EUROPEAN COMMITTEE OF SOCIAL RIGHTS
COMITE EUROPEEN DES DROITS SOCIAUX

27 March 2003

COMPLAINT No. 14/2003

International Federation of Human Rights Leagues (FIDH)

v. France

registered at the Secretariat on 3 March 2003

(TRANSLATION)

Collective complaint against France

Reforms of state medical assistance (AME) and universal medical coverage (CMU) incompatible with Articles 13, 17, E and G of the revised Social Charter

Application to the European Committee of Social Rights

I. Introduction: full coverage of health care costs of foreign nationals illegally resident in France until the 2002 Finance (Amendment) Act of 31 December 2002[1]

The Act of 15 July 1893 introduced free medical care for the least well-off, whether they were French or foreign nationals, via the health protection system.

– *1993: general requirement for a residence permit, except in the case of medical assistance*

The Act of 24 August 1993, the so-called "Pasqua law", made entitlement to social protection conditional on lawful residence. This major reform did not, however, exclude foreign nationals who were temporarily or illegally resident from free access to medical care. They were still entitled to medical assistance (*aide médicale*), a form of safety net that also applied to all those, French or foreign, not covered by social security, such as non-contributors, the economically inactive, recipients of the guaranteed minimum income (RMI) and persons with no fixed abode.

The medical assistance scheme met all the costs of treatment (including the fixed charge normally paid by the patient), but only included certain medical procedures, with optical and dental prostheses among those excluded.

Illegally resident foreign nationals, or illegal immigrants, who had been in France for less than three years could only seek treatment in hospital (consultations and associated prescriptions), since the costs of general practitioner and other community-based medical care were not covered. They were only entitled to non-hospital treatment once they had been in the country for three years or more.

– *2000: introduction of universal medical coverage (CMU) and segregation of illegal immigrants into the state medical assistance scheme*

The main aim of the universal medical coverage (CMU) reform in 2000 was to abolish the medical assistance scheme in favour of a unified health care system in which all the population - active and inactive - would be integrated into the health insurance system. The latter would be accompanied by a supplementary scheme, to be free for the less well-off - in the case of single persons, those receiving less than €542 per month. Entitlement to social insurance is now dependent either on employment-related circumstances (contributors and related beneficiaries) or on stable and lawful residence (CMU).

However the CMU reform has not been taken to its logical conclusion because it has failed to integrate all medical assistance recipients into the health insurance scheme. It excludes illegal immigrants, who remain in the residual state medical assistance (AME) scheme.

[1] See Appendix 1

The AME scheme has the following characteristics:

- it is a subsidiary scheme intended solely for persons in an unstable and unlawful situation. Apart from a few exceptional cases, such as uninsured French nationals repatriated less than three months previously (Article L. 251-1 of the Social Action and Family Code), the AME is only applicable to illegal immigrants;

- the so-called "basket of treatments" whose cost is met by the AME includes fewer items of service than those covered by the CMU supplementary system, to which other low-income groups, both French and lawfully resident foreign nationals, are entitled;

- the eligibility conditions are:

    - income: maximum of €542 (3 600 francs) per month, which is identical to the maximum applicable to supplementary CMU - a single euro over that limit removes entitlement to protection;

    - period of residence in France: there are two categories of AME: medical assistance in hospitals, for which all are eligible, and medical assistance for community-based care (doctors' surgeries and health centres), eligibility for which is conditional on three years' prior residence in France (Article L. 111-2 of the Social Action and Family Code). The system therefore obliges those concerned to seek hospital treatment during their first three years in France;

- treatment is free: once entitlement is established there is nothing to pay;

- the period of entitlement to protection is for a year at a time (Article L. 253-3, sub-paragraph 2 of the Social Action and Family Code).

II. Content of the AME and CMU reform

A. Introduction of patient charges into the medical assistance scheme

Under Section 57 of the Finance (Amendment) Act of 31 December 2002, the French Government ended the system whereby illegal immigrants were exempted from all charges. Beneficiaries now have to pay:

- a flat-rate charge (*ticket modérateur*) that differs according to whether the patient is consulting a general practitioner or a specialist and also applies to prescribed medicines and laboratory tests;

- a daily charge (*forfait journalier*) for in-patient hospital treatment.

Provision is made for exemptions for certain procedures for children and young persons, pregnant women and persons suffering from major and costly conditions. The exempted procedures and conditions and the different flat-rate charges are laid down in decree.

B. The abolition of the two categories of state medical assistance

A distinction has hitherto been drawn between hospital-based AME, to which all concerned are entitled, and community-based AME, entitlement to which is conditional on three years' prior residence in France (Article L. 111-2 of the Social Action and Family Code).

The 2002 Finance (Amendment) Act provides for the abolition of this distinction, leaving a single AME giving entitlement to the cost of care or treatment in either setting.

C. Restrictions on the rights of children and young persons

In late 2001, children and young persons dependent on foreign nationals with no residence permits and those living alone were granted entitlement to basic CMU (Article L. 380-5 of the Social Security Code). This made them eligible for assistance with the cost of all the treatment or care they required, and not just the basket of treatments covered by the AME. This represented genuine progress in French legislation and brought French law into line with the International Convention on the Rights of the Child, which grants all young persons entitlement to social security and prohibits any discrimination based on parents' legal situation. This progress should then have been matched by an equivalent measure granting access to supplementary CMU, thereby ensuring that children and young persons received all necessary medical care totally free of charge.

Instead and as a complete reversal, the 2002 Finance (Amendment) Act excluded children and young persons dependent on foreign nationals with no residence permits and those living alone from the CMU system and returned them to the AME umbrella.

This retrograde step was apparently in response to a failure to apply the 2001 provisions. It therefore has to be asked why, rather than endorsing the unlawful practices of the insurance funds responsible for their application, the authorities did not think of supplying the relevant departments with more information to make this measure more effective.

III. Procedure

The currently contested provisions are incompatible with constitutional values such as the right to health or the right to dignity (see the detailed arguments in Appendix 3).

Unfortunately, in France applications for constitutional reviews of legislation can only be made before its enactment and by members of parliament. No other forms of appeal, for example by citizens, are possible. In the absence of any parliamentary initiative

there may be no check on compliance with the Constitution and laws can come into force even though their provisions breach constitutional principles.

The rule of law calls for means of defence against such paradoxes, one of which is referral to the European Committee of Social Rights. This submission goes on to highlight the threat posed to the health of a very vulnerable group and eventually to public health as a whole, in total breach of the rights enshrined in the European Social Charter.

We call on the European Committee of Social Rights to respond favourably to our arguments.

IV. Violations of provisions of the revised Social Charter

A. Point A of the reform

A.1 The right to social and medical assistance

According to paragraph 13 of Part I of the revised Charter, "anyone without adequate resources has the right to social and medical assistance". Part II clarifies what is involved in the effective exercise of this right. In particular, parties to the Charter must "ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition" (Part II, Article 13.1).

Is the effective exercise of this right by the poorest members of the community compatible with the requirement for patients to pay a flat-rate charge for treatment?

The charges for treatment and the daily hospital charge were initially intended as a disincentive to insured persons with adequate means (who in any case generally benefit from supplementary insurance), to restrict the superfluous use of health care provision. The disincentive effect is probably very limited, particularly as such costs are normally met by supplementary insurance.

In contrast, the treatment and daily hospital charges will inhibit patients with very limited resources from seeking treatment or even prevent their access to care.

They act as exclusion devices for those in financial difficulty. The need to meet, in whole or in part, the cost of medical consultations and associated prescriptions and tests may be enough to dissuade those concerned from seeking treatment. The Committee on Social Rights has frequently ruled that the effective application of Article 13 of the Charter requires exemption from patient charges (see Appendix 2).

This exclusion of unlawfully resident persons from the health system is incompatible with a proper public health policy. Illegal immigrants who are dissuaded by administrative and above all financial obstacles from seeking treatment will fail to benefit from any effective preventive measures or regular follow up. Simple conditions that

could have been dealt with effectively and at little cost will not be treated, leading to serious and costly complications.

Instead of engendering a responsible attitude among illegal immigrants to the take-up of health provision, as it claims, the French Government is quite simply depriving them of their right to health, enshrined in Article 13 of the Charter.

A.2 A right that extends to illegal immigrants

It is true that, in accordance with paragraph 4 of Article 13, to be eligible for the rights listed in paragraph 1 "on an equal footing" with nationals of the country concerned, nationals of other Parties must be lawfully within that country's territories. In other words, equal treatment with regard to the rights embodied in paragraphs 1 to 3 of Article 13 only applies to foreign nationals who are in the country lawfully.

The French CMU system is compatible with these provisions since persons with incomes below €542 per month are entitled to have the costs of all their care and treatment met in full, whether they are French or foreign nationals lawfully in the country.

Nevertheless, Article 13 paragraph 4 does not prevent foreign nationals not lawfully within France from benefiting from the provisions of Article 1. It simply means that they cannot claim the right to benefit from them "on an equal footing" with French nationals. In other words, paragraph 4 authorises a distinctive form of treatment for illegal immigrants without adequate resources, though they must continue to benefit from the effective exercise of the right to health.

The segregation of illegal immigrants into the AME system is not therefore an issue: they are treated differently - the "basket of treatments" approach. However, this alternative approach must not pose a threat to their access to health care. This is the frontier that French legislation has crossed by imposing patient charges on illegal immigrants.

In this respect, French legislation is incompatible with Article 13 of the Social Charter.

B. Point C of the reform

B.1 The right of children and young persons to social, legal and economic protection

Article 17 grants children and young persons the right to appropriate social, legal and economic protection. In practical terms, this necessitates measures "*to ensure that children and young persons ... have the care, the assistance, the education and the training they need, in particular by providing for the establishment or maintenance of institutions and services sufficient and adequate for this purpose*" (Part II, Article 17.a).

B.2 This right is not conditional on legal residence

B.2.1 Foreigners may only benefit from the rights embodied in Article 17 of the Charter "*in so far as they are nationals of other Parties lawfully resident or working regularly within the territory of the Party concerned*" (Appendix to the revised Social Charter). Yet French legislation does not require children and young persons to have a residence permit, unless they wish to work once they reach sixteen, in which case they need a work permit. Consequently, under the terms of the Charter, French legislation on the residence conditions of children and young persons must be interpreted to mean that the latter cannot be required to be lawfully resident in the country in order to benefit from the protection afforded under Article 17. French legislation on the social protection of young foreign nationals must not contravene this principle. Yet this is precisely the consequence of the introduction of patient charges for children's and young persons' access to treatment (or at least certain forms of it).

Moreover, subjecting the children of illegal immigrants to a separate scheme from that applicable to other young persons breaches the principle of non-discrimination.

B.2.2 The Charter's non-discrimination principle

Quite apart from the objections concerning the non-validity of the requirement for children and young persons to hold a residence permit, the Social Charter applies the principle of non-discrimination to the rights it embodies: "*the enjoyment of the rights set forth in this Charter shall be secured without discrimination on any ground such as .... national extraction or social origin, health, association with a national minority, birth or other status*" (Part V, Article E).

In other words, young foreign nationals must benefit from the same treatment in their access to health care as that granted to their French counterparts. Restricting them to the AME rather than integrating them into the scope of the CMU is incompatible with Articles 17 and E of the revised Social Charter.

C. Points A and C of the reform

Protecting public health is the only ground for restricting rights embodied in the Charter

According to Article G - 1: "*The rights and principles set forth in Part I when effectively realised, and their effective exercise as provided for in Part II, shall not be subject to any restrictions or limitations not specified in those parts, except such as are prescribed by law and are necessary in a democratic society ... for the protection of ... public health...*".

In other words, any restrictions or limitations over and above those provided for in the Charter - in this particular case, the abolition of free treatment under the AME scheme and of children's and young persons' entitlement to CMU - are only valid if they are necessary for public health purposes.

In fact the new Article L. 251-2 of the Public Health Code conflicts with public health objectives by introducing charges that are likely to discourage the least well-off from

seeing a doctor. Not seeking such treatment, or delaying the process, is totally incompatible with a preventive policy, which is the basic underpinning of public health.

Similarly, by restricting young persons' access to care to the AME system, with its limited "basket of treatments" and no supplementary cover, the reform is contrary to public health objectives and does not encourage behaviour consistent with health prevention.

The reform of the AME is therefore incompatible with the Social Charter.

APPENDIX 1

New Article L. 251-2 of the Social Action and Family Code

Payment by the State, coupled with exemption from payment in advance, concerns:

1. Costs defined in paragraphs 1 , 2 , 4 , 6 , 7 and 8 of Article L. 321-1 and in Article L. 331-2 of the Social Security Code in application of the rates used to calculate health insurance benefits;
2. The daily charge for in-patient hospital treatment, introduced by Article L. 174-4 of that code.

Article L321-1 of the Social Security Code

Health insurance includes:

1. coverage of general and specialist medical costs, the cost of dental treatment and prostheses, pharmaceutical and equipment costs, the costs of laboratory analyses and examinations, including costs associated with individual investigation procedures, costs of hospital stay and treatment, functional rehabilitation and occupational training or retraining, and the costs of surgical procedures for the insured person and members of his or her family, within the meaning of Article L. 313-3, including coverage of medicines, contraceptive products and objects and the costs of laboratory analyses and examinations necessary for contraceptive prescriptions;

2. coverage of the transport costs of insured persons and their dependents who require to travel to receive treatment or undergo examinations appropriate to their state of health or to undergo health checks prescribed under the social security legislation, according to the rules laid down in Articles L. 162-4-1 and L. 322-5 and subject to the conditions and limits necessitated by the patient's condition and transport costs laid down by decree in the *Conseil d'Etat*;

3. coverage, following a decision of the special education commission established by Section 6 of Act No. 75-534 of 30 June 1975, of the accommodation and treatment costs of disabled children and young persons in special and vocational educational establishments, and of associated costs of treatment associated with such education carried out outside such establishments, other than the part of these costs for which the State is liable under Section 5 of Act No. 75-534 of 30 June 1975;

4. coverage of the costs of hospital stay and treatment associated with the medical termination of pregnancy as provided for in Section I of Chapter III b of Part I of Book II of the Public Health Code;

5. the payment of daily allowances to insured persons whose personal physician certifies, in accordance with the rules laid down in Article L. 162-4-1, that they are physically incapable of continuing or resuming work; such incapacity may also be certified, under the same conditions, by midwives, within the limits of their professional competence and for a period laid down by decree; however, no daily allowance will be

payable for sick leave granted for thermal spa treatment, unless the individual's situation justifies this in accordance with the conditions laid down by decree;

6. coverage of costs relating to preventive procedures and treatments carried out under priority prevention programmes pursuant to Article L. 1417-2 of the Public Health Code, particularly costs relating to screening examinations carried out under programmes pursuant to Article L. 1411-2 of the Code and costs relating to examinations ordered in application of Article L. 2121-1 of the Code and to vaccinations, a list of which is laid down in orders issued by the ministers responsible for health and social security;

7. (repealed)

8. (repealed)

9. coverage of costs relating to the preventive dental examinations referred to in Article L. 2132-2-1 of the Public Health Code.

Article L. 331-2 of the Social Security Code

Maternity insurance covers medical, pharmaceutical, equipment and hospital costs relating to pregnancy, delivery and follow-up care, and the costs of examinations ordered under the second paragraph of L. 154, article L. 156 and the second paragraph of L. 164 of the Public Health Code.

The pharmaceutical costs are subject to a fixed tariff established by the relevant insurance fund.

Article L. 174-4 of the Social Security Code

A daily fixed-rate charge shall be met by persons admitted to hospitals or medical-social establishments, other than establishments referred to in Article L. 174-6 of this Code, Section 52-1 of Act No. 70-1318 of 31 December 1970 and Section 5 of Act No. 75-535 of 30 June 1975. This charge will not be covered by the mandatory social protection schemes, other than in the case of disabled children and young persons accommodated in special educational or vocational establishments, the victims of occupational accidents or diseases, beneficiaries of maternity insurance and beneficiaries of Article L. 115 of the Military Invalidity and Victims of War Pensions Code.

The daily charge may be adjusted according to conditions laid down by decree in the *Conseil d'Etat*, in accordance with one or more of the following criteria: category of the establishment, nature of the service and length of stay. The different levels are laid down by ministerial order.

When the daily charge is less than any patient's contribution or excess the relevant insurance scheme may require the patient to pay, the patient's contribution is payable; in the reverse case the daily charge is payable;

The daily charge may be met by the local health insurance scheme in the *départements* of Bas-Rhin, Haut-Rhin and Moselle, according to conditions laid down by decree.

APPENDIX 2

Portugal, Conclusion XV-1, volume 2
Doc-ID : c-15-1-en2 **Type of text :** Conclusion **Date of publication :** 01/01/2000

"....
The Committee takes note of the information provided on the activities of the *Santa Casa de Misericórdia* in Lisbon, which offers various forms of assistance to persons experiencing need, including non-nationals.

Lastly, the Committee notes that there were two Cypriot nationals resident in Portugal during the reference period. The Committee has noted in previous cycles (Conclusions XIII-5, p. 225), that nationals of Cyprus were not entitled to medical assistance in the form of exemption from patient charges. However, since the introduction of RMG, all persons, regardless of their nationality, who are in receipt of this benefit are also exempt from patient charges. The Committee wishes to know whether nationals of other Contracting Parties who are in receipt of social assistance benefits other than RMG are similarly exempt from patient charges.

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APPENDIX 3

Argument of GISTI concerning the unconstitutionality of the AME and CMU reform

Introduction

The reform of state medical assistance (AME) will require beneficiaries of this scheme - that is illegal immigrants and French nationals normally residing outside of France - to pay the flat-rate treatment charges and the daily hospital charge.

When they are applied to persons with sufficient resources or who have supplementary insurance the treatment and hospital charges have little dissuasive effect. However, when applied to persons who lack security or have limited resources they become exclusion devices which at best act as major disincentives and in the majority of cases make it impossible to get treatment.

This is why under the universal medical coverage (CMU) scheme, persons earning less that € 542 per month (3 600 francs) are exempted from paying the treatment and hospital charges. Four million people are currently below this income ceiling and benefit from this exemption.

Illegal immigrants, who generally have low and irregular incomes below the € 542 threshold, cannot make regular payments of € 10 to 15 to see a doctor, let alone pay the hospital charge. The same applies to many French persons from abroad covered by the AME who return to the country in difficult circumstances. It is not therefore a question of making people more responsible, as the author of the amendment claimed, but purely and simply of depriving people of care.

Admittedly, children, pregnant women and those who are seriously ill will continue to have all their costs met. But this exception represents an acknowledgement that, in its absence, those concerned would not enjoy real access to care. Besides, the distinction between serious and other illnesses is irrelevant for public health purposes. A simple condition that is not treated or detected in time, for lack of medical input, will only be dealt with once it becomes serious or difficult to cure. A person with a delicate constitution and no access to care may die of influenza. A person who, for financial reasons, only consults his or her doctor as a last resort may ignore the symptoms of a serious disease - cancer, aids or tuberculosis - which, even if it is subsequently treated, can no longer be dealt with effectively.

All the voluntary organisations offering care or assistance to vulnerable groups of the population (Médecins du Monde, Médecin sans Frontières, the associations grouped in UNIOPSS, ATD-Fourth World, Act-Up and so on) have sought unsuccessfully to draw these facts to the attention of the authors of the legislation and the Government.

This reform is not only absurd and dangerous, it also conflicts with constitutional principles, since it infringes the powers of parliament and the constitutional right to health protection.

1. The right to health protection

This right is doubly enshrined in the Constitutional Council's case-law: from the standpoint of public health protection and from that of each individual's right to health.

1.1 Protecting public health is a constitutional requirement. In particular, the *Conseil d'Etat* referred to it in connection with the ban on tobacco advertising. It ruled that it was possible to set limits on freedom of enterprise and the right to property when the ban on advertising was based on the requirements of public health protection, which have a constitutional value (decision 90-283 DC of 8 January 1981, 8th preamble). The principle of public health protection was again referred to in its decision 90-287 DC of 16 January 1991, 24th preamble.

Parliament may not therefore enact any measure whose purpose or outcome is to adversely affect public health, for example by weakening the prevention or screening of certain illnesses, particularly epidemics or contagious diseases.

1.2 However, health protection is not simply a collective requirement. It is also a right for each individual. This is established in the 11th paragraph of the preamble to the 1946 Constitution, whereby the Nation must secure health protection for all. This has been applied frequently in constitutional case-law, for example in decision 89-269 DC of 22 January 1990, paragraphs 24 to 26.

Unlike the right to social protection, which according to its current case-law the *Conseil d'Etat* only applies to foreigners stably and lawfully resident in France, the right to health is universally applicable. Its scope is narrower than that of the right to social protection, whose objectives go beyond simply protecting health. On the other hand, the right to health protection, whose boundaries are more restricted, must be viewed as an absolute right, since its exercise is a precondition for the exercise of all other rights and depriving anyone of it constitutes an infringement of his or her physical integrity.

It is therefore unthinkable that anyone should be denied access to essential care or treatment and exposed to serious risks to his or her health, simply because he or she is unlawfully in French territory.

2. This right cannot be divested of legal safeguards

2.1 In connection with the protection of fundamental rights, the Constitutional Council has long applied the ratchet principle, whereby if at any time it is desirable for parliament, acting in accordance with the powers granted to it in Article 34 of the Constitution, to amend existing legislation, or repeal it and replace it, if necessary, with other provisions, the exercise of this power may not have the effect of divesting constitutional requirements of legal safeguards (Decision 86-210 DC of 29 July 1986, AJDA 186, p. 527).

2.2 This rule has been applied to the right to housing (Decision 94-359 DC of 19 January 1995) and the right to the development and protection of the family (Decision 97-393 DC of 18 December 1997).

It also applies to the right to health protection. For example, decision 90-287 DC of 16 January 1991 was concerned with whether new arrangements for approving the charging structure for services provided by private hospitals removed legal safeguards for constitutional principles and challenged the principle of public health protection enshrined in paragraph 11 of the preamble to the 1946 Constitution.

Similarly, decision 89-269 of 27 January 1990 (paragraph 26) stated that parliament must establish appropriate rules for achieving the objective of health protection embodied in the preamble. It illustrated this principle by noting that the reduction in the proportion of medical fees that would still have to be met by insured persons would help to ensure that the aforementioned principle was effectively applied.

Quite recently, in decision 2002-463 DC of 12 December 2002 on the 2003 Social Security Financing Act, the *Conseil* ruled that the rates set for the new reimbursement system aimed at securing more responsible prescribing of medicines had to be compatible with the requirements of paragraph 11 of the preamble to the 1946 Constitution.

From the standpoint of these principles, the reform of the AME is manifestly unconstitutional.

3. The reform conflicts with all the principles referred to above

3.1 It is directly incompatible with the constitutional objective of protecting public health. Hundreds of thousands of poor people permanently resident in the country will be unable to receive treatment or will be very reluctant to seek it. Such a situation can only encourage the spread of infectious diseases and epidemics, particularly conditions associated with poverty, such as tuberculosis, or diseases that have not been eradicated in illegal immigrants' countries of origin. The latter will also miss out on a whole series of preventive and early screening measures, which are generally seen as the future of public health in France.

3.2 It breaches every individual's right to health protection. It is no exaggeration to say that this reform poses a major threat to the health, and in some cases the lives, of those who will pay the cost. Many examples may be cited: the woman with no official documentation who, for lack of regular gynaecological examinations, fails to realise in time that she has breast cancer, the foreign national who is HIV positive and is not informed early enough of his condition, the child who, although theoretically outside the reform's scope, contracts from its parents an infectious disease that has not been picked up because the latter do not see a doctor regularly.

3.3 It constitutes a step back in health protection and as such breaches the principle that parliament may only change the system of fundamental rights and freedoms in order to make it more effective.

Despite certain limitations, the combination of universal medical coverage, for French persons living in France and foreigners in the country legally, and AME represented significant progress in public health protection. The current reform reverses this achievement.

In fact it does more than this since arrangements for meeting the full cost of health provision of illegally resident foreigners existed before the 1999 reform. Even in 1993, when the so-called Pasqua Law, the most restrictive legislation yet concerning foreigners, was enacted, these persons' right of access to health care was not called into question.