2025 SUMMARY REPORT

RENEWING THE 1945 SOCIAL SECURITY PLEDGE: ACCESS TO HEALTHCARE FOR ALL AND GENUINELY UNIVERSAL MEDICAL COVER

OBSERVATORY ON ACCESS TO HEALTHCARE

IN MÉDECINS DU MONDE PROGRAMMES

HEALTH INSURANCE FIT FOR THE TWENTY-FIRST CENTURY

Health is not only a matter of individual luck – it is also a political choice.

Social security came into being eighty years ago with a clear ambition: to make health a common good by socialising the risk of illness through collective, cohesive funding. Today, this anniversary has come round in a climate of marked decline. The French government has announced a five-billion-euro squeeze on the health expenditure budget. The ways mentioned to implement this include increasing the number of days before qualifying for sick pay, increasing the patient's proportion payable for medicine costs, raising the fee for consultations and further tests, and restricting long-term illness provision and health rights for certain population groups. These many measures would increase the burden falling on patients and undermine the provision of their care.

Médecins du Monde has been working for almost forty years in France with people who have difficulty caring for their health. True to our mission – caring, bearing witness and advocating – we observe, document and report on the barriers to accessing effective care and on the major trends undermining our health system.

In this spirit, we wished to produce a situational analysis of health cover in France and to open up fresh scope for public health insurance – Assurance maladie – a pillar of our healthcare system. Recent decades have seen major progress towards widening access to health cover, with Médecins du Monde playing an active role in creating universal healthcare cover – Couverture maladie universelle – in 1999. However, on the ground we are witnessing just how incomplete and unequal this access remains. In 2024, almost four out of five people seen at our centres were unable to exercise their rights, despite being eligible for health cover.

Multiple obstacles exist: a lack of fixed address for those in precarious circumstances, disincentives imposed by the digitisation of procedures, an increase in the proportion of costs not covered and restrictive practices deployed against certain sectors of the public. These barriers translate as delays to and even abandonment of treatment with direct consequences on health. In 2024 our teams saw more than 15,000 people: more than one third had delayed seeking treatment and three out of five patients were diagnosed with a chronic disease. These findings clearly demonstrate that effective access to health protection influences health equality.

For this 25th edition, we have refreshed the format of our report. In a structure that links field findings, testimonies and targeted investigations, we reaffirm our role as an observatory that produces concrete proposals for improving access to care and rights. We reveal the mechanisms which impede access to health protection, and we challenge the funding and governance choices affecting the future of our inclusive model. We put forward concrete recommendations and advocate for structural reform that establishes residence-based universal health cover, and for simplified procedures, equal rights and democratic governance.

Médecins du Monde is calling for a Convention nationale citoyenne de la Sécurité sociale de la santé – a National Citizens' Agreement on Health and Social Care – so that citizens, service users and professionals can together establish the basis for our system in the spirit in which it was founded in 1945. In a context of health-sector privatisation and its accompanying inequalities, and at a pivotal moment for health and social democracy, the agreement would seek to renew our social contract on the issues of health.

Continuing to honour the pledge made by France's Conseil national de la resistance (National Council of the Resistance) is not a utopian dream. It is a societal choice, and it is up to us to sketch out the way forward. Hence we are committed to contributing to the public debate in order to build public health insurance fit for the twenty-first century that is genuinely universal, inclusive and accessible to all.

Dr Jean-François Corty
President of Médecins du Monde

MÉDECINS DU MONDE 2024 IN FIGURES

43 PROJECTS LED BY 1,402 VOLUNTEERS AND 166 SALARIED STAFF IN FRANCE AND FRENCH OVERSEAS TERRITORIES

24 PROJECTS TO STRENGTHEN THE HEALTHCARE SYSTEM COMPRISING:

14 PERMANENT HEALTHCARE, ADVICE AND REFERRAL CENTRES (CASO) AND ONE RECEPTION, SUPPORT AND REFERRAL CENTRE (CAOA)

10 FIXED LOCATION AND MOBILE PROJECTS

7 PROJECTS ON ISSUES OF MIGRATION, EXILE, RIGHTS AND HEALTH

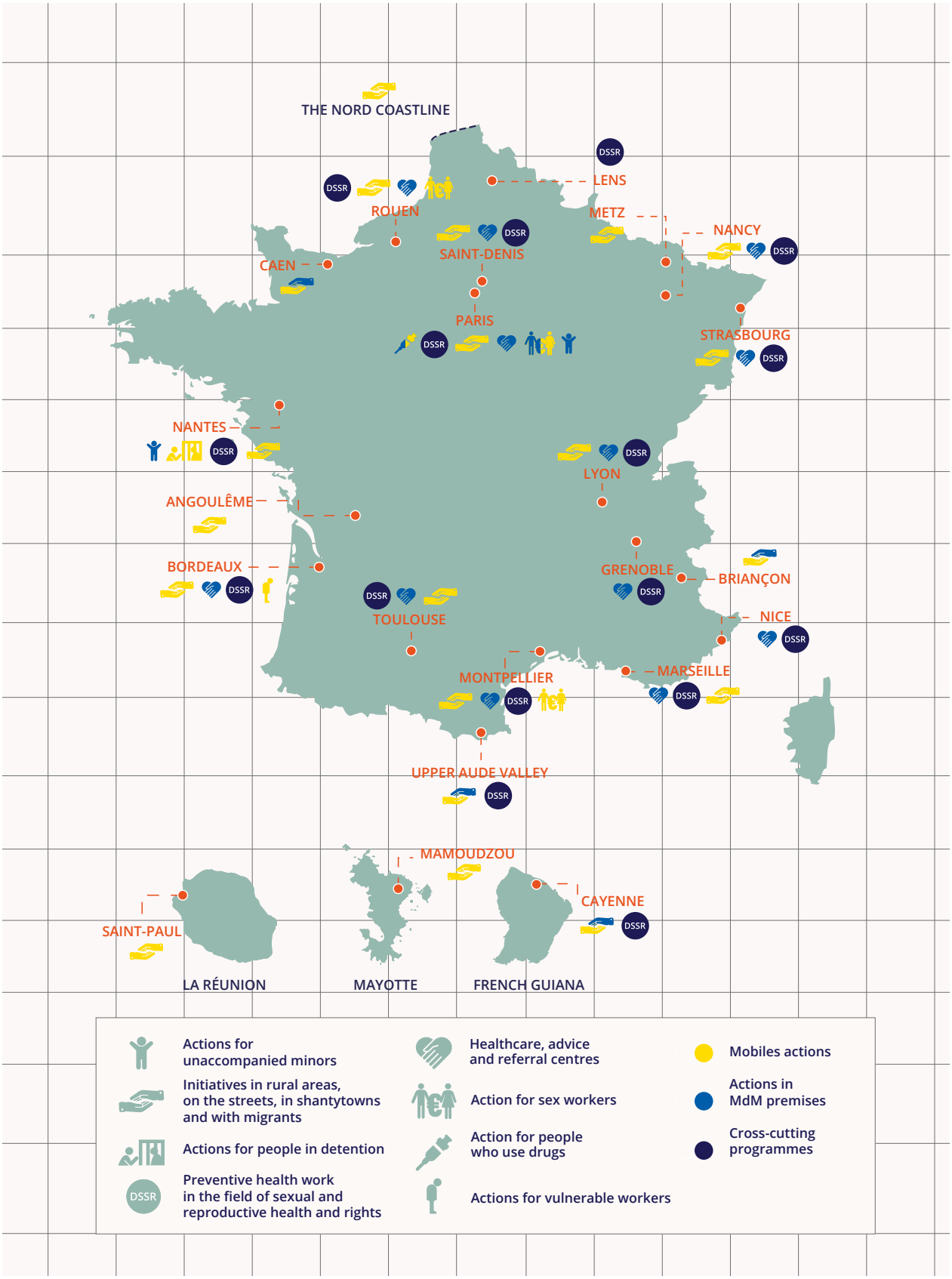
6 PROJECTS ON ENVIRONMENT AND HEALTH ISSUES

1 CROSS-CUTTING PROGRAMME OF PREVENTION IN SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR)

1 SRHR PROJECT

5 HARM REDUCTION PROJECTS LINKED TO DRUG USE AND/OR SEX WORK

PROJECT DISTRIBUTION ACROSS FRANCE IN 2024



OVERVIEW OF MÉDECINS DU MONDE PROGRAMMES IN 2024

Médecins du Monde (MdM) and its teams have been working in France since 1986 when the organisation first opened a centre offering free healthcare to those living in greatest insecurity in Paris. The intention was to close it within six months, having alerted the authorities to the situation of vulnerable and/or excluded populations and having secured their unconditional access to healthcare.

Nearly 40 years later, despite the introduction of numerous public schemes for vulnerable populations, obstacles to accessing rights and healthcare persist, prompting MdM to maintain and develop its programmes throughout France and its overseas territories in the form of Healthcare, Advice and Referral/Support Centres (CASO/CAOA) as well as mobile outreach work.

The thrust of Médecins du Monde's operational strategy is threefold:

- Programmes offering populations unconditional acceptance and outreach initiatives
- Advocacy based on programme findings, data and testimony
- Alliances with voluntary sector and institutional partners.

In December 2024, Médecins du Monde France was running 43 programmes in France and its overseas territories.

24 PROGRAMMES TO STRENGTHEN THE HEALTHCARE SYSTEM:
• 14 PERMANENT HEALTHCARE, ADVICE AND REFERRAL CENTRES (CASO)[1] INCLUDING ONE REFERRAL AND SUPPORT CENTRE (CAOA);
• 10 OTHER PERMANENT AND MOBILE PROGRAMMES

The aim of the Healthcare, Advice and Referral Centres (CASO) is to improve access to prevention, healthcare and rights for the most vulnerable populations in France. The centres receive them with dignity and, depending on their needs, offer them a medical consultation including the dispensing of medication, social support for securing entitlement to medical cover and/or prevention activities. The centres also work to integrate people into the healthcare system. Medical-psychosocial support is inclusive, consistent with empowering people and developing their autonomy. CASO do not impose any conditions on those they accept: people are seen by the multidisciplinary teams, or they are redirected to another facility. A comprehensive, biopsychosocial care package is offered that is centred on what the person requests.

In June 2024, MdM reduced the number of CASO from thirteen to nine, plus one CAOA. The CASO in Ajaccio and Pau closed after transferring their activities, and those in Marseille and Rouen developed different methods of working. Others, such as the CASO in Nice, had also evolved their operations during 2023. Despite these developments in some programmes, they are still referred to as CASO in the context of the 2024 Observatory report. The CASO concerned are in Ajaccio, Bordeaux, Grenoble, Lyon, Marseille, Montpellier, Nancy, Nice, Paris, Pau, Rouen, Saint-Denis, Strasbourg and Toulouse.

In addition to running the 14 CASO, MdM has implemented ten other programmes which are designed to strengthen the healthcare system in the three French overseas territories of Mayotte, Cayenne (French Guiana) and Reunion Island, and in Metz, Lens-Hénin, Nantes, Haute-Vallée de l'Aude, Strasbourg, Lyon and Marseille in mainland France.

For example, the programme in Mayotte is structured around health mediation and in particular involves *reaching out* to populations who are remote from healthcare provision and often living in precarious settlements, in order to bring them closer to the healthcare system and thus reduce disruption to care and avoid abandoned or delayed treatment. The programme in Guiana is also based on a health mediation approach. Its purpose is to increase the autonomy of vulnerable people as they navigate the healthcare pathway and access their rights. To this end, a scheme for accessing city healthcare provision, known as PASS, has been in operation for several years and is scheduled for handover within two years.

Another example is in Metz where, against a background of increasing insecurity and growing social and health inequalities, the teams have fostered coordination and networking between the various actors who encounter vulnerable individuals in their work. The aim is to improve access to healthcare for populations in precarious situations and enable them to enter mainstream health provision. At the end of 2024, the Regional Health Agency officially recorded the introduction of a city healthcare pass, rolled out with the support of MdM.

1 To make the report easier to read, the term CASO is used throughout but also refers to data collected within the CASOs and the CAOA in Paris.

7 PROGRAMMES WORKING SPECIFICALLY ON THE ISSUES OF MIGRATION, EXILE, RIGHTS AND HEALTH

For the majority of its programmes in France and French overseas territories, Médecins du Monde works with people who are migrants, their insecure administrative status being a factor in their health-related vulnerability. The organisation therefore sets up outreach initiatives aimed at those in the most precarious situations, living in squats, encampments or on the streets. The teams offer medical consultations, nursing care, prevention measures and social support. They also take into account not only the physical and psychological suffering endured during their journey to France, but also the degrading living conditions they are faced with once there. Médecins du Monde also runs programmes specifically with migrant people – on the Franco-Italian border in Briançon (mobile unit providing shelter), Paris, Caen in the form of a health mediation project for young exiles, Angoulême and along the Hauts-de-France coast in Dunkirk.

In Toulouse, the programme which has been running since 2021 is aimed at establishing and consolidating a network and resource centre for individuals living in exile and suffering mental health issues. It is working on a handover strategy in 2025.

Unaccompanied minors (UAM) are encountered among those living in exile. Often penniless, feeling lost and worn down by their migration journey and the conditions in which they survive in France, they face many obstacles to accessing their rights and healthcare: a lack of protection, suspicion regarding their age and identity, extremely precarious living conditions on the streets, in squats or encampments, police evictions and harassment, an inability to access medical cover, etc. Through two programmes in Nantes and Paris which are dedicated to UAM excluded from child protection schemes, and as part of a cross-cutting approach in the context of other projects throughout France, Médecins du Monde offers these young people a listening ear, medical and social consultations, collective workshops providing psychosocial support and health prevention, signposting and help with accessing essential items, rights and healthcare.

6 PROGRAMMES WORKING SPECIFICALLY ON ENVIRONMENT AND HEALTH ISSUES

The precariousness of the people encountered is manifested in their dilapidated housing conditions, which are associated with a lack of secure, decent housing, and in their adverse working conditions, whether in the context of informal employment or jobs with minimal protection, such as seasonal grape-harvesting or online platform courier work. These harmful environmental factors generate or aggravate health problems in already weakened individuals.

Deploying mobile teams, Médecins du Monde continues to work in squats, slums, temporary accommodation facilities and day reception centres as well as on the streets in Lyon, Toulouse, Paris, Montpellier and Saint-Denis. The programmes provide:

- Health monitoring, medical consultations, psychosocial support and health mediation
- Support with administrative procedures and securing access to rights
- Information and awareness-raising workshops to enable the people concerned to gain a better understanding of health and take charge of their own health
- Support for medical and social actors to improve their understanding of the issues of insecure housing, homelessness and precariousness, and the impact of those issues on health
- Participation in initiatives promoting direct access to secure accommodation for people living on the streets
- Inter-organisation advocacy in favour of appropriate and long-term accommodation and housing and mobile provision enabling psychosocial support and access to effective care for those who are most excluded.

Médecins du Monde is also pursuing its programme in Bordeaux and the Médoc region. This involves people in precarious situations who work as couriers for online platforms or as seasonal agricultural workers and comprises:

- Supporting access to health rights and care
- Conducting health mediation involving *reaching out* to people and *helping them reconnect* so that they can link up with healthcare facilities
- Providing medical and physiotherapy consultations
- Information sharing and awareness raising about occupational risks and how to avoid them
- Promoting good practice that encourages health at work
- Supporting collectives of people concerned, enabling them to exercise their rights and take better control of their health and make their advocacy messages heard
- Participating in inter-organisational advocacy to draw attention to the deterioration in working conditions for those in precarious employment.

Working in close collaboration with the ministries concerned and as part of a consortium of several operational partners, MdM is involved in an experimental project in Marseille that offers an alternative to custodial sentencing. Consisting of accommodation and intensive monitoring and, in particular, a research component, it proposes an alternative to detention and a way of avoiding imprisonment for homeless people who present severe psychiatric problems.

1 CROSS-CUTTING PREVENTION PROGRAMME IN SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR) AND 1 SPECIFIC PROJECT

The liberty to pursue one's sex life, free from threats or violence and free from the fear of unwanted pregnancy or sexually transmitted infection (STI) is a key health issue. However, Médecins du Monde has found that access to reliable, non-judgemental information and to prevention and treatment services enabling a better sex life and better understanding of one's sexuality remains a major challenge in France, especially for the most vulnerable people.

More than half of Médecins du Monde projects in France, brought together as part of a cross-cutting SRHR Prevention programme, conduct activities aimed at increasing effective access to SRHR in France and in French overseas territories. Depending on the territories and projects concerned, the following activities are implemented:

- Conducting individual health prevention consultations with the offer of screening and collective workshops on SRHR
- Making preventive materials such as condoms and self-testing kits available
- Signposting and accompanying people to mainstream facilities such as sexual health clinics, testing and screening centres and maternal and child health services
- Involving people in their care and treatment by using health mediation, professional interpreting services and person-centred interviewing techniques
- Recording people's state of sexual and reproductive health and documenting the shortcomings in access to services and rights
- Advocating in favour of public policies in this area, including the inclusion of abortion in the French Constitution and making the screening and treatment pathway simpler.

Since 2020, a specific SRHR project has been running in the Nantes metropolitan area and Angers in Pays de la Loire. Using a community approach, the object is to increase access to and enhance the quality of SRHR provision for people in precarious living conditions who are housed in accommodation that is unfit for habitation, substandard and/or informal.

5 HARM REDUCTION PROJECTS LINKED TO DRUG USE AND/OR SEX WORK

Crack consumption sites persist in northeast Paris, including hotspots which vary in extent and are regularly cleared out by the police. This increases the degree of vulnerability of the people concerned by isolating them and distancing them from specialist services. The rise in the violence shown in particular towards women who use psychoactive substances leaves the medico-social services at a loss as to how to respond. Voluntary sector organisations are therefore the ones managing this serious health and social emergency. The Médecins du Monde project is actively strengthening the medico-social system by supporting and complementing provision.
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Together with other voluntary sector organisations, Médecins du Monde is working to ensure that public health policies take account of the specific needs of sex workers as part of a harm reduction approach. MdM is campaigning against the criminalisation of sex work and for greater support for community health organisations who are best placed to respond to need. The Médecins du Monde programmes in Montpellier, Paris and Rouen are fostering access to healthcare and rights for sex workers through outreach, reception and support activities. Lastly, Médecins du Monde is leading a national programme based in Île-de-France that is designed to combat violence against sex workers in their working lives.

SUMMARY

Health inequalities result from the complex interaction between structural determinants, such as socioeconomic and political contexts, and intermediary determinants linked to material and psychological conditions, behaviours, biological and genetic factors and access to the healthcare system. For people in a precarious situation, these determinants tend to accumulate, creating a multiplier effect that accentuates inequalities and further undermines their state of health. Poor housing, social isolation and difficulties with accessing healthcare and treatment are some of the factors which, in combination, compromise physical and mental health over the long term. Precariousness is part of a web of vulnerabilities which in itself represents a major public health issue.

Created in 2000, the Observatory on Access to Rights and Healthcare in MdM programmes in France produces and publishes an annual report. Its three objectives are:

- To contribute to improving knowledge of the most precarious populations in France who are overlooked in official French statistics
- To call out political, institutional and health players
- To draw up proposals for better access to rights and healthcare for populations living in precarious situations.

This 2025 report on access to rights and healthcare for people received by Médecins du Monde projects in France comprises two sections. As in previous years, it begins by using a barometer to illustrate **the profile of the people seen in the CASO in 2024 as well as their state of health which is examined through the lens of the structural and intermediary determinants of health**. The second section of the report is devoted to **the issues of accessing medical cover in France**. In the context of the eightieth anniversary of the introduction of the French social security system, the report provides an in-depth situational analysis of the French health insurance system based on Médecin du Monde's findings in the field.

HEALTH BAROMETER

In 2024, 15,118 people were seen in 14 permanent centres in the country. Of these, 63% indicated their health-related needs during their first visit. The majority were men aged an average of 36 years. **More than two out of five mothers were living alone with a child under 18 years of age. Virtually all were non-French nationals (98%) and, of these, one third had been in France less than three months** at the time of their first visit to a CASO and a further third had been in the country for more than two years. Among the foreign national adults, **62% were undocumented migrants without leave to remain**. One third of foreign nationals from outside the European Union had submitted a claim for asylum prior to their initial interview, 18% of whom had been classed as Dublin III claimants. Two-thirds of people considered their housing situation insecure or temporary. **Almost a quarter of people were actually homeless or in emergency accommodation.**

During their first medical consultation, 71% of people stated that they had never been screened for HIV, 72% for hepatitis B and 74% for hepatitis C. Almost nine out of ten women aged between 15 and 49 years and concerned with contraception did not use any form of it and **just over four out of five women aged between 25 and 65 years had never had a smear test or did not know whether they had had one. One third of pregnant women presented at the consultation with their antenatal check-ups behind schedule.**

Such deprivations have an impact on health. In 2024, 13,431 medical consultations were conducted with 9,352 patients. The four main pathologies diagnosed were linked to digestive (22%), musculoskeletal (19%), respiratory (19%) or dermatological (13%) conditions. **Nearly three out of five patients had been diagnosed with at least one chronic disease. According to the doctors, more than one third of patients showed signs of having delayed seeking treatment. Such delays were even more significant in people who were homeless or in emergency accommodation and in those who stated that they had foregone healthcare.**

Every year, unacceptable numbers of people seen at the CASO have no medical cover. At their initial interview, **85% of people had no medical coverage. Entitlement rates were particularly low given that almost four out of five people eligible to benefit from medical insurance had not secured their entitlement to it. Almost 89% of people had not secured entitlement to French state medical assistance (AME) despite being eligible, and this figure exceeded 59% for those eligible for French universal health cover (PUMa).**

FOCUS ON

RENEWING THE 1945 SOCIAL SECURITY PLEDGE: ACCESS TO HEALTHCARE FOR ALL AND GENUINELY UNIVERSAL MEDICAL COVER

Eighty years after the introduction of social security in France, Médecins du Monde is devoting the second part of the report to an analysis of the national health insurance scheme (*Assurance maladie*), a cornerstone of the French healthcare system. For several decades, many major reforms, such as the creation of universal healthcare cover (*Couverture maladie universelle,* CMU) in 1999, the introduction of universal health protection (*Protection universelle maladie, PUMa*) in 2016, followed by the establishment of complementary inclusive

healthcare cover (*Complémentaire santé solidaire,* C2S) in 2019, have widened access to health insurance cover to include the majority of the population. But in reality access remains unequal and incomplete. Numerous administrative and financial obstacles or questions of administrative status still prevent a proportion of the population living in the country, particularly those who are most deprived, from benefiting from effective, continuous healthcare cover. This finding is set against a wider context of the digitisation of administrative procedures, thereby exacerbating inequalities of access, progressively disengaging the state from funding health to the detriment of households and increasing the power of the argument for privatisation, all of which undermine the basis of the French solidarity model.

This report draws on findings in the field from Médecins du Monde's permanent health centres and mobile units, complemented by targeted studies conducted in 2024 and 2025. It seeks to highlight the mechanisms by which access to comprehensive health coverage is hampered and does so by combining field observations, analysis of public policies and testimony from the people concerned. The purpose is twofold: to analyse the structural causes of inequalities of access and to put forward concrete solutions to overcome them. Major issues are at stake which directly affect public health and the populations' state of health. Abandoning or delaying seeking treatment, a lack of preventive measures and the difficulties faced by health professionals in supporting patients throughout their care pathway are symptoms of a system on its knees that urgently needs transforming.

The first three chapters are organised in such a way as to track the administrative process experienced by the people supported, from initial steps to the effective dispensing of care. The first chapter deals with establishing a 'registration' address for people with no fixed abode in order to secure entitlement to healthcare cover which is not uniformly and effectively applied across French territories. The second chapter explores the consequences of the digitisation of the national health insurance scheme in a context where physical reception centres are closing, thereby complicating the administrative procedures for submitting and tracking applications for a significant proportion of the population. The third chapter affords a critical reading of existing key public health protection schemes in France (statutory health cover, complementary inclusive health cover, state medical assistance (*aide médicale de l'État,* AME), measured according to three criteria: population covered, risks protected against and conditions for access. Lastly, the fourth chapter broadens the focus to examine the financing and governance choices that constitute the framework for today's national health insurance scheme while laying the foundations for rebuilding an inclusive, democratic system.

The purpose of this analysis is to contribute to a public debate about the future of the component of health social security. In the short term, some operational recommendations have been formulated to improve the actual conditions for accessing health protection at each stage of the administrative process. In the medium term, our organisation is calling for structural reform involving introducing universal healthcare cover based on secure and effective residency, simpler procedures, equal rights and more democratic governance. All these milestones are necessary in order to uphold the pledge made in 1945 and build a national health insurance scheme for the twenty-first century that is genuinely universal, inclusive and accessible to all.

A 'registration' address: an administrative requirement that is difficult to fulfil

Anyone who is of no fixed abode has the right to use a Community/Intercommunity Centre for Social Action (*Centre communal/intercommunal d'action social,* CCAS/CIAS) or municipal office as their 'registration' address for administrative purposes. This is essential for accessing numerous social rights, including the provision of health insurance, maternity cover, complementary inclusive healthcare cover (C2S) and state medical assistance (AME). Despite the important role played by a 'registration' address, the right to access it is far from guaranteed, particularly for those in the greatest insecurity. In 2024, 27.5% of people seen by Médecins du Monde stated during their initial interview that they did not have a postal address. This finding illustrates the many structural barriers and unequal practices that compromise effective access to an address for administrative purposes.

Huge disparities in coverage persist across the country. In some areas, particularly rural ones, there is no service offering a 'registration' address, forcing the people concerned to face considerable travel and transport difficulties. Comparative analysis of a densely populated urban area (Ile-de-France) and a sparsely populated rural one (Médoc) highlights common difficulties: a lack of information, limited accessibility and restrictive practices when processing applications. These difficulties are particularly acute in rural locations where, too often, there is a lack of human resources and dedicated interlocutors. Conversely, some municipalities demonstrate considerable commitment, proving that a good quality public service providing addresses for administrative purposes is possible as long as it is allocated the necessary resources.

Many administrative hurdles are involved: excessive demands for documentary proof, restrictive interpretations of what a connection to a municipality means, unreasonable deadlines and even unjustified rejections. These are sometimes reinforced by discriminatory practices, directed particularly at residents with irregular administrative status. In both Ile-de-France and Médoc, 4 CCAS out of 10 stated that requests for a 'registration' address were either explicitly or implicitly refused in cases where a person lacked leave to remain. These discriminatory practices are also aimed at people living in precarious accommodation: 46% of CCAS in Ile-de-France interviewed refuse to provide an address for people living in slums, 54% for those in a squat and 57% for those rough sleeping. These barriers are often imposed locally and are based on the law being interpreted and applied restrictively, particularly as regards 'connection to the municipality'. According to the regulations, a connection can be established by any means, including having received healthcare in the municipality concerned – a criterion that is only rarely recognised as sufficient. Some municipalities impose additional conditions and thus covertly refuse to provide a 'registration' address.

The procedures for obtaining a 'registration' address are not well known, either by the people concerned or by the agents responsible for issuing decisions. A lack of professional training, absence of clear and accessible information and inadequate publicising of the mechanism contribute to its limited use. In addition, many CCAS lack the human, logistical and financial resources to provide a comprehensive service. In the absence of support, some municipalities delegate or

reduce their provision, further undermining access to this fundamental right.

RECOMMENDATIONS

To ensure an efficient public service providing 'registration' addresses for administrative purposes, Médecins du Monde recommends coordinated action at all levels:

At national level: consolidate the framework and means of action

- Extend the financial support given to the CCAS and ensure it is durable
- Integrate provision of a 'registration' address service into policies designed to overcome its non-use
- Establish a mechanism for a prefectural substitute service in the event a municipality is clearly failing in its provision.

At prefectural level: guarantee the right and ensure consistent monitoring of territorial provision

- Ensure that the CCAS and municipalities respect their legal obligations
- Ensure that departmental plans are renewed and moderated with the participation of the actors concerned
- Instigate regional monitoring in areas of high mobility, such as Ile-de-France.

At local level (municipalities, CCAS and CIAS): guarantee a 'registration' address that is in an applicant's vicinity

- Improve the accessibility of the public 'registration' address service
- Equip the agents and align practices
- Foster effective access to the 'registration' address service for people with mobility issues or with attachments to several territories

Transformations in accessing the public health insurance service: the consequences of digitisation

The digital transformation of the public health insurance service has significantly reduced the number of physical reception centres in favour of developing online processes and recourse to telephone services. While this evolution can simplify the administrative procedures for many users, for others it represents a major barrier to accessing their rights.

The findings in the field, notably those emerging from a survey of users of the local public health insurance agency (*Agence de la caisse primaire d'Assurance maladie* (CPAM)) in Rouen, have revealed the many obstacles encountered by users in accessing their rights. Individuals who are most vulnerable, are elderly, do not speak French as their first language or are not comfortable using digital tools are particularly exposed to these difficulties. An accumulation of factors such as a lack of equipment or insufficiently developed digital skills and the absence of any support or of a non-digital alternative solution make accessing administrative procedures difficult for a proportion of the population. The difficulties encountered when carrying out the procedures online or telephoning the CPAM are not inconsequential: 44% of people surveyed stated that they had abandoned an administrative procedure conducted remotely on at least one occasion in the previous twelve months. By giving up on these procedures, people risked losing their entitlement or never being able to exercise their right to it. What should be a means to simplify administrative processes has thus become a factor in the exclusion of certain groups and a hindrance to accessing rights.

The reception service afforded by a physical agency remains an essential point of recourse for many users, notably for obtaining direct assistance with procedures or for accessing information and advice about their rights. Yet these are becoming increasingly difficult to access stemming from the regular requirement for a prior appointment, the lack of easy-to-read materials on administrative procedures within agencies and the systematic redirecting to automatic terminals or online services with no human support. People do not always manage to complete the necessary procedures: half of people surveyed considered that they had been unable to sort out the steps required (24%) or had only partially done so (27%), despite visiting an agency. As a result, many people find themselves with no real solution as to how to exercise their rights.

The *Maisons France Services* are presented as a local contact point for bringing public services closer to users. However, our survey conducted in the department of Haute-Garonne showed that they only partially compensate for the progressive withdrawal of national health insurance services. Their accessibility, the quality of the reception, their remit and the agents' level of training vary hugely from one place to another. Consequently, they are not always capable of meeting the needs of the most rights-deprived groups.

Those benefiting from AME are particularly penalised by the ways in which the national health insurance services have evolved. Our study, conducted across six departments, revealed a cluster of specific obstacles: inadequate geographical coverage of appropriately skilled contact points, the lack of a walk-in service in some departments, insufficient information on rights, no interpreting services and poor quality responses provided by department telephone services. Entitlement to rights thus depends on tackling a real obstacle course which gives rise to procedural delays, non-use and even abandonment, with serious consequences for access to healthcare.

RECOMMENDATIONS

To ensure a public health insurance scheme that is accessible to all, Médecins du Monde recommends action be taken to:

- Provide equal and fair access for all users
  - Systematically maintain several means of access to services (physical, telephone and digital) to respond to the range of situations
  - Preserve a geographical network of local health insurance agencies
  - Improve remote provision by guaranteeing its accessibility and the quality of the responses supplied by telephone services
  - Make digital services genuinely accessible to all by seeking to end digital exclusion and by maintaining non-digital alternatives for people who need them
  - Facilitate the administrative pathway for AME applications to eliminate non-use, delays and abandonment of this right

- Consolidate the network of Maisons France Services but not as a substitute for the roles fulfilled by the operators of the public health insurance scheme

Establishing genuinely universal health protection founded on place of residence

Universal health protection (PUMa), which came into force in France in 2016, was intended to achieve the ambition that initially led to the creation of the system of universal healthcare cover (CMU) in 1999. CMU guaranteed that anyone working or residing in France would have their healthcare costs covered using an uncomplicated process. These reforms have brought about historic advances towards a more inclusive form of health insurance that covers a large part of the population. But in reality the ambition of achieving universality remains unfulfilled. This third chapter examines the current mechanisms of public service health protection – statutory health insurance (*Assurance maladie obligatoire* (AMO)), complementary inclusive healthcare cover (C2S) and state medical assistance (AME) – by analysing them through the lens of three key aspects of universality – the extent of population coverage, the nature of the risk protection afforded and the conditions for accessing services.

The findings gathered by Médecins du Monde in the field reveal a fragmented system in which access to comprehensive healthcare cover remains unequal and uncertain, particularly for the most vulnerable people. In 2024, the rate of entitlement to rights remained extremely low among people seen in our CASO: almost four out of five people eligible for healthcare cover had secured no entitlement whatsoever. This situation affected 89% of people who could have benefited from AME and more than 59% of those eligible for the national health insurance scheme.

In 2019, the merging of historic complementary public schemes under the complementary inclusive healthcare insurance scheme (C2S) did increase coverage for a proportion of these population groups. But an unacceptable lack of awareness of this scheme persists. Despite the crucial role it plays for people of minimal means, the absence of clear and accessible information, the impact of the required threshold and the complexity of its procedures generate a high level of non-use. Access to the national health insurance scheme is increasingly hampered for non-nationals in a context of tougher conditions for accessing leave to remain. The digitisation of regularisation procedures is undermining effective access to secure leave-to-remain status and, as a knock-on effect, to registering for national health insurance cover. Certain populations are particularly affected, such as those seeking asylum, unaccompanied minors and European citizens in precarious situations.

Foreign nationals with irregular administrative status continue to be widely excluded from mainstream provision, relegated to a separate scheme – AME – whose scope is more limited, with access to it peppered with pitfalls. Nonetheless, this crucial scheme is subject to frequent political and media attacks, and these are undermining its legitimacy. On the ground, this takes the form of significant differences in treatment as is illustrated by the survey-test conducted by Médecins du Monde with orthodontic/dental surgeries in Montpellier: in 38% of cases, AME beneficiaries found they were refused an appointment although a timeslot was offered for an identical request submitted by a person with social security cover.

Given the complexity of the system – multiple schemes, variations in the conditions for accessing these depending on administrative status, complex procedures and deprivation of rights – Médecins du Monde is calling for structural reform, namely the creation of a single health protection regime based on secure and effective residence in France. This regime would guarantee everyone living on French territory the same rights independent of their nationality or immigration status. Such a restructuring would simplify the administrative pathway, secure access to rights and establish a rationale of genuinely universal inclusivity at the heart of the healthcare system.

RECOMMENDATIONS

Médecins du Monde is advocating for genuinely universal healthcare cover to be established that guarantees everyone residing in France – whatever their administrative status – full, individual public health cover, with no residual healthcare costs payable. Such reform presupposes the merger of the statutory health cover (Assurance maladie obligatoire) and existing public schemes (C2S, AME) within a single regime based on the criterion of secure and effective residency in the territory.

While waiting for this restructuring, it is essential to:

- Make C2S more effective by countering non-use through the introduction of simpler procedures and through guaranteed continuous and genuinely accessible cover for people in precarious circumstances.
- Simplify access to healthcare cover by making the system clearer and preventing deprivation of rights, particularly during periods of transition in administrative status or situation.
- Guarantee effective access to healthcare for foreign nationals without leave to remain.
- Put an end to discriminatory practices and the refusal to treat by ensuring that all those benefiting from health protection schemes – including AME and C2S – can access good quality healthcare without being stigmatised or impeded due to their status.

Financing and governance: healthcare cover fit for the twenty-first century

This final chapter broadens the scope of the report to launch a substantive debate on the financing, organisation and governance of French healthcare cover. It advocates an ambitious restructuring based on the introduction of universal healthcare cover, supported by residence in France and guaranteeing everyone effective access to healthcare with their healthcare costs fully met.

Over several decades, social security – originally viewed as an independent, democratic institution – has been brought progressively under state direction on the grounds of budgetary control. In the area of healthcare cover, this has resulted in increasingly powerful finance legislation voted

through parliament without real debate around the health needs of the population. At the same time, public finances have been weakened, and the proportion of costs payable (contributions, exemptions and excess fees) has increased, thereby transferring a growing share of the cost of healthcare to patients. In 2023, this rose to an annual average of €274 per person, with evidence of huge disparities.

Far from strengthening national solidarity, the public authorities have encouraged development of a market for complementary health provision. This has led to a dual model combining partial statutory health cover and complementary insurance cover from which almost 2.5 million people, namely 4% of the French population, remain excluded. In addition to being more costly and complex, this two-tier system of reimbursement maintains social inequalities in access to healthcare. Based on risk selection, it is shifting away from the principle of the universality of rights: the more advanced one's age or the poorer one's health, the more expensive the complementary cover, independent of the redistributive capacity of the system. It therefore goes against the redistributive rationale on which French public healthcare cover is founded.

In 2022, the French council for the future of health insurance – *Haut Conseil pour l'Avenir de l'Assurance Maladie* (HCAAM) – put forward the idea of the *Grande Sécu*, a scenario in which 100% of reimbursable healthcare costs would be met by public health insurance. It would involve replacing the private contribution paid to complementary insurance schemes with a public contribution, via social security contributions, that would be more equitable and efficient. Such a reform would generate estimated savings of 5.4 billion euros, notably by eliminating duplications in treatment and redundant commercial costs (client acquisition, advertising, marketing, etc.). While this marks a step towards greater clarity, universality and economic efficiency, the proposal remains incomplete. It does not clearly set out the scope of the healthcare concerned, avoids the central question of excess fees and ignores the conditions for how the scheme would be financed and democratically governed.

Médecins du Monde is proposing a more ambitious reform built on full coverage of healthcare costs, identified democratically according to populations' needs. This would entail creating a single health insurance scheme based on residency which would combine the current fragmented schemes (PUMa, C2S, AME) and guarantee the same rights to every person residing in France. This restructuring presupposes revising the governance system so that it fully involves citizens, health professionals and health sector players.

Recommendations

To guarantee access to healthcare for all, Médecins du Monde is advocating:

- 100% of healthcare costs, identified on the basis of populations' needs, guaranteed covered by public health insurance
- Implementation of universal healthcare cover, based on residency
- More democratic governance of the public health insurance scheme

To achieve this, we recommend launching a democratic debate on the future of public health insurance via the organisation of a citizens' assembly on Health and Social Security.

MÉDECINS DU MONDE

French Operations Directorate and the Health and Advocacy Directorate – Observatory on Access to Rights and Health
84, avenue du Président-Wilson 93210 La Plaine-Saint-Denis
Telephone number: +33 01 44 92 15 15
PoleRechercheApprentissages@medecinsdumonde.net
www.medecinsdumonde.org

Coordination:
Valérie Brunel (MdM-Fr)

Translation:
Anne Withers

Proofreading
Marie Vattaire and Roxanne Laaboudi (MdM-Fr)

Graphic design
Claire Béjat
www.clairebejat.fr

Photo :
Christophe Da Silva

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