Other countries tried the public option and it is failing.

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France Fights Universal Care's High Cost

By DAVID GAUTHIER-VILLARS

When Laure Cuccarolo went into early labor on a recent Sunday night in a village in southern France, her only choice was to ask the local fire brigade to whisk her to a hospital 30 miles away. A closer one had been shuttered by cost cuts in France's universal health system.

Agence France-Presse/Getty Images

Doctors, trade unions and others have called national protests against French health-care cutbacks this year. One petition signed by prominent physicians said they feared the intent of the reform was to turn health care into a 'lucrative

business' rather than a public service.

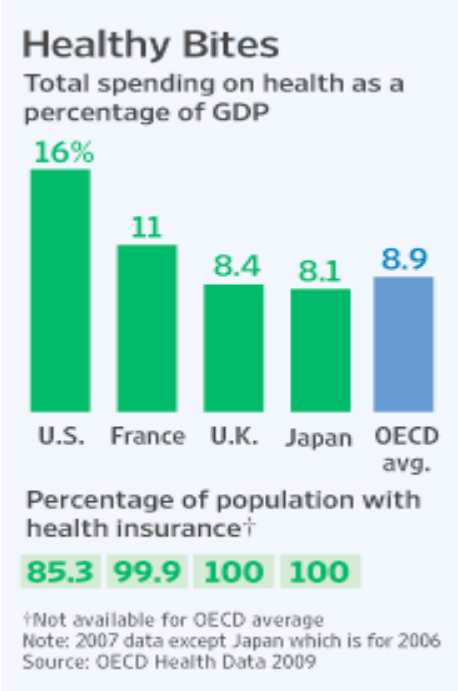
Ms. Cuccarolo's little girl was born in a firetruck.

France claims it long ago achieved much of what today's U.S. health-care overhaul is seeking: It covers everyone, and provides what supporters say is high-quality care. But soaring costs are pushing the system into crisis. The result: As Congress fights over whether America should be more like France, the French government is trying to borrow U.S. tactics.

In recent months, France imposed American-style "co-pays" on patients to try to throttle back prescription-drug costs and forced state hospitals to crack down on expenses. "A hospital doesn't need to be money-losing to provide good-quality treatment," President Nicolas Sarkozy thundered in a recent speech to doctors.

And service cuts -- such as the closure of a maternity ward near Ms. Cuccarolo's home -- are prompting complaints from patients, doctors and nurses that care is being rationed. That concern echos worries among some Americans that the U.S. changes could lead to rationing.

The French system's fragile solvency shows how tough it is to provide universal coverage while controlling costs, the professed twin goals of President Barack Obama's proposed overhaul.



French taxpayers fund a state health insurer, Assurance Maladie, proportionally to their income, and patients get treatment even if they can't pay for it. France spends 11% of national output on health services, compared with 17% in the U.S., and routinely outranks the U.S. in infant mortality and some other health measures.

The problem is that Assurance Maladie has been in the red since 1989. This year the annual shortfall is expected to reach €9.4 billion ($13.5 billion), and €15 billion in 2010, or roughly 10% of its budget.

France's woes provide grist to critics of Mr. Obama and the Democrats' vision of a new public health plan to compete with private health insurers. Republicans argue that tens of millions of Americans would leave their employer-provided coverage for the cheaper, public option, bankrupting the federal government.

Despite the structural differences between the U.S. and French systems, both face similar root problems: rising drug costs, aging populations and growing unemployment, albeit for slightly different reasons. In the U.S., being unemployed means you might lose your coverage; in France, it means less tax money flowing into Assurance Maladie's coffers.

France faces a major obstacle to its reforms: French people consider access to health care a societal right, and any effort to cut coverage can lead to a big fight.

For instance, in France, people with long-term diseases get 100% coverage (similar to, say, Medicare for patients with end-stage kidney diseases). The government proposed trimming coverage not directly related to a patient's

primary illness -- a sore throat for someone with diabetes, for example. The proposal created such public outcry that French Health Minister Roselyne Bachelot later said the 100% coverage rule was "set in stone."

Health Expenditures

Total expenditure on health in 2007, as a percentage of GDP.

Australia	8.7%†
Austria	10.1%
Belgium	10.2%*
Canada	10.1%
Czech Republic	6.8%
Denmark	9.8%
Finland	8.2%
France	11.0%
Germany	10.4%
Greece	9.6%
Hungary	7.4%
Iceland	9.3%
Ireland	7.6%
Italy	8.7%
Japan	8.1%†
Korea	6.8%
Luxembourg	7.3%†*
Mexico	5.9%
Netherlands	9.8%*
New Zealand	9.2%
Norway	8.9%
Poland	6.4%
Portugal	9.9%†
Slovak Republic	7.7%
Spain	8.5%
Sweden	9.1%
Switzerland	10.8%*
Turkey	5.7%‡
United Kingdom	8.4%

United States	16.0%

* Estimated

† For 2006

‡ For 2005

Source: OECD Health Data 2009

"French people are so attached to their health-insurance system that they almost never support changes," says Frédéric Van Roekeghem, Assurance Maladie's director.

Both patients and doctors say they feel the effects of Mr. Sarkozy's cuts. They certainly had an impact on Ms. Cuccarolo of the firetruck birth.

She lives near the medieval town of Figeac, in southern France. The maternity ward of the public hospital there was closed in June as part of a nationwide effort to close smaller, less efficient units. In 2008, fewer than 270 babies were born at the Figeac maternity ward, below the annual minimum required of 300, says Fabien Chanabas, deputy director of the local public hospital.

"We were providing good-quality obstetric services," he says. "But at a very high cost." Since the maternity closed, he says, the hospital narrowed its deficit and began reallocating resources toward geriatric services, which are in high demand.

In the Figeac region, however, people feel short-changed. "Until the 1960s, many women delivered their babies at home," says Michel Delpech, mayor of the village where Ms. Cuccarolo lives. "The opening of the Figeac maternity was big progress. Its closure is perceived as a regression."

For Ms. Cuccarolo, it meant she would have to drive to Cahors, about 30 miles away. "That's fine when you can plan in advance," she says. "But my little girl came a month earlier than expected."

France launched its first national health-care system in 1945. World War II had left the country in ruins, and private insurers were weak. The idea: Create a single health insurer and make it compulsory for all companies and workers to pay premiums to it based on a percentage of salaries. Patients can choose their own doctors, and -- unlike the U.S., where private health insurers can have a say -- doctors can prescribe any therapy or drug without approval of the national health insurance.

Private insurers, both for-profit and not-for-profit, continued to exist, providing optional benefits such as prescription sunglasses, orthodontics care or individual hospital rooms.

At a time when the U.S. is considering ways of providing coverage for its entire population, France's blending of public and private medical structures offers important lessons, says Victor Rodwin, professor of health policy and management at New York University's Wagner School. The French managed to design a universal system incorporating physician choice and a mix of public and private service providers, without it being "a monolithic system of Soviet variety," he says.

It took decades before the pieces fell into place. Only in 1999 did legislation mandate that anyone with a regular residence permit is entitled to health benefits with no strings attached. Also that year, France clarified rules for illegal residents: Those who can justify more than three months of presence on French territory, and don't have financial resources, can receive full coverage.

That made the system universal.

In the U.S., health-overhaul bills don't attempt to cover illegal immigrants. Doing so would increase costs and is considered politically difficult.

View Full Image

Agence France-Presse/Getty Images

A protest in April in Caen, France.

Today, Assurance Maladie covers about 88% of France's population of 65 million. The remaining 12%, mainly farmers and shop owners, get coverage through other mandatory insurance plans, some of which are heavily government-subsidized. About 90% of the population subscribes to supplemental private health-care plans.

Proponents of the private-based U.S. health system argue that competition between insurers helps provide patients with the best possible service. In France, however, Assurance Maladie says its dominant position is its best asset to manage risks and keep doctors in check.

"Here, we spread health risks on a very large base," says Mr. Van Roekeghem of Assurance Maladie.

Journal Community

" Even with all its disadvantages, the French national health-care plan is glaringly better and more cost effective than ours. "

— David Wayne Osedach

The quasi-monopoly of Assurance Maladie makes it the country's largest buyer of medical services. That gives it clout to keep the fees charged by doctors low. About 90% of general practitioners in France have an agreement with Assurance

Maladie specifying that they can't charge more than €22 (about $32) for a consultation. For house calls they can add €3.50 to the bill.

By comparison, under Medicare, doctors are paid $91.97 for a first visit and $124.97 for a moderately complex consultation, according to the American College of Physicians.

In France, "If you are in medical care for the money, you'd better change jobs," says Marc Lanfranchi, a general practitioner from Nancy, an eastern town. On the other hand, medical school is paid for by the government, and malpractice insurance is much cheaper.

In 2000, the World Health Organization ranked France first in a one-time study of the health-care services of 191 countries. The U.S. placed 37th.

Financial pain has long dogged the French plan. As in the U.S., demand for care is growing faster than the economy as people take better care of themselves and new treatments become available.

Tilting the Balance

Since France began building up its universal health-care system, in 1945, successive governments have been faced with the challenge of balancing the national health insurance budget without going back on the original promise of taking good care of the entire population. For the past three decades, small reductions in health care coverage and incremental increases in health-care taxes have been the main recipe.

1976 -- Coverage of ambulance costs is reduced.

1977 -- Coverage of some medications is reduced. Some hospital beds are closed.

1982 -- Patients must pay a "moderating fee" of 20 francs (3 euros) out of pocket when they are hospitalized.

1985 -- Coverage of some paramedical procedures is reduced.

1986 -- Increase in health-care payroll taxes.

1987 -- Letters sent to the national health insurance must be stamped.

1988 -- Creation of a special tax on medication advertising to help fund health care.

1990 -- Introduction of the CSG, a new tax levied on all types of income to help fund health care.

1991 -- Increase in health-care taxes levied on payroll.

1993 -- Increase in CSG rate. Coverage of doctor consultation is reduced.

1996 -- Increase in health-care taxes. A new health-care tax is levied on private health-care plans.

1999 -- New tax levied on drug makers when their revenue exceeds a pre-defined level.

2000 -- Doctors are required to explain to the national health insurance why they granted a worker sick leave.

2003 -- The "moderating fee," which was increased over time, is raised to 15 euros.

2004 -- Patients must register with a "preferred" general practitioner who will reroute them toward specialists when necessary, or face lower reimbursement for care.

2005 -- The national health insurance deducts 1 euro off doctor consultation fees before it starts calculating how much it must reimburse patients.

2008 -- The national health insurance deducts 50 cents off every pack of medicine before it starts calculating how much it must reimburse patients.

Source: WSJ research.

Since the 1970s, almost all successive French health ministers have tried to reduce expenses, but mostly managed to push through only minor cost cuts. For instance, in 1987, patients were required to put a stamp on letters they mailed to the national health insurer. Previously, postage was government-subsidized.

In 2004, France introduced a system under which patients must select a "preferred" general practitioner who then sends them onward to specialists when necessary. Under that policy -- similar to one used by many private U.S. health-care plans -- France's national health insurance reimburses only 30% of the bill, instead of the standard 70%, if patients consult a doctor other than the one they chose.

At the start, patients balked, saying it infringed on their right to consult the doctors of their choice. But the system is now credited for helping improve the coordination between primary and specialty care, which remains one of the main weakness in the U.S. health-care system.

In recent years, Assurance Maladie has focused on reducing high medicine bills. Just like U.S. insurers and pharmacy-benefit managers, France's national health insurer is promoting the use of cheaper generic drugs, penalizing patients when they don't use them by basing reimbursements on generic-drug prices.

The most important aspect of Mr. Sarkozy's latest health-care legislation, passed this summer, focuses on reducing costs at state hospitals. About two-thirds of France's hospitals are state-run, and they are seen as ripe for efficiency savings. Among other things, Mr. Sarkozy has asked them to hire more business managers and behave more like private companies, for instance, by balancing their budgets.

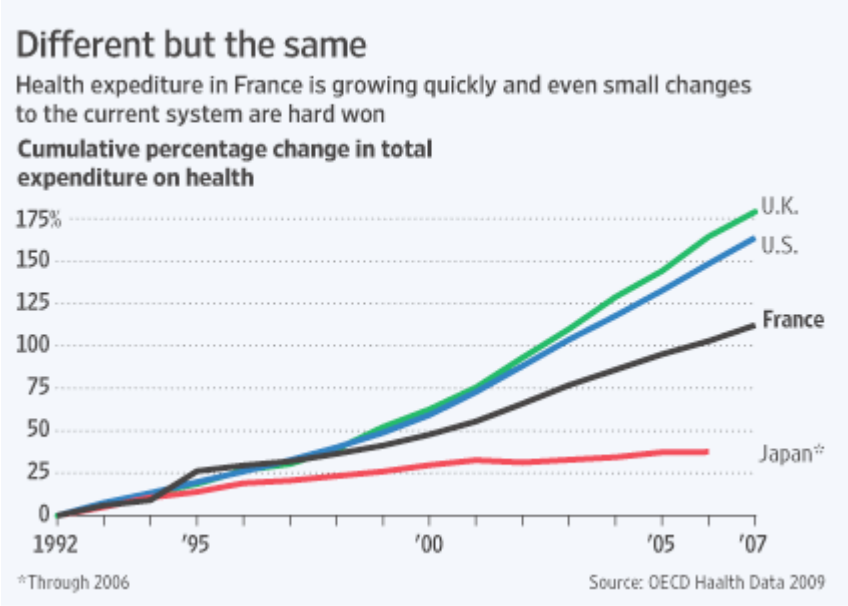
The proposals didn't go down well.

In April, some of France's most famous doctors signed a petition saying they feared Mr. Sarkozy would turn health care into a "lucrative business" rather than a public service.

In the U.S., hospitals are paid for each individual procedure. This system, called fee-for-service, is suspected of contributing to runaway costs because it doesn't give hospitals an incentive to limit the number of tests or procedures.

Ironically, France is actually in the midst of shifting to a fee-for-service system for its state-run hospitals. The hope is that it will be easier for the government to track if the money is being spent efficiently, compared with the old system of simply giving hospitals an annual lump-sum payment.

France's private hospitals are more cost-efficient. But state hospitals say it is unfair to compare the two, because state hospitals often handle complex cases that private hospitals can't.



"When a private hospital has trouble with a newborn baby, we are here to help, night and day," says Pascal Le Roux, a pediatrician at the state hospital in Le Havre, an industrial city in northern France. "Having people standing by costs money."

In theory, Assurance Maladie should be able to contain hospital costs the same way it does with doctors: by harnessing its position as the dominant payer in the health-care system. In practice, it doesn't work that way.

The state hospital of Le Havre, called Groupement Hospitalier du Havre, or GHH, has nearly 2,000 beds and is one of the most financially strapped in France. A 2002 report by France's health-inspection authority found that the hospital had a track record of falsifying accounts in order to obtain more state funds.

Philippe Paris was hired about two years ago to help fix the hospital's spiraling costs. He is cutting 173 jobs out of the staff of 3,543.

And he is trying to enforce working hours. "People don't work enough," he said. "If consultations are scheduled to begin at 8 a.m., that means 8 a.m. and not 11 a.m."

Yet even the smallest budget moves are proving controversial. Local residents are up in arms over a cost-cutting measure that makes patients pay €1.10 an hour to park at the hospital. "It's a scandal," says retired local Communist politician Gérard Eude. "It goes against the very idea of universal health care."

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