ESPN Thematic Report on Inequalities in access to healthcare

France

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Gilles Huteau – Michel Legros

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European Social Policy Network (ESPN)

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

The ESPN is managed by the Luxembourg Institute of Socio-Economic Research (LISER) and APPLICA, together with the European Social Observatory (OSE).

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Summary / Highlights

The French health system gives patients and doctors a great deal of freedom, at the same time as guaranteeing extensive coverage of health expenditure. The social security health insurance system is generalised to cover the entire population with a comprehensive care package.

Most people also have a complementary health plan (95% of the population[1]), which they either take out individually or through their employer. Since 2000, people on low incomes (up to €8,810 per year for a single person, depending on household size) have benefited from a specific measure called *couverture maladie universelle complémentaire* (CMU-c), which is granted with no need for contributions.

As a result, in France patients' out-of-pocket spending on healthcare and medical goods is in net terms half that of other European countries. After reimbursements from the social security health insurance system (covering on average 77% of spending) and complementary health insurance, just 8.3% is borne by households.

Nevertheless, a noteworthy 5% of the French population do not have complementary coverage. This mainly concerns the unemployed and retired people with low pensions.

With the exception of beneficiaries of CMU-c, patients can be subject to significant co-payments when they find themselves confronted with medical fees in excess of the health insurance reimbursement tariffs; or with poorly reimbursed expenditure on optical items and prosthetics. These two types of situation are in fact the reason for most non-take-up of healthcare by people on low incomes.

In addition to this financial obstacle to accessing healthcare, regional disparities in the availability of healthcare are also an issue. While France ranks as average in Europe in terms of medical services density, access to care has become difficult in some geographic areas, mainly in rural zones, because of the shortage of practising doctors. This problem is set to get worse in coming years as large numbers of retiring doctors are not replaced.

Beyond these more visible aspects, inequalities in access to care stem from other factors. They reflect differences in socio-cultural behaviour and economic insecurity, which in particular make women from disadvantaged groups less likely to take up preventative care. They are also particularly marked for some female pathologies, as illustrated by disparities in access to breast cancer screening.

Appraisal of health inequalities is based on the collection of statistics by state services and the work of research teams from public institutions and universities.

In particular, the accent is on measuring and explaining the non-take-up of healthcare based on surveys that consist in questioning a broad panel of health system users. However, given the disparities between the results obtained in different surveys, the analysis of the collected data remains to be consolidated.

However, the creation of a new indicator of disparities in healthcare availability (local potential accessibility - *accessibilité potentielle localisée* – APL) marks a substantial step forward insofar as it takes into account the level of activity of healthcare professionals and the characteristics of healthcare demand over a given geographic area. This creates the conditions for a more detailed analysis of regional disparities by adding other available data such as 'access time by road in minutes'.

[1] Boriel M., Beffy M.,Raynaud D. (dir.), 'La complémentaire santé en 2016', DREES, 2017.

1 Description of the functioning of the country's healthcare system for access

1.1 Key principles of the functioning of the healthcare system

The French healthcare system is unusual in that it combines a considerable number of private-sector healthcare services for which expenditure is covered by the social security system. This involves the health insurance part of the social security system, known as basic health insurance, which takes the form of a reimbursement of the costs of healthcare and medical goods.

Universal healthcare protection (*protection universelle maladie* - PUMA), which dates from 2016, provides all 18-year-olds and over with healthcare insurance, provided that they live in France on a stable, regular basis (including asylum-seekers and political refugees). For the under-18s, their parents' health insurance can provide a guarantee against healthcare costs. Foreign nationals in an irregular situation who have been living in France for over three months are covered by state medical assistance (*aide médicale de l'Etat*), which provides them with minimum medical care.

Healthcare insurance covers all types of healthcare and goods, such as the fees of private practitioners and other healthcare professionals, hospital costs, and expenditure on medicine, glasses, appliances, and medical transportation. Coverage of the corresponding expenditure is based on tariffs established by either the state or health insurance funds.

In exchange for this freedom of access to healthcare, the basic health insurance scheme requires that beneficiaries participate in financing their healthcare costs (co-payment). In practice, this financial participation is often covered by complementary healthcare insurance, which may either be voluntary and individual, or obligatory and imposed by an employer.

1.2 Impact of financing the consumption of healthcare and medical goods on access to healthcare

In 2016 the social security system's healthcare insurance scheme covered 77% of the consumption of healthcare and medical goods, whereas the share covered by complementary organisations was 13.3%. Final co-payment made by households amounted to 8.3%[2], which is relatively low compared with other EU countries. On a slightly wider measure of current expenditure on healthcare, the co-payment to be met by households was 7% in France in 2015, compared with an average of 15% in the EU-15[3].

These high levels of coverage of expenditure nevertheless mask significant disparities from one expenditure item to another. Thus, 91.4% of hospital care and mental care was covered by basic health insurance in 2016, with the co-payment by the patient amounting to 2.3%. In contrast, households had to cover a total of 11.6% of non-hospital treatment. The social security system provides the least coverage for medication and in particular other health goods, leaving households to make up a higher proportion of the cost. Thus for optical care, the share of expenditure covered was only 4%, compared with 74% on average by complementary insurance schemes[4]. For dental care, social security health insurance only covered 33% of expenditure, with 39% covered by

[2] Beffy M. et al., (dir.), 'Les dépenses de santé en 2016', DREES, 2017.

[3] Bureau for the analysis of social accounts and Mission for international relations and studies, 'En 2016, les dépenses de santé retrouvent leur dynamisme', DREES, Etudes et résultats, n° 1024, September 2017.

4 Ibidem.

complementary insurance and 25% by households. The remaining 3% pertained to universal complementary coverage (CMU-c) and state medical aid.

However, although the final 8.3% to be paid by patients should not be overlooked, it is worth remembering that complementary insurance is based on insurance mechanisms that can contribute to creating social inequalities in the access to healthcare[5]. Unlike financial contributions made to the social security system, the contributions made to complementary insurance organisations are not related to income and vary depending on the insured party's family responsibilities and age group, to the detriment of older people.

To encourage people to take up complementary insurance, the Act of 13 August 2004 provided for assistance to acquire health coverage (*aide à l'acquisition d'une couverture de santé* - ACS), for optional, individual contracts only. This measure, financed by public funds, concerns people whose annual income is up to 35% higher than the resources ceiling that conditions access to CMU-c (€11,894 for *l'aide à l'acquisition d'une complémentaire santé* in 2018 for a single person depending on household size). The amount of financial aid granted varies according to the beneficiary's age group (ranging from €100 for those aged under 16 to €550 for those over 60) to reflect the insurance pricing policies of complementary insurance organisations.

In addition, the guarantees provided reveal highly diverse contracts that offer very different coverage in addition to the social security coverage[6].

1.3 Unequal availability of healthcare in the country

Healthcare system users are free to choose their general practitioner or specialist, as well as other healthcare professionals (medical auxiliaries, pharmacists, etc.) and hospital facilities. Nevertheless, at the risk of a financial penalty, social insurance contributors are obliged to choose and sign up with a specific general practitioner and consult them before making an appointment with a specialist.

All private healthcare professionals can sign an agreement with the health insurance funds to deliver healthcare and goods to patients insured by the system. This agreement establishes the terms, the professionals' relations with the insured parties and insurance funds, and in particular their tariffs and fees.

Freedom of choice in healthcare access can be compromised by the unequal availability of healthcare throughout the country. In terms of the density of doctors, France ranks as average among OECD countries, with a ratio of 3.3 doctors per 1,000 inhabitants[7]. However, doctors are more prevalent in the south-east, the west coast and urban hubs known for their dynamic atmosphere and quality of life (e.g. Bordeaux, Nantes, Besançon), and relatively scarce in most rural territories and major town centres in the Paris region and northern France. This issue has been a topic of public debate for several years, and has given rise to the term 'medical deserts'. While the phenomenon mostly concerns private doctors, it also affects hospital care and other services.

In a study on the 'health divide' published in June 2016[8], the consumer rights group UFC-Que Choisir indicated that "in four years, 27% of French people have seen a reduction in their geographic access to general practitioners, and up to 59% for gynaecologists".

[5] Tabuteau D., 'Le "New Deal" des assurances maladie obligatoire et complémentaire', Revue de droit sanitaire et social, 2014, p.791.

[6] Garnero M., Le Palud V., 'Les contrats les plus souscrits auprès des complémentaires santé en 2010', DREES, Etudes et résultats, n° 837, April 2013.

[7] OECD, 'Health at a Glance, 2015'. As well as doctors delivering care, these data include, for France and other countries, doctors who practise in other health sectors as administrators, teachers or researchers (http://dx.doi.org./10.1787/health-data-fr).

[8] Cited in Cardoux J.-N., Daudigny Y., 'Rapport d'information sur les mesures incitatives au développement de l'offre de soins primaires dans les zones sous-dotées', Senate, n° 686, July 2017, 129 p.

Almost 15 million French people, or 23% of the mainland population, experience difficulties finding a general practitioner closer than a 30-minute drive from their home. For specialists (ophthalmic opticians, gynaecologists and paediatricians), access within 45 minutes is difficult for 28% to 33% of the mainland population[9]. This situation leads to longer delays in obtaining an appointment, and shifts the demand for treatment to emergency hospital services[10].

1.4 Incomplete coverage of healthcare costs by basic health insurance

The health insurance system is based on the principle of financial participation from insurance contributors, which mostly takes the form of a partial contribution. This represents a variable percentage of the expenditure depending on the nature of the care and health goods concerned (20% for hospital treatment, but 30% for medical fees, and as much as 75%, even 90%, for some drugs). Exemptions include the following three categories: one connected to the nature of certain interventions and treatments; one linked to the cost or duration of treatment, in particular for chronic conditions (e.g. diabetes, cancer); and one linked to specific social security law (maternity insurance, occupational accident insurance, special social security schemes, etc.).

Other forms of financial contribution, most of which date from the mid-2000s, are made in addition to the above: a €1 lump sum per medical intervention (2004), a lump-sum participation of €18 for 'complex' interventions (2006), a deductible of €0.50 per medication pack (2007), €2 for medical transportation, etc.

The issue of co-payment by insured parties in the healthcare insurance system is currently intensified by the high increase in practices charging excess fees, i.e. fees that are higher than the standard fixed fees charged under the public insurance scheme; these may be by private doctors, private health facilities, and sometimes even government hospitals. This phenomenon only concerns some registered doctors: 1 doctor in 4 on average, but many as 4 in 10 specialists, and over half in the case of some specialities such as ophthalmology. These practitioners are authorised by the health insurance schemes to set their own fees, whereas their patients are refunded within the limits of the regulated tariffs. Since 1990, only doctors with specific qualifications have been authorised to apply these excess fees. Between 1990 and 2015 the average excess fee more than doubled, going from 25% to 52%[11], and amounting to €3.2 billion.

More generally, the differences between the tariffs covered by the healthcare insurance system and the fees actually charged for some medical devices (glasses, prostheses, braces), which total €12.2 billion[12], raise an issue of access to healthcare for the country as a whole.

1.5 Changes in complementary health insurance with a view to promoting equal access to healthcare

Recent changes include the creation of complementary universal health coverage *(*couverture *maladie universelle complémentaire* – CMU-c) and the general extension to private-sector employees of complementary healthcare coverage (*acquisition d'une complémentaire santé – ACS*) dating from 1 January 2016.

The CMU-c covers the total cost of healthcare and medical goods for the most disadvantaged individuals. Under this system, the items that people typically tend to do

[9] This study, which was based on health insurance data on the location of private-sector doctors, available from the scheme's 'health directory', classifies access to doctors as difficult when medical density is more than 30% lower than the national average.

[10] Court of Auditors Report, 'La sécurité sociale', September 2017, 719 p.

[11] Barlet M., Marbot C. (dir.) 'Portrait des professionnels de santé – edition 2016', DREES, 2017.

[12] Beffy M. et al., (dir.), 'Les dépenses de santé en 2016', DREES, 2017.

without (glasses, dentures) feature in a list known as a '*panier de biens et soins médicaux*'. These items benefit from higher coverage tariffs than under standard healthcare insurance and are related to actual prices on the healthcare market. In addition, private doctors are not allowed to charge excess fees to patients who benefit from CMU-c and must practise third-party payment to avoid them having to pay upfront. CMU-c reduces the numbers of people who do not take up healthcare for financial reasons to a level comparable with standard complementary coverage[13].

In addition, to encourage them to take out a personal complementary healthcare insurance plan, people whose income amounts to up to 35% of the CMU-c access threshold can claim help to acquire a complementary health plan. The amount of help depends on the age group of the beneficiary. A study by the French state statistics department (*Direction de la Recherche, des Etudes, de l'Evaluation et des Statistiques* – DREES), published in February 2014[14] shows that this category of people renounces care twice as much than those with complementary healthcare insurance. It indicated that 30% of people not covered by a health plan had gone without treatment at least once during the year preceding the survey. This shows the importance of extending complementary health plans to combat unequal access to healthcare.

Following the national inter-professional agreement of January 2013, the Act of 14 June the same year established the generalisation of complementary health plans as from 1 January 2016 for all employees in the private sector. As a result, complementary healthcare coverage is now financed by contributions from both employers and employees, and must conform to a minimum legal basis. It must be sufficient to cover: full co-payment; 125% of the reimbursement tariff for dental care; and optical expenditure based on tariffs similar to market prices. Former employees continue to benefit from this complementary healthcare plan for one year after leaving the company.

The new system has the effect of increasing the number of beneficiaries of complementary health plans, but it does bring some risks in terms of promoting equal access to care. Although complementary health insurance is mostly organised into individual contracts (mutual insurance schemes and insurance companies), it is marked by a shift towards occupational insurance for employees. This kind of change could have a negative effect on the long-term unemployed and pensioners insofar as employees exiting from individual contracts, who are relatively healthy and thus viewed as 'good risks', could push up contribution rates for such contracts. It can also lead to 'demutualisation' (non-renewal of an individual complementary health insurance plan) among certain categories of people (old people, unemployed people) who do not have access to collective agreements. Increased financing for ACS could potentially be a solution for this emerging problem.

1.6 Regional inequalities in access to healthcare

In 2015, the number of doctors aged under 70 was 261,700, the highest level recorded during the last forty years[15]. With a density of 3.3 doctors for 1,000 inhabitants, France ranks around the average among OECD countries. While the number of dental surgeons is at a standstill, that of nurses and physiotherapists is increasing by 3% to 4% per year. Densities are unequal from one region to another. At local *département* level, disparities are rising. The rate of general practitioners can double from one area to the next, with an even greater difference for specialists. Density differences are even wider for other

[13] Jess N., 'Les effets de la couverture maladie universelle sur le recours aux soins', DREES, Etudes et résultats, December 2015, n° 0944.

[14] Coppoletta R., Le Palud V., 'Qualité et accessibilité des soins de santé : qu'en pensent les Français?', DREES, Etudes et résultats, n° 866, February 2014.

[15] Bachelet M., Anguis M., 'Les médecins d'ici à 2040: une population plus jeune, plus féminisée et plus souvent salariée', DREES, Études et Résultats n° 1011, May 2017.

medical professions, with up to four times as many physiotherapists and seven times as many nurses available in some areas compared with others.

The perspective of a medical demographic gap in the next five years, the ageing of the medical profession (27% of doctors are 60 or over), the arrival of young doctors preferring to work for a salary and shorter hours, coupled with a predicted rise in the demand for care, are likely to put significant pressures on the health system. During recent years, problems caused by these pressures have been described as 'medical deserts'.

2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

Several mechanisms contribute to establishing inequalities in access to healthcare. While non-take-up of benefits increases more or less in line with a drop in income or the geographic distance between the patient and the healthcare system, other causes are also apparent relating to people's situation, and even to certain pathologies.

2.1 Social inequalities in access to healthcare and prevention

According to recent studies[16], the healthcare expenditure co-paid by patients is unequal: the lower the household income the higher the rate, both in hospital and non-hospital situations. Other research by IRDES[17] (*Institut de Recherche et Documentation en Economie de la Santé*) indicates that the 10% of households subject to high co-payments are mainly outpatients treated for chronic diseases, people in precarious situations hospitalised in state facilities, employed people consuming dental care, and non-hospitalised old people.

Despite the existence of enforceable health insurance tariffs for beneficiaries of complementary universal healthcare (5.4 million people at the end of 2016), inequalities connected to the cost of medical services are on the rise and tend to concentrate in certain regions. The proportion of general practitioners authorised to charge excess fees (sector 2 of the convention – by contrast GPs under sector 1 are obliged to respect the health insurance funds' reimbursement tariffs) rose from 39.2% in 2006 to 44.3% in 2015. Concerning specialists, 84% of gynaecologists and 69% of ophthalmologists are established in sector 2 with a high geographic concentration. Most of these specialists can be found in Île-de-France (Paris region) with the exception of Seine-Saint-Denis, Bas-Rhin, Haute-Savoie, Alpes-Maritimes, Rhône and Côte d'Or. The establishment of new doctors only tends to amplify the existing disparity.

Studies carried out by ODENORE (Observatory on Non-Take-Up of Social Rights and Public Services – *Observatoire DEs NOn REcours aux droits et services*)[18], show that general public surveys reveal that up to a quarter of the population fail to seek treatment when needed. These surveys, carried out in 18 *départments,* show that women are more likely not to seek treatment than men. Single-parent families and people living on their own are the most concerned. The fact of not having a job or complementary insurance increases the level of non-take-up. Those who do not take up care have a more negative view of their state of health. Dental care, firstly prosthetics followed by restorative

[16] Perronnin M., 'Restes à charge publics en ville et à l'hôpital : des taux d'effort inégalement répartis', IRDES, Questions d'économie de la santé, n° 218, May 2016: www.irdes.fr/recherche/questions-d-economie-de-la-sante/218-restes-a-charge-publics-en-ville-et-a-l-hopital.pdf.

[17] Franc C., Pierre A., 'Restes à charge élevés : profils d'assurés et persistance dans le temps', IRDES, Questions d'économie de la santé, n° 217, April 2016: www.irdes.fr/recherche/questions-d-economie-de-la-sante/217-restes-a-charge-elevés-profil-assures-et-persistance-dans-le-temps.pdf.

[18] https://odenore.msh-alpes.fr.

dentistry, is the most common treatment not to be taken up, followed by ophthalmological appointments and purchases of glasses, specialist consultations, and lastly general practitioner consultations. When asked why they fail to seek treatment, respondents mention financial obstacles, followed by waiting times, and also their own lack of availability[19].

Compared with other European countries, France has a low level of failure to seek treatment (2.8% compared with the European average of 3.3%), but for the poorest 20% this rate is 6.6% compared with 6.4%. Lastly, according to the social protection and health survey (ESPS), 25% of people declared in 2014 that they had not taken up treatment for financial reasons at least once[20].

2.2 Unequal access to care related to gender and/or age and/or situation

The fact that life expectancy at birth for women is higher than for men (85.4 years vs 79.5) tends to mask social health inequalities to the detriment of women. Women have made slower progress than men in terms of both life expectancy and life expectancy in good health, which is now similar for both sexes[21], which raises questions as to whether the healthcare system is capable of taking gender factors into account. While breast cancer is subject to a strong prevention campaign, heart attacks have become the leading cause of death for women, and women are now more likely to die from lung cancer than men.

This reduced attention paid to diseases incorrectly considered as masculine is reflected in inadequate screening, later treatment and less dynamic gender-focused research. The under-representation of women in studies and groups concerned with research on the risks of heart attack and cardio-vascular disease is a good indicator of this androcentrism.

Economic insecurity accentuates these inequalities to the detriment of women, including in the area of reproductive health. Thus, women in precarious situations have fewer gynaecological check-ups, they use less contraception (6.5% of female manual workers have no contraception compared with 1.6% of female managers), have more high-risk pregnancies, and are less likely to be tested for breast and uterine cancers than the general female population[22].

While a general lack of access to healthcare is not observed, a number of worrying situations was identified in a report published by the Human Rights Defender (*Défenseur des Droits*) in 2017[23], as follows.

- School medical services and mother and child protection services are in great difficulty due to lack of renewal and resources.
- 45% of patients treated by *Médecins du Monde* living in slum areas are children.
- There are 8,000 foreign, non-accompanied minors who are not able to benefit from unconditional access to healthcare.

[19] Revil H., 'Diagnostic quantitatif du renoncement aux soins des assurés de 18 caisses primaires d'assurance maladie', ODENORE/Pacte/CNRS, June 2016, 78 p.

[20] Célant N., Guillaume S., Rochereau T., 'L'enquête santé européenne - Enquête santé et protection sociale (EHIS-ESPS) 2014', IRDES, October 2017: http://www.irdes.fr/recherche/rapports/566-enquete-sante-europeenne-ehis-enquete-sante-et-protection-sociale-esps-2014.pdf.

[21] Billon A., Laborde F., 'Femmes et santé : les enjeux d'aujourd'hui', Senate, n° 592, July 2015, 184 p.

[22] Bousquet D., Gouraud G., Lazimi G., Collet M., 'La santé et l'accès aux soins : une urgence pour les femmes en situation de précarité', Haut Conseil à l'Egalité, 29 May 2017, 124 p.

[23] Toubon J., Avenard G., 'Droits de l'enfant en 2017', Défenseur des Droits, November 2017, 122 p.

- The guarantee of continuity of care for the 290,000 children benefiting from child welfare is under threat.
- There are questions regarding the effectiveness of the rights of hospitalised children, including the right to parental presence.

In addition, for asylum-seekers and undocumented migrants, the Committee for the Health of Exiles (*Comité pour la Santé des Exilés* - COMEDE[24]) points to the continued deterioration of access to healthcare for foreign nationals in precarious situations. As well as difficulties in accessing healthcare and mental healthcare, including in some hospitals as pointed out by migrant support associations[25], linguistic mediation is frequently unavailable.

The overcrowding of prisons[26] also has a considerable negative impact on the dispensing of good-quality healthcare, despite the fact that under the law: "*The quality and continuity of healthcare are guaranteed to imprisoned people in conditions equivalent to those enjoyed by the general population"*[27]. More precisely, waiting times continue to increase, since the number of health professionals is insufficient to cope with demand. This complexity is compounded in the case of external dental care. Regarding psychiatric treatment, demand-response times are becoming unacceptable and can amount to several months[28].

2.3 Pathologies with unequal access to healthcare

Of patients suffering from terminal chronic kidney failure, 33,700 have received a kidney transplant and 42,500 are on dialysis. "*When possible, kidney transplants offer greater life expectancy and better quality of life than dialysis and are more efficient*", according to the higher health authority (*Haute Autorité de Santé* - HAS).[29] However, the lack of available organs limits the access to kidney transplants. "*Unequal access to this list exists today in France (in terms of age, gender, comorbidity and waiting lists),*" the HAS says, estimating that 1,800 people are not registered on the waiting list and that 12,000 today could have benefited from a transplant.

"Although the regulations define the rules for distributing transplants from deceased people, they do not stipulate the rules concerning registration on the waiting list", notes the HAS. This registration is left to the assessment of medical teams, with disparities from one region to the next in terms of registration periods (from 0 to 10 months) and anticipated registration rates (from 6.5% to 25% of patents are registered before dialysis). Apart from these excessive disparities and waiting times, the HAS observes "*unjustified non-registrations"* for some patients who are aged over 70 or present a comorbidity such as diabetes or obesity. An examination of the list also indicates that

[24] Cited in 'Rapport d'observation et d'activité 2017', Comité pour la santé des exilés (COMEDE), September 2017, 120 p. www.comede.org.

[25] Siffert I., Cordone A., Réginal M., Le Méner E., 'L'accès aux soins des "migrants" en Île-de-France: une enquête auprès des centres d'hébergement d'urgence migrants en Île-de-France, au printemps 2017', Observatoire du Samusocial de Paris, January 2018, 181 p.: http://samusocial.paris/sites/default/files/images/santemigrantsrapportarsiledefrance.pdf.

[26] The threshold of 70,000 people incarcerated was reached for the first time in France on 1 April 2017. The number amounted to 48,594 on 1 January 2002.

[27] Article 46 of the Prison Law of 2009.

[28] 'Les droits fondamentaux à l'épreuve de la surpopulation carcérale', Contrôleur général des lieux de privation de liberté, Paris Dalloz, 2018, 52 p.

[29] 'Transplantation rénale: Accès à la liste d'attente nationale - Du repérage à l'inscription : critères d'orientation et indications', Haute Autorité de Santé, October 2015: https://www.has-sante.fr/portail/upload/docs/application/pdf/2015-11/rbp_greffe_renal_fiche_synthese_criteres_v1_pao.pdf

women are under-represented: for the same age, associated diseases and professional status, they have 30% less chance of being registered than men[30].

Of the 1,080 people tested as HIV- or hepatitis-positive who were questioned by the AIDES association, almost one quarter said they had been discriminated against in a medical situation. Insecure conditions are also a major source of discrimination, noted the association in its 2016 report entitled '*VIH/hépatites: la face cachée des discriminations'*. One respondent in ten (including all serologies: HIV, hepatitis C, etc.) declared that they had been refused healthcare over the last 24 months and the most common refusal came from dentists. In 2015, a testing of dental surgeries and gynaecologists had already drawn attention to this phenomenon. In 2016, an HIV/hepatitis survey carried out by AIDES once again showed that 23.6% of people living with HIV and 27.3% of hepatitis carriers had been subject to discrimination or been refused by health carers[31].

2.4 Reforms and on-going debates

In order to limit health expenditure co-payment by insured parties, the national health strategy for 2018-2022 aims to achieve a '*reste à charge zéro*' (zero co-payment) on dental prosthetics, optical items and hearing aids, in line with President Macron's election commitment. Yet reaching this objective implies defining the scope of healthcare and items that are indispensible in this area, and the conditions for their total coverage by the obligatory complementary health insurance schemes.

However, not all of the expenditure required to acquire these items justifies 100% coverage: choices partly depend on personal considerations, mostly aesthetic, which should therefore be met by the interested parties. More precisely, according to the reforms currently planned, people covered by national health insurance will be offered a range of health items (glasses, dental prosthetics, hearing aids) not subject to co-payment because they are judged necessary. However, they will also be able to make different choices for personal reasons, and pay the additional expenses themselves.

Without doubt, the success of this zero co-payment will depend on meeting its cost, which is likely to be around €4-5 billion per year. The question thus arises of who will shoulder the financial burden: social security health insurance, complementary health insurance schemes, or perhaps dental surgeons and dental prosthetists, opticians, audioprosthetists, or even manufacturers of glasses and hearing aids?

Current negotiations on the subject of zero co-payment point to both an extension of basic and complementary health insurance coverage, but also and in particular, greater efforts from suppliers to establish the prices of the range of healthcare items that come under the scope of the zero co-payment.

3 Discussion of the measurement of inequalities in access to healthcare in the country

3.1 Organisations producing information on non-take-up of healthcare

Along with the state statistics bodies, Insee (*Institut National de la Statistique et des Etudes Economiques*) and DREES, the following two organisations produce statistics:

- IRDES (*Institut de Recherche et Documentation en Economie de la Santé*) was created in 1985 under the name CREDES – Centre for Research and

[30] HAS December 2015.

[31] AIDES, 'Rapport discriminations 2017' (Discriminations report).

Documentation of Economics and Health – and renamed[32] in 2004, when it merged into a public interest group with the independent-living support fund (*Caisse Nationale de Solidarité pour l'Autonomie* - CNSA). Its twofold mission comprises applied research and production of data in the health insurance and medical-social domains. Since 1988, IRDES has carried out the ESPS survey. In 2014, in collaboration with DREES, the ESPS survey was used to support the European Health Interview Survey (EHIS), which is now, for France, the only general survey on the subject covering the general population. For 2019 and the following campaigns, scheduled every six years, the French version of EHIS will include, along with European questions under the Eurostat rules, a specific question for France on complementary health coverage. The IRDES team comprises around thirty researchers.

- Created in 2003, and including a team of a dozen researchers led by Philippe Warin (research director at the CNRS, UMR Pacte, Grenoble), ODENORE[33] is a university body linked to a CNRS (*Centre National de la Recherche Scientifique*) laboratory whose research aims to assess the numbers of people not taking up their rights, mostly in the health and social policy domain, as well as to look for the causes and suggest solutions to reduce the rate.

3.2 Data for comparison

At the request of the national health insurance fund, ODENORE questioned 29,000 people attending CPAMs (local health insurance offices). About 39% of them said they do not take up dental prostheses (not subject to a price ceiling until 2017), and 34% do not take up restorative dental care even though prices are regulated. Non-take-up of care also concerns specialist consultations, ophthalmology and glasses.

In their responses, 59% said that the patient co-payment was too high, and 32% that upfront payment was impossible. Unacceptably long waiting lists for an appointment or lack of available doctors were only highlighted in respectively 12% and 11% of cases. With variations from one survey to the next depending on the way the questions are asked[34], indications of non-take-up figures are at times very high and Eurostat data appear to considerably underestimate this phenomenon.

In 2014, according to the EHIS-ESPS 2014 survey carried out by IRDES, 25% of people in mainland France declared that they had not taken up at least one treatment for financial reasons. Non-take-up of dental care for financial reasons concerns 17% of beneficiaries of health insurance aged at least 18, 10% for optical care, 5% for doctor consultations, and 4.5% for other types of care.

In the same survey, 16% of adult health insurance beneficiaries claimed that they had not taken up at least one treatment in the course of the previous twelve months because the waiting time for an appointment was too long, and 3% because the doctor's surgery was too far or because they had transport difficulties. Unlike non-take-up for financial reasons, this failure to seek care due to access difficulties is linked neither to complementary health schemes nor economic factors.

3.3 Innovations in terms of indicators of accessibility to healthcare

DREES and IRDES have developed an indicator of disparities in healthcare availability called local potential accessibility (*accessibilité potentielle localisée* - APL). Along with a

[32] IRDES, 117 bis rue Manin, 75019 Paris, www.irdes.fr.

[33] ODENORE/MSH-Alpes, CNRS - BP 47 - 38040 Grenoble Cedex 9. https://odenore.msh-alpes.fr/presentation.

[34] Legal R., Vicard A., 'Renoncements aux soins pour raisons financières', DREES, Dossier solidarité et santé, n° 66, July 2015.

measurement of the distance to the closest healthcare professional, this indicator considers the level of practitioners' activity using full-time equivalents (FTE) and healthcare requests that consider different needs depending on age. These needs are examined against consumption of healthcare for each age group at national level.

For each town and type of professional, APL provides a number of accessible FTEs for 100,000 inhabitants, weighted in accordance with their healthcare consumption.

This indicator completes the data available on 'access time by road in minutes' and 'urban area zoning' managed by Insee, which divides the country into types of municipality according to the level of influence of urban hubs[35].

[35] On territorial accessibility indicators, see: Com-Ruelle L., Lucas-Gabrielli V., Pierre A., 'Recours aux soins ambulatoires et distances parcourues par les patients : des différences importantes selon l'accessibilité territoriale aux soins', Questions d'Economie de la Santé, IDRES, n° 219, June 2016.

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