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Some proposals for the future of publically funded hospitals in France ?

To tackle the problem of financing medical establishments in France in their entirety is too complicated and I am not in a position to do so.

I also think that it is better to use the method of placing one stone after another in order to erect an edifice which lives up to our expectations…those of giving quality care to the entire population in a region.

I have therefore tried to reply to the question which Claude and Etienne ROBIN set me… what can one do and suggest for a public facility in one's role as a medical manager ?

If the current economic climate has completely demolished the dream of 'health at any price', should we resign ourselves or… try and suggest new ways of doing things ?

I am neither an economist, nor a financier, nor a hospital director, but a doctor who has had responsibilities in the shape of head of department, president of the Departmental Evaluation Committee (CME) and secretary of the National Conference of University Hospitals.

At the level of my local hospital, I have tried to develop a strategic plan consisting of medical projects incorporating quality medical research and economic equilibrium together with the general managers.

The stakes were high for the University Hospital of Nîmes, positioned as it is between the University hospital of Montpellier and the University hospital of Marseille, in a national context of minimising costs and closing hospitals. We had to find very specific solutions.

Our plan was based on 4 premises :

- The university hospital of Nîmes plays a role in a larger territory than the administrative area nominally allocated to it, with a specific part to play along the Rhone corridor (as far as Montélimar…).
- The hospital of Nîmes cannot exist on its own. On the other hand, it can expand the services it offers in collaboration with the private sector and with public establishments. We are talking here about an essential change in paradigm as, a few years ago, the university hospitals were used to working together, never mind whether their healthcare facility was public or private… !
- The hospital of Nîmes had to find new solutions at the medical and administrative level.

- The hospital of Nîmes needs to put into place a team or group approach in order to give the majority of medical and caring staff the desire to improve the efficiency of our practice.

A – The strategy

If official directives (letters of engagement from general managers) were to reduce or to abandon certain activities, it seemed difficult for a president of the hospital's medical committee to accept these proposals.

A consensus was rapidly reached with the chief executive around putting into place new projects, finding new sources of finance, providing thus a medical and organisational challenge, but the only solution capable of building up a financial reserve for the future.

B – The initiative

Two medical committees were proposed, to be assisted by managers :

- One to put in place core services
- The other to put together the business case

The president of the hospital medical committee and the chief executive took no part in these meetings apart from at the preliminary stages or if there was a conflict between the committee members.

Those responsible for each committee had to meet all the heads of service and their teams to tell them about the project and to hear what they were expecting before making suggestions.

This information gleaned was shared at each medical committee meeting (about once a month) and to the whole of the trust in the shape of three general meetings during the year.

For the medical project, the general management agreed to provide specific funding for an external audit, to facilitate the work of the doctors and managers.

In conclusion:

- ***10 core services were established in premises belonging to the trust :***

    **** Medical alignment for certain core services, such as surgery, imaging.***

    **** Functional alignment for others; mothers and children…***

- ***The 'Hospital without walls' project was written and validated by everyone (doctors and allied health care professionals) and the majority of hospital committees.***

This stage was particularly unifying for the majority of the team, and validating for the nursing and medical teams.

C – The results

I – in the administrative management

T2A (payment by results) was presented as a financial opportunity to….support medical activity. In effect, increasing activity permitted us to equip ourselves with the necessary financial means to develop the service.

General management put into place an overview of finances, and above all, an initiative to discover options which had previously not been known about or not until then made use of.

I – 1: Increasing central government funding in the shape of

- Merri and Migac budgets (the central funding for research and work in the community
- Innovative non-reimbursed activity (Biologie Hors Nomenclature). After a year of regular meetings between the Minister, the doctors and the directors, the budget was increased from €40,000 to €1.5 million reimbursed.

I – 2: Developing clinical research

General management also agreed to fund 2 medical writers, 2 doctors of scientific methodology, 15 clinical technicians, and 20 clinical research assistants, by finding help from the Ministry (CINGEPS), by looking for publications by doctors which did not necessarily cite the hospital of Nimes first… and by asking the medical teams to undertake to publish more in the future.

I – 3: Information technology

It seemed difficult to ask the medical and nursing teams to increase their clinical activity and, at the same time, to spend time looking after the on line records which we were nonetheless obliged to put into place…!

The debates and arguments were numerous…

Management agreed to provide specific personnel to help code the notes after a first coding done by the doctor. So, 10 people, of which 5 who were redeployed, were affected in each core service. This allowed an improvement in coding and therefore added value financially… far exceeding the cost of the personnel required. The pilot was therefore validated by general management and this initiative encouraged.

I-3-a: when coding the notes, the same initiative was introduced with the dieticians who assisted the core services and the specialties with….the same financial result, while at the same time improving the medical quality of the notes.

I-3-b: this initiative was facilitated by putting in place electronic prescribing

This feature, connecting the specialties and central pharmacy, allows prescriptions to be checked in order to choose the best prescription according to best practice, and avoids dangerous drug interactions and over-prescribing. It has also led to safer prescribing and significant financial savings.

At the moment, the initiative has in place a clinical pharmacist in each core service in order to ensure this way of working continues. We are caring better and at less cost, and the doctors work in collaboration with the pharmacists.

I-*4: Improving the partnership with community hospitals.*

I-4-a: Communication remains difficult and always coloured by the suspicion that the larger wants to 'absorb' the smaller institution. In spite of this, with the passage of time, a certain trust has been established and this has been evidenced by certain concrete results.

- Establishing shared directors
- More advanced consultation with doctors at the university hospital and greater sharing with access to the technology available at the university hospital for physicians (cardiologists) or surgeons from other hospitals.

This approach has been very useful for hospitals which are near bye, allowing them to recruit doctors who would never have come without access to the technology available at the university hospital.

I-4-b: Telemedicine

This project started in obstetrics and gynaecology in 1994, in collaboration with the University VI of Paris.

The idea of the trust was to improve the management of emergencies. I asked a Parisian colleague to do a study to determine the waiting times of our colleagues. As far as they were concerned, the only thing which interested them was the time taken to obtain the diagnostic antenatal ultrasound.

We therefore started by getting together the gynaecologists and the sonographers, both private and public, to define what equipment was required and to learn to work with this new ultrasound and telemedicine technology, taking the approach requested by our colleagues rather than that which we had proposed.

A partnership was therefore developed with Sony and the pharmaceutical companies since the previous chief executive did not look kindly on this project for which we had had an aid budget from the French ministry of the environment and town and country planning.

The doctors chose the technology, to avoid the 'master/slave' system which was being suggested by industry and champions of the project, in order to adopt an 'internet' type system.

The contact person in this context was no longer identified by their grade or where they were geographically but by their competence.

This system is still working and has been opened up to other areas and other disciplines.

At the level of the university hospital, we currently have 4 audio-visual conference rooms.

I-5: Putting into place a public-private partnership

This has only happened under pressure from the board members who planned on closing certain public and/or private facilities because of insufficient activity.

After many discussions…very difficult ones, all the participants agreed to work together to keep the medical services in the region.

I-5-a: Oncology

We are in the process of building a common private building with a floor space of 80000m² which will house 4 departmental radiotherapy treatment machines, 2 private and 2 public, a private and public imaging centre, and all private and public oncology clinics, clinics closer to home being provided by local institutions.

I-5-b: Neurosurgery

This was basically provided in the private sector. The minimum numbers led to its closure and the transfer of the service to Montpellier. A public-private neurosurgical centre is going to be built on the university site, with 2 private neurosurgeons and 2 neurosurgeons working in the public sector.

We are currently looking to take an initiative in cardiac surgery which has basically developed in the private sector.

I-*6: Putting in place a foundation to receive donations* with the recruitment of a person filling the role of fund-raiser. This has allowed us to finance the simulation suites used in teaching at a cost of €300,000.

II – Management transformed

The general management has understood the need to support doctors and nurses in this training.

1 - In order to allow the decisions to be shared by those delivering care, an organisation, the chief executive and doctors representing the Departmental Evaluation Committee, the following arrangements have been put in place;

- For finance,
- For clinical research,
- For quality assurance,
- For the patient pathway.

2 - General Managers agreed to finance external consultants to facilitate the work of the doctors

3. Care has been taken to employ full-time junior doctors on the correct pay-scale, whereas before, in the first year of their employment, they were less well paid than when they became senior registrars.

4 - New models of finance have been proposed, such as making private practice part of annual leave. Before, if leave was not granted by the management, it was not possible to expand the practice. Today, the system has been reversed, and medical activity generates income which allows the granting of leave, thanks also to the management's legal help in preparing these contracts.

5 - Training has been suggested for directors, heads of department and chiefs of core services and unit heads, to allow them to learn how to fulfil their role and to get to know better each other's roles. At the same time, particular attention has been paid to junior registrars in order to suggest to them a career in hospital medicine……at least we are trying, even if it isn't perfect!

6 - It has been decided to give benefits and extra support to those who adopt these changes:

- For computer records: a call centre available with a doctor and an IT specialist, breakfasts where people are free to talk….
- Access, for those who wish it, to a dictation system.

7 - Very quickly, a new project for 2011-2016 has been considered… in order to maintain momentum and prepare for further developments. This project aims to allow us to move from a 'hospital where you stay' to a 'hospital you move through', by facilitating the coordination of care. In effect, the lack of coordination has a very high cost both financially and on the human level, with problems of re-admission, return to the emergency department, in other words excessive medicalization.

Conclusions

What should we remember… Recommendations…

I have avoided representing the debate about the future of our hospitals with a political slant, but I have chosen rather to describe to you our journey.

Practically, what are we to do to achieve the goal of public health which is our remit, or rather, of service provider as they say in Britain ?

What are the essential elements required ?

- cohesion of the medical and nursing body with management on a project which brings them all together,
- a radical change in the mind-set of public bodies who have to provide the necessary finance,
- the need to affirm that certain services provided by the hospital cannot be financed by payment by results but need to be funded by grants awarded by specialty champions for particular services: new medication, the care of people with medical and social problems…
- local staff need to assume responsibility for the defence of their role, to publicise it and justify it. We can no longer think that the role of a hospital is acquired by definition… for example, because it is a public service.

Useful recommendations, but… not for long… Nothing is achieved for certain !

In effect:

- The Ministry is blocking any increase in health budgets and every year reduces the cost of the most commonly used treatments….efforts to adapt rapidly reach their limit as does the capacity for teams to increase activity,
- We must constantly adapt, innovate, motivate and above all permanently question the purpose of all the professions involved in delivering healthcare. This, therefore, puts medicine in a new space in society:
  - Healthcare costs are increased ten-fold by lack of coordination of care, but also an absence of public health policies to prevent disease, never mind prolong life. Add to this, the misuse (bad use) of medication, a source of inefficiency and iatrogenic harm, and therefore wasteful of public money.
  - Thinking about healthcare problems has to be done at the regional level and not just around the idea of public-private,
  - but we also need to integrate new IT tools (telemedicine/home automation systems…), allowing the monitoring of health to be modified. On this subject, doctors must think of new ways of doing things and not just wait for industry to think of them.
  - The recognition of the role of the caregiver for the patient in their management can be one of the essential vectors in a sane evolution of systems of care and healthcare delivery.

Is it not the opportunity to move from a medicine which treats illnesses to a medicine of the person ?