

Alternative European Healthcare Perspective

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[Roger Steer](#)

It doesn't take an expert in psephology to recognise that the UK is entering the end days of its electoral cycle. The reappearance of George Galloway in Parliament should be confirmation enough.

With [dissatisfaction with the NHS named as the biggest national issue](#) in polls, it raises the question of why the UK finds it difficult to regulate its health services to ensure effective delivery compared to, say France and Germany, avoiding the boom-bust cycle (or more accurately the bust, bust, slight expansion, bust political cycle) and the vagaries of the personality of political leaders distracted by other things.

This newsletter therefore looks at the respective healthcare regulatory regimes of France, Germany and the UK and questions what works, and why in the UK it may not. Hopefully, it provides a good starting point for discussion.

As always, I include a roundup of issues of interest across Europe.

The French healthcare regulatory regime

[France has a mixed system with both public and private components](#) (see in particular section 2.7 on Regulation in the linked document). The **Sécurité Sociale** covers most citizens. [The French system is highly centralised, with strong government involvement. This further link identifies an article that describes a system open to new private entrants but constrained by legislation enforcing co-operation and subject to extensive negotiation.](#)

Agence Nationale de Sécurité du Médicament et des Produits de Santé (ANSM) regulates medicines, medical devices, and cosmetics. France employs the [numerus clausus system](#),

controlling access to medical schools. The French medical professionals must get their qualifications recognised in the EU country where they want to work. [Automatic recognition applies to some professions, while others follow specific national rules](#)

French hospitals accreditation is provided through [Haute Autorité de Santé \(HAS\)](#).

Accreditation in France is mandatory since 1996. HAS assesses hospitals using a range of levels, including accreditation, accreditation with recommendations, accreditation with reservations, conditional accreditation due to major reservations, and non-accreditation.

HAS evaluates hospitals based on quality, safety, and patient-centeredness.

Compliance with standards is intended to ensure consistent high-quality care.

This 2021 article describes in more detail the relatively independent process for accreditation of hospitals – [Haute Autorité de Santé - The certification of hospitals for quality of care \(has-sante.fr\)](#)

The German healthcare regulatory system

Germany has one of the world's oldest universal healthcare systems dating back to the 1880s. It is a legal obligation for all residents to have health insurance. [Both public and private systems coexist in Germany.](#)

The German health system is decentralised, with governance shared between federal and

state levels. [Various corporatist bodies of self-governance play essential roles in shaping healthcare policies and practices.](#)

The Social Code (SGB) is a comprehensive system governing the healthcare system. It outlines the rights and obligations of all stakeholders, including patients, providers, and insurers; the German Hospital Act (KHG) addresses hospital-related matters; the [German Medical Devices Act \(MPG\) regulates medical devices within the healthcare system.](#)

In Germany the medical professions are governed by a combination of federal and state laws. The government annually sets the *numerus clausus*, which controls access to the second year of study in medical schools. This mechanism is used to regulate the number of doctors and their areas of specialisation. [It was introduced in 1968 and was controversial](#) at the time.

Doctors, nurses, midwives, dental practitioners, and pharmacists have automatic recognition of their professional qualifications. [They must submit proof of their qualifications and await permission from authorities before practicing.](#)

The German healthcare system emphasises self-administration. While state legislation defines the framework for medical care, administrative bodies (such as the National Association of Statutory Health Insurance Physicians and the German Hospital Federation) decide details like reimbursement by statutory health insurance (SHI).

Around 73 million Germans are covered by SHI, while 10 million have private health insurance (PHI). Both SHI and PHI are funded by contributions from members. [SHI contributions are salary-based, while PHI contributions are based on health, age, and coverage.](#)

Hospitals in Germany are accredited through Cooperation for Transparency and Quality in Hospitals (KTQ). However, accreditation in Germany is voluntary. The KTQ system focuses on transparency, quality improvement, and

patient safety. [Hospitals participate voluntarily and undergo rigorous assessments to achieve accreditation.](#) The German Accreditation Body (DAKKS) is the national accreditation body for Germany. It issues accreditations in the field of conformity assessment, including .healthcare. [While not specific to hospitals, it plays a crucial role in ensuring quality standards.](#)

The UK Healthcare System of Regulation

The NHS provides publicly funded healthcare. It is a single-payer system funded through taxation. The UK system is more centralised than either France or Germany, with the NHS overseeing most aspects of healthcare.

The Medicines and Healthcare Products Regulatory Agency (MHRA) is responsible for regulating medicines, medical devices, and blood components.

The General Medical Council is the primary medical regulator but other healthcare professions have their own (Health and Care Professions Council, General Chiropractic Council, General Dental Council, General Optical Council, Nursing and Midwifery Council, General Pharmaceutical Council). Professionals in the UK can practice under the same conditions as nationals of the host country.

The NHS oversees hospital accreditation in the UK through the Care Quality Commission (CQC). The CQC is the independent regulator of health and social care in England. It assesses and rates hospitals based on safety, effectiveness, and patient experience. Accreditation is mandatory for all healthcare providers.

So what can we learn from this comparison?

On the face of it there are more similarities between the three countries than differences. Each has a legislative framework, extensive public funding support, and independent regulatory and accreditation processes. The devil is in the detail: paradoxes emerge.

It is not a simple matter of centralised versus decentralised. Germany with a relatively autonomous, decentralised and corporatist healthcare system seems to benefit from lack of national political interference but at the same time [extensive legislative change took place in 2023](#) and the powerful Minister of Health has advised [health systems to prepare for war](#).

In my view we are seeing long needed changes to the relatively generous tariff system, which was still not sufficient to protect smaller units from closure. A compromise therefore has been produced to try to reconcile the need to protect local interests and to promote national efficiency.

Similarly, although the French centralised system may appear oppressive; in practice everything is negotiable.

To illustrate this point from a different industry, there is no better example than how President Macron took on the potentially explosive confrontation with the farmers on 24 February 2024, and reached a settlement, or at least a truce.

Contrast this with the negotiating tactics used by the UK government in relation to the junior doctors' dispute. All the government is doing by being resistant to negotiation, is to stoke the fires of the dispute and encourage others to join cause.

The UK has the worst of all worlds. A centralised system driven by the overarching objective to cut public expenditure rather than to meet health and care needs; a supine regulatory framework where the clear subtext is to place responsibility as far down the organisation as possible, while denying real power to change matters significantly at that level; and a set of managers effectively unaccountable for performance because the only real objective is to stay in budget; and what amounts to regulatory negligence as

everyone looks to someone else to do something.

This latter thought was provoked by reading the long list of indemnities provided by government to the members of a host of NHS regulatory bodies in the Department of Health Annual report. What value is regulation if the regulators themselves can wash their own hands of the risks involved?

With the UK newspapers full of [horror stories about deaths in hospital waiting rooms, deaths on waiting lists](#) and [failures in A&E services](#) this cannot be regarded as unfortunate errors. It is more systematic than that. It is a failure of the regulatory systems.

The issue is what can be done about it. As always [Deepdyve](#) provides a treasure trove of articles of relevance [This one from the Statute Law Review discusses issues involved in suing the state for negligent legislation](#).

The authors argue that, *It cannot be right for individuals to have no redress for harm suffered by legislative negligence*, or in effect wilful blindness in refusing to act to enact legislation to solve manifest problems.

Yet another from the [Medical Law Review](#) discusses gross negligence manslaughter in healthcare and the increasingly punitive approach to blaming individual practitioners for injustices rather than authorities responsible for poor training, poor working conditions and long hours.

The article argues instead for restorative justice to compensate individuals adversely affected. This has been fiercely resisted on the grounds of the costs involved.

Yet another article from Statute Law Review discusses [the idea of strict liability](#). Principally whether '*mens rea*' or the notion of knowledge of wrong doing is required to determine liability. Extending this discussion, it would be difficult to hold as a defence that no one knows that capping health and social care expenditure

isn't detrimental to those at the thresholds of care, that extended periods on waiting lists result in deaths, or that waiting for emergency care for a very long time without adequate care and attention results in deaths and harm.

As an aside, the discussion in the first article helps to explain the fervent dislike in some quarters to the European Convention and Court of Human Rights.

There is a fear that States could be held liable for damages subject to an applicant showing that they relied upon a right identified from a European Community measure, and secondly, that the applicant would have to show a causal link between the State's breach of its obligations and the harm suffered (this would extend to measures not directly affective). Subsequently the principle was extended to non-implementation of European directives but also where the implementation of legislation is found to be ineffective and/or insufficient.

It seems that State Liability was already operational in the legal systems of all 27 Member States in 2007 when the article was written. I cite this not to reargue the case for membership of the European Community but to suggest that the State has a liability for ensuring effective delivery of healthcare. [For a further discussion see this article](#) from OpininioJuris.

My assertion is that this legal bolster to healthcare rights in other European countries such as France and Germany, guides policy-making whereas in the UK, the ability to claim damages requires the identification of deliberate negligence. That's why the UK gets away with its relatively poor performance, with impunity. It's a pity this was not made clear in the debate on membership of the EU. I suspect we will be revisiting the debate on regulatory and legislative negligence in the future.

What is the impact of Numerus Clausus?

Numerus Clausus refers to agreements for training numbers for doctors set nationally in France, Germany and the UK. I raise the matter again because NHS England [issued an update on Training numbers on 28 February](#). Whilst promising to double numbers in the future it claims credit for increasing training numbers by a paltry 71 in September 2023. I am reminded in turn of 2012 when [Dan Poulter as Minister for Health in that year cut the number of trainees by 2% and a further 3% in 2015 because of worries of oversupply](#).

It was madness then and all predictions made by commentators at the time, including myself, have come true. It has cut quality and increased costs.

The policy of pandering to professional concerns of oversupply is counterproductive. The solution to a supply problem is to increase supply.

Roundup from around Europe

It is instructive that in a [recent Parliamentary report on Prevention and Social Care](#) drawing attention to the social determinants of health, predominantly housing, but also access to a good environment and social services, that no effort was made to compare the quality of housing across Europe and access to social services and transport.

If our parliamentarians took the trouble, they would [identify data showing the UK with the smallest residence size in Europe](#); almost the highest level of tenants paying full market price; and with the largest proportion of financially overburdened residents.

Furthermore it would be informative to compare the UK to other European countries as comprehensively compared in this report from the European Commission, [access to essential services](#). It compares each European country in terms of access to water and sanitation, access

to energy, access to transport, digital communications and financial services.

There is a further set of reports [looking at access to social services](#) published over recent years. Perhaps the Parliamentary Health and Social Care Committee should ask how the UK compares. Then they might learn something.

[The Nuffield Trust](#) discusses how the UK 'lags at least two decades behind many other countries [in provision of social care] such as [Germany](#), [Denmark](#), Japan and [South Korea](#), which foresaw the future pressures and addressed them by putting in the building blocks of a functioning system'. It's becoming increasingly difficult to see how this inaction can continue. As the next election gets closer it is noticeable that neither main party wants to go there. The Nuffield Trust provides links to lots of recent work on Social Care. But is anyone listening?

The European Observatory on Health Systems and Policies meanwhile reminds us that Scotland appears to have gone back to the drawing board on its plans to establish a National Care Service.

This announcement follows a series of delays and alterations reflecting concerns from local government and civil society bodies and parliamentary committees.

These led in 2023 to a decision to delay passage through the Scottish Parliament and an agreement with local government that they would retain responsibility for delivery and ownership of assets.

Common areas of concern included a lack of detail on funding and governance, and challenges to the assumption that removing powers from the local level was necessary to improvement.

In Autumn 2023, there had been a National Forum where Scottish Government officials engaged with stakeholders about the Bill, and

signals from the Scottish Government that the radicalism of change would be tempered.

The National Care Service as originally envisioned would have removed responsibility for social care in Scotland from local authorities and moved it to 31 care boards. These care boards would replace integrated joint boards (which integrate health and local authority services), and take on their responsibility for community health services. Each care board would be directly responsible to Scottish Government ministers. The new structure was supposed to achieve goals set out by the 2021 independent review of adult social care, which argued for national driving of improvement and standardised terms and conditions for staff across Scotland. The process of change was intended to be complete by 2026.

Scotland has full autonomy to decide its own health and social care policies but is still finding it difficult to break away from the English model.

I draw attention to the English estates data base. It's a mine of easily accessible information on the NHS estate. I can find no European national equivalent. If only politicians took notice. The messages about cost increases well above headline inflation levels and the rise in backlog maintenance are clear enough.

The total costs of running the NHS estate were £12.4 billion. This is an increase of 12 per cent since 2021/22. The total cost to eradicate the estates maintenance backlog was £11.6 billion, an increase of 13.6 per cent since 2021/22.

[The UK Institute of Government](#) examines the fate of so-called 'independent' regulators. The link discusses the case of David Neal, the independent chief inspector of borders and immigration (ICIBI) who had given interviews to the press about some of the findings of the backlog of reports sitting unpublished in the Home Office.

The Home Secretary's reaction was a peremptory sacking for breaching the terms of his contract.

I cannot understand why Cleverly remains a minister (although he has been recently demoted).

As the article discusses, Parliament needs to ensure departments cannot hobble those overseeing them; an absolutely basic requirement is the right of overseers to make their findings public; and, Government should ensure that independent control of publication is the rule. [If only walls had ears](#). A review is taking place into the role of regulators and inspectors but I suspect the issue will be kicked into the long grass.

To add balance, the [German financial services](#)

regulators is not unknown elsewhere. But that was different.

The EU observer provides a good review of health issues across Europe. It recently published a [special investigation](#) into asbestos fibres in drinking water as a cause of the rising levels of cancer of the stomach, colon and rectum. Asbestos is in fact the number one cause of workplace fatalities in the EU, with around 90,000 people dying each year from asbestos-related cancers. [Unfortunately it looks like this is an issue for national governments.](#)

[There seems to be a lot of bowel cancer around](#) as this article from the Guardian shows: there has been an 80% rise in cancer for the under 50's worldwide (except in France).

I'll be getting my test done at least. Look after yourselves.

[regulator was sacked in 2020](#) so sacking of