosis-related group, GHS homogeneous stay group

them have been making some attempts in this regard since 1996. Recent health insurance reforms are about to change this situation. Since 1 July 2005 all those benefiting from health insurance coverage in France are obliged to choose their main physician (*médecin traitant*). As a result there will be higher user charges if a person chooses to consult a specialist directly without being referred by her/his "gate-keeping" *médecin traitant* general practitioner [7]. The basket of reimbursable outpa-

tient curative services is defined by a positive list which is also used as a fee-schedule for health professionals in private practice. Until March 2005 the NGAP was the only list and applied to all services. This will be replaced by the new CCAM classification. In a rather lengthy process CCAM is currently being developed. At this stage CCAM specifies only technical procedures such as diagnosis, surgery, and radiology performed by specialists and dentists. CCAM is also being used in public

hospitals to charge for outpatient care and to specify the reimbursement rate. This classification is not yet used for specialist consultations or procedures carried out by other healthcare professionals who are still in use of the NGAP. The CCAM is fully comprehensive in content as it contains details of all medical procedures, even those that are not reimbursable. Each procedure corresponds to only one label and one code, eliminating any ambiguity and making it easy to use. The classification

is structured according to the anatomical classification and specialties. There are 17 chapters which are based on the organ system to which the procedures refer. The CCAM is based on the rule of procedural totality, meaning that each label implicitly contains all the operations necessary for the performance of the medical procedure. It was drawn up as a resource-based relative value scale (RBRVS) by the main health insurance fund (CNAMTS) with the collaboration of health professionals, and the ANAES being involved in the selection of effective procedures.

Since the reform of 13 August 2004 the UNCAM, which includes representatives of the three main sickness funds, is in charge of preparing and updating the positive lists. UNCAM will be assisted in its decision making by the advice of the two newly created bodies, the High Health Authority (Haute Autorité de Santé), which replaced the ANAES and the National Union of Complementary Health Insurance Organizations (Union Nationale des Organismes d'Assurance Maladie Complémentaire, UNOC). The same criteria used for the NGAP will be used for the taxonomy of medical procedures leaving room for improvements in medical services and achieving cost-containment at the same time [8]. Nevertheless, the ministries of health and social security retain the right to reject UNCAM's decisions and to include or exclude goods and services in or from the list, especially if public health issues are concerned. A commission comprising healthcare professionals' unions and representatives of UNCAM has been created to determine the general rules for drawing up the RBRVS and then for validating the scale proposed by the health insurance fund services. In addition, UNCAM is responsible for negotiating the tariffs of medical procedures with healthcare professionals' unions and for determining the levels of copayment and coinsurance.

Other outpatient services such as auxiliary services provided by nurses, physiotherapists, orthoptists, speech therapists and chiropodists must be provided on medical prescription in order to be reimbursed. In the area of complementary and alternative medicine (CAM) special recognition is given to acupuncture and homeopathy. These two therapies are thus

recognized and may be legally practiced, but only by physicians or licensed physiotherapists on medical prescriptions for acupuncture. A few osteopathy and chiropractic procedures have recently been included in the CCAM in addition to certain vertebral manipulations which were already listed in the NGAP. The range of services covered by statutory health insurance does not include cosmetic surgery and some other treatments and services of uncertain effectiveness such as spa treatments. The issue of the allocation of scarce resources means that choices must be made which may result in the nonreimbursement of certain procedures, for example, bone density measurement when performed in the private sector as a preventive measure, and the imposition of limits on the frequency for which they can be reimbursed, such as mammography for cancer screening purposes.

Home care services

The entitlements laid down in the SSC include services provided by independent physicians (home visits) and by other health professionals such as nurses and hospital-at-home services. Regarding palliative care at home, according to Article R 162-1-10 of the SSC, a multidisciplinary team of health professionals can be organized at the special request of a person whose state of health demands it, to provide palliative home care. The remuneration can be paid on a fee-for-service basis or as a lump sum.

Discussion

This study faces a number of limitations which may affect the analysis of the French health benefit basket. Firstly, the study was carried out in a period of changes related to the redefinition of the medical procedures for both inpatient and outpatient care. This will make some statements in the previous catalogue become obsolete. Furthermore, the introduction of the new CCAM catalogue has been postponed several times due to conflicts of interest between health professionals, especially those between the physicians' unions and the health insurance funds. The catalogue deals with the two issues of the

remuneration of healthcare professionals and the state regulation. Secondly, the recent health insurance reform (Health Insurance Act, 13 August 2004) affects all actors involved in the definition of the benefit catalogue and thus the decision criteria. The High Health Authority, for instance, is expected to have considerable powers. At the same time, UNCAM is also playing an important role in the drawing up of the positive lists of procedures. However, the ministers of health and social security still retain their right to reject the UNCAM's decisions. It could be asked whether the change regarding the delegation of the task of drawing up benefit catalogues to a so-called "self-governing body" is fully effective, as this is the case in Germany. It is too early to assess the consequences that these new regulations will bring about, but it can be anticipated that it might well be a case of *plus ça change, plus c'est la même chose*, as both the French government and the physicians have always played a major role in the healthcare decision-making process. Thirdly, the French system offers a mix of explicit regulation for ambulatory care, pharmaceuticals and medical devices, dental care, etc., with benefit catalogues and positive lists and of implicit regulation for a large part of inpatient care [9]. Altogether the package of health care services covered is comprehensive and wide-ranging although that the additional billing is rather high for certain types of goods and services. As a consequence of the implicitness of the coverage with particular respect to inpatient care, we have noted some differences between principles and practice, indicating that not all services are actually covered to the same extent. The interviews carried out at the Ministry of Health confirmed this finding.

Finally, the drawing-up of the positive lists still remains hotly contested among those at the health and social security ministries who were interviewed for this study. Current French health policy combines the harmonization of regulation with the reduction in health inequalities on the basis of improved knowledge of public health needs. However, this policy is being implemented in a context of increasing health expenditure and especially of increasing user charges. It is a contradictory

situation in which things that have been received by the one hand have again been taken away by the other one.

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