Health Care: Can Britain Learn from France?

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Introduction

This paper is a brief account of how the French provide health care and why they seem so much more content with their system than Britain is with its National Health Service. But first there will be a brief examination of the reasons why our own NHS has come to be increasingly criticised. In its early days the NHS was regarded by many as a huge improvement on the patchwork of services, including the 'panel system' for employees that had preceded it, and many regarded it to be the envy of the world. But it has ceased to be so.

Many patients continue to be properly and promptly cared for, but many others are not. The aim of the NHS to be "comprehensive and free at the point of use" can only be attained by keeping more and more patients waiting for ever longer. Outdated facilities are failing to be renewed and expensive drugs are being withheld. As a result, a parallel system of very expensive private medicine has developed for those who want a better service and are able to afford it - giving them the consumer choice which is denied to the majority. One consequence of the growth of private medicine is that the limited supply of doctors and nurses is constantly siphoned off into the private sector, thereby further eroding the ability of the NHS to provide a satisfactory service. This consequence is often forgotten.

The present government is making Herculean attempts to restore the NHS partly by increasing expenditure on it, and partly by attempting to introduce reforms to the supply of services, especially reforms to the way hospitals are run. These attempts are beginning to bear some fruit, but for reasons to be explained later, it is doubtful if they can permanently raise the level of provision or of consumer satisfaction.

The author is Professor Emeritus of economics at Brunel University. In writing this he has drawn heavily on *Health Care in France and Germany* by David G. Green and Benedict Irvine (Civitas 2001). He also wishes to acknowledge the help he received from Benedict Irvine and Ruth Elkan, and (with word processing) from Min Tan.

One reason is that the NHS was designed for the 1940s. Since then there have been three major developments which have directly affected the provision of health care. We have become an infinitely more affluent society, which means that people want, and can afford, to spend more on keeping well. Secondly, the proportion of old people in the population has greatly increased and will continue to do so, which means that people need medical services for longer. Thirdly, there have been huge advances in treatment which have mostly, but not invariably, increased its cost, often requiring expensive new equipment and drugs.

A totally state financed and state supplied health care system may no longer be the most appropriate way to provide health care. The proud claim to be providing a "comprehensive system based on clinical need, not ability to pay, and free at the point of use" is no longer feasible in practice and it is a mistake for policy to aim to "*restore* the NHS". Instead the aim should now be to provide as good a service as possible, and to maximise consumer satisfaction. How far we fail at present to satisfy that aim is shown by the World Health Organisation's international comparison of health care systems in which France comes out in first place, although Switzerland and Canada are close rivals. Britain appears in 18th place. It may therefore be helpful to have a careful look at the French system to see if there is anything that Britain might learn from it.

Health Care in France

The French system of providing health care appears to result in a great deal of consumer satisfaction, though it is also often said that it is needlessly expensive. The object of this paper is to provide British readers with an account of the main features of the French system, drawing attention to where it differs from ours. We also hope to show which features of the French system seem to explain its greater popularity with patients, and we shall also ask whether it is true that it is more expensive, as is often said.

French health care is insurance-based. This immediately calls to mind America which seems to fail to provide cover for a sizeable minority of poorer people and is therefore ruled

out by many as a model for Britain. The French system, although also insurance-based, is totally different.

The first thing that strikes any visitor to France is that medical services seem very well endowed. Patients are seen promptly and admitted to hospital without waiting. They can ask to see a specialist without having to be referred by a GP, and they can change doctors as easily as we in Britain can now change dentists. French doctors compete with one another and until very recently there was free entry to the profession, in the sense that there were no restrictions on entry to medical school. Public and private hospitals compete with one another for patients as do nurses working independently and laboratories in the High Streets offering all kinds of tests.

In Britain we have 1.7 doctors for every 1000 of the population. The French have 3.0 per 1000. They have 8.4 hospital beds per 1000 of the population. Britain has 4.1. The only 'shortage' is of certain specialists and specialist facilities in certain areas. As in all countries, people living in cities and affluent parts of the country are better served than those who live in remote rural areas, and in France with its huge land area, this is seen as a major problem [Redwood 2000 p42]

We shall approach a description of the French health care system by showing how it is paid for. The major source of finance, accounting for some 75% of the total is provided by the National Sickness Insurance Funds, which also provide sickness benefits in cash to help people over absences from work because of sickness. The insurance funds are in turn financed by compulsory contributions payable by employers (12.8%) and employees (recently reduced from 7% to 0.5%). A recently introduced additional contribution is a 7.5% charge on every form of income - be it income from employment, self-employment, dividends or interest. The new system is seen as fairer to employees. Previously the self-employed and people with unearned incomes were exempt, whilst employees paid sizeable contributions.

The size of the contributions is determined by considerations of what is regarded as “social justice”- not by actuarial risk. There is therefore no guarantee that, in the absence of other measures, insurance revenue will cover expenditure. We shall return to this later.

The largest of the National Sickness Insurance Funds embraces 80% of the total population. The remaining Funds are associated with particular occupations or sectors of the economy like agriculture, the professions, or the self-employed. In contrast to Germany which pioneered insurance-based health care, there is no competition between these French National Sickness Insurance Funds, and they are in fact quasi public monopolies.

When people go to see a family doctor, or have any other kind of out-patient consultation, they pay the full cost of the consultation but 75% of the fee is refunded by their National Sickness Insurance Fund. Those who have no other insurance therefore end up having made a so-called 'co-payment' of 25% of the fee. But 90% of the population take out further supplementary insurance to cover these co-payments, so that they end up being reimbursed the whole of their initial outlay. This supplementary insurance is provided by a great variety of institutions, though predominantly by so-called *mutuelles* which are non-profit making, and which are something like our Friendly Societies. Some of these insurers are ordinary commercial firms, operating for profit. The larger employers are often able to negotiate special deals with insurers on behalf of their employees.

People who are not insured, perhaps because they are out of work or on very low, or sporadic, incomes, are covered by a provision introduced in 2000 called CMU (*Couverture Maladies Universelle*). Anyone who is legally living in France and is not covered by insurance will have their medical expenses paid for by CMU. It is as though they had paid for National Sickness Insurance as well as supplementary insurance to cover co-payments and instead of being reimbursed they will not even have to pay in the first instance. In this way the French ensure that the principle of 'solidarite', or 'the common good' is secured. Those who are too poor to pay are taken care of by the rest. It is the National Sickness Insurance Funds which pay for them, not the Government.

We turn now to the financing of hospital care. In the year 2000, there were just under 500,000 beds in France, or 8.1 beds per 1000 population. Hospitals fall into three categories: public, private for-profit and private not-for-profit. The public hospitals are fewer but larger and therefore account for some 65% of all hospital beds. They are generally better equipped. They consist of 29 major teaching and regional hospitals spread out

across the country. But they also comprise more locally based specialist cancer and psychiatric hospitals and some other local hospitals that are not so well equipped. [Green DG and Irvine B, 2001 p44ff]

Private-for-profit hospitals which account for some 100,000 beds (20%) tend to concentrate on acute care and on surgery. Though mostly smaller than the public hospitals, there has been a certain amount of amalgamation in recent years.

Private hospitals run not-for-profit but by religious and other charitable foundations- including several of the 'mutuelles' - account for about 25,000 beds (5%) and typically deal with medium to long-term care, but also include about 20 specialist cancer units [Green DG and Irvine B, 2001 p44].

The capital costs of all these hospitals will have been met by the Government, private firms and charitable institutions. But their recurrent costs are financed in the same way as visits to GPs and specialists, by payments from the National Sickness Insurance Funds, and by organisations providing supplementary insurance as well as non-reimbursed co-payments by patients. There are, however, several important differences between what patients pay their GPs and what they pay if they become hospital inpatients. Whereas all except the poorest pay their GP first and are then reimbursed, hospital patients suffering from acute-, chronic-, or long-term illnesses are not expected to pay first. The hospitals are paid directly, and patients are not required to make a co-payment, irrespective of whether they could get it reimbursed or not. Patients who are not exempt and have to pay in the first instance, are reimbursed, as with ambulatory care But all patients are expected to make a fixed non-reimbursable contribution of £7 per day towards the 'hotel charges'. Doctors in public hospitals are paid a salary. In private hospitals they receive fees-for-service.

Doctors who are normally employed in public hospitals are also allowed to work in private hospitals in much the same way as in Britain. But doctor's fees and hospital charges generally are highly regulated by a very complex series of institutions so as to contain total expenditure on medical care.

The third major element in health care that needs to be financed consists of pharmacies and the drugs they dispense, as well as laboratories which in Britain tend to be in hospitals but in France are found on every high street. As with doctors and hospitals, patients pay and claim reimbursement. But they are fully reimbursed only for vital or very expensive drugs. Other prescription drugs are reimbursed at the rate of 65% or 35%, depending on what they are. Drugs that one buys over the counter without prescription are not reimbursed.

Looked at in total, French health care absorbs £83 billion or 10% of its GDP, compared with Britain's 7.1%. Expressed as expenditure per head of population it is about £1,400 in France, compared with about £900 in Britain. In 1997 the French total was financed as follows:

National Sickness Insurance Funds	73%
Supplementary Insurance	
a) *mutuelles* 7%	
b) others 5%	12%
Households (non-reimbursed charges)	10%
Government (central and local)	5%
	100%
	(£83 billion)

Source: La Sante en France, 2000 p253

The Sickness Insurance Fund not only pays for health care but also for the equivalent of Britain's Sickness Benefit - cash payments to anyone temporarily unable to work because of ill health. But 85% of its expenditure is devoted to health care. Unemployment benefits, pensions and other social security benefits are financed by separate contributory insurance funds. The total cost of social security in France is high.

Role of Government

The small Government contribution of only 5% of the total expenditure on health care may give the impression that the Government's role is negligible. And so, indeed it normally is in terms of its contribution to the financing of the scheme. But it plays a major role in determining total expenditure by its control over the insurance premiums, hospital and laboratory charges, doctors' and nurses' fees and the prices paid for pharmaceuticals. Some of these controls are direct. Most take the form of supervising negotiations which determine these fees, rates and prices. It is part of the philosophy of the French health care system, that its cost should be determined by agreement between 'social partners', defined as those who provide or supply health care, and those who pay for it:- the insurance funds, those who contribute to them, and the consumers of health care.

But the government exerts considerable influence on the outcomes of negotiations between the social partners. One reason is that if finance proves insufficient to meet the costs imposed by providers, and the insurance funds go into deficit, as has happened on several occasions in the past, the government has to make good the shortfall. It therefore has a crucial interest in preventing that from happening. In recent years it has had some success in that. Since the reforms of the mid-1990s commonly referred to as the Juppe Reforms, the French Parliament lays down detailed ceilings for total expenditure on health care - not just Government expenditure. There are also now strict controls on the intake into medical schools as a way of gradually reducing what is seen as an exces supply of doctors, which needlessly raises the cost of health care.

As in all other countries, an ageing population, medical advances and rising expectations have led to increasing pressure to spend more on health care in France. Spending on health care has increased from under 6% of GDP in 1970 to the present 10% and this increase has been very largely the result of an increase in the amount of health care supplied, not as a result of rising prices. In other words, it was the number of doctors, nurses, hospital beds etc that increased until the mid-1990s - not their fees or charges.

This has two corollaries. The first is that the 'strict incomes policy' has made people working in health care increasingly disgruntled, to the point where in January 2002, many

general practitioners and nurses went on strike. Secondly, it is thought that the increase in supply may have exceeded the increase in demand, resulting in increased competition. This has helped to keep prices down. It helps to explain why there are no waiting lists, and why consumers are so satisfied. It also explains why French hospitals have been more than happy to accept British patients paid for by the NHS!

Lessons to be Drawn

What lessons can we draw from this examination of the French health care system? A major weakness of the NHS is the uncertainty about future finance. This uncertainty is due to the fact that the NHS is entirely state financed. One reason why the French health care system is more popular is that although it too is substantially a government controlled system, it is shielded from politically determined ups and downs in its sources of finance. For years the NHS was underfunded because in order to be elected or re-elected, political parties found it imperative to keep taxes down, which led to cuts in many areas of public expenditure. The political climate has changed for the moment, and to be re-elected the government is anxious to show a willingness to greatly increase expenditure on public services, including the NHS. But will that last? Or will the government in office at the time of the next recession once again feel impelled to cut public expenditure - including expenditure on health care?

The French way of financing health care largely from National Insurance Funds supplemented by patients' 'co-payments', mostly reimbursed by private insurance, shields health care from changing attitudes to government expenditure and taxation.

As in every other country the cost of health care in France has been escalating and the Government has tried very hard to prevent it from getting out of control, knowing that deficits in the National Insurance Funds would have to be paid by the Government. They have had some success in this without patients being made to feel that they are being rationed. It is sometimes said that British governments would sooner ration supply than face protests if they were to raise taxes, whilst French governments would sooner pay up than face the wrath of voters if they rationed supply [Lancry and Sandier 1996]. But in

practice French governments have in recent years recouped overdrafts that they had initially financed.

The supply of health care - doctors, nurses, hospital beds etc per head of population is in fact more ample in France than almost anywhere, and certainly more so than in Britain, as we have seen. The French have ample access to medical care compared to Britain. They also make use of it.

Does the fact that most patients pay to see their doctor rein in the demand for medical services and cut out unnecessary or even frivolous visits that are said to plague British GPs? It is difficult to give an unambiguous answer. Knowing the cost of their treatment is said to inculcate a more responsible attitude. Against that are the statistics showing the large number of visits to doctors in France, which include sizeable numbers of second opinions that are often quite unnecessary. A French annual household survey for 1998 showed that in a sample of 23,000 persons which was representative of 95% of households, 33% had visited a doctor at least once in the month of the survey.[Green D., and Irvine B., p49]. The French are said to demand and receive more health care services than any other European population [ibid p49]. British patients saw their GP an average 4 times during 1998. Or to put it differently, 740,000 people a day had a total of 270 million consultations with their GPs in the course of the year [Office of Health Economics, Compendium of Health Statistics, London 2000 , p36]. The fact that payments to doctors are mostly reimbursed probably reduces their deterrent effect.

There is also the related question whether having to pay deters people who ought to see their doctor from doing so - especially poorer people. The absence of such deterrence is said to be one of the key merits of the British NHS. Here the answer is almost certainly 'no'. One reason is that poorer people are covered by CMU and therefore do not have to pay - not even in the first instance. In America, another country with an insurance-based health care system, poor people are very vulnerable, and very much at the mercy of charity. Large numbers have no medical cover of any kind unless they are above the age of retirement and are therefore protected by Medicare which is provided and administered by the Federal Government. But in France a concern for social responsibility - or what

the French refer to as the untranslatable 'solidarite' - led to the introduction of CMU which takes care of virtually anyone who is not insured.

A question that is sometimes posed it whether it is the structure of the French health care system which explains the greater 'consumer satisfaction', or simply the higher level of expenditure. Certainly competition makes for greater efficiency as does the less restrictive environment for providers and patients alike. If Britain were to raise expenditure to French levels without introducing greater competition or easing the restrictive environment, health care would be better but still not as good as in France. But posing this question misses the point. What needs recognition is that there is a close relationship between the structure of a system and the level of expenditure. As was argued earlier, in a state financed system expenditure is determined by the government, and is determined by political considerations. The French system approximates more closely to a situation in which expenditure is determined by consumer preference. How much is spent on health care is determined by how much people are prepared to pay, in the same way as how much is spent on holidays or domestic service. Even the French system falls short of that ideal, mainly because the National Sickness Insurance Funds do not compete and the 'premiums' they receive are not determined by actuarial considerations but are negotiated by collective bargaining procedures. The lack of actuarial balance then forces the government to limit expenditure on health care, so as to prevent the funds from running into deficit in a situation where people neither in their capacity as contributors nor as patients are prepared to pay higher contributions or make higher co-payments.

An Expensive System?

It is often said - not least by the French themselves- that the French health care system is very expensive. It does indeed absorb 10% of GDP, compared to Britain's 7.1%. But does that make it expensive? When it is said that a given country spends a given percentage of its GDP on recreation or drink and tobacco, no one says it is "expensive". It simply reflects consumer choice as does expenditure on health care. It may of course be that an identical supply of medical goods and services could be provided at lower cost, perhaps because there are inefficiencies or elements of profit arising from monopoly, or unnecessary administrative costs. For instance, the reimbursement procedures have often been cited

as an unnecessary administrative cost. But computers have dramatically reduced that. Undoubtedly, French health care provision contains elements of other cost-enhancing features, such as the inadequate control over the pharmaceutical industry, and if Britain were to re-shape its own system along the lines of the French system it would need to be careful to avoid the undesirable features, including a good deal of needless bureaucracy. What one should try to emulate is the way the French system enhances consumer choice. Why should people be free to choose how much of their incomes to spend on recreation or on drink and tobacco but not on health care to which most of us attach far greater importance ? What is suggested here is that there is nothing intrinsically wasteful or extravagant about wanting to spend more on health care, even if the outcome in terms of the expectation of life is not noticeably improved. Choice of doctor and hospital, less time spent in waiting rooms and shorter waiting lists are themselves objects that people desire and are prepared to pay for, irrespective of their effect on the expectation of life.

In Conclusion

The French health care system is very different from the British. This poses the question whether France's much greater consumer satisfaction is the result of the difference in her health care system, or is simply due to the much higher level of expenditure on health care. The answer is that the two are intimately related. It is the way that French health care is financed, and which embodies the principle of consumer choice, which then also explains why expenditure is so much higher. It therefore does not follow that if Britain were simply to raise expenditure on the NHS, as presently constituted, it would achieve the same level of satisfaction. Above all, in the British system there is always the risk that expenditure on the NHS is suddenly cut again as a result of a general drive to cut public expenditure as a whole. However, as well as facilitating increased expenditure on health care, the French system routes spending through the consumer. One is more likely to obtain a more satisfactory outcome, arising from health expenditures if expenditure is routed through the consumer, who has an element of choice, rather than planning the allocation of resources centrally. In particular, with regard to the general practitioner system, there is much greater choice in the French than in the UK health care systems.