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HEALING PEOPLE, PART III

France on $3,000 a Year

Hala Kodmani

PARIS—In the visitors' book of the exhibition "Humanization of the Hospitals," one recent comment observed: "In this museum you're in a dream...It's so different from the hospital I have to return to next week." This exhibit of what French hospitals ought to be is essential. The French public may seem like they are all too often persuaded that their health care system—so praised and envied abroad, held up as an example even among other developed countries—is one of the best in the world. This isn't the case.

France spends 11 percent of its GDP on health care, second only to the United States among OECD countries. That's some $3,601 per capita each year, with a public health insurance program that covers 99.9 percent of its population. Almost every French citizen or resident holds a green card, the "Carte Vitale," which gives access to an efficient and state-of-the-art health system. This electronic proof of coverage carries an individual's personal information, and by handing it off to a medical center, laboratory, public hospital, private clinic, or even drugstore or physiotherapist, a patient can get whatever treatment may be needed, often without spending a single euro. Health care professionals are then automatically reimbursed on the basis of fixed rates for each service or product by the *sécurité sociale,* the public health insurance system, which covers 60 to 100 percent of all costs. The balance is usually reimbursed by a private complementary insurance company or a mutual fund. Almost all French citizens covered by public health insurance are also affiliated with private, supplementary policies, connected to the government system. Together, they are meant to work seamlessly and cheaply.

But to get total and immediate free coverage, it's better to be very poor, very sick or very old. A lower-middle class, middle-aged worker suffering from a minor flu or stomach ache will find the system lacking. Each visit to one's primary care physician—a required first step to enter the process of coordinated care—costs $26. The patient is immediately responsible for the €8 not covered by the federal *sécurité sociale,* then waits for possible reimbursement from their private policy.

Cashing Out

"For some low-income people, these small co-pays can be a deterrent—either not to go to the doctor or to postpone the visit," says Dr. Mady Denantes, a general practitioner working in the 20th arrondissement of Paris, one of the poorest neighborhoods in the French capital. She tells the story of

Marie, 45, a laborer earning the minimum wage of $1,434 per month, who eventually came to see her after long weeks of pain in her legs.

"She was just asking me to prescribe a sick leave, so she could rest for a few days. I gave her a paper entitling her to sick allowance while on leave but also prescribed further tests, including X-rays and blood tests," Dr. Denantes recalls. "Marie came back to see me a few months later with the same pains but without having done the tests I had prescribed. She explained reluctantly that she was part of a very small minority of French workers who have chosen not to subscribe, for cost reasons, to a private health insurance plan, and couldn't afford to pay the 20 to 30 percent of the costs of these tests not covered by the *sécurité sociale*. When I convinced her of the priority of these tests for her health, she had them made, revealing that she had a blocked artery in her leg. Needing an operation, she then benefitted from the 100 percent coverage the *sociale* gives to patients with chronic diseases and has had no further problems being followed or treated."

Just 10 percent of France's population benefit from programs for long-term illnesses, allowing them full coverage from the *sécurité sociale* for all services linked to their chronic disease, including specialist fees, tests, drugs and nursing care, as well as operations, hospitalization and even roundtrip transportation by ambulance or taxi from home to treatment facilities. The prime beneficiaries of this program are the elderly with heart and artery problems or diabetes. Another program for full health coverage is available for the lowest-income population, mainly the young or long-term unemployed, as well as others with very low incomes or none at all. "Guaranteeing protection against life's contingencies for everyone" is the basis of the French social security system. No one may be excluded.

Rich vs. Poor

France's health care system is inclusive, democratic and well-organized—yet 70 percent of its population is dissatisfied with their coverage. In April, the main health consumers' association, Collectif Interassociatif Sur la Santé (CISS) published the results of a national study, including that staggering level of dissastisfaction. The CISS explained that there was growing fear among the populace regarding the financial and social burdens of the health care system. While the French are particularly adept at complaining, there is real cause for concern.

France has an annual budget deficit reaching $167 billion, and the country cannot continue running social security at a deficit. The struggle, however, comes down to maintaining the quality of the benefits embedded in a system that is regarded as a national birthright. Since the entire French population—workers, employers and the retired—has some 20 percent of its income deducted at the source to fund the health care system (taxes on alcohol, tobacco and the rich also contribute), everyone pitches in. And if everyone is entitled, then there is just not enough to go around.

The CISS study goes on to identify a growing trend in French government—a lowering of reimbursement rates for medical services, instead relying on private insurance co-payments to make up the balance of the cost of delivering care. Insurers, in turn, are raising their rates and lowering the benefits they are prepared to pay out. When reimbursement for a specialist ranges from $30 to $42, the time and quality of the consultation are no longer guaranteed. Further inequalities result from what an individual can afford, or what their employer offers. Physicians treating the wealthy receive up to five times the basic rate for their services, as their patients pay $200 or more per month for insurance. In a nation that prides itself on universal health care, a two-tiered,

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Lariboisière Hospital, Paris. An enlightened 1846 response to cholera.

class-based system is growing all but unchecked and unregulated. Quite simply, it is a question of the comfort and quality of medical care being increasingly difficult to match with traditional equality for all patients, long central to the French system.

"Of course I could have taken my three-year-old Hugo to a medical clinic," says Mme. Florence Douat, while she waits in the elegant sitting room of a pediatrician in Paris's chic seventh arrondissement. "But I would waste at least three hours there waiting among sicker children before having the doctor examine my boy for 10 minutes, then take a prescription and be pushed away without being able to call him on the telephone in case Hugo doesn't sleep well tonight. I'd rather come here to Hugo's old pediatrician and wait 10 minutes before seeing the doctor for half an hour who will answer all the questions I have, then pay the $84 fee, which will be fully reimbursed within 10 days thanks to the complementary health insurance my husband is offered through his company."

And Then There Are the Hospitals…

In many respects, the difference between public and private hospitals is similar to the discrepancies in routine medical treatment. Public hospitals are grouped under the nationwide *assistance publique*, while private hospitals are linked to the *sécurité sociale* by contract only. The system leaves the choice to the patient, or (more often the case) the physician. The differences in the quality of care can be quite striking—leading to yet another gap that the French government has been unable to close and another reason for the growing unrest among health care consumers.

Nathalie, the only daughter of Jean-Claude and Nicole Legendre, recently experienced the significant differences between the two systems with her sick and aging parents. At the very moment her father was suffering in various wards of l'Hôpital Cochin, one of the huge public hospitals in the south of Paris, her mother's cardiologist called to say he had just arranged for her to have an urgent bypass at the private Clinique Bizet. Leaving

her father in an old urology department bed, Nathalie rushed to drive her mother to the little private hospital, less than a mile away from her home in the 16th arrondissement.

"The contrast was amazing," recalls Nathalie. "The building looked brand new and was shining clean. A smiling medical secretary welcomed us, took my mother's Carte Vitale, then ordered a wheelchair, which was not really needed, to take her to her room on the second floor, with a wide window overlooking a garden. I think my mother started to feel better already at that moment, given all that we were going through since my father went into the hospital."

Some 45 minutes after she was in bed in the intensive care unit, a heart monitor had been attached, blood tests completed and, best of all, a handsome and reassuring surgeon had arrived to explain to her how he would identify which arteries were blocked by conducting a catheterization the next morning. Without complications, she should expect to be out of the hospital in 48 hours. "What joy amid all the misery we had been enduring," recalls Nathalie. That same day, she had to rush back to Hôpital Cochin, where the nurse on duty had promised her that the urologist would pass by at the end of the afternoon to see her father and answer her questions. It was M. Legendre's second week waiting for his prostate surgery in this tiny and sunless ground floor hospital room, which he shared with three other men over 80.

"My father also had a serious lung infection, and a month earlier he had spent three weeks at the pulmonology department of Cochin," explains Nathalie. "He had also undergone another major operation in his intestines two months earlier in the same hospital. I had been trying for days to make the connection between the three departments of this same hospital to make sure that the newly planned surgery wouldn't affect his other illnesses. I spent hours running from one unit to another." When Nathalie eventually was able to talk to her father's urologist, she had to give him the names and telephone numbers of his colleagues in the other units of this 18th-century hospital—scattered across 30 buildings with some 1,200 beds—so they could coordinate his case. Meanwhile, her mother had been discharged with clean arteries from Clinique Bizet and was resting at home.

Since private hospitals are so pleasant, efficient and no more expensive than public facilities, it's the specialties, equipment and locations that all too often dictate patient and doctor choice. In Nathalie's father's case, Bizet—where her mother was treated—has neither urology nor pulmonology units. Moreover, private hospitals are largely restricted to minor surgeries, even video microsurgery, while open heart operations are performed in public facilities—as are 70 percent of all childbirths. When confronted with a major health problem or surgery requiring complex equipment and top medical specialists, the French often have to choose the better-equipped if overcrowded and under-staffed public hospitals.

"Our huge, multi-wing hospitals absolutely need restructuring so that the public sector becomes as well-organized as the private one," says Professor Pierre Coriat, head of the anesthesia unit of the Pitie-Salpetrière, the largest public hospital group in Paris (88 buildings scattered across 90 acres). As the elected president of the physicians practicing in Paris's public hospitals, Dr. Coriat is one of the major partners negotiating the government's strategic reform of its hospitals. Since public hospitals account for 44 percent of health care spending in France, it is a critical and high-priority project.

Government Blunders

Nathalie remembers the time her father kept entering and leaving Hôpital Cochin. She

was torn between his insistence that he leave, her mother's fear of having him back home in his weak condition and the hospital's decisions, which defied all logic. "One Friday morning, the chief pulmonologist saw my father and said if the results of the tests in the afternoon showed the end of the infection, he could go home. We were relieved to know when the laboratory results came that they were fine. But as I started packing his things, a nurse came in the room to stop me because the pulmonologist hadn't signed the authorization of departure before he went away for the weekend, while the doctor on duty thought it better to keep my father in his hospital bed at least until Monday morning." The result? Three additional days of costly and unnecessary hospitalization.

Most hospital stays are unnecessarily extended, especially among the elderly, who suffer from multiple health problems. The length of hospitalizations is a particularly acute problem in France where life expectancy is one of the highest among industrialized countries. Providing care at home for the aged is difficult and costly, while specialized institutions for the elderly are inadequate and very expensive. "Hospitals cannot go on providing for all the miseries of the world," Dr. Coriat says. "Our job is to concentrate on health care, not social work." Change means creating local facilities for the elderly, the handicapped and the chronically diseased. "Deep structural reforms are the only way to ensure the survival of our national health system," he explains. "The blunder in the government's approach was presenting the needed reform of the hospitals as an economic initiative, designed to reduce spending by such measures as grouping hospitals to trim costs and jobs. For the past 20 years the number of medical students has been deliberately and steadily reduced because of the wrong thinking that with fewer physicians we'll have lower health spending." This policy, Dr. Coriat observes, resulted instead in a massive influx of foreign physicians to French public hospitals, while French doctors fled because of plummeting working conditions. "The badly needed restructuring of our system should have been presented as a necessity to modernize the health care being provided," he concludes, adding that one key measure is to cut the number of hospital beds across the country, since modern medical technologies allow shorter stays for surgeries and treatments.

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Indeed, in France, unlike other developed nations, reform must take place in the context of a universal health system that is both expected and taken for granted. And despite their complaining, the French do recognize how fortunate they are to live in a country where there are more hospitals and doctors per capita than in most developed nations, and where crushing individual bills for health care are all but unknown. ●