Liberté • Égalité • Fraternité
RÉPUBLIQUE FRANÇAISE

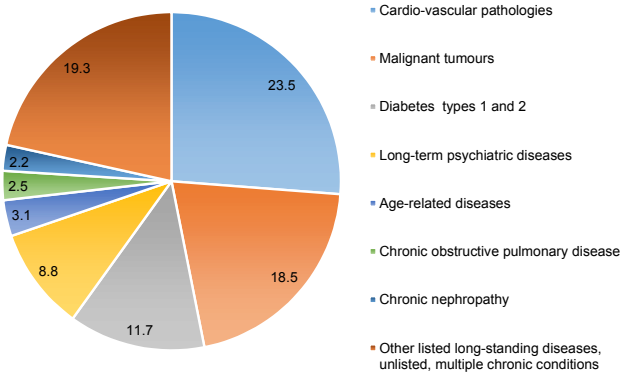
No. 145
April 2015

TRÉSOR-ECONOMICS

What is the future of France's healthcare expenditure reimbursement system for patients with long-standing diseases?

- Expenditure for patients suffering from a recognized long-standing diseases (*Affection de Longue Durée* - ALD) currently represents a major share (€90bn in 2011) of total reimbursed healthcare expenditures. The ALD system itself, which supplements standard reimbursements by granting patients copayment exempt status for all medical procedures and services related to LSDs, costs the national health insurance system an additional €12.5bn, but accounts for only a modest 14% of the total reimbursed healthcare expenditure for patients having a recognized LSDs.
- Attributable in equal measure to population ageing and the rising prevalence of chronic diseases, over a fifteen year period reimbursed healthcare expenditures are projected to increase by 1.6 percentage points of GDP, reaching 8.3% of GDP in 2025. The share of ALD beneficiaries would thus rise from 15.4% of the population in 2011 to 19.7% in 2025.
- The ALD system generates inequalities in patient management and may leave patients with high out-of-pocket expenses. Firstly, because the approach in France is singularly based on medical rather than economic criteria, the ALD system means that two patients facing the same healthcare expenditures could ultimately be reimbursed very different amounts, if one enjoys exempt status under the ALD system and the other does not. Furthermore, the system only partially achieves its goal of limiting annual out-of-pocket expense, given that one patient in twenty still incurs annual out-of-pocket expense for medical care and medical supplies of over €900, which does not take account of either extra-billing, that is, additional fees or extra charges billed for procedures or services covered by the social security system, or coverage by supplementary health insurance. Moreover, ALD beneficiaries, who account for one-third of the one in twenty patients that is nearly twice their percentage of the total population-remain at risk of incurring high out-of-pocket expenses for medical care unrelated to their recognized LSDs.
- Incremental improvements to the ALD system are welcome, and some are already under way: checks on the "two-part" prescription form, consistency in the ALD-eligible list of pathologies, and the introduction of a timeframe for ALD coverage. However, these changes cannot fully overcome the system's limits. A more ambitious, comprehensive reform to regulate public expenditure and patients' annual out-of-pocket expense on the basis of parameters to be determined-such as annual out-of-pocket maximum, level of exemption if any, and copayment amounts-could prove to be more appropriate. Management of healthcare expenditure by the mandatory national health insurance system based on economic criteria would thus restore equity among patients irrespective of their medical disease, while preventing excessive annual out-of-pocket expenses.

French national health insurance expenditure by type of long-standing diseases in 2011 (in €bn)



Source: DG Trésor calculations.

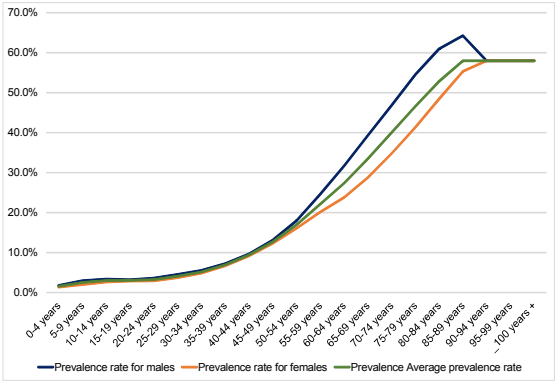
MINISTÈRE DES FINANCES ET DES COMPTES PUBLICS

MINISTÈRE DE L'ÉCONOMIE DE L'INDUSTRIE ET DU NUMÉRIQUE

As a rule, France's mandatory national health insurance system does not cover the total amount of any healthcare expenditure. Patients contribute to the cost of care through a copayment[1]. The ALD system for LSDs was established in 1945. It exempts from copayment all patients suffering from "diseases requiring extended care and particularly costly treatment"[2]. The diseases entitling patients to benefit from the ALD system are set out in a list of thirty recognized LSDs (the "ALD 30" list) established by decree following recommendations of the French National Authority for Health (*Haute Autorité de Santé* - HAS). In addition to the thirty listed diseases, two ALD codes were created in 1986 to capture "unlisted" pathologies: ALD 31 for cases in which "the patient suffers from a progressive or disabling form of a severe disease" and ALD 32 for multiple chronic diseases (MCCs), *i.e.*, cases in which "the patient suffers from multiple medical disorders causing a severe disabling medical disease". For each of the thirty recognized LSDs on the ALD 30 list, there are medical criteria governing eligibility for the ALD system and thus exemption from copayment. Upon diagnosis, approval by a medical officer from the national health insurance system is required to confirm patient eligibility for the ALD system. Since 1986, and particularly since the introduction of the "two-part" prescription form in 1993, only the medical procedures and services related to the ALD diseases are exempted from copayment.

In 2011, ALD beneficiaries account for only 15% of the total population, however the percentage increases significantly as a function of age, and exceeds 50% from age 80 onward (Chart 1). Most of these patients suffer from cardio-vascular diseases, malignant tumours or diabetes (Table 1).

Chart 1: Prevalence rates of long-standing diseases by age and gender in 2011



Source: CNAMTS, adjusted by DG Trésor at advanced ages.

Note: Owing to the small sample sizes at very advanced ages, the prevalence rates of LSDs beyond age 90 would be significantly underestimated in the population as a whole. We therefore consider the prevalence rates of LSDs for ages 90 and over to be the same for males and females, and equal to the prevalence rates for males and females combined for ages 85-89.

Table 1: ALD aggregates by type of LSD: number of patients and expenditures covered by the national health insurance system (all schemes combined) in 2011

	Number of patients (thousands)	Average annual reimbursement for ALD beneficiaries (€)	National health insurance system expenditure (€bn)
Cardio-vascular diseases	2 566	9 200	23.5
Malignant tumours	1 712	10 800	18.5
Diabetes types 1 and 2	1 596	7 300	11.7
Long-term psychiatric diseases	949	9 300	8.8
Age-related diseases	290	10 600	3.1
Chronic obstructive pulmonary disease	229	10 700	2.5
Chronic nephropathy	70	31 500	2.2
Other listed long-standing diseases, unlisted, MCCs	2 349	8 200	19.3
Total	**9 763**	**9 200**	**89.6**

Source: CNAM, , expenditures for the health insurance general scheme extrapolated to all schemes, DG Trésor calculations.

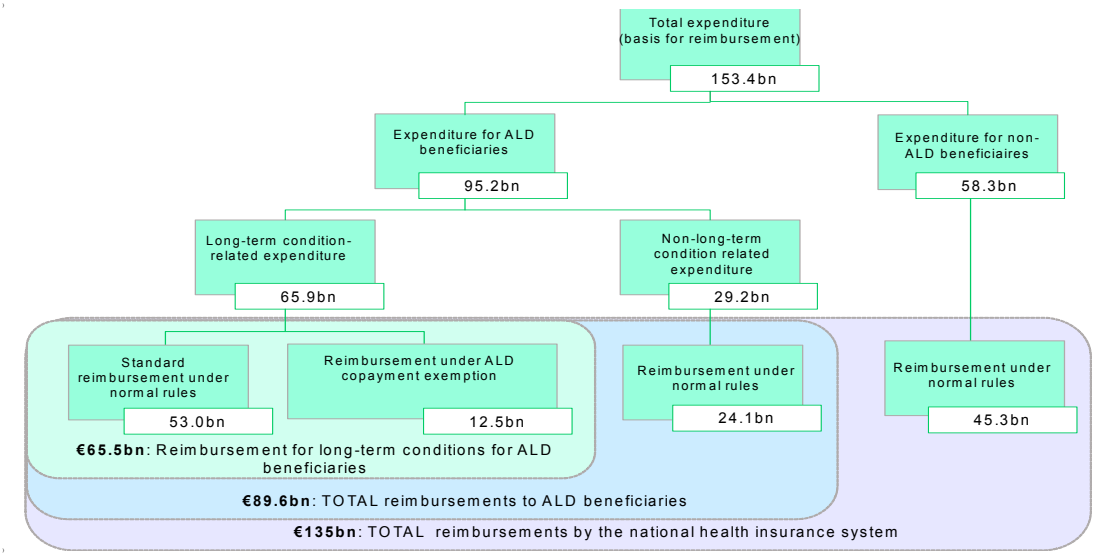
1. The ALD system costs the national health insurance system €12.5bn per year (or 9% of its total expenditure)

A distinction must be made between the amounts covered by the ALD system and the amount reimbursed for patients with LSDs, which totalled €89.6bn in 2011 (Figure 2). Based on the "consumption of care and medical goods" aggregate[3], excluding the fixed budget grants to hospitals, ALD system reimbursements account for two-thirds of total reimbursements by the national health insurance system. This amount, however, does not reflect the actual cost of the ALD system, for two reasons:

- It includes spending unrelated to the exempting diseases, even if that spending accounts for only a third of the expenditures for ALD beneficiaries.
- It also includes reimbursements made under the normal health insurance rules whereas, compared the normal rules, exemption from copayment is the only additional cost arising from the ALD system.

(1) In addition to any extra-billing incurred for certain medical procedures and services.
(2) Article L 322-3 of the Social Security Code.
(3) "Consumption of care and medical goods" (Consommation de Soins et Biens Médicaux: CSBM) is an aggregate of the national health accounts. It includes the consumption of hospital care, ambulatory care, transport of patients and drugs, and other medical goods.

Figure 2 : Breakdown of expenditure covered by the national health insurance system in 2011 and related reimbursements to ALD beneficiaries and non-beneficiaries (€bn)



Source : CNAMTS, adjusted by DG Trésor.

Note: Because of fixed contributions and annual deductibles, not all ALD system-related expenditure is fully reimbursed.

Box 1: **Estimation of the cost of the ALD system**

The main data used in this paper were supplied by the French National Health Insurance Fund for Salaried Workers (CNAMTS) based on an analysis of the exhaustive data in the SNIIR-AM[a] database for the health insurance general scheme in 2011. The data are extrapolated to allow calculation for the entire national health insurance system (all schemes combined). The ratio of the amount reimbursed to the reimbursement basis, which we will call the actual rate of reimbursement, is on average higher for ALD beneficiaries than for non-ALD beneficiaries (Table 2 below).

Table 2: Average of actual reimbursement rates (%) of reimbursable expenditure in 2011

	ALD beneficiaries	Non-ALD beneficiaries	Difference
Ambulatory care	90.7	65.1	25.6
Hospital care	97.4	93.3	4.1
Total	**94.2**	**76.8**	**17.4**

Source: SNIIR-AM.

The difference is very small for hospital care: 50.4% of reimbursements for ALD beneficiaries versus 45.8% for non-ALD beneficiaries. Note that in hospital care the copayment is often waived on grounds other than the ALD exemption[b].

To determine the cost of the ALD system, it is first necessary to distinguish between expenditures exempted from copayment under the ALD system and those that are not. The distinction is indicated on the "two-part" prescription form. After isolating the fixed contributions (*participations forfaitaires*) and annual deductibles (*franchises médicales*) (€57 on average for each ALD beneficiary[c]), the unreimbursed portion for ALD beneficiaries is therefore the copayment for the portion of expenditure unrelated to the ALD diseases. Accordingly, from the known amount of unreimbursed expenditure and the rate of reimbursement for patients not covered by the ALD system, we can compute the level of expenditure unrelated to the ALD diseases[d].

If there were no ALD system, patients would be reimbursed under the normal rules. We can therefore calculate the cost of the ALD system as the difference between actual reimbursements and those that would have been made under the normal rules. This implicitly assumes that the expenditures for ALD beneficiaries would be the same in the absence of the ALD system, and that the structure of their healthcare consumption would be comparable to that of patients not covered by the ALD system[e].

The cost of the ALD system is thus estimated to be €12.5bn[f] in 2011. For ambulatory care alone, the cost for the health insurance system (all schemes combined) is estimated at €10.7bn. This figure is consistent with the amount calculated by the Directorate for Research, Studies, Assessment and Statistics (DRESS)[g], which estimates that the cost of the ALD system for ambulatory care was €7.9bn three years earlier, in 2008, for the general scheme of the health insurance system, based on Échantillon Généraliste des Bénéficiaires (EGB) panel survey data[h].

a. SNIIR-AM is the comprehensive database of the national health insurance system. It contains records on all reimbursed medical services and procedures, with their detailed codes, and information on patient age, gender, whether or not covered by CMU-C (universal complementary health coverage), whether or not covered under the ALD system, *département* and region of residence, and date of death. The database for 2011 contains 58,240,000 individuals.
b. "*Les restes à charge à l'hôpital (public et privé*" - 2013 annual report of the Higher Council for the Future of Health Insurance (Haut Conseil pour l'Avenir de l'Assurance Maladie - HCAAM).
c. The fixed contribution and annual deductible were introduced in 2005 and 2008, respectively, and are capped at €50 a year. The €57 figure is the average of the sum of the two amounts.
d. This assumption holds because the analysis is based on homogeneous groups in terms of age, gender, and the closeness of their date of death. In addition, we compare ALD and non-ALD reimbursement rates separately for each of three types of care: ambulatory care, care in private hospitals, and care in public hospitals.
e. See previous note.
f. Of which €1.8bn for hospital care and €10.7bn for ambulatory care.
g. Baillot, A. (2010), " Une estimation du coût du dispositif des affections de longue durée en soins de ville pour le régime général d'assurance maladie ", DREES (Direction de la Recherche, des Études, de l'Évaluation et des Statistiques), national health accounts.
h. General sample of national health insurance beneficiaries, managed by CNAMTS.

2. Nearly 20% of the population would be eligible for the LSDs system in 2025

The number of ALD beneficiaries rose steeply from 3.3 million in 1994 to 9.5 million in 2012[4]. Only part of this increase is due to population ageing. The main factor is the greater prevalence of LSDs at a given age and gender, which grew at an annual rate of 3.7% between 2001 and 2011[5]. There are several possible explanations for this trend. Seen in a positive light, it reflects better screening or improved survival rates, whereas a more pessimistic view sees the effects of deteriorating living conditions and lifestyles, including physical inactivity, pollution, and poor nutrition.

Box 2: **Projection methodology**

Our methodology is based directly on the PROMEDE model[a], which we have adapted for the purposes of this study. We begin by using the baseline scenario of the most recent population projection by INSEE (the French national statistical institute) to determine the annual number of deaths and survivors by gender and age. Death or survival in a given year must be taken into account in estimating healthcare expenditure, because of the very high level of healthcare consumption in the last year of life[b].

We then use the prevalence rates of ALD-listed diseases by age, gender and survival to the following year, as observed in 2011, to divide the population into two categories: ALD beneficiaries and non-ALD beneficiaries.

The amount of reimbursed expenditure per person in 2011 is then allocated between the two categories.

We have refined the original version of the PROMEDE model to recognise the specific characteristics of the various ALD-listed LSDs. Rather than treating all the diseases as a single class, we assign them to eight categories, based on the similarities of their medical characteristics (Table 3), and we employ all the statistics for prevalence and average reimbursement by age and gender for those eight categories. The statistics are drawn from the exhaustive SNIIR-AM data for the health insurance general scheme in 2011[c].

Table 3: Average annual change in prevalence by types of LSDs between 2008 and 2011

Long-standing diseases	Average annual change
Diabetes types 1 and 2	6%
Chronic obstructive pulmonary diseases	3%
Chronic nephropathy	7%
Cardio-vascular diseases	4%
Age-related diseases	4%
Malignant tumours	2%
Long-term psychiatric diseases	3%
Other ALD long-standing diseases	5%
Total	**3%**

Sources: CNAMTS, SNIIR-AM.

While the original PROMEDE model forecast rising costs using the GDP elasticity of healthcare expenditure, which may be difficult to interpret, our projection is based solely on the expected increase in the number of ALD system beneficiaries. This methodology appears to match more closely the changes observed in the past decade. We have thus extrapolated prevalence rates from the trends observed in the recent past (Table 3). Since these trends cannot be expected to continue indefinitely[d], we assume that the annual increase in the prevalence slows by 10% a year. Since the faster pace of growth in healthcare expenditures than in GDP has been factored into the increase in prevalence, average expenditures by age and gender are assumed to be constant (in 2011 euros).

Under these assumptions, there would be 13.2 million ALD beneficiaries, or 19.7% of the population, in 2025, compared with 15.4% in 2011.

The model foresees that the cost arising from the ALD system in 2025 would be €17.1bn in constant euros, compared with €12.5bn in 2011. The €4.6bn increase over 2011 can be split into two components: a demographic effect relating to population size and ageing (+€2.4bn) and the impact of higher prevalence (+€2.2bn). **The rise in expenditure associated with LSDs is attributable as much to demographic changes as to the increase in disease prevalence.**

The growth in the ALD system cost is part of the broader context of rising healthcare expenditures. In 2011 euros, our projections show a €32bn increase in total healthcare reimbursements to €168bn or 8.3% of GDP by 2025.

a. Geay, C. and de Lagasnerie, G. (2013), "Projection des dépenses de santé à l'horizon 2060, le modèle PROMEDE", *DG Trésor working paper*, no. 8.
b. Ibid, section 2.2.2. (pp. 17ff).
c. We assume here that the prevalence rates for LSDs observed in the general scheme of the NHI are the same in the other schemes. SNIIR-AM is the comprehensive national health insurance database, which covers the general scheme and the other schemes.
d. This is to take account of a slowing in the rate of increase of prevalence.

(4) For patients enrolled in the national health insurance general scheme.
(5) Source: Annex 1 of PLFSS 2013 « Programmes de Qualité et d'Efficience - Maladie », p. 67. Field: national health insurance general scheme.

Given these rates of increase, reimbursed expenditures for ALD diseases as a percentage of total expenditure reimbursed by the national health insurance system rose from 44% in 2002 to 59% in 2009[6].

The forecasting model used in this study (Box 2) indicates that the percentage would increase from 66%[7] in 2011 to 68% in 2025. Over the same period, reimbursed healthcare expenditures would rise by €32bn from 6.6% to 8.3% of GDP[8], primarily because of higher expenditure for ALD beneficiaries, who would then account for 19.7% of the population (up from 15.4% in 2011).

3. The ALD system does not fully meet its objectives

3.1 Annual out-of-pocket expenses remain high, despite the system

The ALD system was put in place when the French national health insurance system was created in 1945. Its implicit purpose is to limit annual out-of-pocket expense for patients with high expenditures. While it does reduce beneficiaries' annual out-of-pocket expense and can potentially improve their access to care[9], this objective has not been achieved. The 5% of patients with the highest annual out-of-pocket expense (not including extra-billing amounts) spend €900 a year for their health care[10]. This potentially concerns all patients:

- Non-ALD beneficiaries may incur high healthcare expenditures-for example, an individual with multiple fractures following a fall. This is the case for two-thirds of the 5% of patients with the highest annual out-of-pocket amounts. The ALD approach, based on medical diagnosis and a list of diseases, is therefore not sufficient to protect the population against the risk of incurring very high annual out-of-pocket expenses-because not all "costly" diseases are exempted-and against the attendant risk of being unable to access healthcare services.
- ALD beneficiaries are also subject to the same risks, as they account for one-third of the 5% of patients with the highest annual out-of-pocket amounts. While their eligibility for the ALD system should protect them against high out-of-pocket amounts, a disproportionate number of them are in this situation, as ALD beneficiaries account for only 15% of total patients. This shows the limits of the ALD system. These high out-of-pocket amounts arise from the non-exemption for expenditure not related to an ALD-listed LSD, and to a lesser extent from €1 fixed contributions and deductibles.

3.2 Patients are not treated equally

The ALD system is based on a purely medical approach. This singular feature of the French system means that two individuals receiving similar care could be reimbursed differently. For instance, one person with a series of accidents or illnesses could have high healthcare expenditure and a high annual out-of-pocket amount, without receiving the same reimbursement as a patient in the ALD system with a similar level of expenditure.

Moreover, entry into the ALD system could in itself be a source of unequal treatment. Because of poor information, some patients may fail to request entry into the system, even if eligible. In that case, their entry may be dependent on their physician's assessment which also varies. While objective criteria do exist for some LSDs (such as fasting plasma glucose), subjective criteria also sometimes come into play. A study by the French National Health Insurance Fund (CNAMTS) reports that long-term psychiatric diseases are not handled uniformly in all French regions. This proves that criteria that are not strictly medical play a role in determining whether or not a patient should benefit from the ALD system[11]. In particular, it is not unknown for national health insurance medical officers to take patients' financial resources into account, as the CNAMTS observed in the case of severe hypertension[12]. This may well have been a commendable attempt to promote public health and ensure access to care. However, if such considerations are to come into play, it would be better for the criteria to be objective and transparent. Failing that, a person's financial resources could be taken into account through a means-tested system for capping the annual out-of-pocket amount (see below).

3.3 The cost is rising uncontrollably

As noted above, healthcare spending will increase largely owing to expenditure for ALD beneficiaries. While it is not illogical for healthcare costs to rise faster than GDP in a context of technical progress and population ageing, the absence of any tool for regulating ALD-related expenditure could undermine the system's sustainability. The ALD system is devoid of any mechanism for regulation on either the supply side or the demand side[13]. Thought must be given to identifying measures to better control the current trend.

(6) Source: Annex 1 of PLFSS 2011 "Programmes de Qualité et d'Efficience - Maladie", p. 65. Because of a change in the methodology for calculating the portion of expenditures relating to ALD beneficiaries, it is not possible to provide the trend for 2002-2011. The field for which the trend is calculated, which includes an individual allocation of the fixed budget grants to hospitals, differs from the field for the rest of the study.

(7) This figure is for a field other than the one for which the 59% figure mentioned above was calculated. In particular, it does not include the individual allocation of the fixed budget grants to hospitals.

(8) The GDP figure for 2025 is taken from COR (Conseil d'Orientation des Retraites) scenario B, December 2012 report.

(9) Dourgnon, P., Legos, L. and Or, Z. (2013), "L'impact du dispositif des affections de longue durée (ALD) sur les inégalités de recours aux soins ambulatoires entre 1998 et 2008", IRDES.

(10) Source: DG Trésor, calculations on the EGB panel (see note h p. 3).

(11) Vallier, N., Salanave, B. and Weill, A. (2006), "Disparités géographiques de la santé en France: les affections de longue durée", CNAMTS, *Point de repère*, no. 1.

(12) See Vallier et *al.*, note 11.

(13) Excluding fixed contributions and annual deductibles.

4. What changes could be made in the ALD system in order to continue to protect patients?

Because the ALD system has important limits, as seen above, modernisation is required to ensure its sustainability.

4.1 Proposals to reform the current system can be considered

4.1.1 Proposal 1: Reduce the number of diseases covered by the ALD system

In theory, one way of slowing the increase in the number of ALD beneficiaries would be to remove certain diseases from the scope of coverage. A precedent was set when severe hypertension, except in the case of "proven clinical severity", was removed from the list of diseases in 2011. However, it should be noted that the decision was justified by the fact that hypertension is a risk factor and not a disease (see the opinion on the matter by the French National Authority for Health, HAS[14]). This approach could be envisaged only if removal of a disease from the system is justified on medical grounds.

4.1.2 Proposal 2: Stricter compliance with the "two-part" prescription form

There is some evidence that the "two-part" prescription form[15] arrangement is not always complied with properly. This results in excessive reimbursement of healthcare expenditures that are wrongly considered to be related to the exempting disease. Stricter compliance with the "two-part" arrangement could be achieved by checks, by raising awareness among physicians from the time of their initial training, and by greater efforts to educate patients[16]. This would also limit overconsumption and the tensions that may sometimes arise between patients and healthcare professionals concerning total exemption.

Despite recent efforts, there is still some room to improve compliance with the "two-part" prescription arrangement. However, the actual impact on hospital expenditures would be limited. This is because the many grounds for exemption from copayment other than the ALD system-including costly procedures (exceeding €120) during hospitalisation, disability and maternity-mean that copayment would be waived in most cases, and there would be no change in either behaviour or reimbursements.

By contrast, regarding ambulatory care, if, for example, 5% of expenditures currently reported as related to the exempting ALD disease were reclassified as unrelated, reimbursements would fall by €530 million, and possibly even more if the absence of full reimbursement were a deterrent to consumption.

4.1.3 Proposal 3: Stricter control on access to, and exit from, the ALD system

If there were total compliance with the "two-part" prescription form arrangement, whether or not a patient is an ALD beneficiary would have no impact on reimbursements. A patient accepted in the ALD system but cured of the disease would no longer have any expenditure related to the exempting disease, and all his or her care would be reimbursed under the normal rules. But compliance with the "two-part" prescription is not total (see previous section). In addition, there will inevitably be a margin for interpretation when a patient is in the ALD system. For example, a visit to a general practitioner may cover several matters and may easily be considered to be related to the exempting LSD, even if the benefit for that disease is questionable. Therefore, despite the "two-part" prescription form, it is important to exclude patients who are not eligible, or no longer eligible, from the ALD system.

Since 2005, general practitioners have received an annual fee of €40 per ALD patient they manage. While this might be considered an incentive to register and maintain ALD beneficiaries, a 2011 amendment to the Social Security Code providing for a 2- or 5-year ALD registration period should have a regulating effect, so that patients who are cured no longer benefit from ALD status. For ALD registration to be extended, the general practitioner must submit a substantiated application to the national health insurance medical officer. This effort to regulate the system should continue.

4.1.4 Proposal 4: Specify the diseases for ALD 31 and ALD 32

The French National Authority for Health (Haute Autorité de Santé: HAS) could conduct more systematic and more periodic reviews of the list of recognized LSDs, taking into account both medical progress and changes in the cost of treating the diseases covered. Entry into the system under ALD 31 and ALD 32 could be made more objective through lists of the diseases and multiple chronic diseases (MCCs) covered by those codes. The longer list could contribute to better control over entry into the ALD system, in that the decision to list a disease would be made by a college of HAS experts rather than on the basis of the individual assessment of each medical officer, as is currently the case.

4.2 … Although it would be preferable to consider a systematic reform of healthcare cost management

The ideas set out in this section for structural reform of the French healthcare system more broadly could nonetheless have an impact on the ALD system and safeguard its sustainability. A 2007 opinion by the HAS points out the confusion that sometimes surrounds the ALD system as a mechanism exempting from copayment-the subject of this paper-and the ALD system as a mechanism for establishing care protocols. A distinction must, therefore, be made between the system's two meanings and the care protocol mechanism-a valuable arrangement-will not be discussed here.

4.2.1 Acting on the prevalence of LSDs

Our projection shows that half of the expected growth in ALD system expenditure over the next ten years is due to the expected increase in prevalence. If preventive measures were to reduce the expected increase by 50%, that alone would reduce annual healthcare expenditure by €7bn[17] by 2025.

It could therefore be cost-effective to invest in measures to prevent LSDs[18].

(14) HAS (2011), "Avis de la HAS sur le projet de décret visant à la suppression de l'ALD hypertension artérielle".
(15) See Vallier et *al.*, note 11.
(16) This would have the positive externality of citizens better informed about the role of the mandatory national health insurance system. This would increase their willingness to pay, as well as provide them with fuller information for choosing a supplementary health insurance plan.
(17) This figure includes the additional cost arising from the ALD system plus standard reimbursements under the normal rules.
(18) "Prevention" is used here with the meaning: "to prevent the occurrence of illnesses."

4.2.2 Reimbursements based on expenditure, not medical disease

A system with differences in reimbursement outcomes based on medical criteria and on a list of diseases is specific to France. Most other countries prefer a more economic-based approach, with a cap on annual out-of-pocket expenses (Box 3). This is not to say that the French approach completely ignores economic considerations: to be eligible for the ALD system, the treatment must satisfy a medical criterion (severity) and a time criterion (over six months); it must also be "particularly costly due to the cost or frequency of medical procedures, services and therapies"[19]. No official definition of what is a particularly costly procedure or service has been provided, however, since 1986, when the limit on payment by patients was set at 80 francs per month (equivalent to €20 in 2014), thus establishing a de facto cap on the out-of-pocket expense.

Box 3: Comparison of systems to limit the financial burden on patients for chronic diseases in 4 European countries

Country	Requirements for entry into the chronic disease system	Measures to limit financial burden
France	List of diseases for access to the system (and some "unlisted" diseases) after approval by national health insurance medical officer.	Copayment exemption for care related to the LSD(with the "two-part" prescription form).
Germany	Patient receiving medical care for one year + high care dependency or disability rating of at least 60% or requiring continuous drug therapy.	Expenditure capped at 1% of household annual income (instead of 2% for individuals outside the system).
Belgium	Individuals requiring long-term nursing care, having had long hospital stays, receiving social or old-age benefit.	Flat-rate benefit of €253.60 per year. To access the system, expenditure must be at least €365 (for disadvantaged individuals) or €450.
Sweden	No specific system for chronic diseases.	Cap of €100 for consultations, €200 for drugs and €222 for medical devices, or a total cap of €522.

Source: HAS (2007), « La participation des patients aux dépenses de santé dans cinq pays européens », HAS working paper.

The economic approach based on the amount reimbursed and a cap on annual out-of-pocket expenses has the advantage of treating all patients on an equal footing according to their medical disease. As underscored by the French National Authority for Health (HAS) in December 2007)[20], there is a degree of inequality between patients whose disease is on the ALD list and are exempted from copayment, and those who are not exempted, while having high expenditures and annual out-of-pocket amounts.

The fact that multiple chronic diseases (MCCs) are grounds for exemption from copayment may be viewed as a step away from the list of diseases and the start of a generalised approach in which the level of coverage would be based on expenditure rather than on medical diagnosis.

According to the ISIS model[21], for ambulatory care, and assuming an unchanged level of expenditure by the national health insurance system, the elimination of the ALD system would facilitate the introduction of an out-of-pocket maximum of €570[22] for the year 2010. By comparison, 5% of patients currently have annual out-of-pocket expenses of over €900. Financed by redirecting the existing program, this system would introduce an effective cap on out-of-pocket expenses for all patients, whether or not currently in the ALD system. However, it could increase the burden on some patients registered in the ALD system who consume little healthcare unrelated to their ALD-listed LSD.

Conclusion

The ALD system for LSDs is sometimes criticised as being responsible for the increase in healthcare expenditures. Yet while the exemption from copayment is indeed an additional cost for the national health insurance system, that cost is limited, accounting for 9% of total expenditure. The sharp rise in the cost is attributable in equal measure to population ageing and to the increased prevalence of chronic illnesses. The ALD system, which will cover some 20% of the French population by 2025, fails to cap annual out-of-pocket expenses, and it offers no genuine assurance of sustainability.

One could envisage marginal adjustments in the ALD system, such as consistency in eligibility criteria, better compliance with the "two-part" prescription form, and a review of the list to eliminate ALD codes 31 and 32. However, a comprehensive reform may be more appropriate. The reform could consist in abandoning the ALD system and its medical approach based on a list of diseases, and replacing it by a system that would set the contribution by the national health insurance system as a function of the patient's expenditure. This would ensure equity for all patients irrespective of their illnesses, eliminate high out-of-pocket expenses, and provide an adjustable system (with parameters such as the amount of the spending cap, the level of any deductible, and average rate of reimbursement) capable of delivering both controlled healthcare expenditure and quality medical care.

Daniel CABY, Alexis EIDELMAN

(19) Article R322-6 of the Social Security Code.
(20) HAS (2007), "Affections de longue durée: liste et critères médicaux d'admission", Avis ("Long-standing diseases: list and medical criteria for entry into the system", Opinion).
(21) De Lagasnerie, G. (2012), "Évaluation de modifications du système de remboursement des soins, enseignements de la maquette ISIS", *DG Trésor working paper*, no. 4.
(22) This amount does not include extra billing and does not take into account reimbursements by supplementary health insurance.

Publisher:
Ministère des Finances et des Comptes Publics
Ministère de l'Économie de l'Industrie et du Numérique

Direction Générale du Trésor
139, rue de Bercy
75575 Paris CEDEX 12

Publication manager:
Sandrine Duchêne

Editor in chief:
Jean-Philippe Vincent
+33 (0)1 44 87 18 51
tresor-eco@dgtresor.gouv.fr

English translation:
Centre de traduction des ministères économique et financier

Layout:
Maryse Dos Santos

ISSN 1962-400X
eISSN 2417-9698

Recent Issues in English

April 2015

No 144. The world economic situation in spring 2015: global acitivity is accelerating, driven by the advanced countries
Marie Albert, Flore Bouvard, Guillaume Cléaud, Thomas Gillet

February 2015

No 143. Labour mobility in the EU: dynamics and policies
Yves-Emmanuel Bara, Maxence Brischoux, Arthur Sode

January 2015

No 142. Children, family policy and taxation: transfers from the welfare and tax redistribution system to families in 2014
Denis Boisnault, Anne Fichen

No 141. Part-time work and work-sharing: a comparison between France and Germany
Nicolas Costes, Laurence Rambert, Emmanuel Saillard