
LEGAL AND ECONOMIC ASPECTS OF HEALTHCARE SYSTEMS IN FRANCE AND UNITED KINGDOM

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1. INTRODUCTION

France and the United Kingdom are separated only by the 33.3 kilometers wide Strait of Dover, but they have completely different state and legal systems as well as many other determinants of their functioning. Their healthcare systems also differ, but according to the *Euro Health Consumer Index*,¹ the *Sustainability Index*² and the

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¹ A. Björnberg, A. Yung Phang, *Euro Health Consumer Index 2018*, Health Consumer Powerhouse 2019, pp. 24–25.

The Euro Health Consumer Index is considered the most significant healthcare systems evaluation tool in Europe. Among its criteria there are: patient rights and information (patient organizations involved in decision-making, the right to second medical opinion, access to own medical record, registry of bona fide doctors, access to web or twenty-four hour and seven-day telephone health consultant information, possibility of cross-border care seeking, catalogue of providers with quality ranking, e-accessible patient records, online booking of appointments and e-prescriptions); accessibility (family doctor same-day access, direct access to a specialist, major elective surgery in less than ninety days, cancer therapy in less than twenty-one days, CT scan in less than seven days, waiting time for pediatric psychiatry); outcome (thirty-day AMI case fatality, thirty-day stroke case fatality, infant deaths, cancer survival, deaths before sixty-five years of age, MRSA infections, abortion rates, suicide rates, diabetes patients with HbA1c higher than seven); range and reach of services provided (equity of healthcare systems, cataract operations per 100,000 people sixty-five and more years old, kidney transplants per million population, dental care including in public healthcare, informal payments to doctors, long-term care for the elderly people, percentage of dialysis done outside of the clinic, caesarean sections); prevention (infant eight-disease vaccination, blood pressure, smoking prevention, alcohol, physical activity, HPV vaccination, traffic deaths); and pharmaceuticals (Rx subsidy, novel cancer drugs deployment rate, access to new drugs, arthritis drugs, statin use, antibiotics per capita).

² *The Sustainability Index 2018*, Future Proofing Healthcare 2018, <https://futureproofinghealthcare.com/sustainability-index> (accessed on 17.06.2019).

Commonwealth Fund Comparison,³ they both belong to the twelve most effective ones in Europe. The other operate in Austria, Belgium, Denmark, Finland, Germany, Luxembourg, the Netherlands, Norway, Sweden and Switzerland.

The life expectancy at birth in France is one of the highest among the European Union countries and reached 82.4 years in 2015, while the amenable mortality is one of the lowest and dropped to 78 people per 100,000 population in 2014. The unmet care needs amounted to 1.4% in 2015. The health condition of French people is high, but there are disparities among them resulting from gender and economic as well as social status. Some segments of the healthcare system of the country need improvement. These are: prevention and better serving the increasing number of chronically ill persons.⁴

In the case of the United Kingdom, the life expectancy at birth reached 81.0 years in 2015, the amenable mortality amounted to 116 people per 100,000 population in 2014 and the unmet care exceeded 3% in 2015. The health condition of the population of the United Kingdom is improving. Men and women live longer than before but not in good health during these additional years. The whole healthcare system consists of four delegated health subsystems in England, Northern Ireland, Scotland and Wales. The recent policy of the country is to achieve higher integration of them with “place-based” care, which will improve efficiency of the services.⁵

2. LEGAL REGULATION OF HEALTHCARE IN FRANCE

At the beginning, the healthcare system in France was based on a Bismarck model of payment for the medical care and supply of health services and products. Its first law was published in 1902.⁶ Until 1930 more than 60% of citizens of the country were covered by the mutual insurance associations. During decades, however, the French healthcare has been gradually tending towards the Beveridge model and now it is the mixture of the both.⁷

The above models are defined as follows: “Bismarck healthcare systems: Systems based on social insurance, where there is a multitude of insurance organisations, Krankenkassen etc., who are organisationally independent of healthcare providers. Beveridge systems: Systems where financing and provision are handled within one

³ E.C. Schneider et al., *Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally*, The Commonwealth Fund, New York 2017, <https://www.commonwealthfund.org> (accessed on 6.09.2019).

⁴ OECD/European Observatory on Health Systems and Policies, *State of Health in the EU. Country Health Profile 2017: France*, OECD Publishing, https://ec.europa.eu/health/sites/health/files/state/docs/chp_fr_english.pdf, pp. 1–2.

⁵ OECD/European Observatory on Health Systems and Policies, *State of Health in the EU. Country Health Profile 2017: United Kingdom*, OECD Publishing, https://ec.europa.eu/health/sites/health/files/state/docs/chp_uk_english.pdf, pp. 1–2.

⁶ L. Chambaud, C. Hernández-Quevedo, France, [in:] B. Rechel et al. (eds), *Organization and Financing of Public Health Services in Europe: Country Reports*, Copenhagen 2018, p. 23.

⁷ K. Chevreul, K. Berg Brigham, I. Durand-Zaleski, C. Hernández-Quevedo, *France: Health System Review*, WHO/European Observatory on Health Systems and Policies: Health Systems in Transition Vol. 17, No. 3, 2015, p. 19.

organisational system, i.e. financing bodies and providers are wholly or partially within one organisation, such as the NHS of the UK, counties of Nordic states, etc.”⁸

The statutory organization of French healthcare system was introduced in 1930 under the Act on Social Insurance, which guaranteed health protection to employees with earnings lower than the fixed level. Payments for their healthcare were contributed by employers and covered illness, disability, maternity, advanced age and death. In 1945 the national social health insurance system (*l'assurance-maladie*, SHI) with many different schemes was launched. At the beginning, SHI was dedicated to workers and their families only. Year by year, it has been extended to the whole population.⁹

The next crucial step was made in 1999 along with the Universal Health Coverage Act (*Loi No. 99-641 du 27 juillet 1999 portant création d'une couverture maladie universelle*). It combined the privileges resulting from SHI with the residency of the insured persons and created the CMU Fund (*Fonds CMU*), which provides public coverage to the people with income lower than the certain limit. Citizens who earn more than that level and are not covered by SHI, pay part of the cost of their care. Foreigners who live in France three months and longer are entitled to state medical assistance (*l'aide médicale de l'État*, AME).

The health policy priorities in France are regulated by its parliament with the public health acts. The first Public Health Act was adopted in 2004 (*Loi No. 2004-806 du 9 août 2004 relative à la politique de santé publique*). In 2009 the Hospital, Patients, Health and Territories Act created twenty-seven Regional Health Agencies which were reduced to eighteen in 2016.

In 2014 the Interministerial Health Committee (*le Comité interministériel pour la santé*) was established, and subsequently the relations between the national and the regional levels of the system were introduced and 100 indicators (which illustrate the condition of health of the population and effectiveness of the health system) defined.¹⁰

The next regulation, the Law on Modernisation of Healthcare System, was announced in 2016. Its aim was to intensify prevention, amplify primary care and unwrap patient rights. It established the Public Health Agency (*l'agence nationale de santé publique*, called *Santé publique France*, SPF), which merged three former bodies, i.e. the French Institute for Public Health Surveillance (*l'institut national de veille sanitaire*, InVS), which was monitoring health condition of the nation and alerting; the National Institute for Prevention and Health Education (*l'institut national de prévention et d'éducation pour la santé*, INPES); and the Health Emergency Preparedness and Response Agency (*l'établissement de préparation et de réponse aux urgences sanitaires*, EPRUS), responsible for reacting to serious health crisis and dangers in France and elsewhere.¹¹

⁸ A. Björnberg, A. Yung Phang, *Euro Health Consumer Index 2018*, op. cit., p. 21.

⁹ K. Chevreul et al., *France: Health System Review*, op. cit., p. 22.

¹⁰ L. Chambaud, C. Hernández-Quevedo, *France*, [in:] B. Rechel et al. (eds), *Organization*, op. cit., pp. 23–24.

¹¹ *Ibid.*, p. 24.

The Ministry of Health and Solidarity (*le Ministère des Solidarités et de la Santé*) prepares periodically the National Strategy for Health (*la stratégie nationale de santé*). The last strategies and the present one (for 2018–2020) intended to minimise social and geographic health differences, to increase prevention and care for chronic illnesses, to improve efficiency and equity of the whole French health system, to empower patient rights, to increase patient participation in designing health policy and in managing of health agencies, and to reach other healthcare goals.

The French parliament votes on the annual Social Security Finance Acts. The following institutions participate in preparing them:

- the Auditors Office (*la Cours des comptes*), which monitors state and social organizations on proper use of public sources,
- the High Council for the Future of Health Insurance (*le Haut Conseil pour l'avenir de l'assurance maladie*, HCAAM),
- the High Council for Public Health (*le Haut Conseil de la santé publique*, HCSP),
- the National Health Conference (*la Conférence nationale de santé*, CNS).

The Ministry of Health and Solidarity is the highest authority of the French Administration of Health and Social Affairs (*l'administration sanitaire et sociale*). It comprises of the General Directorate of Health (*la Direction générale de la santé*) which oversees healthcare policy, the General Directorate of Healthcare Supply (*la Direction générale de l'organisation des soins*) which supervises capital and human assets, the Directorate of Social Security (*la Direction de la sécurité sociale*) which is responsible for the social security system and the General Directorate for Social Policy (*la Direction générale de la cohésion sociale*) which oversees health and social care for older, disabled and vulnerable people.¹²

The representatives of the ministry in charge of health, the ministries responsible for public accounts and for social security, the SHI and the National Solidarity Fund for Autonomy (*la Caisse nationale de solidarité pour l'autonomie*, CNSA) form the National Steering Council (*le Conseil national de pilotage*, CNP) which supervises Regional Health Agencies (*Agences régionales de santé*, ARS) representing the Administration of Health and Social Affairs at the regional level.

A significant role in the French healthcare system is played by the French National Health Authority (*la Haute Autorité de Santé*, HAS), which is an independent public body with a wide range of activities aiming to keep and constantly improve the quality and efficiency of healthcare. There are also other agencies and public bodies, dependent on the ministry or more or less independent. The most important among them are:

- the French Biomedicine Agency (*l'Agence de la biomédecine*) responsible for reproductive technologies, prenatal and genetic diagnosis, embryo and stem cell research, procurement and transplant of organs, tissues and cells,
- the French National Agency for Medicines and Health Products Safety (*l'Agence nationale de sécurité du médicament et des produits de santé*, ANSM) responsible for all safety decisions referring to health products,

¹² K. Chevreur et al., *France: Health System Review*, op. cit., pp. 23–24.

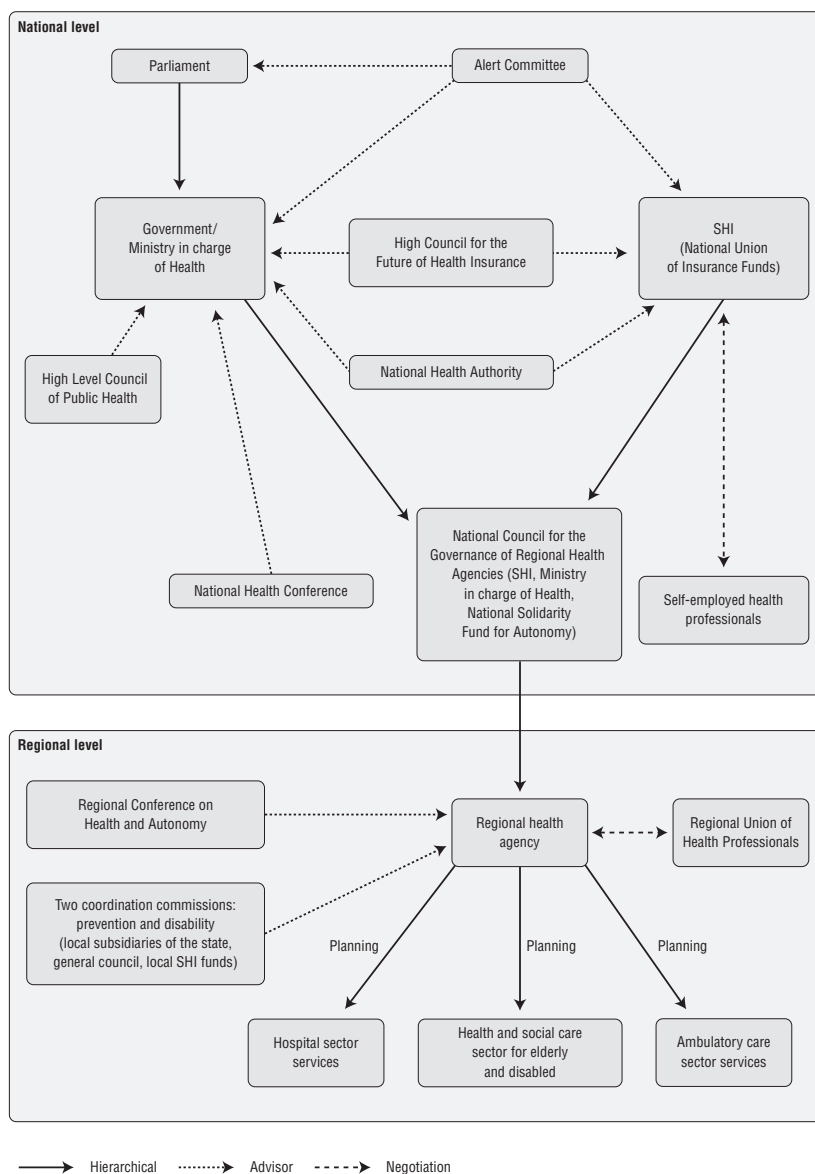
- the French Blood Agency (*l'Établissement français du sang, EFS*),
- the French Agency for Food, Environmental and Occupational Health Safety (*l'Agence nationale de sécurité sanitaire de l'alimentation, de l'environnement et du travail, ANSES*),
- the Radioprotection and Nuclear Safety Institute (*l'Institut de radioprotection et de sûreté nucléaire, IRSN*),
- the Agency for Information on Hospital Care (*l'Agence technique de l'information sur l'hospitalisation, ATIH*),
- the National Agency to Support the Performance of Health and Health and Social Care Institutions (*l'Agence nationale d'appui à la performance des établissements de santé et médico-sociaux, ANAP*) which advises and helps entities providing health and social care and supports the Ministry and Regional Health Agencies,
- the National Agency for the Quality Assessment of Health and Social Care Organizations and Services (*l'Agence nationale de l'évaluation de la qualité des établissements et services sociaux et médico-sociaux, ANESM*),
- the Prudential Control and Resolution Authority (*l'Autorité de contrôle prudentiel et de résolution, ACPR*) which supervises voluntary health insurance suppliers,
- the National Union of Complementary Health Insurance Organizations (*l'Union nationale des organismes d'assurance maladie complémentaire, UNOCAM*),
- the School of Public Health (*l'École des hautes études en santé publique, EHESP*),
- the National Institute for Cancer (*l'Institut national du cancer, INCa*).¹³

In France there are also professional organizations associated with healthcare which may be divided into the two groups: professional associations or chambers (*conseils de l'ordre*) and trade unions. They are organized in the regional unions of health professionals (*Unions régionales des professionnels de santé*) and the National Union of Health Professionals (*l'Union nationale des professions de santé*).¹⁴ Figure 1 presents the organizational overview of the French healthcare system.

¹³ *Ibid.*, pp. 26–28.

¹⁴ *Ibid.*, p. 30.

Figure 1. Overview of the health system in France, 2014



Source: K. Chevreur, K. Berg Brigham, I. Durand-Zaleski, C. Hernández-Quevedo, *France: Health System Review*, WHO/European Observatory on Health Systems and Policies: Health Systems in Transition Vol. 17, No. 3, 2015, p. 21.

3. ORGANIZATION AND ECONOMICS OF HEALTHCARE IN FRANCE

The general feature of the healthcare system in France is its social insurance based on the mix of Bismarckian and Beveridgean models (see Introduction).¹⁵ The whole French social insurance is divided into the statutory one (SHI), which covers 99% of population, and the complementary one (VHI), which is used by about 95% of inhabitants.¹⁶ In 2012 SHI financed 75.4% of the personal healthcare expenditure and 74.3% of the total national healthcare spending (74.7% in 2013).¹⁷

SHI acts through a number of schemes which depend on professions and place of work of their holders. It receives financial resources from employers and taxpayers, taxes on tobacco, on alcohol and from pharmaceutical firms. On the other hand, it offers benefits of two types (in-kind and in-cash) which are connected with the lists of medical procedures for physicians and other healthcare specialists, reimbursable medicines, medical devices and health materials. Since the moment of its creation, SHI has been financing the curative care connected with illnesses and accidents. Now it covers more and more preventive care. As distinct from SHI, the complementary social insurance finances approximately 14% of the total healthcare expenditure.¹⁸

The total publicly funded health expenditure in France amounts to 79%, and is among the highest shares in the European Union, while the out-of-pocket payments of patients account for 7% only, which makes the lowest percentage in the UE, much below the average amounting to 15%. The total health spending in France per capita in 2017 came to USD 4,931 (in 2018 estimated USD 4,965)¹⁹ and ranked ninth in the European Union, however as the percentage of GDP allocated to health (11.3%) it was the second highest.²⁰ Figure 2 shows the financial flows in the French healthcare system.

Healthcare services in France are provided mostly by self-employed physicians, hospitals and other entities. Hospitals belong to the state, non-profit bodies owned by foundations, religious organizations and mutual-insurance associations and private profit-making units. The responsibility for planning their resources and activities as well as supervising them is shared between the Ministry of Health and Solidarity, and Regional Health Agencies.

15 A. Björnberg, A. Yung Phang, *Euro Health Consumer Index 2018*, *op. cit.*, p. 21.

16 OECD/European Observatory on Health Systems and Policies, *State of Health in the EU. Country Health Profile 2017: France*, *op. cit.*, p. 6.

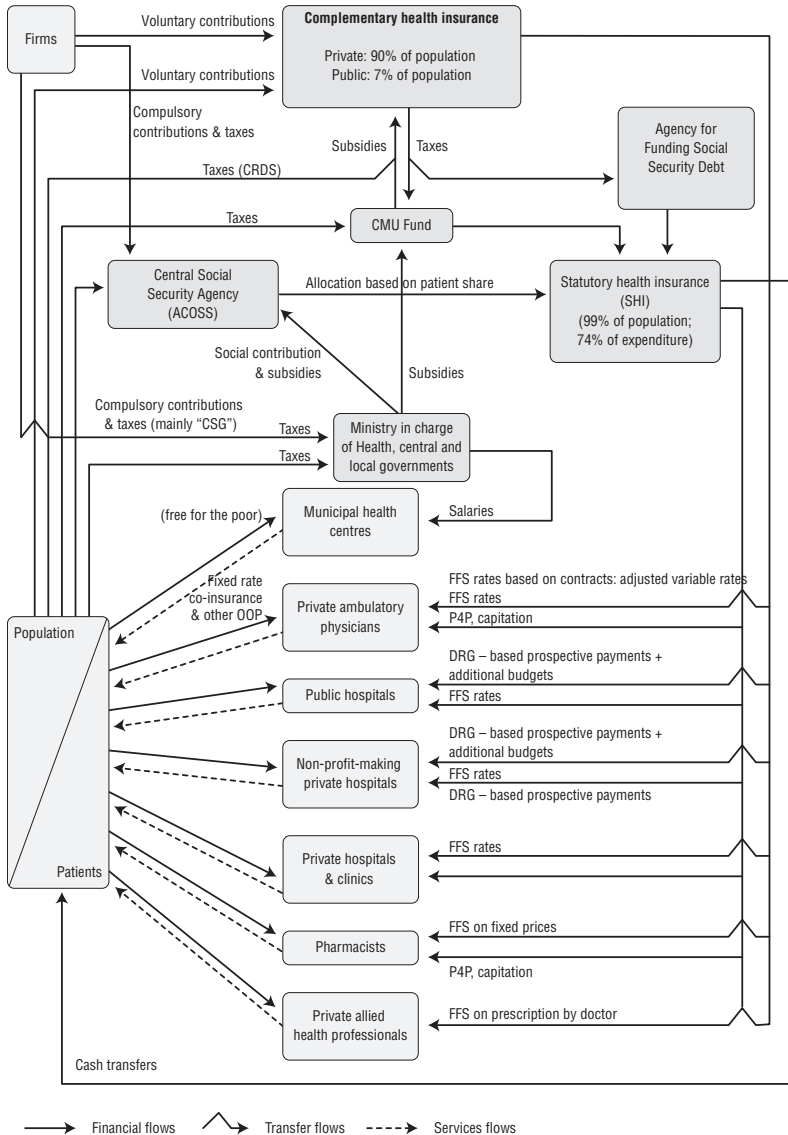
17 K. Chevreur et al., *France: Health System Review*, *op. cit.*, p. 68.

18 OECD/European Observatory on Health Systems and Policies, *State of Health in the EU. Country Health Profile 2017: France*, *op. cit.*, p. 6.

19 OECD, *Health Statistics 2017*.

20 *Ibid.*

Figure 2. Financial flows in the French healthcare system (excluding long-term care and prevention)



Source: K. Chevreur, K. Berg Brigham, I. Durand-Zaleski, C. Hernández-Quevedo, *France: Health System Review*, WHO/European Observatory on Health Systems and Policies: Health Systems in Transition Vol. 17, No. 3, 2015, p. 70.

4. LEGAL REGULATION OF HEALTHCARE IN THE UNITED KINGDOM

The contemporary healthcare system in the United Kingdom follows the Beveridge model.²¹ It was inaugurated with the establishment of the National Health Service (NHS) in 1948. The NHS was dedicated to England, Scotland and Wales, while a semi-autonomous system operated in Northern Ireland. In the 1950s and 1960s, the NHS underwent the renewal of its properties and technologies. In 1972 Northern Ireland started to be governed directly by the United Kingdom government and its local healthcare system lost its autonomy.²²

In 1974 the NHS in England and Scotland were modernised under the National Health Service Reorganisation Act 1973, which created regional and area health administration as well as Family Practitioner Committees. The new territorial bodies had to integrate acute, community and preventive services. Because they started to be seen as non-efficient, in 1980 they were converted from the area health authorities to the district ones. In 1990, with the National Health Service and Community Care Act, the government established the internal market which separated purchasing and delivery of medical services. The aim was to increase their quality, competitiveness and efficiency. The Act introduced GP fundholding which allowed general practitioners with 11,000 or more patients to ask for their own budget. The general practitioners together with district health administration became the most serious purchasers of services on behalf of their patients. Community services and hospitals (providers) were organized in semi-independent NHS trusts.²³

In 1997 the healthcare system in the United Kingdom was reshuffled again in the connection of withdrawing a part of political power from the central parliament to the local administrations in Scotland, Wales and Northern Ireland. As a result, the four countries of the UK started to have more and more diversified healthcare systems. In England, GP fundholding was removed. Primary care trusts (PCTs), responsible for primary and community healthcare replaced local health authorities. Regional health authorities were replaced with strategic health authorities (SHAs). Whole country standards and targets as well as stronger regulation and supervising were introduced. To cope with the new duties, the National Institute for Health and Clinical Excellence, converted in 2012 into the National Institute for Health and Care Excellence (NICE), and the Commission for Health Improvement, which became the Care Quality Commission (CQC) in 2009, were established.²⁴

Starting from 2002, the country health policy has been inspiring more strongly investors to increase private sector volume. It enforced the competition among suppliers of medical services and goods. The introduction of the Health and Social

²¹ A. Björnberg, A. Yung Phang, *Euro Health Consumer Index 2018, op. cit.*, p. 21.

²² J. Cylus, E. Richardson, L. Findley, M. Longley, C. O'Neill, D. Steel, *United Kingdom: Health System Review*, WHO/European Observatory on Health Systems and Policies: Health Systems in Transition, Vol. 17, No. 5, 2015, p. 14.

²³ *Ibid.*, pp. 14, 16.

²⁴ *Ibid.*, p. 16.

Care Act in 2012 eliminated a bunch of the obstacles which existed in buying NHS-financed services from different suppliers, including the private or voluntary sectors. Starting from 2014, the initiatives to strengthen internal competition and supply of private medical services have been introduced dynamically.²⁵

Over the time, some significant changes have been taking place in local English, Welsh, Scottish and Irish healthcare systems. For instance, Scotland limited the number of trusts which in 2004 were converted into the new health boards (LHBs). The separation between the buyer and the supplier in this part of the UK was eliminated in 2009 with a reduced number of bigger local health boards. In Northern Ireland such separation was continued, though the Health and Social Care (Reform) Act (NI) 2009 introduced substantial changes. Similar and various modifications have been done in all four countries composing the United Kingdom.²⁶

“While care has never been delivered the same way across the United Kingdom, the health care system is now perhaps more divided than ever, as health policy decisions are made at the level of individual nations. Nevertheless, despite this diversity in the way the systems are organized, some aspects of the regulatory framework continue to operate on a United Kingdom-wide basis in line with European standards”.²⁷

The UK Treasury (ministry of finance) prepares the budget for all kinds of social services in England, Northern Ireland, Scotland and Wales. The budget is built in the way proportional to the number of inhabitants but with several weightings (according to the Barnett Formula²⁸). The UK Department of Health (ministry of health) is responsible for the health system in England only, but also for national strategic policies, leadership and international cooperation of the whole United Kingdom. It cooperates with the health authorities of Northern Ireland, Scotland and Wales. Direct responsibility for the NHS and care services (except for England) was removed from it by the 2012 Health and Social Care Act.²⁹

The health and social care system in Scotland is administered by the Scottish Cabinet Secretary for Health and Wellbeing, which at the same time has the position of the Chief Executive of NHS Scotland. The similar, but varying in details, duties belong to the Director General, Health and Social Services in the Welsh government and the head of the Department of Health, Social Services and Public Safety (DHSSPS) in Northern Ireland.³⁰

The other important institutions of the UK healthcare system are the already mentioned National Institute for Health and Care Excellence (NICE) and the Medicines and Healthcare products Regulatory Agency (MHRA). The NICE is

²⁵ *Ibid.*

²⁶ *Ibid.*, p. 17.

²⁷ *Ibid.*

²⁸ M. Keep, *The Barnett Formula*, House of Commons Library, briefing paper No. 7386, 23 January 2018, <https://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7386> (accessed on 31.08.2019).

²⁹ J. Cylus et al., *United Kingdom: Health System Review*, *op. cit.*, pp. 17–18.

³⁰ *Ibid.*, pp. 20–21.

financed by the Department of Health but is independent in its activities. Its aim is to evaluate efficacy and costs of the new drugs and treatments and to deliver main clinical instructions and managerial advice for all entities dealing with health and social services, whereas the MHRA controls whether medicines are safe enough.³¹

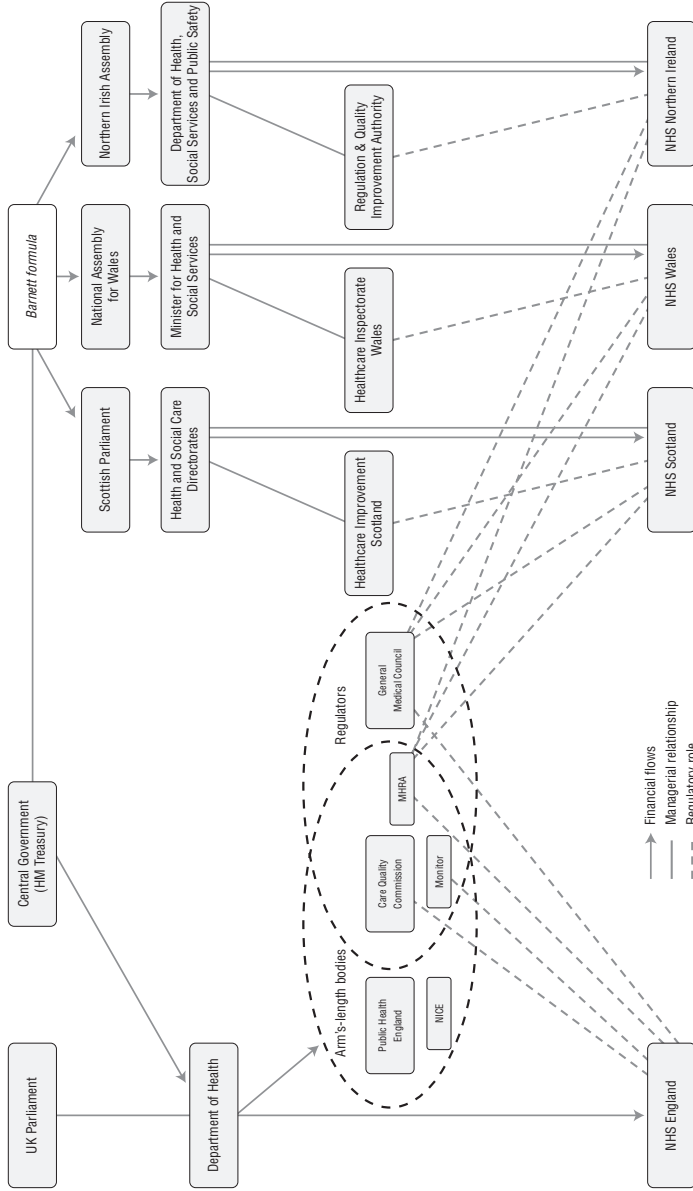
The other bodies are: the United Kingdom General Medical Council (GMC), which registers and disciplines doctors; the United Kingdom General Dental Council (GDC), which acts in the same scope for dentists; the United Kingdom Nursing and Midwifery Council (NMC), which is responsible for nurses and midwives; and the Great Britain General Pharmaceutical Council. Apart from them, some number of trade unions care about collective and individual interests of the people working in the health and social care in the United Kingdom. The British Medical Association (BMA), established in 1832, is completely independent and associates more than 60% of physicians in the country. The others are the British Dental Association (BDA), UNISON, Unite the Union, GMB, the Hospital Consultants and Specialists Association, the Academy of the Medical Royal Colleges with the Royal Colleges of Physicians, the Royal Colleges of Surgeons, the Royal Colleges of Midwives, the Royal Colleges of Nursing, and a bunch of less significant ones.

Private and non-profit sectors, which play the supplementary role in the UK healthcare system, undergo the same national regulations as the NHS. The health employees in public and private sectors are registered and licensed in the same way. According to the 2012 Health and Social Care Act, the NHS may buy medical services from private suppliers to broaden their offer to the people. In Scotland private providers are used only to shorten the waiting time for treatments. Some NHS hospitals deliver services also to patients that pay for them. Dental and ophthalmic care is mostly private.³² Figure 3 presents the organizational overview of the healthcare system in the United Kingdom.

³¹ *Ibid.*, pp. 21–22.

³² *Ibid.*, p. 23.

Figure 3. Overview of the health system in the United Kingdom



Source: J. Cylus, E. Richardson, L. Findley, M. Longley, C. O'Neill, D. Steel, *United Kingdom: Health System Review*, WHO / European Observatory on Health Systems and Policies: Health Systems in Transition, Vol. 17, No. 5, 2015, p. 15.

5. ORGANIZATION AND ECONOMICS OF HEALTHCARE IN THE UNITED KINGDOM

“Each of the United Kingdom countries has its own advisory, planning and monitoring framework for its health system and its own Public Health agencies to tackle health protection and inequalities.”³³

In 2017 the total health expenditure of the United Kingdom grew to 9.6% of its GDP (estimated 9.8% in 2018) and was equal to the average in the European Union. In terms of the purchasing power, it amounted to USD 3,943 (estimated USD 4,070 in 2018).³⁴ The 80% of the total health expenses was financed from public sources, while the average level in the European Union was 79% in the same time. The government distributed its money (mostly coming from general taxation) in England directly, and in Northern Ireland, Scotland and Wales through block grants. These grants were then distributed to local receivers and targets in the three countries on the basis of their own budgets, priorities and needs. Devolved administrations made decisions which services are preferred in the constrained budgetary limits. The out-of-pocket spending amounted to 15% of the national health expenses which was equal to the European Union level. The same spending as the share of domestic costs was the third lowest in the EU (1.5% against 2.3%).³⁵

The estimates pointed that in 2021 the deficit in the public NHS financing will reach GBP 30 billion, and to avoid it, the additional money had to be invested into the health system. The number of hospital beds in 2015 was the third lowest in the European Union (similar to Ireland; 2.6 per 1,000 citizens versus 5.1 in the EU). The same situation referred to doctors (2.8 per 1,000 and 3.6 in the EU).³⁶

In 2015 in the whole UK there were 155 acute and 56 mental NHS trusts in England, most of them with several hospitals, with proportionally lower numbers in the three remaining countries. Around 11% of the citizens of the United Kingdom had (in 2013) private health insurance of various kinds, what equaled to 4 million people. In this number, 18% of the insured people bought it individually and 82% were provided with it by their employers.³⁷ Figure 4 shows financial flows in the UK healthcare system.

³³ OECD/European Observatory on Health Systems and Policies, *State of Health in the EU. Country Health Profile 2017: United Kingdom*, op. cit., p. 6.

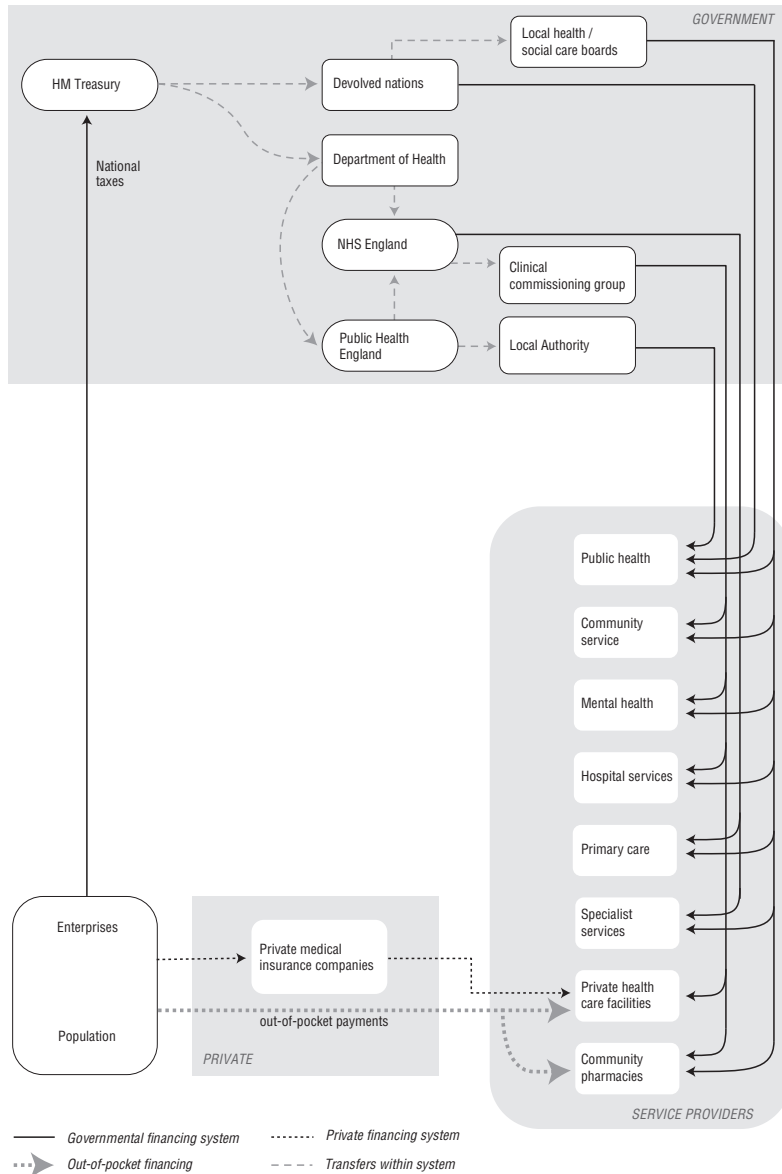
³⁴ OECD, *Health Statistics 2017*.

³⁵ OECD/European Observatory on Health Systems and Policies, *State of Health in the EU. Country Health Profile 2017: United Kingdom*, op. cit., p. 1.

³⁶ *Ibid.*, p. 7.

³⁷ J. Cylus et al., *United Kingdom: Health System Review*, op. cit., p. 64.

Figure 4. Financial flows in the healthcare system of the United Kingdom



Source: J. Cylus, E. Richardson, L. Findley, M. Longley, C. O'Neill, D. Steel, *United Kingdom: Health System Review*, WHO/European Observatory on Health Systems and Policies: Health Systems in Transition, Vol. 17, No. 5, 2015, p. 49.

6. CONCLUSIONS

France and the United Kingdom are separated only by the sea strait, but the organization of their states and various internal systems differs to a large extent. This refers also to their healthcare systems. In France, the healthcare is administratively centralized but provided by many different entities. Over the decades, it has passed from the clear Bismarck model to the mixed one with the Beveridge influences. In the United Kingdom, it is split between its four inner countries (England, Northern Ireland, Scotland and Wales) which have worked out a significant amount of their own health competencies and decisions. The central government does not interfere too much in their local regulations. Apart from this, the national health institution, the NHS, is almost the monopolist insuring and providing institution on the health market. According to the European and U.S. health statistics, both systems belong to the twelve most efficient in the European Union. The American medical data (measuring more categories than the UE) show significant supremacy of the United Kingdom healthcare system in terms of performance over the French one,³⁸ but more European health statistics place the French system much ahead of the British one.

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³⁸ See E.C. Schneider et al., *Mirror, Mirror*, *op. cit.*

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LEGAL AND ECONOMIC ASPECTS OF HEALTHCARE SYSTEMS IN FRANCE AND UNITED KINGDOM

Summary

The article presents the essential legal regulations, organization and economics of the healthcare systems in France and the United Kingdom. In order to provide the bird's-eye view of these systems, the fundamental acts introducing them have been presented. Other most important regulations and principal bodies introducing, consulting and controlling them

have been enumerated. The principal economic conditions and organization of the health systems in both countries have been discussed. The organizational overviews of both systems and their financial flows have been included. The whole analysis aimed to deliver primary information on how one of the most centralised healthcare systems in the European Union with many providers (the French one), compared with one of the most devolved in the EU but based mainly on one NHS provider (the UK one), have nearly similar effectiveness, i.e. provide nearly equalized medical services to their citizens.

Keywords: legal aspects, economic aspects, healthcare systems, France, United Kingdom

PRAWNE I EKONOMICZNE ASPEKTY SYSTEMU OCHRONY ZDROWIA WE FRANCJI I W WIELKIEJ BRYTANII

Streszczenie

Artykuł przedstawia główne regulacje prawne, organizację i ekonomiczne uwarunkowania systemów ochrony zdrowia we Francji i w Wielkiej Brytanii. W celu przedstawienia widoku z lotu ptaka na oba te systemy, zostały wymienione najważniejsze akty prawne, przy pomocy których je wprowadzono. Zostały także wskazane inne znaczące uregulowania prawne, odnoszące się do obu systemów oraz główne instytucje tworzące, konsultujące i kontrolujące je. Pokazano również podstawowe warunki ekonomiczne i organizację obu systemów. W tekście znalazły się ich schematy organizacyjne oraz diagramy ukazujące przepływy finansowe pomiędzy najważniejszymi ich częściami składowymi. Artykuł ma na celu dostarczenie wstępnych informacji o tym, jak jeden z najbardziej scentralizowanych systemów ochrony zdrowia w Unii Europejskiej, oparty na dużej liczbie dostawców (francuski), porównany z jednym z najbardziej rozproszonych w UE, ale opartym głównie na jednym narodowym dostawcy pod nazwą NHS (brytyjskim), mają zbliżoną efektywność, a więc dostarczają niemal wyrównane produkty medyczne swoim mieszkańcom.

Słowa kluczowe: aspekty prawne, aspekty ekonomiczne, systemy ochrony zdrowia, Francja, Wielka Brytania

ASPECTOS LEGALES Y ECONÓMICOS DEL SISTEMA DE PROTECCIÓN DE LA SALUD EN FRANCIA Y EN GRAN BRETAÑA

Resumen

El artículo presenta la regulación principal, organización y condiciones económicas del sistema de protección de la salud en Francia y en Gran Bretaña. Para presentar estos dos sistemas se mencionan las leyes más importantes que los implementan y también otras regulaciones que afectan estos dos sistemas y las instituciones principales, que los crean, sirven de consulta y los supervisan. El artículo presenta también las condiciones económicas básicas y la organización de ambos sistemas. Incluye esquemas de organización y diagramas que demuestran flujos financieros entre las partes integrantes de los sistemas. El artículo pretende aportar información básica sobre uno de los sistemas de protección de la salud más centralizados en la Unión Europea, basado en número elevado de contribuyentes (el sistema francés) y lo compara con uno de los sistemas más dispersos en la UE, basado principalmente en un contribuyente

nacional denominado NHS (perteneciente al Reino Unido). El resultado de esta comparación demuestra que la efectividad de ambos sistemas es similar, suministran casi iguales productos médicos a sus ciudadanos.

Palabras claves: aspectos legales, aspectos económicos, sistema de protección de la salud, Francia, Reino Unido

ПРАВОВЫЕ И ЭКОНОМИЧЕСКИЕ АСПЕКТЫ СИСТЕМЫ ЗДРАВООХРАНЕНИЯ ВО ФРАНЦИИ И ВЕЛИКОБРИТАНИИ

Резюме

В статье представлены основные правовые нормы, организационные и экономические условия систем здравоохранения во Франции и Великобритании. Чтобы представить обе эти системы с высоты птичьего полета, были перечислены наиболее важные правовые акты, с которыми эти системы были введены. Указаны также другие важные правовые нормы, относящиеся к обеим системам, а также основные учреждения, создающие, консультирующие и контролирующие их. Также показаны основные экономические условия и организация обеих систем. Текст включает их организационные структуры и диаграммы, показывающие финансовые потоки между их наиболее важными компонентами. Целью статьи является предоставление предварительной информации о том, как одна из самых централизованных систем здравоохранения в Европейском Союзе, основанная на большом количестве поставщиков (французская), по сравнению с одной из самых рассредоточенных в ЕС, но базирующейся в основном на одном национальном поставщике под названием NHS (принадлежащая Соединенному Королевству), имеют аналогичную эффективность и, следовательно, предоставляют почти равные медицинские продукты своим жителям.

Ключевые слова: правовые аспекты, экономические аспекты, системы здравоохранения, Франция, Великобритания

RECHTLICHE UND WIRTSCHAFTLICHE ASPEKTE DES GESUNDHEITSSYSTEMS IN FRANKREICH UND GROSSBRITANNIEN

Zusammenfassung

In dem Artikel werden die wichtigsten gesetzlichen Regelungen, die Organisation und die wirtschaftlichen Rahmenbedingungen der Gesundheitssysteme in Frankreich und Großbritannien vorgestellt. Um dem Leser einen Überblick über beide Systeme zu verschaffen, werden die wichtigsten, den jeweiligen Gesundheitssystemen zugrunde liegenden Rechtsakte und die entsprechenden Durchführungsbestimmungen dargelegt. Es werden auch sonstige, auf beide Systeme anwendbare, wichtige gesetzliche Regelungen angeführt und die wichtigsten Institutionen benannt, von denen die Gesundheitssysteme ausarbeitet, konsultiert und kontrolliert werden. Dargestellt werden die wirtschaftlichen Rahmenbedingungen und die Gestaltung beider Systeme. Organigramme zeigen die Organisationsstruktur beider Gesundheitssysteme und in Diagrammen werden die Finanzströme zwischen den wichtigsten Elementen dargestellt. Der Artikel soll erste Informationen darüber liefern, wie eines der am stärksten zentralisierten Gesundheitssysteme der Europäischen Union, das sich auf eine große Anzahl von Anbietern von Gesundheitsdienstleistungen stützt (Frankreich) und eines der dezentralsten Systeme in der EU,

das im Wesentlichen auf einem einzigen nationalen Gesundheitsdienstleister, dem NHS beruht (Vereinigtes Königreich) eine etwa gleiche Effizienz aufweisen, das heißt wie beide Gesundheitssysteme den Bewohnern der jeweiligen Länder nahezu gleiche Medizinprodukte bereitstellen.

Schlüsselwörter: rechtliche Aspekte, wirtschaftliche Aspekte, Gesundheitssystem, Frankreich, Vereinigtes Königreich

ASPECTS JURIDIQUES ET ÉCONOMIQUES DU SYSTÈME DE SANTÉ EN FRANCE ET AU ROYAUME-UNI

Résumé

Cet article présente les principales réglementations légales, l'organisation et les conditions économiques des systèmes de santé en France et au Royaume-Uni. Afin de présenter une vue à vol d'oiseau de ces deux systèmes, les actes juridiques les plus importants avec lesquels ils ont été introduits ont été énumérés. D'autres réglementations juridiques importantes faisant référence aux deux systèmes et aux principales institutions qui les créent, les consultent et les contrôlent ont également été indiquées. Les conditions économiques de base et l'organisation des deux systèmes sont également présentées. Le texte inclut leurs organigrammes et diagrammes montrant les flux financiers entre leurs composants les plus importants. Cet article vise à fournir des informations préliminaires sur la manière dont l'un des systèmes de santé les plus centralisés de l'Union européenne, basé sur un grand nombre de fournisseurs (français), comparé à l'un des plus dispersés de l'UE, mais principalement basé sur un fournisseur national dénommé NHS (appartenant au Royaume-Uni), ont une efficacité similaire et fournissent donc des produits médicaux presque égaux à leurs résidents.

Mots-clés: aspects juridiques, aspects économiques, systèmes de santé, France, Royaume-Uni

ASPETTI GIURIDICI ED ECONOMICI DEL SISTEMA SANITARIO IN FRANCIA E NEL REGNO UNITO

Sintesi

L'articolo presenta le principali regolamentazioni, l'organizzazione e le condizioni economiche dei sistemi sanitari della Francia e del Regno Unito. Per fornire una visione generale di entrambi i sistemi sono stati elencati gli atti giuridici più importanti attraverso i quali sono stati costituiti. Sono state anche indicate altre significative regolamentazioni giuridiche che fanno riferimento a entrambi i sistemi, nonché le principali istituzioni responsabili della loro creazione, consultazione e autocontrollo. Sono state anche mostrate le condizioni economiche fondamentali e le organizzazioni di entrambi i sistemi. Nel testo vi sono i loro schemi organizzativi e i diagrammi che mostrano i flussi finanziari tra le loro componenti più importanti. L'articolo ha lo scopo di fornire informazioni preliminari su come uno dei sistemi sanitari più centralizzati dell'Unione Europea, basato su un grande numero di fornitori (quello francese), e uno dei più distribuiti dell'UE, ma basato principalmente su un unico fornitore denominato NHS (posseduto dal Regno Unito), hanno un'efficienza molto simile, e quindi forniscono prodotti medici praticamente allineati ai propri abitanti.

Parole chiave: aspetti giuridici, aspetti economici, sistema sanitario, Francia, Regno Unito

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