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Challenges Posed by Increasing Costs of Health Care Systems in France and Togo

Les défis posés par l'augmentation des coûts des systèmes de soins de santé en France et au Togo

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Abstract:

Most member countries of the Organization for Economic Co-operation and Development (OECD) have established a functional, complex health care system. Nonetheless, there is an on-going lack of resources in this sector, and these countries invest to improve the quality and quantity of health care offered. As such, the need for financing health care expenditures in developed countries such as France has become a growing burden to governments, communities, and the public. In contrast, in a developing country like Togo, the health care system is far from making services accessible to the overall population. In both cases, policy changes may be necessary to curb the problems linked to existing or fragmentary social protection structures. The lack of resources in health care from its stakeholders—regardless of whether it derives from decrease or stagnation caused by governments, communities, households, or economic partners—ultimately represents a major limitation in achieving efficiency in health care.

Résumé:

La plupart des pays membres de l'OCDE ont mis sur pied un système de soins de santé complexe et fonctionnel. Cependant, le manque de ressources persiste dans ce secteur et ces pays y investissent pour améliorer la qualité et la quantité de soins offerts. Par ailleurs, les besoins de financement des dépenses en soins de santé dans les pays développés tels que la France est devenu une charge de plus en plus lourdes sur les gouvernements, les communautés et le public. En contraste, dans un pays en développement comme le Togo, le système de soins de santé n'est pas à la portée de toutes les bourses. Dans les deux cas (pays développés et pays en développement), le changement des politiques semble nécessaire si l'on veut résoudre les problèmes liés aux structures de protection sociale fragmentaires ou existantes. L'absence des ressources en soins de santé, due à la baisse ou la stagnation du financement par les gouvernements, les communautés, les ménages ou les partenaires économiques—représente ultimement une contrainte importante dans l'efficacité en soins de santé.

Keywords / Mots clés

Health care, Resources, Systems, OECD, Pharmaceutical products.
Soins de santé, Ressources, Systèmes, OCDE, Produits pharmaceutiques.

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INTRODUCTION

Many societies throughout the world have devised different types of health care systems. Examples range from public integrated models in Sweden, the United Kingdom, Italy, and Spain, to public contract models in Germany and Holland, to the reimbursement model in the United States (Oxley et MacFarlan, 1994; Bac, 2004). The dominant model in most African countries is a colonial one closely related to those of France and Britain. A number of differences arise when comparing the health care systems of France and Togo, particularly while examining the ongoing difficulties they both face such as the health care expenditures, availability of professionals, and public systems.

The health care systems of member countries of the Organization for Economic Co-operation and Development (OECD) may vary in structure or have unique features (OECD, 2016 a), but generally, OECD countries work towards the common goal of providing accessible health care to all. As a result, the national budgets of OECD member countries allocate billions of dollars towards health care (Figures 1 and 2). Despite the vast amount of resources allocated to health care, most countries with good results continue to invest more in these systems for two reasons. Firstly, efforts to reduce and to rationalize costs of medical expenses have led to operational difficulties in some developed countries' health care

systems (European Commission, 2001). Secondly, many factors contribute to the inflation of health care expenses. In France, for instance, the aging of the baby boom generation, the persistence of chronic diseases, and the expensive costs of medical technologies are some of the problems that challenge the health care system (OECD, 2004). Moreover, efforts made to improve social security benefits in France are not sufficient to satisfy citizens. For example, France is lagging behind other OECD countries in areas, including the prescribing of antibiotics or alcohol consumption (OECD, January 2016b). Moreover, politicians advocating reductions in health care expenditures face great opposition, perhaps because citizens question the country's true reasons for restructuring the health care system (Belliard, 2010).

On the other hand, the health care system in Togo continues to deteriorate. It was put in place during the colonization period, and at the time, Togoleses were entitled to free health care (Alioune, 2008). In the 1980s, a change in health care occurred, but the country was not able to maintain a high-quality level of service. Hence, while the French system is currently in deficit, the Togolese model is in excess (World Bank, 2006). This excess may result from the fact that users do not know enough about their rights (which would explain why AIDS, malaria, child mortality, and morbidity continue to trouble the health care system). Another possibility is that the social security branch of the entire social protection system invests a lot in land and real estate. To elaborate, the Togolese social security system has three branches: family benefits, pensions (invalidity, aging, and death survival), and occupational/professional accidents. However, it does not cover illness or unemployment (Auffret, 2011). Therefore, this could be the main reason why the Togolese model is in excess.

Underlying motivations have produced deep changes in social security benefits in the respective health care systems of each country. Investments in health care in France were made possible through national funds and programs (OMS, 2004). A closer look reveals that OECD member countries invest considerably in health care, even sectors with less mobilized resources (OECD, 2006), allowing analysts and policymakers to evaluate the progress made and what needs to be improved. In Togo, statistics are too limited to discuss in detail the different resources and capitals allocated to health care. The lack of data shows the need for improving the health care system beyond inadequate international interventions.

OVERVIEW OF HEALTH CARE SYSTEMS IN DEVELOPED COUNTRIES: FRANCE

In the 1990s, medical care expenses per resident in France in real terms (i.e., outside inflation) increased by an average of 2.2% per year (Bac, 2004). Between 1990 and 2001, prices for most pharmaceutical products increased from 16.9% to 21% (Bac, 2004). The inflation of medicines was higher than normal in OECD countries, but was surpassed by the USA in 2001 (OECD, 2006). As per Figure 1, France's total health care expenses in 2001 were 9.5% of the Gross Domestic Product (GDP), about 1% more than the average for OECD member countries (OECD, 2006), but less than those of the United States, which had the highest in the world at 13.9% of the GDP, followed by Switzerland, Germany, and Canada (OECD, 2004).

The health care system in France is essentially financed by social collects and taxes (OMS, 2004). Private or public practitioners and hospitals provide medical care services funded by either the patient or the public, respectively. While primary care practitioners are remunerated based on services provided after negotiation, hospital personnel are salaried (Béraud, 2014). Patients have a wide variety of choices. Upon paying their regular doctor, they have 70% of their expenses reimbursed by social security (Belliard, 2010), and the remainder by group insurance, depending on the level of its reimbursement. At the pharmacy, patients can choose to pay only their co-pay and the remainder is supplied by the insurance or they can decide to pay the total cost and be reimbursed later, around 70% by the social security fund and 30% by their own private insurance fund (Bac, 2004). As such, the introduction of universal health care in 2000 has mostly benefited low-income individuals lacking personal health insurance, as they receive full medical and prescription coverage from public funds.

One of the measures implemented in France to ease the financial burden of the health care system for governments was to boost the participation of consumers in defraying the costs of pharmaceutical products through medical franchises, which put a cap on annual medical expense benefits (Belliard, 2010). Thus, as with most OECD countries, the number of ineligible medicines for reimbursement has increased in France, especially those without proven therapeutic value (Belliard, 2010). In the meantime, lobbyists for large pharmaceutical groups continue to encourage the release and sale of these products. Pharmaceutical pressure groups along with the government work to reduce the financial deficit called "the gap" of social security protection in France (Belliard, 2010).

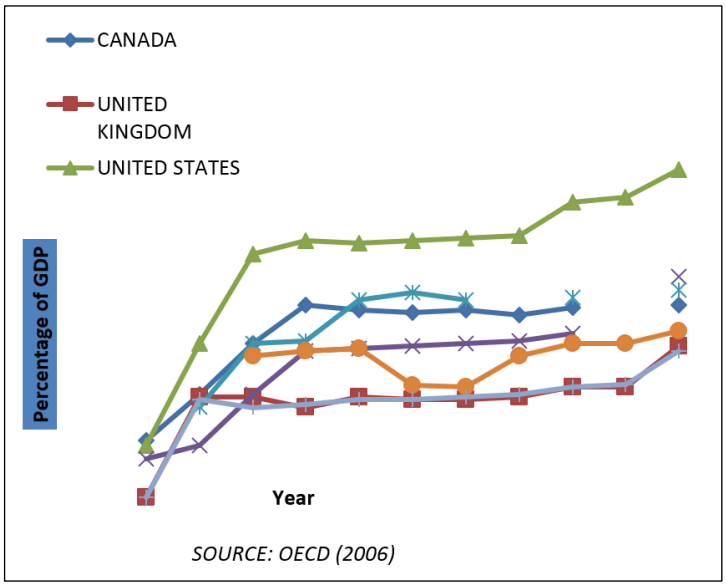


Figure 1: Total Health Care Expenditures as Percentage of GDP

OVERVIEW OF HEALTH CARE SYSTEMS IN DEVELOPING COUNTRIES: TOGO

The Economic Commission of the World Health Organization (WHO) estimated the annual health expenses resulting in the reinforcement of interventions and the mobilization of annual domestic resources in low and middle internal revenue countries (Tables 1 and 2). According to the Commission, about 30 to 40 US dollars were needed per person per year to cover basic interventions, including pandemic diseases such as HIV/AIDS (WHO, 2000). The Commission explained that developing countries could increase domestic resources in health care by utilizing them more efficiently (WHO, 2000). Even if a significant portion of the GDP has already been allocated, the required health care funds are well above the capacity of a large number of developing countries with low internal revenue to provide proper health care for their populations (WHO, 2000).

In 2004, estimates predicted that aid from foreign donors would increase from 6 billion US dollars in 2007 to 38 billion in 2015 (Husson, 2004). For instance, the investment of The Global Fund into the health care sector is growing. In September 2015, The Global Fund had disbursed 27 billion US dollars in programs supports to fight against HIV, tuberculosis and malaria (The Global Fund, 2015). Foreign aid and interventions must be used adequately to reach the goals of proper health care and accessibility to basic medicines, but there remain existing constraints and structural problems within established systems, such as corruption, mismanagement, and chaotic misuse of foreign aid (European Commission, 2001 & Tizio, 2004).

A comparison of limited statistics on social protection based on data published by the WHO reveals that there are many deficiencies in the Togolese health care system (World Health Statistics, 2013). Access to good health care for the whole population is a distant reality in Togo. The deterioration of public health care services, the abolition of free health care services, and the drastic decrease in spending capacity of the population have made it necessary to seek new ways to provide good health care and preventions against illness (Auffret, 2011).

The summary analysis presented above on Togo and France indicates that Togo has no organized statistics or legal documentation, especially for complementary health insurances. Complementary health insurance can be collective or private insurance. Private insurance is very inadequate in Togo in terms of affiliations, contributions, and coverage (Alioune, 2008). In recent years, community insurance has been in sensible development and micro-insurance has been in fast proliferation (Jütting, 2005). However, by nature, whether lucrative or non-lucrative, these structures can last for a long time only if health is perceived as an inestimable good over the value of money. Table 3 displays the true state of the situation in Togo.

	2002	2007	2015
Low Revenue	8.3	28.6	43.7
Middle Revenue	12.6	16.4	19.5

Source: Commission of Macroeconomics and Health, 2000

Table 1. Average estimation of health care expenditures for developing countries (in billions of US dollars)

	2002	2007	2015
Low Revenue	7.0	10.8	17.5
Middle Revenue	12.5	16.5	22.9

Source: Commission of Macroeconomics and Health, 2002

Table 2. Average estimation of annual domestic resources for developing countries (in billions of US dollars)

Indicator	1999	2000	2001	2002	2003
Population	4,506,000	4,629,000	4,740,000	4,854,000	4,970,000
Gross Domestic Product (million)	280,700,000	278,500,000	277,800 000	289,600 000	296,800 000
General Budget of the Country (million)	155,057,362	179,375,949	155,433 378	183,201 877	158,980 274
Operational Budget (million)	13,650,554	7, 902,491	7,731,112	7,676,114	8,103,182
Investment Budget (million)	3,104,000	585,000	362,000	2,101,150	463,000
Total Health Budget (million)	19,070,868	10,727,680	11,382,275	10,407,264	8,265,862
Portion of the Budget Allocated to Health	12.3%	6.0%	7.3%	5.7%	5.2%
Total Health Care Expenditure by GDP	6.8%	3.9%	4.1%	3.6%	2.8%
Total Health Care Expenditure Per Capita (FCFA*)	4,232	2,380	2,401	2,145	2,510

****Franc (currency) of Communauté Financière d'Afrique (Financial Community of Africa)***
Source: DISER, Division of budget, General Direction of Health, Lomé, 2003

Table 3. Budgetary health indicators from 1999 to 2003 for Togo in Franc of Financial Community of Africa (CFA)

PUBLIC HEALTH IN DEVELOPING COUNTRIES

In Africa, 784 million people continue to contract avoidable and treatable diseases, which not only cause death and suffering, but also impact economic and social development (WHO, 2000). Despite some progress, a new projection for the 2014 report entitled "Levels and Trends in Child Mortality" reveals that in 2013, 6.3 million children under five were dying mainly from preventable causes (WHO, 2014). The newest phenomenon is the explosion of chronic diseases linked to aging. In 2000, HIV/AIDS, tuberculosis and other respiratory infections, malaria, pathological diarrhea, measles, and maternal and prenatal complications comprised about 60% of the estimated 10.7 million deaths in Africa (WHO, 2000). These deaths were largely caused by poverty and deficiencies in the health care system, in particular, the lack of an efficient social protection system (Tizio 2004), which may explain the low level of health care expenditures and the inequality in access to quality health care. Presently, only 35% to 46% of African countries spend an average of US $12 per person per year on health care (OECD, 2004). Some sub-Saharan countries, especially the least developed ones, allocate less than $6 per person per year to health care (WHO, 2000). Currently, less than 45% of the populations in sub-Saharan Africa have access to basic medicines (Organisation Mondiale de la Santé, 2013).

Poor citizens suffer disproportionately due to low public investment in health care, as well as the fact that medical expenses represent a large proportion of their income. Disability can impoverish families for several years, leading to income loss and accumulated debt from medical expenses. In Togo, the lack of a universal health care system demonstrates the country's inefficiency in meeting the needs of its population, mainly those in rural settings. The poor and the rural populations have limited access to health infrastructure, basic medicines, health care professionals, and financing mechanisms for health care (Auffret, 2011). To improve access to health care for those who need it most, public health care systems should be charged with the frequent organization of interventions against common diseases.

PUBLIC HEALTH CARE IN DEVELOPED COUNTRIES

Prior to the work of Newhouse in 1973, analyses of health care expenditures focused on the aspect of demand (Mahieu, 2000). Since then, it has been driven almost exclusively by income effect (Mahieu, 2000). Thus, Denmark and Austria allocated a small fraction of their national wealth to health care expenditures—6.4 % and 7.9 % respectively—in 1996. In comparison, Portugal, which is much less wealthy, allocated 8.2% to health care (Husson, 2004). In this context, nowadays, a priority is granted to the analysis of supply, such as the organization of health care systems and methods of integrating new medical technologies.

A country-by-country analysis completed by Mahieu in 2000 and updated in 2002 indicates that the amount of demand introduced by contractors would vary significantly from one country to another, and could for the most part explain the variability, and therefore the gap in dynamics, between the systems of various OECD countries. In 2004, Husson posited that Mahieu hypothesis of a well-defined unique economic model may affect both demand, which varies little from one country to another, and supply, which widely responds to the organization of health care systems. The organizational method of health care systems (contractual, integrated, or reimbursement) in turn seems to influence the evolution of health care expenditures. From 1975 to 1993, countries operating primarily on the refund model in the health care system experienced an annual average increase in health care expenditures greater than 0.6 percentage points, in comparison to what was observed where the system is contractual or integrated (Mahieu, 2000). This explains a differential increase in health care expenditures greater than 11% (Mahieu, 2000).

PUBLIC HEALTH CARE MODELS IN OECD COUNTRIES

Since 1960, the composition of expenditures in public health and medical goods has changed, thus, causing the organization of public health care systems and the integration of new medical technologies. Furthermore, these consequences generally correlate with the impacts of the introduction of demand. Health Economy traditionally distinguishes three models of public health care systems (OECD, 2006):

(1) The public integrated model is representative of existing systems in developed countries such as Sweden, the United Kingdom, Italy, Spain, and countries in southern Europe. Essentially based on public financing, the model provides the population with a universal umbrella or protection covering public hospitals, whose staff members are public servants. General practitioners are salaried or paid per capita.

(2) The public contract model applies mainly to Germany and the Netherlands. Public underwriters form contracts with private health care suppliers. Patient insurance is a function of income, and mandatory public insurance covers low-income patients.

(3) The reimbursement model serves in the United States and France: in the former, insurance is private; in the latter, it is public. Private, for-profit, health care providers receive compensation once service is provided. The main difference between the American and French systems resides in the patient insurance coverage system. In Europe, insurers provide near-full coverage, while in the United States, it largely depends on private insurance companies (Oxley and MacFarlan, 2008).

In 2001, 76% of public health care expenditures in France were financed through public funds (OECD, 2004). This level was slightly higher than the average of other OECD countries such as Spain, Belgium, and the Netherlands; however, less than that of most Nordic countries, such as Denmark, Sweden, and Norway (OECD, 2004). In that sole year, private insurance, including mutual insurance companies and supplementary insurances, financed about 13% of all health care expenditures in France, a relatively important proportion compared to most other OECD countries (OECD, 2004). This is, however, less than the contributions made through private insurance in the United States and the Netherlands, which were both 35% (OECD, 2004). Total expenditures of about 10% directly paid by consumers in France represent a portion below most OECD countries (OECD, 2004).

PHARMACEUTICAL PRODUCTS

Since 1997, the cost of medicines has represented a major proportion of the global investment in health care expenditures (Husson, 2004). France ranked second worldwide in the consumption of medicines per resident at $537 per person, behind the United States at $605 (OECD, 2003). This is double the Netherlands amount and two and half times higher than those of Denmark and Ireland (OECD, 2003).

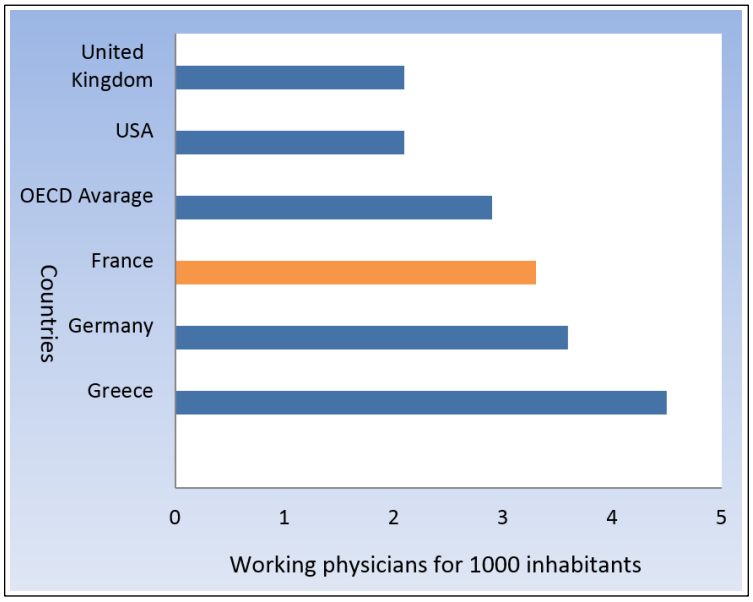
The increase in public and private expenses for pharmaceutical products initiated by the release of new and costly drugs was a leading factor for increasing the overall health care expenditures in several OECD

countries. Expenses in pharmaceutical products increased by more than 70% in real terms between 1990 and 2001 in Australia, Canada, the United States, Finland, Ireland, and Sweden (OECD, 2004). Pharmaceutical products represent more than 10% of total health care expenditures in virtually every country of the OECD, and more than 20% in France and Italy (OECD, 2004).

In terms of refunds for pharmaceutical products, the co-pay required from patients is higher than that required for care services provided to patients (Husson, 2004), and a large number of pharmaceutical products are not covered by public insurance systems (Husson, 2004). Between 1990 and 2001, the portion of public sector investments allocated to pharmaceutical expenses was in decline in several European countries such as Germany, Italy, the Netherlands, and Sweden. In 2001, public sources funded 66% of all pharmaceutical expenses in France, a share significantly larger than the OECD average (OECD, 2004). An overconsumption of medicines was thus reported during the same year (OECD, 2003).

AVAILABILITY OF HEALTH CARE PROFESSIONALS

Several interpretations have attempted to define and justify the effects of supply on increasing health care expenditures. In particular, in 1997, Blomqvist posited that in the measure where health is a relatively intensive good in terms of work, or intensive labor, its price will tend to increase with income range. Introducing the notion of "production function of health services," he defined health care as an economic value wherein price has the tendency to increase for patients as the basic pay rate increases, and therefore leads to an increase in health care expenditures, and to the perception of health care as a superior good (Blomqvist, 1997). In 2000, while there were only two physicians available per thousand individuals in the United Kingdom, France hit 2.9 times higher than OECD average by counting 3.3 physicians per thousand (OECD, 2004). However, notable disparities persist in the supply of primary care givers in France. There is a higher density of health care professionals in Paris and the Mediterranean region than in other areas (Vilanova, 2010). Many public health specialists believe that, in general, the larger the number of first-line health care providers per thousand, the lower the waiting times to see a physician, and therefore, the more significant the results (Carrasco, 2005). In her research, Carrasco identified nearly a quarter of patients coming to the Emergency Department as having no family doctor. In other words, the number of first-line health care providers is a health indicator. However, the number of physicians available per thousand does not necessarily correlate with a country's level of health care expenditures. For instance, countries like Greece, Italy, and Slovakia have a density of nurses greater than the average in OECD countries, whereas the number of physicians per thousand is significantly less in countries like Canada, Japan, and Ireland (OECD, 2004). In general, this data does not reflect the true level of health care expenditures of these countries (OECD, 2004). Other factors such as expenditure on pharmaceuticals and therapeutic appliances, and the number of hospital beds available as well as the length of stays in hospitals, are other indicators for these countries' health care expenditures.



Source: OECD (2004)

Figure 2. Working Physicians per 1000 Inhabitants, 2002

CONCLUSION

Understanding the costs of health care systems in Togo and France offers to researchers' insight in their choices of making achievable to afford health care. Current options include voluntary or mutual insurance, public subsidies, and a reallocation of national resources to make economic growth readily available to all workers and community members. Poverty has been growing at an alarming rate in Togo while governments are far from providing universally accessible, high-quality services, resulting in an established health care system not fully satisfying public needs. Moreover, in France further measures appear necessary to curb existing or fragmentary social protection structures until clamping down succeeds. A common challenge remains the achievement of universal health care coverage in a context of financial crisis and an acute lack of resources. Decrease or stagnation of resources assigned to health care by governments, communities, households and partners of development in health represent a major limitation to the efficiency of the health care system.

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