Health care in France: facing hard choices

Filmmaker Michael Moore frames the for-profit insurance industry as a bankruptcy-causing cancer on the US health care system in his latest documentary, *Sicko*, and champions socialized medicine as the preferred cure.

To bring his point home, Moore presents a utopian vision of the Canadian, British, French and Cuban health care systems, while essentially asserting that Canadians believe they're entitled to health care as a human right, without fretting about nuances like the bill.

But unlike Moore, Canadians can't ignore the reality of wait times measured in months for diagnostic tests or orthopedic surgeries like knee and hip replacement, rising pharmaceutical costs and the exclusion of dentistry and optical aids from medicare. In such areas, whether in cash or in reduced quality of life, Canadians do pay.

The French don't.

At least, not yet.

In the year 2000, the World Health Organization (WHO) anointed the French health care system the best in the world. The assessment was based on a number of indicators, ranging from life expectancy and infant mortality to timely, universal access and out-of-pocket cost to the patient.

The WHO ranked Canada 30th in the same survey. The 2 countries enjoy similar life expectancy, infant survival and immunization accessibility rates. They even spend about the same amount per capita on health care. The biggest difference lies in speed of access to specialists and diagnostic technology. French wait times are minimal to nonexistent compared to those of Canada.

French patients can choose their own specialists. They barely have to wait for magnetic resonance imaging or computed axial tomography scans. And if a patient is unable to make it to the doctor's office, it is not at all unusual for the doctor to come to them.

Barbara Sibbald

Bas relief above the entrance to the Université René Descartes-Paris 5, which was established in 1970 as 1 of 13 autonomous, successor universities of the reorganized University of Paris, which is often commonly referred to as the Sorbonne. Like Canada, France reduced medical school enrolments until the mid-1990s because of concerns over a physician surplus. But a projected shortage has since prompted enrolments to rise from a low of roughly 3500 in 1993 to current numbers topping 5000 annually.

That's primarily due to the numbers of doctors and particularly specialists available in the French system.

According to the latest tallies available from the WHO (2004), France has 203 487 physicians, or 3.37 per 1000 people. Nurses number 7.24 per 1000 or just over 437 000 in total. Canada's doctor to population ratio is roughly 2.14 per 1000, with a slightly higher nurse to population ratio of 9.95 per 1000. France also has nearly double the number of hospital beds available per capita.

Yet, just because doctors are far more common in France doesn't mean a patient can always get one, especially far from Paris and other urban centres. But France is so much smaller than Canada that the French do not suffer inaccessible-care stories like those of northern Canadians being flown hundreds of miles south to a neonatal unit. The French simply have more doctors and other health care professionals available in a much smaller physical area than we do (Box 1).

The French have also long since resolved the relentless public–private wrangle that dominates health care debate in Canada. In the case of prescription drug costs, as with doctors' visits and other health care needs, French patients are reimbursed an average of 65%–70% by the country's nationally mandated health insurance fund. Private insurance, typically provided by an employer but readily available to individuals, makes up the difference. About 95% of the population is covered by 3 main health insurance funds, distant descendants of a variety of trade- and craft-union funds, now regulated by the Ministry of Social Security. (The final 5%, such as the military, have their own funds.)

In short, privatization of the health system isn't an issue. It's a long-established fact. For-profit doctors and hospitals have been integrated into the system from the beginning without penalty.

Even though there is far more private money in France's system than Canada's, the unemployed and low-income earners (defined as those whose taxable income is less than €6600, or roughly $9100, per year) are largely ex-

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Box 1: Facts on France

Demographics

- Area: 643 427 km²
- Population: 60 876 926
  - Median age: 39 years (37.5 male, 40.4 female)
  - Age structure: 18.6% under 14; 65.2% 15-64 years; 16.2% over 64
  - Birth rate: 12.91 births/1000 population
  - Death rate: 8.55 deaths/1000 population
  - Infant mortality rate: 3.41 deaths/1000 live births (3.76 male, 3.04 female)
  - Life expectancy: 80.59 years (77.35 male, 84.00 female)

Economy

- Gross domestic product per capita: US$31 200
- Unemployment rate: 8.7% (December 2006 estimate)
- Population below poverty line: 6.2%
- Government revenues: US$1.15 trillion (2006 estimate)
- Government expenditures: US$1.211 trillion (2006 estimate)
- Public debt: 64.7% of gross domestic product (2006 estimate)

Health

- Total health expenditure as a percentage of gross domestic product: 10.5%
- Government share of total health expenditure: 78.4% (2004)
- Per capita total expenditure on health: US$3464 (2004)
- Number of physicians: 203 487 (2004); density per 1000 population: 3.37
- Number of nurses: 437 525 (2004); density: 7.24

Sources: Central Intelligence Agency World Factbook, World Health Organization.

empted from having to pay. They receive coverage under the Universal Coverage Act (*La couverture maladie universelle*) which extends health coverage to anyone who can prove they've been a legitimate resident of France for more than 3 months as of the year 2000.

But the French may find themselves paying in the long-term for all of this seemingly low-cost access.

In 1996, in an attempt to control rising public-sector budget deficits, France's government of the day, under then-prime minister Alain Juppé, passed the Social Security Funding Act, which set an annual limit on growth in total spending by the health insurance funds. It looked good on paper. But this so-called *Objectif national des dépenses d'assurance maladie* has been exceeded every year since its inception. With an aging population, that trend is unlikely to change.

Around the time of this and other reforms, according to the Organization for Economic Co-operation and Development, France's total expenditure on health as a percentage of gross domestic product (10.5% in 2006) began to match and then surpass Canada's (9.5%). The reforms of 1996–1998 also sought to widen the financial base of the social security system. Until then, health care was paid for out of general revenues and mandatory payroll taxes. Juppé's centre-right government reduced the contributions of employers and employees to 0.75% of earnings and increased the *contribution sociale généralisée*, a tax on total earnings. By 2003, under the succeeding Socialist government, the component of healthcare funding that came from general revenues — hobbling the government's ability to pay for anything else — had grown to 40%, but the system still wasn't paying for itself. The French national insurance system has been running constant deficits since 1985; the deficit now tops $14.77 billion.

Public spending on doctors' consultations and treatments this year alone was $2.76 billion over budget, by early summer. The government had hoped to hold health care deficits for all of 2007 to $1.52 billion.

Dr. Nancy Salzman can understand why the targets for doctors' services are falling well short. She is a Canadian doctor who has had a private practice in Paris for over 12 years.

"If I have a patient with high blood pressure," says Salzman, "I might see them once every 6 months, prescribe them appropriate medicine, tell them to contact me if anything changes — but otherwise, see you in 6 months."

"Sometimes I'll see other doctors' patients for various reasons and I'll ask, 'How often do you see the doctor?' They'll say, 'Every month.' Every month? With no change?"

"So there you have a doctor who's charging the system 5 times more often than me... And it's just because he's trying to make his rent."

Salzman has opted out of the state system. Most French GPs, who haven't chosen to opt out, make so little from the government-set appointment fee of €22 ($30.36) that they can't afford to hire administrative help. Even Salzman employs a secretary but has no nurse and conducts examinations in a screened-off corner of her office.

"They do everything themselves, from opening the door to patients to taking their own calls, booking their own appointments and taking payment," says Salzman. "I have no idea when they have time to do actual medicine."

It will be the generation now entering the workforce who will pay for the years of deficit spending through some mix of higher taxes and reduced access. All of this is made worse by a looming demographic crunch. With the number of French aged 65 and older expected to grow from about 16% of the population (according to Council of Europe projections in 2003) to an estimated 24% by 2030, the pool of workers contributing to the social security system will be greatly outnumbered by those needing increasing care and medical services.

Thus far, the government has responded by restructuring oversight of the system and it will be interesting to see what comes of the decision by new French President Nicolas Sarkozy to split the health and social security ministries. The former Ministry of Health and Solidarity has become the Ministry of Health, Youth and Sport. With the change, responsibility for the country's Social Security scheme is no longer with the health department, whose officials worry about patients, but with the new Ministry for the Budget and Public Accounts, whose officials worry about deficits. Any changes made to the coverage offered un-

der the insurance funds will be outside the health ministry's control.

The economic forecasting group Global Insights has projected that removal of the social security mandate from the Health Ministry should ultimately cut the social security deficit in half, to under $5.52 billon by year's end.

During last spring's election campaign, Sarkozy promised to introduce minimal out-of-pocket charges on consultations, treatments and hospital visits, up to a yearly spending cap, exempting children and seniors. Over the summer, Sarkozy made good on that promise, with a €2 ($2.76) charge for ambulance rides and 50 centime (69 cents) fee to fill a prescription, to a maximum €50 ($69) per year. The new Health Minister, Roselyne Bachelot, hopes the reforms will instill patients with a greater sense of responsibility toward the health care system.

Yet, the modesty of Sarkozy's user fees reveals that it would be political suicide for any French government to radically limit health care access to a populace who have grown used to Michael Moore's ideal of access to free health care as a fundamental human right. And it may be economic suicide not to.

Monsieur Sarkozy has some hard choices ahead. — Christina Lopes, Paris, France

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Adverse events reported for HPV vaccine

As 4 provinces began immunizing schoolgirls to prevent the human papillomavirus, a watchdog group in the United States warned of dangerous adverse events stemming from the vaccine's delivery — concern government regulators dismiss.

Public health officials in Ontario, Nova Scotia, Prince Edward Island and Newfoundland and Labrador began administering the Merck Frosst vaccine Gardasil to select groups of girls (grades 6, 7 or 8) in September, just as the US advocacy group Judicial Watch released documents obtained through Freedom of Information indicating that 3 deaths and 1637 adverse events occurred after the vaccine was administered (prior to May 15).

Judicial Watch acknowledged, however, that it did not analyze the adverse events data from a medical perspective. "We wanted to get the information out in a public light. ... It's out there for people who know more than us to interpret," program manager Dee Grothe said, adding that the organization's main concern is that the vaccine not be mandated by state governments.

The adverse events data comes from the US Food and Drug Administration's Vaccine Adverse Event Reporting System. According to the Centers for Disease Control and Prevention in Atlanta, as of June 30, there were 2531 adverse reports, including 9 deaths, out of 7 million doses dispensed. The figures, however, can include multiple reports of the same event, since physicians, manufacturers and patients report to the same system.

Health Canada, meanwhile, received 82 adverse event reports out of 162 000 doses distributed as of Aug. 17. Five adverse events required hospitalization, including 2 later determined to be appendicitis. One patient fainted, 1 event appears related to a viral infection, and 1 appears related to encephalopathy, which Health Canada is investigating.

"This is not unusual," says Dr. Theresa Tam, director of the Public Health Agency of Canada's Immunization and Respiratory Infections Division. "Every new vaccine that comes on the market, people monitor the safety profile, and inevitably, there are things that occur following immunization."

Lisa F. Young / iStockphoto

Quebec recently became the fifth province to announce its HPV plans, unveiling a "voluntary" program that will vaccinate girls as early as grade 4.

Neither the product monograph nor permission forms that parents (in Ottawa, for example) receive from local public health authorities contain a list of possible adverse events, such as deaths, following administration of Gardasil.

Although Canadian authorities are aware of the US reports, the deaths are not listed as possible adverse events because there is no scientific evidence proving a causal relationship with the vaccine, says Tam. "At this point, there is nothing that I can see that is of particular concern. ... It's what we probably would expect to see based on the clinical trials and the background rates of some of these conditions."

Centers for Disease Control and Prevention spokesman Curtis Allen says all deaths and other serious adverse events requiring hospitalization are investigated. The agency has classified 5% of vaccine-reported events as "serious." The most common reactions have been pain at the injection site, general pain, nausea, dizziness and fainting. The incidence of fainting is slightly higher than the background rate normally expected among that age group, Allen says. As a result, "we're suggesting that physicians keep patients in their office for 15 minutes after administering the vaccine."

Some of the 9 deaths were duplicate reports, while 1 patient turned out to be "very much alive," Allen added. There are 4 confirmed deaths in girls or women who received the HPV vaccine, but it is not known to have caused any of those deaths.

In 2 cases, women died after suffering pulmonary embolisms, but they were also taking birth control pills, a known risk factor, says Allen. In 2 other instances, girls had influenza, and myocarditis resulted in the death of 1 of those patients.

"The deaths do not appear to be connected at all with the vaccine," Allen says. "It appears to be a very safe and effective vaccine and we believe it's very important to women's health."

Sheila Murphy, a spokesperson for

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