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France's health care system

Articles about health care in other countries are uncommon in *CMAJ*, so I was pleased to read the interesting News article about the French system.¹ Alas, Christina Lopes presents misleading conclusions from the World Health Organization's 2000 report on international health care systems² as have other commentators, including Michael Moore in his film *Sicko*.

It is misleading and simplistic to state that "the World Health Organization ... anointed the French health care system as the best in the world" and that it "ranked Canada 30th in the same survey." The World Health Organization report includes 9 tables with international rankings along with an additional summary table. France is ranked first in only 1 of the tables: Table 10, which indicates health system performance. This index was calculated by relating a country's overall health achievement to its expenditure on its health system. Simply put, France ranks first in efficiency.

According to the World Health Organization, one must measure 5 things to assess a health care system: the overall level of health, the distribution of health in the population, the system's level of responsiveness, the distribution of responsiveness and the distribution of financial contribution.² The way in which the system deals with access to specialists and wait times, which Lopes highlights as a star feature of the French system, falls into the category of the system's level of responsiveness. The

World Health Organization report combines these 5 features of a health care system into 1 composite measure, overall health system attainment, in Table 9. It is a country's ranking in Table 9, one can argue, that is the most important ranking: it provides an indication of how well the system works for the user. Canada ranks seventh in this table and France ranks sixth. Japan ranks first.

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The news article by Christina Lopes on France's health care system¹ may mislead *CMAJ* readers in 2 important ways. First, Lopes states that "there is far more private money in France's system than [in] Canada's" and that "privatization of the [French] health system isn't an issue. It's a long-established fact." Neither of these statements is true.

Total health expenditure per capita in these 2 countries is almost identical after adjustment for differences in prices: US\$3326 in Canada and US\$3374 in France in 2005.² The percentage of total health expenditure borne by the public purse in 2005 was actually higher in France (79.8%) than in Canada (70.3%). Even after the introduction of user fees that will be ineligible for reimbursement via private health insurance, private financing will play a smaller role in France than it does in Canada. Notably, the publicly financed system in France covers prescription drugs whereas the Canadian system does not. Readers interested in learning more about the French and other European health systems could start with the country reports produced

by the European Observatory on Health Systems and Policies (available online at www.observatory.dk).

Second, Lopes argues that it may be "economic suicide" not to "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." We are unaware of any evidence showing that "free health care" leads to a country committing economic suicide. On the other hand, there is reasonably good evidence showing that the introduction of user fees results in patients neglecting to see their physicians when they need to, discontinuing prescription medications prematurely and suffering worse health outcomes.^{3,4}

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Finasteride therapy for benign prostatic hyperplasia

In their otherwise informative commentary on therapeutic advances in the treatment of benign prostatic hyperplasia, Michael Jewett and Laurence Klotz conclude that finasteride should be used routinely in men with lower uri-

nary tract symptoms, pointing out that finasteride reduced the risk of prostate cancer by 25% in the Prostate Cancer Prevention Trial.¹ However, the results of this trial were not really that unequivocal.²

The prevalence of prostate cancer in this trial was indeed significantly lower in the finasteride group than in the placebo group. Among men with a diagnosis of prostate cancer, however, high-grade prostate cancer occurred significantly more often in the finasteride group than in the placebo group (37.0% v. 22.2%). When one looks at the entire study population included in the trial's final analysis, the rate of high-grade prostate cancer was also higher in the finasteride group than in the placebo group (6.4% v. 5.1%).

The commentary that accompanied the trial report advises caution.³ The trial results have also been disturbing enough to raise concerns about the prescription of finasteride for baldness in young men.⁴ To my knowledge there have not been any new studies to dispel these concerns. Thus, I do not think finasteride can be recommended unequivocally.

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Ideology and the Canadian health care system

I disagree with Matthew Stanbrook and colleagues when they discount ideology as a driving force in the Canadian

health care system.¹ If one frames the health care debate in terms of equitable access and human rights rather than in terms of the public versus private provision of health care, there are real and substantially different ideologies at work. For instance, the Canada Health Act exempts workers compensation plans from its mandate and does not include the provision of drugs.² As a result, different populations in Canada have substantially different access to health care.

Canada is a signatory to the United Nations Declaration of Human Rights and International Covenant on Economic, Social and Cultural Rights,³ which mandates equal access to health care for everyone: "By virtue of article 2.2 and article 3, the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health."⁴

I suggest that we should first affirm the principle that health is a human right, honour an international treaty our country has signed and expand the scope of the Canada Health Act. We can then decide how to allocate the increased funding our health care system needs.

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Noninvasive positive-pressure ventilation

In their in-depth review of noninvasive positive-pressure ventilation in acute respiratory failure,¹ Oscar Peñuelas and colleagues did not discuss the use of this treatment in patients with infections that are transmitted through aerosols. The efficacy of noninvasive positive-pressure ventilation in such patients has not been adequately tested, but anecdotal reports and observational studies have shown that this treatment can be successfully used in patients with acute respiratory failure resulting from human-adapted avian influenza, aspergillosis and varicella.²⁻⁴ The use of noninvasive positive-pressure ventilation eliminated the need for intubation in most patients with severe acute respiratory syndrome.^{5,6} When critical care resources are overstretched, such as during an influenza pandemic, noninvasive positive-pressure ventilation may be of value as an alternative to invasive ventilation or it may at least buy clinicians some time until invasive ventilation is available for their patient.

The available data on the risk to health care workers of acquiring infectious diseases through aerosols while they are performing noninvasive positive-pressure ventilation are conflicting and often methodologically flawed.^{5,6} Indeed, in a recent set of World Health Organization guidelines this procedure was included as one of the aerosol-generating procedures for which the risk of pathogen transmission is still controversial or possible but not documented.⁶ Nevertheless, experience in the field mostly shows the use of noninvasive positive-pressure ventilation to be safe, if appropriate precautions are taken^{5,6}; infected patients should be placed in appropriate