The health-care grass isn't always greener

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The recession has taken health care out of the headlines at home and abroad, but debate remains over which countries in the world provide the best system.

Some commentators have suggested that Canada look to France and other European countries for the answer. After all, France does have a large number of doctors, more than double the number of hospital beds per capita, a high standard of service, almost non-existent waiting times.

What can we learn from their model? One feature that seems to have worked well for the French is cost sharing, which may have helped hold down health-care costs by discouraging overuse. Indeed, co-payments have increased consumers' sensitivity to the real cost of the care they buy.

On closer examination, however, the French system is far from perfect.

For one, it carries a big price tag. One reason there are no waiting times there is that there is a large supply of doctors per patient - 50 per cent more doctors per capita than Canada. (French-speaking doctors have fewer alternative markets to serve than Canada's English-speaking doctors, whose language and credentials easily travel to larger markets, such as the United States.)

As a result, France spends about 11 per cent of national income on health, making it the third-most expensive health system in the world. Like Canada's system, France's universal health care is largely financed by government through national health insurance. About 99 per cent of French citizens are covered by national health insurance.

However, most health services require substantial co-payments, ranging from 10 to 40 per cent of the cost. So more than 92 per cent of French residents purchase complementary or supplementary private insurance. (In Canada, that figure is 65 per cent.) In fact, private insurance makes up 12.7 per cent of all health-care spending in France, a percentage exceeded only by the Netherlands and the United States.

Problematically, the French system has been running deficits the past few years. Indeed, the health system is the single largest factor driving France's overall budget deficit. The impact will surely begin to affect the amount and quality of services provided.

Tight budgets and investment shortfalls for hospitals have led to a recurring lack of capital equipment, resulting in a shortage of medical technology and lack of access to the most advanced care. Hospitals that are in danger of exceeding their budgets have pushed patients to other facilities to save money. And while the French system has managed to avoid waiting lists in most areas, they do have queues for specialized treatments. France will likely have larger lists in the future when it looks for ways to cut costs.

If we want to improve our system, we need to find cost-effective solutions, drawing relevant lessons from other countries. For example, Canadian hospitals should create stronger incentives to reduce waiting times, similar to Britain's. Implementing what has been known as the "targets and terror" regime, hospitals there have adopted centrally managed targets for waiting times for in-patient care while imposing penalties for managerial failure.

Indeed, the British model has resulted in a lower proportion of people waiting for elective treatment. Other solutions include revising the cap on the number of doctors we train and streamlining the licensing process for internationally trained doctors already in the country. And the use of co-payments may help control costs by discouraging overuse. These co-payments could be set at low levels for the general population and refund to low-income individuals, to ensure equity in access.

There is plenty of room for improvement in our health system. But it is not terrible, and could be made better with shrewder application of human resources and better-managed financial incentives.

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