The Reform of Health Care System and the Complementary Health Insurance in France

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Introduction

In this paper, I will review the Chadelat Report and private insurance leading up to the health insurance reforms of August 2004 in France. In Western European countries, private health insurance functions as or complements public health insurance. However in Japan, the relations between public health insurance and private health insurance are not adequately and fully defined. In France, a work group which was presided by Mr. J.-F. Chadelat studied the complementary role which private insurance should play in the public healthcare system on the occasion of health insurance reform in 2004, and I think that the proposal presented at that time is instructive to the japanese healthcare system, because it is by no means inconceivable that even partially the structure of private insurance is to be introduced in the public healthcare system in Japan.

1. Health Insurance in France

Public health insurance in France - in the same way as in Germany, Japan, etc. - has partially adopted principles of private insurance, but has been managed with priority on different principles than that of private insurance, namely collectivity and a redistribution of income in order to achieve the realization of overall welfare. However, once a certain objective of public health insurance is achieved, the demerits of the collective principle come to the fore and the inefficiency and lack of responsibility on the part of the insured in public insurance rise to the surface. There has been an increase in interest in the efficiency of private insurance as one means of resolving these problems with public insurance.

On the one hand, the condition has arisen even in private insurance with its priority on market fairness (fairness with regard to risk) where activities are not allowed which would nullify the relationship with public insurance through the spread of public insurance and changes in the social environment. In Japan, a peak has been observed, in the distribution of the hospitalization days of public health insurance, at the same period as the waiting period which private insurance had set up for daily benefits during hospitalization as if to be synchronized with it. This type of example shows that the multi-faceted relationship between public insurance and private insurance is one that cannot be ignored.

French healthcare system has adopted the same type of insurance method as that of Japan, but a difference from the Japanese systems is that France has adopted a reimbursement system rather than a third-party payment method (known as the "benefit in kind" method in Japan) for outpatient treatment (ambulatory medicine in private practice). Also, in France is recognized a contract to cover the patients' share of the costs in public health insurance, for which in Japan does not recognize the direct participation of private health insurance. Private insurance not only covers the patients' share of the medical expenses, but also reduces to a large extent the burden of the insured through the contracts which provide for medical supplies and services that public health insurance does not cover.

After the end of "golden thirties" in France, there was a repetition of procurement of various resources and measures to reduce healthcare expenditures in the same manner as in other countries in order to combat the almost continuous deterioration of public health insurance finance, but these efforts of more than 20 years have not been definitive solution. In this time, there has been a heightened awareness of the inability to improve this situation through individual and ad hoc financing policies and measures to control healthcare expenditures. Consideration has been given to comprehensive health insurance reform, and many reports have been made for this purpose. Among others is a 1994 report by Raymond Soubie titled, "Livre blanc sur le système de santé et d'assurance maladie (White paper on the healthcare system and health insurance)" which evaluates the healthcare systems of each country and gives a comparative review of the advantages and disadvantages of the various healthcare systems of each in a proposal for reform of the French health insurance system.

Among the options in health insurance reform are nationalization on the far left and privatization on the far right. From the 1980's through the early 1990's, various administrations warned that nationalization of medical insurance was inevitable if the restoration of health insurance finance was not successful, seeking agreement to contain national health expenditures, but the people did not desire either nationalization or privatization, but rather chose to maintain the status quo based on national

protection (guarantee of health insurance finance by the government). However, the problem was not only in the field of medicine, and a dangerous condition became visible in all fields of public insurance such as pension insurance, etc. In order to get out of this dangerous situation, a reform of the pension system was carried out in June 2003 as the first part of a general reform of public insurance. The next reform to be launched was that of the health insurance system in August 2004 (cf. References 21).

The details of the 2004 health insurance reform will not be directly touched upon in this paper, but one focus of the reform was the restructuring of public and private insurance. Much preliminary work was done towards the creation of a health insurance reform bill and working groups prepared several dozen reports, and the reports of 3 working groups of the Social Security Accounting Commission (Commission des Comptes de la Sécurité Sociale) were prepared as a proposal which should be the gist of the reform. But, Chadelat who was asked to prepare a report on the relation between public and private insurance, drew a draft of health insurance introducing the structure of private insurance, which was beyond the intention of the clientele. So, when the report was published, it was exposed to keen oppositions and criticisms that the plan aimed at privatization of the public health insurance. If the report is read carefully however, one can understand that, as Chadelat said, it is not a privatization, but rather a plan to draw private insurance toward public insurance, taking over one part of it, and defining a frame (obligation) into which private insurance would be placed while recognizing its free activity. Consequently, the proposals of the Chadelat report were not directly adopted into health insurance reform, but it can be said that they were partially adopted in organizational and financial measures directed toward the strengthening of the relationship with private insurance.

The word containment is avoided as much as possible in health insurance reform, with a structure being implemented which strengthens the "awareness of responsibility" in patients, medical professions, insurers, etc. and an improved "quality" in "primary physician(médecin traitant)", "coordinated course of care (parcours de soins coordonnés)", "personal medical file (dossier médical personnel)", etc., although actually it is something which is aiming to control healthcare expenditures. One other reform that deserves attention is to transfer the bloated competence of government to health insurance (the insurer). This can be said to be deregulation within public insurance, but the original French health insurance system is based on the principle of self-regulation (autogestion) by interested parties (the medical profession and the insured) handed down from the tradition of mutual societies, and so by this is meant not "transfer" but rather "return to the origin", and should therefore be seen as a shift in principle from the government to the citizen.

From the above it can be said that the health insurance reform of 2004 was a step forward (a step which includes the formulation of the relationship between public and private insurance) towards establishment of a new healthcare system by organizing patients and medical profession and strengthening insurer functions.

2. Chadelat's report and discussions on the role of public and private health insurance

In September 2002, Jean François Mattéi, Minister of Health at the time, requested 3 experts, Rolande Ruellan, Alain Coulomb and Jean-François Chadelat, to create reports to consider the problems related to the healthcare system, as a basic health insurance reform task. The titles of the reports submitted by these 3 experts were, respectively, "Clarification of the Relationship between National and Public Insurance", "Control of National Objectives of Health Insurance Expenditures (ONDAM, Objectif National des Dépenses d'Assurance Maladie)" and "Sharing of Public and Private Health Insurance Roles Related to Health Expenditures." It happened that the third of these reports, the one by Chadelat, was heavily debated and drew criticism before it was made public, and because of this the government held another advisory council to request further proposals on health insurance reform.

What, then, was the content of the problematic Chadelat report? When Minister of Health Mattéi assigned this task to the Chadelat Commission, the issues of increase of healthcare expenditures and lack of public funding arose, giving birth to doubts about the validity of the system of compulsory collection from labor income. The problem was that it clearly delineated the scope of the solidarity (public health insurance) so that people with low incomes could get buy without paying for secondary healthcare needs i.e. private health insurance. Also, because of the complicated competence for private insurance to be able to supplement public health insurance, in which participation is mandatory, there is the problem of the danger of the lack of regulation and unreasonableness of payment on both sides. These points were emphasized. In other words, what Minister of Health Mattéi wanted was clearly defined boundaries between private insurance and public health insurance.

The public health insurance side emphasized the preservation of the public insurance system based on the collective solidarity of the people, but when the President of the National Health Insurance Fund for Employed Workers (CNAMTS, Caisse Nationale de l'Assurance Maladie des Travailleurs Salariés) wanted to stress the word "insurance", the problem was the surprise expressed that private insurance was limited to "secondary needs."

However, Chadelat did not stop at setting the boundary of public and private insurance, matters entrusted by the Minister of Health, but stepping into the field of complementary insurance, proposed basic complementary healthcare system, as well as a complementary insurance with completely free voluntary participation.

2.1 Understanding of Chadelat Report about the current condition

We will begin with 2 points of awareness regarding the current condition. One is the awareness that basic medical care does not fully cover treatment for those with low incomes. The other is that the sharing of roles between the basic system and the complementary system is insufficient.

(a) Complementary health Insurance

Public healthcare system is divided into 3 important systems: a general system (CNAMTS), an agricultural system (MSA, Mutualité Socilae Agricole) and a system for non-employed / non-agricultural workers (CANAM, Caisse Nationale d'Assurance Maladie et Maternité des Tracailleurs non Salariés). These 3 systems cover 95% of the population. The remaining 5% fall into special systems (the national railway (SNCF), the Paris subway (RATP), etc.).

The complementary systems (private insurance, etc.) cover about 1,500 insurers, divided between mutual societies, provident institutions and insurance companies. The total amount of complementary health insurance fees in 2002 was at a scale of 18.9 billion euros.

The public health insurance system covers 77% of overall healthcare expenditures, with the remainder covered by private insurance (12%) and family finances (11%).

These 3 parties differ in the way that payment is made. In the case of inpatient, payment of the private insurance is limited, but the coverage is large when drugs are prescribed, and the reimbursement of healthcare expenses plays a large role in relation to dentistry and ophthalmology.

Up to this point, measures enacted in health insurance reform which do not reimburse the healthcare expenses or lessen the healthcare benefits are preferable for the private insurance business. Also, it has become the preferred method for business group subscription and for the self-employed to take advantage of the preferential tax measures of participation in private insurance.

The establishment of the complementary universal healthcare system (CMUC: the complementary system for CMU, Couverture Maladie Universelle) adopted in 1999 is something which should be called the maturing of policy up to that point, and the Chadelat report mentions that due to its establishment "it confirms that the public basic healthcare system level does not ensure sufficient access to healtcare."

Furthermore, the report indicates that "CMUC is the victim of extremely large marginal effects, and the value of this is increasingly harmful due to being set too low because of financial difficulties." The report also mentions that even though CMUC is applied, 5% of the population does not have the financial freedom to apply for complementary healthcare system.

(b) No consistency in role sharing between public and private insurance

The following facts are put forth regarding "public and private role-sharing":

- It keeps in step with the large number of public health insurance benefits, especially the General System regarding benefit in kind
- On the other hand, the content of private insurance contracts varies greatly
- The complementary universal healthcare system is in a completely different category, meaning that it embraces the various problems regarding the services delivered. For example, with regard to eyeglasses and dental prosthetics, private insurance must deliver them at a fixed price.
- The definition of the scope of public health insurance is being done in an experimental and unclear fashion

It follows that the conclusion is that the share of costs between public health insurance (obligatory health insurance (AMO, Assurance Maladie Obligatoire)), private health insurance, complementary health insurance (AMC, Assurance maladie Complémentaire) and family finances is not based on clear and rational decisions.

Above all, AMC, with no link to healthcare benefits packages (panier de soins) and no link to risk management, makes the French healthcare system a system of non-responsibility and the meaning of the patients' copayment is especially unclear since private insurance pays for it. As long as there is no agreement between AMO and AMC regarding non-payment of a fixed rate of healthcare expenses, it means nothing to rationalize the healthcare

expenses themselves. This failure to agree on cooperative measures between CNAMTS and the complementary health insurance system in 1999 shows the difficulty of reaching this type of agreement.

Besides, the adoption of CMUC makes the overall image of health insurance hard to understand. This confusion is derived from the fact that the insured is admitted to participate complementary health insurance managed by public insurance (Caisse Primaire de l'Assurance Maladie) if he does not want to participate private insurance. In other words, the report says that the existence of a passive role such as the AMC is not preferable.

The Chadelat report forms the basis for an awareness of current conditions such as the above, and objectives such as those below have been set:
- To meet the nation's objectives of healthcare, state should secure sufficient healthcare benefits for the population
- Optimal contribution (premiums) should be made to healthcare and health insurance expenditures
- Those related to the healthcare system (family, medical professions, public and private insurance and the government) should all have a higher awareness of their responsibilities
- Overall access to healthcare should be improved and simplified

2.2 A new proposal - generalized healthcare system (CMG)

The Chadelat report adopts a new system known as the generalized healthcare system (CMG, Couverture Maladie Généralisée).

(a) The principles of reform proposals

CMG is composed of AMO and basic complementary medical insurance (AMCB, Assurance Maladie Complémentaire dite de Base), and through the CMG, state secures prescribed healthcare service for all people. That is, state fully participates the management of CMG.

The outline of health policy is something that is decided by parliament, but academic and practical experts and medical science authorities participate in this decision, and opinions of public and private health insurance are heard, with everyone being consulted with regard to healthcare. These procedures are in common with the procedures proposed by the ONDAM decision in the Coulomb report. Specialists are consulted with regard to the content of healthcare benefits packages that CMG manages, and then the government makes decisions after deliberations between the public and private insurance, the medical profession and the pharmaceutical industry.

Additionally, it is necessary for the AMCB healthcare packages to include sharing of copayment, the extra financial burden for the medical supplies (eyeglasses, dental prosthetics, medical equipment, etc.) and the fixed charge of hospitalization.

With the establishment of CMG, consideration must be given as to whether or not it is valid to include payments with problematic validity concerning whether past public insurance coverage should be included, as well as payments that are not justified according to medical science, in private insurance contracts.

Also, AMCB choices are completely entrusted to individual freedom. Even though there are differences between individual and group participation, the participation in AMCB is the same as the participation in private insurance.

(b) Things that have the meaning of reform proposals

The first is the establishment of personal support that is meant for the purchase of AMCB based on income conditions fixed by CMG. The support is enacted degressively with regard to income, and does not take age or household composition into account. AMCB alleviates the threshold effect of CMUC, making it easier for everyone to participate in complementary insurance.

The second is that the national contract decided by the government includes not only the payment provided by AMCB, but also the system (co-regulation, prevention, etc.) implemented by complementary health insurance.

There is a fixed frame in the principle of free determination of medical service fees as well:
- Compliance with ethical principles of public insurance (Principles where solidarity is required: a ban on risk selection, the prohibition of setting premiums based on health status, and prohibition of the waiting period)
- Rate in AMCB should be settled in a different way from that in general private insurance
- Possibility of setting maximum rates (for example, rates for the elderly do not exceed a certain percentage of the average, rates for youth are no less than a certain percentage of the average, etc.)

Third, public and private health insurance is to build a partnership based on the two principles of "co-payment" and "co-regulation".

The goal of "co-regulation" is for the activities of one party to not negate the activities of another party (for example, for the intervention of complementary insurance not to be obstacles of the patient education activities enacted by public health insurance or the medical profession). Also, it is to determine the exact content of the healthcare benefits

package.

To ensure maximum efficiency, both AMO and AMC must have a guiding role with regard to various problems. For example, to raise the awareness of the insured, they must create, in cooperation with the medical profession, some kind of "way to use healthcare services", and carry out a monitoring of healthcare usage (dental treatment costs, high healthcare expenses for patient diagnosis, etc.). Through discussions with the medical profession, manufacturers of eyeglasses can proceed to come to an agreement on prices.

(c) Financial Resources

The Chadelat report has also made proposals regarding financial support for participation in complementary health insurance. Resources can be created by abolishing or amending the preferential measures of the Madelin law or the preferential measures in terms of taxes paid by and in terms of benefits to businesses and employees for the purpose of group participation in health insurance and also they can be created reviewing tax credits and bases of social insurance contribution.

2.3 Accusations and opposition against the proposals of Chadelat's report

(a) Criticism that it isprivatization

Five trade unions submitted comments (the CFDT, Confédération Française Démocratique du Travail, the CFE-CGC, Confédération Française de l'Encadrement - Confédération Générale des Cadres, the CFTC, Confédération Française des Travailleurs Chrétiens, the CGT, Confédération Générale des Travailleurs) and the CGT-FO (CGT-Force Ouvriére), but although the various opinions differed, CFDT, opposing the view that public insurance is something that should be changed, said that "it would break the solidarity of social insurance", and in the same way CGT expressed that "it is destructive of public insurance's principle". CGT-FO kept pace with this, saying that they "refuse to sell public insurance for the reason of financial difficulties". These 3 unions consider the establishment of CMG to be the systematization of complementary health insurance and consequently consider public insurance as becoming partially privatized. What CFDT says is that public insurance has partially pulled out of certain healthcare benefits due to the establishment of CMG, saying that this is due to the possibility of it being delegated to private insurance. CGT-FO have the same concerns, saying that CMG will eventually completely withdraw from basic health insurance, and that basic complementary health insurance (AMCB, Assurance Maladie Complémentaire de Base) will degrade into various private insurance companies in the competitive marketplace, and thinks that the current complementary health insurance will have its face changed into additional insurance by public health insurance (in other words, that it will become additional insurance or quasi-public insurance).

In short, these criticisms view Chadelat's report as beginning a step towards what is called co-regulation starting with the public insurance and private insurance that it proposed.

(b) Criticism that it is nationalization

"Those who criticize Chadelat's report saying that it represents a privatization of public health insurance should read the report again more carefully. It is actually a nationalization of private insurance" is the opinion of Jean-François Johanet, former Secretary General of CNAMTS. Chadelat says that while what Johanet says is not incorrect, it is going too far to call it nationalization of private insurance, answering that it is a re-organization of private insurance.

Privatization was exposed to much media criticism, but nationalization was not exposed to as much media criticism. CFTD emphasizes that the government should take on a strong leadership role in public insurance, private insurance and co-regulation in which the government participates. To CFTC, the draft of health insurance reform that Chadelat's report draws is something that leads toward privatization of public health insurance, a privatization which the government should lead overall, and says that in any scene the face of the government can be seen, however this criticism becomes one not knowing whether one is criticizing privatization or criticizing the state control.

Against the accusation that the Chadelat report is the road leading to privatization, Chadelat spoke at the Senate's Social Affairs Commission, "I think that the French health insurance resembles American healthcare system, the worst one in the world on many points (n.b. contrary to Chadelat's view, according to the WHO report 2000, France is first in the ranking of the world's health systems). Those with high salaries from big companies have access to a high level of healthcare, while the poor have only CMU. There is nothing that closes the gap." While being recognized, the proposals of the Chadelat report on one hand provide income regressive financial support for middle-income, and try to match the abolition of financial support for the extensive high-level complementary health insurance currently being provided. On the other hand, with regard to basic complementary health insurance, it proposes a compromise on the coexistence of both, leaving CMUC the way it is while at the

same time strongly criticizing it, but there is also criticism regarding the complexity of the coexistence of two complementary healthcare systems.

By the way, the proposal in Chadelat's report for a financial support system for participation in the complementary health insurance is not a new one. The financial support proposal was discussed in the work created by a law related to the establishment of CMU on July 23, 1999. Rather than CMU, it was through personal financial support that the proposal to recommend participation in complementary health insurance was made from the interprofessional national federation of mutual societies (FNIM, Fédération Nationale Indépendante des Mutuelles). The National Federation of French Mutualities (FNMF, Fédération Nationale de la M utualité Française) proposed the establishment of the tax credit system. The Chadelat report especially took up the FNMF tax credit proposal as financial support for participation in AMCB.

In addition, not only does the Chadelat report have the awareness essential to health insurance reform through the cooperative relationship between public health insurance and private insurance, such recognition has already been growing since the 1990's. In July 1999 an agreement in principle on the public and private health insurance systems was concluded between the CNAMTS, the FNMF and the technical center of provident institutions (CTIP, Centre Technique des Institutions de Prévoyance). In this agreement, it is confirmed that the public and private health insurance systems "cover the same basket of benefits which are reimbursed" and aim to "build partnerships with the medical profession, the pharmaceutical industry and hospitals". Furthermore, the progress of informatization in the medical profession, the expansion of new methods of healthcare service such as organized healthcare networks (réseaux de soins coordonnés) and technical cooperation for the spread of medical IT, etc. are also included. The conclusion of this agreement is on the one hand evaluated for its "ambitious efforts", and the Minister of Social Affairs at the time, Martine Aubry, publicly expressed her opposing opinion regarding the connection with the privatization of health insurance (this was a natural reaction for the Minister of the Socialist Party whose supporting body is labor unions).

The cooperation of public and private health insurance could not see the light under the Socialist government, but at the 37th Convention of French Mutual Societies in 2003 President Chirac emphasized that private insurance should be one party of new convention system through building true cooperative relationship between private insurance and public health insurance.

In a speech at the 2005 Davos convention, Minister of Health Douste-Blazy stated, "We have tried everything, and now all that remains is to clarify what should be accepted as public health insurance and what should be accepted as private health insurance." This idea is still being dealt with under the Sarkozy administration. At the 39th Convention of French Mutualities in June 2009, President Sarkozy spoke of a "new partnership" for public health insurance with private insurance, but of course this can be understood that it mean to transfer the burden of public health insurance to private insurance.

3. Private health insurance

3.1 French private health insurance

In France, the generalized health insurance exists, but because the benefits are insufficient many French people participate in private complementary health insurance. In OECD member countries, the percentage of French people enrolled in private insurance is next only to Holland and America, whose healthcare systems center on private insurance.

One of the reasons that French private insurance enrolment is high is due to the historical background of preferential tax measures for the contribution of employer. Because of the high employer's contribution, roughly half of the insurance contract is made through the company, although the subscription rate varies by occupation and industry. In other countries, similar subscription rates tend to be proportional to income. In 2000, France adopted the CMU. This is public coverage for low-income earners who enroll in complementary health insurance. Due to this, the rate of participation in complementary health insurance enrollment rose from 86% to 92%.

Forcing the enrolment of the whole nation into the public health insurance system will further worsen the deficit suffered by health insurance finance. To solve these financial problems, the government is considering use of private insurance one of these being the Chadelat report that was made public in April 2003 and exposed in a firestorm of opposition. But on the private insurance side there are some voices in approval of the shift of healthcare service from public insurance to private insurance. However, non-profit mutual societies have not supported a decrease in the role of public health insurance.

The legal treatment of private health insurance in France is said to be less developed than neighboring countries. France, in conflict with the same rules on insurance business owners as those required by the EU directive, changed its rules handling

complementary insurance in 2003, so it is possible that the position of exclusive dominance of mutual societies in the field of complementary insurance could become eroded.

3.2 History and status of private health insurance

The OECD working paper (Caudron, 2005) gives French private insurance, including mutual societies, helpful information.

Until the establishment of public insurance in 1945, employees with income below a certain level were forced to join health insurance, in the same way as in Germany, so means tests were also conducted in health insurance.

Until social insurance was established in 1928, the basis for security of living for many French people derived from the mutual societies of the mid-19th century. In 1900, about 1,300 associations had about 2 million subscribers, with the number of subscribers to medical mutual societies rising to about two-thirds of the population by the outbreak of the Second World War. In the era of social insurance between 1928 and 1945, mutual societies had participated in the management of social insurance, but they were not able to directly participate in its management after the war. Therefore, the possibility of the continued existence of mutual societies lay in the role of a complementary system to social insurance. Mutual societies did not participate in the market as non-profit organizations, and continue to have considerable impact even in today's public welfare policy. The existence of mutual societies is thus the reason for the high rate of subscription in private (or complementary) health insurance in France.

French healthcare system covers basically all citizens, and the freedom of both medical providers (practitioners) and patients in basic healthcare service has come to be insured. In other words, patients can receive free medical treatment from the doctor they wish, including medical specialists (free access). Healthcare providers are compensated by fee-for-service payment, in which a wide range of freedom (discretion) is recognized. "Gate-keeping" did not exist, and because there are many medical facilities, there is no waiting in line to see a doctor. However, the coordinated course of care introduced by the health insurance reform in 2004 added restrictions to this freedom in health care services.

In France, private insurance provides reimbursement for patient's share of healthcare expenses and medical supplies and services where the public health insurance benefit is considerabley lower than market price. So, it provides a complementary function for public health insurance.

Enrolment in French private health insurance is not because one prefers a particular medical institution or because one dislikes waiting in line to see a doctor with public health insurance, but due to the access to drugs and services for which the rate of patient cost sharing of public insurance and payment is low (especially for ophthalmology treatment and dental treatment).

Looking at the benefit rate of public health insurance and the percentage of subscribers to private insurance, the public health insurance coverage for medical care and dental care combined has fallen over 8 points between 1980 and 1995, meanwhile, between 1980 and 2000, the percentage enrolled in private health insurance increased by 17 points The percentage of overall cost of medical expenses paid by private insurance was 10.6% in 1992, but increased to 12.7% in 2002. On the other hand, the percentage paid by family finances fell from 12.4% to 10.6% (cf. References 10). It can thus be said that there will be a corresponding decline in the level of public health insurance payment for private health insurance needs. By the way, the public health insurance payment for hospitalization is close to 100%. Additional charges for private rooms are added to the fixed price of main patient charges for hospitalization of 13 euros per day as of January 2004 (16 euros since 2007). Most private insurance will pay for the fixed prices, but payment for private rooms is mixed.

The insurance rate for public health insurance for practitioner services is low compared to hospitalization, 65% to 72% of medical expenses. The rate of patient cost sharing is 30% of the amount agreed upon between the public health insurance and the medical associations. Patient cost sharing, as shown by the word "ticket-modérateur (moderation-ticket)", is that which was paid by the insured to the Health Insurance Fund prior to physician's consultation. This ticket was intended to reduce the moral hazard. By the way, looking at the patient copayment in 2003, in the case of general practitioner, it was 6 euros, that is 30% of 20 euros and 6.9 euros in the case of specialist (in 2009, these are respectively 7.6 euros and 8.5 euros). Moreover, there are another group of practitioners who are called "Sector 2" and permitted to charge a fee over and above the agreed rate In this case the patient must pay a surcharge. (practitioners who obey the rates agreed by the National Convention of health insurance are called " Sector 1").

For drugs prescribed by doctors, rate of patient cost sharing is zero if the drug is an expensive and non-alternative - otherwise it is 65%, 35% or 15%. Partial sharing for drugs is covered by most private insurance (complementary health insurance).

Table 1: Health Expenditures by Financing Agent (2002 and 2007)

	Total	Inpatient Care	Pharma-ceuticals	Physician Sevices	Other Medical Goods	Dental Sevices
Percentage of Total Expenditure	100 (100)	43 (44.3)	21 (20.4)	24 (23.8)	6 (5.8)	6 (5.7)
Source of Payment						
Public	76.4 (77.9)	92.0 (92.4)	65.3 (69.0)	71.8 (76.6)	44.8 (44.4)	34.8 (37.9)
Private insurance	12.4 (13.6)	4.2 (5.1)	17.6 (17.5)	20.2 (15.4)	25.4 (35.7)	35.2 (35.6)
Households	11.1 (8.5)	3.7 (2.5)	17.1 (13.5)	8.0 (8.0)	29.8 (19.9)	30.0 (26.5)
Total	100 (100)	100 (100)	100 (100)	100 (100)	100 (100)	100 (100)

(Note) The number in parentheses is the number for 2007.
Data: Comptes Nationaux de la Sant?, Eco-Sant? 2003, 2007

Accordingly, drug fees for almost everyone are completely covered by both public and private insurance.

One can see from Table 1 that the public health insurance expenditure, especially for other medical supplies and dental treatment, is very low. Other medical supplies include eyeglass lenses, dental prosthetics not covered by insurance, etc. Medical insurance includes these as insurance benefits, but the amount of health insurance reimbursement is very low compared to the market price. According to Arnaud (cf. References 2), the amount of health insurance reimbursement for eyeglass lenses and frames combined is 4.82 euros (15.33 euros if they are bifocals, etc.), but the amount that the insured pays is not the average 200 euros but 500 euros. It is also low for dental prosthetics, with the reimbursement amount for an actual cost of 750 euros being only 75.25 euros (cf. References 27). Compared to the figures from 2007, the amount of the overall decrease in the burden of family finances is the amount by which the burden of complementary insurance has increased. Looking at the private insurance, contrary to the decrease of the proportion of "Inpatient Care", that of "Other Medical Goods" increases.

The amount paid by "Private insurance" is similar with regard to "Physicians" and "Other medical goods", but the large difference from public insurance in the percentage paid by Households is because the things covered by public and private health insurance are different and for physicians, the payment by private insurance is equivalent or a part of the patient sharing (the copayment) of public insurance. There is the CREDES report which says that coverage by private insurance further induces the use of public health insurance, and as well in Japan a strong correlation has been observed (in the form of a peak in hospitalization days) between the waiting period for daily benefits for private insurance for hospitalization such as 3 days or 7 days and the hospitalization days statistics of public health insurance. Meanwhile, because the copayment undertaken by private insurance is based on the rates agreed by public insurance, there is no risk of the loss of private insurance due to the risk of rising healthcare expenditures. There is the possibility that rates of Sector 2 doctors will rise, but most of the excess charges are a percentage of agreed rates, so the risk to private insurance is limited.

The public health insurance payment for eyeglass lenses and dental prosthetics is very low. According to the High Council for the Future of Health Insurance (Haut Conseil pour l'Avenir de l'Assurance Maladie), in the case of dental prosthetics, the percentage paid by public insurance will not exceed 18% of the actual cost, and the remainder is covered approximately half by private insurance and half by family finances. Because of these factors, this is where private insurance comes into play, but there is a danger of risk to private insurance as well. Here, private insurance avoids the risk through determination of a fixed yearly amount for insurance fees. Between 1991 and 1999, the amount paid for eyeglasses and dental treatment by mutual societies was 13% and 8% respectively. Meanwhile, expenditure for drugs rose by 5% and that for doctors rose by 6%.

The primary cause for the increase in healthcare expenses since 2000 is the increase in demand for healthcare due to the establishment of the CMU in 2000. CMU complementary insurance makes payment for the part of copayment of public health insurance. In the case of the CMU's predecessor, public assistance for healthcare, excessive billing was not prohibited, but with CMU a law has been established which prohibits billing that exceeds the charges agreed by the public insurance. An upper limit was set for fees for eyeglass lenses and dental prosthetics for CMU beneficiaries, and the full amount of the difference between the agreed rate and the market rate is now refunded to the patient.

A survey of IRDES (ex-CREDES), related to the status of subscription to complementary insurance, shows that the medical benefits covered differ according to the status of employment and income,

etc. When the percentages of those not insured by private health insurance before CMU was implemented in 2000 are compared with those in 2006, the rate of subscription to complementary insurance clearly differs according to the level of income, but there was no large difference before and after CMU was implemented, and there was no change in the non-subscription rate (over 40%) of the first quintile, those with the lowest level of income. The overall number of non-subscribers is declining with the exception of those with jobs in agriculture or unskilled labor, and the number of non-subscribers is greatly decreasing among managers and skilled workers. The number of subscribers who described their state of health as above average (88.4% responded "Good") was greater than the 80% of subscribers who described their state of health as bad, with those who responded "Very Bad" being a mere 68.8%.

3.3 The private health insurance market and its current condition

In the future, 3 types of complementary insurance will compete in the private insurance marketplace. Non-profit mutual societies have about a 60% share of the current market, with 15% to 20% being held by non-profit provident institutions and something over 25% being held by insurance companies (commercial institutions). During the last few decades, there was almost no change in the share held by mutual societies, but mutual organizations have taken more of the share from insurance companies. However, some mutual organizations are collaborating with insurance companies, and so it is said that the share of private health insurance is actually becoming larger.

The number of mutual societies in 2000 was 1,275 (due to the merging of mutual societies because of EU laws, the number was 1,070 at the end of 2007). About 40% of the mutual societies account for 90% of the total payments. The basis of mutual societies is occupational, the largest being the public sector, mostly teachers and postal workers. There are also individual subscribers in local areas. Since mutual societies are based on the principle of mutual solidarity, there was no stress about risk selection and differentiation of contributions due to risk size or type. The financial source of mutual societies is the contributions which are proportionally based on income of its members, but 90% of the spending is outsourced to insurance companies. The percentage of group members to individuals joining the societies is about half and half.

The provident institutions have historically provided for the employed the retirement benefits or the equivalent of public pension, the institutions being operated by both labor and management. 63 provident institutions provide complementary health insurance, and the number of subscribers has exceeded 1 million (in 2008, 57 institutions and 5.7 million subscribers for complementary healthcare contract).

A revision of the rules related to complementary insurance was made in accordance with a EU directive, and came into effect in 2000. Under the revised rules, complementary welfare programs are to be managed by separate institutions, and must meet more strict solvency requirements. The new code clarifies the principles of mutual societies, and modulates the contributionts, especially those based only on member income, living location, number of family members, age, etc. (Le code de la mutualité L121-1). Meanwhile, if private insurance does not adopt the principle of solidarity, insurance premiums can be set based on the health evaluations for the subscribers. In the case of a comprehensive insurance contract, insurance companies will not necessarily require a medical check.

In France, healthcare services are guaranteed publicly and its expenditure is financed by the public health insurance, and they do not adopt the competition in the markets unlike those of Holland and Switzerland. In Holland, which is based on private insurance, virtual private insurance is a monopoly in each area, and it is said that it is almost impossible to change the contract over to other private insurance, but in France public insurance and complementary private insurance are separated, so it is easy to choose complementary insurance or to change an insurance contract to other insurance. Also because mutual societies and private insurance are operated under different tax systems, mutual societies have an advantage over private insurance companies.

In the 1980's, private insurance companies aggressively entered the French health insurance market. Mutual societies, which until this time had a lot of power in this field, did not insure with the same contributions which were proportional to income rather than to risk, and did not engage in price competition to reduce high risk. Meanwhile, private insurance, which set insurance fees based on risk, changed insurance fees according to age and the results of medical checks, etc. They provided benefit packages across the spectrum of the subscriber risk base, and practiced risk screening in some cases by denying subscription to some healthcare benefits.

By specifying public sector employees, etc. in target group contracts, mutual societies have not felt a big threat of private insurance subscriptions, but

private insurance, thinking that low-risk individuals may switch from mutual societies to private insurance have worked aggressively in the individual market, competing with mutual societies, and so many mutual societies, sensing a crisis, began to introduce competitive principles like those of private insurance.

Today, both mutual societies and private insurance modulate their insurance contributions depending on age, with the exception of group insurance contracts. Elderly subscribers pay additional insurance fees, and those above 65 years of age are exempt from some part of the contracts. However, the age division in mutual societies is rough and approximate compared to private insurance, and the use of factors such as gender and health condition which are adopted in private insurance are under the ban in mutual societies. Both insurers have a fixed waiting period for payment. More different types of payment are available than before with mutual societies, although not as many as with private insurance.

By the way, mutual societies have conventionally owned and operated directly managed facilities such as dental clinics, ophthalmology centers, pharmacies and hospitals (welfare services for elderly people with disabilities are also provided by mutual societies).

Since the mid-1990's, private insurance has, in a sense, attempted to model the American system in order to advance overall medical insurance management, and in this, AXA, in the Île-de-France region, made a proposal to operate healthcare services in this way (*L'Express*, 06/08/1998). Being exposed to cryticism as a "privatization of social insurance" this proposal was withdrawn, but also showed that there is a drift toward "managed care" in French healthcare system.

4. Conclusions

We have discussed the Chadelat Report and private health insurance leading up to the health insurance reforms of August 2004 in France. The healthcare system of France and that of Japan have many similar points compared to other Western European countries which are based on public health insurance, but the relationship between public health insurance and private insurance is very different. First is the way in which healthcare services are provided for all japanese people. In 1960, as regards healthcare services, all the people in Japan were covered by any public health insurance when the National Health Insurance System became mandatory, but in France, the "overall coordination and generalization （harmonization et généralization）" of public insurance in 1974 and 1975 sought in vain to cover all citizens with mandatory health insurance. The CMU and its complementary system CMUC enacted in 2000, which should have filled the gap between the real meaning of "general", is reminiscent of the stillborn "welfare system for healthcare services" of Japan which was proposed in discussions of the so-called "fundamental reform of the healthcare system" in 1970's and was to target the low income bracket, but it has failed to win support by reason that it is deemed discriminatory.

Secondly, the history of mutual societies, which have such a large position in France, does not exist in Japan, and therefore sole public insurance has covered the national healthcare needs. The copayment in the Japanese public health insurance is 30% in general which is almost the same as in France. However, because a "system for high-cost medical care benefits" exists, the amount which exceeds the fixed amount of the patient's share is reimbursed by health insurance, so until now there is not a very large margin to enter private insurance that will take care of the patient's charge. However, if hospitalization is required for cancer and other situations that require high-cost treatment, the expenses that exceed the amount covered by the individual's health insurance will not be ignored. It is conceivable that, in the future, the "high-cost medical care system" reduces its share of medical expenses, and if so, the benefits of public health insurance must be much more limited. If the burden of patients increases, the insured will of course be forced to depend on private insurance. Enrolment in private insurance is currently left to the personal choice of the individual, but it may be that in the not-so-distant future public health insurance may require to consider the complementary role of private health insurance.

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