THE INTERVIEW: FRANCK DROIN

DIRECTOR OF KADRIS CONSULTANTS

"THE EXTENSION OF SOCIAL HEALTH PROTECTION CALLS OUT FOR PLUMBERS WITH A VISION!"

Interview with Franck DROIN, Director of Kadris Consultants; independent consultancy agency specialised in strategy and management in the health sector, social protection and risk management in France and at the international level.

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Good afternoon Franck, could you briefly explain to us the mission and the activities of KADRIS?

Franck: Let's start with some key figures to help situate KADRIS. The society was founded in February 2001; and today employs around 45 people who are for the most part located in France, with the exception of one representative in Belgium and one in Morocco.

Kadris' mission consists in providing intellectual services for public and private organisations wishing to improve their operational mode, expand their range of activities, their services, improve their management conditions or increase their profitability.

Our speciality is that we only work for actors involved in the health sector and social protection. With Kadris we took the following observation as our cornerstone: in order to provide advisory services it's essential to build up a relationship of trust with our clients.

Trust, first of all this means faith in our technical competence. It's important to know what you're talking about; and this requires specialisation because the sector in which we work (health and social protection) is very specific and is constantly evolving.

Trust is built up because we are sincere in our recommendations, which reflect a genuine commitment on our part towards the people with whom we are working. This kind of trust is built up over time, and is revealed little by little; it's not something that can be taken for granted.

Today it's no longer possible to work solely for the financing of healthcare without knowing what's going on with health providers, whether in terms of prevention, medical treatment, or the auxiliary care of patients. It's in this vein that the French National Health Insurance Fund, over and above its role as a payer, has set up disease-specific management programmes ("disease management") for Type 2 Diabetes.

In France it seems that we are just getting to know this side of things while in the US they've been operating like this for a long time: the insurer fully incorporates the health dimension. The insurer takes on the role of checking that the offer of healthcare services is consistent with the package of healthcare given, as well as carrying out the piloting of the healthcare services offered (as in the case of American Health Maintenance Organisations, for example).

The mission and the activities of Kadris follow in the same vein: it's not possible to be a good advisor in the field of health and social protection without taking on board the health and financial dimensions.

Today it's clear that the health and social protection sector in France is heavily partitioned; there are the public insurers, the other mutual health organisations, then the health providers and finally the pharmaceutical companies. These different groups neither know nor understand each other, which means that the management systems don't operate in a unified way. Since Kadris has an overview of the whole sector, the role of Kadris also lies in the building of bridges between these different actors.

So, if I had to sum up Kadris in three words I would say that we are a specialised actor, because it seems to me that today we cannot concretely understand our subject unless we are specialised; that we seek to incorporate the two dimensions in our work; that of the payer and that of the healthcare provider, and finally that we seek to establish connections between actors, because everyone has something to gain from it. Our competitive edge does not only lie in our precise knowledge of each profession but also (and above all) in our capacity to forge links between the business of our clients and that of other professions.

So does Kadris mainly operate in France…?

Franck: Yes, today we are principally based in France; our activities in France account for 85% of our turnover while our international activities account for just 15%. Among our French clients 70% are mutual associations, providence societies, insurers or insurance departments within banks (for example the French "caisse des dépôts"; the Deposit and Consignment office) which are interested in health, risk management, long-term care. And 30% are actors operating in the medical-social sector.

It seems to me that you work at the conception stage rather than at the implementation stage?

Franck: Yes, indeed we are not at all involved in the implementation process.

At the beginning when we first created Kadris the idea was to provide intellectual services and nothing else; under no circumstances were we to become an operator. Hence the fact that we don't sell any IT

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solutions, neither do we get involved in the overhaul of back office management…

You can't be everywhere at the same time; it's not possible to be an advisor and have an interest in how the advice given gets put into practice. This is what allows us to give really sincere advice… and in turn allows us to build up trust and a loyal clientele.

Do you find that for those younger members of the team who are just starting out on the job this very concrete dimension, that of "getting your hands dirty" is missing?

Franck: Some employees do feel the need to branch out into other vocations that are more operational or to follow up on the projects that they have initiated. But in general the members of my team have such a wide diversity of subjects to cover that they don't feel at all frustrated; in one year they learn what they might learn in two or three years elsewhere.

What kind of activities does Kadris undertake in the medical-social sector?

Franck: We work for example on the evaluation of health networks (for example, cancer or diabetes). There are different types of networks in France… There are networks that target a particular group, for example pregnant women whose pregnancies are considered to be at risk (perinatal networks), elderly people (gerontology), people living with HIV/ AIDS, people who are dependent on drugs or alcohol, etc. There are also illness-specific networks, (cancer, diabetes). They are generally set up by hospitals or GPs and nurses working in the hospital environment. It's very difficult to precisely gauge the efficiency of these networks given the multidimensional nature of their impact

Oh yes, Groupama has also set up a network in the Pyrenees…

Franck: Yes, Groupama set up a network of GPs whose goal was- through the exchange of practices- to break their isolation and to improve their medical practice. Through dialogue and exchange, the GPs who are members of the network realised that giving out prescriptions wasn't the only way of responding to patients' demands… And they reduced the number of medical prescriptions by 15%!

How did Kadris become an international consultancy?

Franck: There are reasons related to the structure of the company and to the market and there are personal reasons.

Today we are the No.1 Team in our sector in France. There are of course big consultancy agencies out there, but within those agencies the departments responsible for social protection are all smaller than Kadris. There are also medium-sized consultancy agencies, but in general they have either diversified their activities towards other branches of insurance or they have started providing insurance-related IT services.

The following question comes up: in what way can we expand? What are the main levers that will allow us to expand effectively?

The French market is quite stable with a turnover of 23 million Euros… There are of course other challenges, new leading themes such as that of "health in the workplace". There is growing recognition of the need to take better care of physical and mental health in the workplace, to fight against stress and the use of psychotropic drugs in the workplace. Companies are aware that they have every interest in investing in the health of their employees in terms of the prevention of epidemics (one vaccination campaign costs a lot less than tens of working days lost in the case of an epidemic). A study has shown that for every Euro invested in the prevention of addictions (drugs, alcohol) in the workplace there is a 7 euro return. That's the kind of message that gets through to businesses!

With the development of Corporate Social Responsibility, businesses are becoming players in the health sector in their own right; concerned with the health of their personnel and even that of people indirectly related to their activities (for example people living near production sites). Thus an oil rig based in Africa or Asia has every interest that the health and social situation around the exploitation sites is acceptable in order to protect its own personnel from health risks, social risks and any eventual security risks.

Today we are aware that questions related to health have become major issues and that rich countries can no longer ignore what is happening in developing countries for various reasons; for a start because of health risks and risks brought on by the spreading of epidemics. The exaggerated nature of discrepancies between healthcare systems of countries that are in the same geographic proximity (for example Guyana-French enclave in Latin America) creates inequalities and tension.

The models of risk management such as those of France and Belgium have begun to emerge as reference models. Kadris with its knowledge of the French social protection system has thus been given a significant competitive advantage.

At the international level, what kinds of missions has Kadris taken on?

Franck: For 6 years Kadris has been working as an evaluator of projects financed by the European Union on the use of technology in the field of health. We have evaluated projects in Romania, in Germany etc. Progressively our contacts in these countries have

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asked us to design social protection systems and that's when we realised that there's a real place for Kadris at the international level; because we have the strategic capacities and because we also know how social protection systems work from the inside. With the health and social protection sector it's all about being a plumber with a strategy. You need to have both a strategic and political vision as well as to be able to understand and know how to build the whole of the works and the plumbing.

At the same time the plumbing is something strategic; it takes three years to come up with the design and to set up an information and management system for health insurance; on the other hand it takes thirty years to remove it.

You've done work in Morocco, I think… and in which other countries?

Franck: Yes, we're currently working in Morocco on modernising the management system "CNOPS" within the framework of the implementation of the AMO (Obligatory Health Insurance programme).

At the European level we've worked on a project called DIAFRE bringing together several countries (Denmark, Spain, France, Israel) that consists of improving preparedness for large scale pandemics.

I'm currently managing a project that aims for the exchange of skills and know-how between Russian and French hospital doctors in the field of the fight against addictions. In the Eastern countries and in particular in Russia, one of the biggest problems is that of medical demographics and the need to find concrete solutions that compensate for the reduced number of doctors and specialists. See for example the TANA initiative on the subject of telemedicine and mobile health units.

MORE INFO
See the TANA website

We've also been carrying out a study in Burkina Faso for UNAIDS with the objective of seeing how efforts on the part of funding agencies can be better coordinated in the fight against and management of HIV/ AIDS so as to improve the healthcare access of those persons affected by the virus. As part of this study we proposed the setting up of a delegate responsible for management (Third Party Administrator) whose job is to improve the management of funds and their use for the better treatment of people living with HIV/ AIDS. This type of work gives a good indication of our ability to reuse in a different context the skills we acquired in the French market, in which we participated in the formation and setting up of several TPAs.

How can your experience in Europe be useful when you work in developing countries? What kinds of knowledge or skills are the most useful for the projects you are associated with in developing countries?

Franck: I think that our best asset in the countries of Sub-Saharan Africa will be the ability to come up with operational management plans allowing the development of health insurance systems that are currently being set up in a certain number of countries and that cover the whole or part of the population.

However, there are many risks involved. We're missing the operational intermediaries… thus the risk is to carry out studies and then more studies that just end up in the filing cabinet. Another potential trap is that of responding to demands that have already been dealt with. We're living in the information and communication era; it's important to share our respective databases, the studies that we carry out, the on-site investigations etc. in order to avoid re-doing what's already been done. Another potential pitfall that we've identified is that of negotiated contracts; we prefer to associate ourselves with projects with whom the ILO and other organisations are associated.

What are the principal barriers to the extension of social protection in developing countries in your opinion?

Franck: In Africa the main barriers are related to the implementation stage and the functioning of health insurance systems, with the necessary design and implementation of information and management plans that are transparent and that are efficient in dealing with the potential challenges brought on by the increased solvency of demand.

In Eastern Europe the barriers are more historical; for the moment they don't want to know anything about collective risk sharing; which explains their fascination with liberal models. The logic of the all-powerful market runs the risk of inducing a rupture between those who have access to private insurance and to quality care, and those who are excluded… and therefore creating the need to restore the balance.

Do French mutual associations and more broadly social protection bodies in France have a role to play in the extension of social protection coverage in Africa and in Asia?

Franck: French mutual associations are going through an identity crisis; they are struggling to say in what way they are solidarity-based and what makes them specific from other players in the market, like insurers. Their involvement in projects for the extension of social protection in developing countries would allow them to give renewed significance to their activities and perhaps in doing so to prove that they are still operating on a solidarity principle.

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Thank you Franck.

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