



Why the health service works for patients in France

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Thoughts on French health care from a British business leader living in France, Ed Hoskins.

It is of great sadness to me that political dogma manages to blank out any consideration that methods and experience from elsewhere could ever be applicable in the UK.

This is particularly so in the NHS, where the dogma that the government has to be directly responsible from taxation for the supply of health care has been inbuilt for so long.

This combined with ‘free at the point of use’ is particularly damaging. What is even more amazing is the fact that so little in the NHS is actually free at the point of use. We have prescription charges, dental costs (if available on the NHS at all) and endemic rationing, which itself translates into huge costs for the individual patient.

So why are things so different here in France? These are a few simple conclusions:

- A. The system is run on an insurance basis with income support available and a mandate from the state, but with no direct participation by the state. The insurers are even competitive amongst themselves. The system has state protection for the low paid, the chronically ill, pensioners and children. Top up insurance can be purchased to cover the balance not paid for by the system - 92% of the population do so.

The insurance organisation reports on all transactions and produces an annual account for each of its insured clients showing the premiums paid and the amounts disbursed on behalf of the insured, so that the actual costs of health services are abundantly clear.

- B. ‘Free at the point of use’ in the UK is a fallacy and only encourages people to use UK medical services unnecessarily and to regard the access to such services as a right. The public perception of that ‘right’ may even be one of the causes of violence towards hospital staff in UK Accident & Emergency departments.
- C. Here the modest €22 fee payable to the GP, most of which is normally reimbursed later, is a disincentive to time wasters and malingeringers, even in this country of hypochondriacs. It is amazing how effective the cash flow consequences of having to pay the doctor his €22 fee, even though much of it can be claimed back later, is in making sure that patients really need

to be there. Anyone who has a noted chronic condition or is socially disadvantaged will be reimbursed 100% and if he has a Carte Vitale (the French electronic health card) the GP is credited automatically without money changing hands. The fees charged by GPs or consultants are their income and they, like other health professionals, face overt competition.

- D. Here the €22 per visit is the GP's income not a capitation fee, so he will welcome patients and be attentive as he should, in order to remain competitive with his colleagues.
- E. The pharmacist will provide over the counter advice and drugs for almost any common ailment. He will also provide prescription drugs (un-reimbursed) if needed at his discretion. Thus, the load placed on the GP is much reduced.
- F. The local pharmacist also doubles as the hospital pharmacy for any outpatient day procedures and it is the patient's responsibility to get the drugs prescribed before and take them to his appointment.
- G. All the providers in the system (GPs, consultants, diagnostic staff, district nurses, etcetera) are members of independent organizations or are self-employed private contractors within the system. They normally work at prescribed fee scales.
- H. The contractors in the system choose their mode of working from the point of view of their own businesses and lifestyle choices, within those fee scales. This results in outcomes that would be remarkable in the UK, except perhaps in the costly private sector:
 - The GP has no secretary and no appointment system. You can turn up when you need and wait perhaps 15 minutes on a busy day
 - GPs are not paid by a capitation fee based on patient numbers, only on their actual patient appointments (comparable to remuneration for UK dentists). Recently, a 'gatekeeping' system in which patients are assigned to GPs has been introduced in order to reduce costs – prior to this, patients had had open choice
 - The patient also has the choice of which consultant to see but the GP will always recommend the one he considers suitable. It is not necessary to get a referral via a

- GP to be able to see a consultant, patients can just phone up and make an appointment
- The GP will also be happy to make home visits, as the reimbursed charge is rather more
 - The dentist has no dental nurse and runs the practice single-handed. A significant proportion of his fees are reimbursed to the patient
 - The busy cardiology practice with three consultants has just one administrative assistant
 - The district nurse will turn up at on the doorstep to take a blood sample at 7.00 am in the morning for a fee of €6.35, which is then reimbursed
 - The consultant dermatologist answers his own phone and makes his own appointments without any need for administrative help
 - As well as doing major surgery, the consultant orthopaedic surgeon does his own minor splint work on the spot

Thus the administrative load created by centralised control and rationing of consultants and hospital appointments does not exist.

- I. As separate private contractors, all health professionals work as if their time was their money. Most UK hospital consultants are already private contractors as well as being well-paid part-time government employees. The difference in France is that their health service fees are regulated by the government and controlled by the insurers.
- J. There is a real emphasis on preventative medicine and prompt treatment is considered to be economically worthwhile. Thus, in my experience, waiting lists just do not exist.
- K. There is an abundance of medically qualified people in the system and there is a degree of competition between them. According to OECD figures, there are more medically qualified professionals per head of population than in the UK health service.
- L. The medics run the hospitals and other facilities, not the government or the administrators. They see the benefit of having an absolute minimum of administrative overheads. Those that exist are mainly involved with ensuring that insurance organisations are charged correctly. This also means that there are no artificial limits placed on maximizing the use of

expensive capital equipment and the hospital installations. There seems to be no multi-tier administrative structure of boards, trusts and 'quangos' to control the system. That costly administrative load is therefore eliminated.

M. Also, crucially, as the government is not supplying the service, the state does not own the product of the service nor, most importantly, the patients' medical records:

- Patients have bought the service either directly at the prearranged rates or via their insurance and they are therefore the owners of the results
- Responsibility for the ownership of such records is reasonably granted to the patient
- This eliminates another whole swathe of administrative costs. And as there is no government duty of care with regard to patient records, there is no need, obligation or demand to create an expensive nationwide database of everyone's medical records
- I believe that it is only in very few chronic cases that longstanding records are essential for treatment
- Any minimal useful information (such as the fact that I am diabetic, my allergies, my blood type, etcetera) is retained on the chip of my Carte Vitale. The Carte Vitale is a type of credit card with a chip and is used to organise the data required for my health insurer to pay the sums necessary to whichever part of the health system I have used. The card can be updated automatically at a terminal at any pharmacy, in order to reflect new health circumstances. This seems to be a truly efficient use of Information Technology as applied to the health service
- Along with a pragmatic hands-on approach to consultant referral and appointment making, the need for a failed £20 billion government-organised health IT project collating everyone's medical records is eliminated at a stroke. So here, a much simpler IT system works and it has been working for decades. Nobody in the UK seems to have bothered to cross the channel to ask how it worked

I certainly believe that health outcomes for a somewhat similar percentage expenditure of GDP are much better here than in the UK. The NHS is certainly not the only way of organising a health service and the clear evidence is just across the channel.

The care about hospital infections is also particularly impressive. This is because the staff are aware that it would be quite possible for a patient to choose to go elsewhere and therefore that having an outbreak of MRSA or C. difficile would be disastrous for the business of the hospital, and thus their livelihoods.

The additional complexity of GPs (as opposed to care trusts) controlling and being limited by their budgets in what they can provide in terms of drugs, treatments or referrals does not exist. The spending on care seems to be much more laissez-faire. The professionals are trusted, so those other tiers of administration are non-existent.

The system does not seem to mind if its patients are old. The ageing, like me, are treated with a lot of respect and are sincerely cared for. Going to hospital here creates no fears for me and I am very glad, even as someone with a UK medical background, that I do not have to face the prospect of treatment in the UK.

So in effect everyone in France gets a quality private service, at a cost not much higher than what we pay for a nationalised service in the UK.

The nation's health, not the National Health Service, should be the priority of government.

As someone who worked in the NHS, albeit some time ago, frankly I feel that Sir David Nicholson should be in court for 10,000 cases of manslaughter and all those administrators below him should join him for their participation and be disciplined and sacked.

The NHS would run a lot better with less than half of the current administration.