FEDERATION EUROPEENNE DES MEDECINS SALARIES
EUROPEAN FEDERATION OF SALARIED DOCTORS

Registered Office/Siège Social :
39, rue Victor Massé
F-75009 Paris/France

http://www.fems.net

Presidency:
Dr. Claude Wetzel
Hôpitaux Universitaires
F-67098 Strasbourg/France
Tel +33 3 88 12 70 75 ou 76
GSM +33 6 60 55 56 16
Fax +33 3 88 12 70 74
claude.wetzel@chru-strasbourg.fr

Permanent Secretariat:
Rue Guimard 15
B-1040 Brussels/Belgium
New Tel. + 32 2 736 60 66
New Fax + 32 2 732 99 72
e-mail: info@fems.net

Date :	12 – 07 -2010	**Document** **F10-063 EN**
Title / Titre:	**Non-profit health care hospitals in France**	
Author/ Auteur :	**Valentin Petkantchin**,(IEM Institut Economique Molinari)	

Table 1

Seriousness of cases treated in public hospitals and private non-profit hospitals Comparison (with 100 as the base, corresponding to the national average) between public hospitals and private non-profit hospitals	
Public hospitals	
Of which regional university hospital centres	113,3
Of which hospital centres	91,5
Non-profit private hospitals	
Cancer treatment centres	110,2
Other non-profit hospitals	105,2

Source: Social security financing bill, 2005

Establishments such as the Groupe hospitalier catholique de Lille, the Centre chirurgical Marie Lannelongue (created through a donation from a family of industrialists) or the Institut Arnault Tzanck (created by a doctor) play an important role in the provision of hospital care in their respective regions.[5]

A SECTOR THAT IS PENALISED

These performances have been achieved despite a range of regulatory obstacles[6] that have impeded the development of private non-profit hospitals in the last few decades.

The differential in social security contributions and the deferral of expenditures are two major examples that have put them at a disadvantage compared to public hospitals in particular.[7]

The differential in social security contributions

Labour costs generally account for about 70% of total costs in health care establishments. In this regard, private non-profit hospitals are penalised by higher compulsory social security contributions than those that apply to public hospitals. The latter also benefit from the job guarantees that go with their civil service status, making it easier for them to attract hospital staff.

According to official estimates from 2007,[8] social security contributions were 27.1% higher on average for all private non-profit hospitals taken together in the employment of medical staff. This means, for example, that to pay a net salary of 1,000 euros, public hospitals have a total labour cost of close to 1,870 euros (of which 870 euros go toward social security contributions altogether), whereas private non-profit hospitals must pay out 2,105 euros, which is 235 euros more (see Figure 2, p. 3).[9]

This is especially punishing in the context of the current T2A (fee for service) system. The public authorities in effect apply the same fees, but the differences in compulsory charges on public hospitals and private non-profit hospitals put the latter at a disadvantage.

Deferral of expenditures/charges

Deferral of charges, commonly practised until 2006 by public hospitals, was forbidden for private non-profit hospitals. It amounts to "an expenditure that should normally have had to be financed in the current fiscal year and that, due to insufficient revenues, ended up being paid in the following fiscal year, with the revenue for that fiscal year"[10], even if taken from the appropriations intended to finance the filling of vacant positions for doctors.

"Charges' deferral" is a practice that can take several forms that are not always explicit. This has enabled public hospitals to hide deficits and untenable financial situations. As noted by the Court of Auditors, "detecting this would require an examination by item."[11]

Table 2

Examples of private non-profit hospitals in the 2009 ranking in *Le Point* (partial list)

NAME OF PRIVATE NON-PROFIT HOSPITAL	PATHOLOGY / RANKING
Institut mutualiste Montsouris	Prostate cancer, 1st Kidney cancer, 1st Foot surgery, 1st Lung cancer, 2nd Colon and intestinal surgery, 2nd Rectum surgery, 4th Prostate adenoma, 2nd; etc.
Groupe hospitalier Diaconesses/Croix-Saint-Simon	Proctology, 1st Gall bladder, 1st Knee or hip prosthesis, 1st Urinary incontinence, 3rd Rectum surgery, 5th Foot surgery, 6th; etc.
Fondation Rothschild	Myopia surgery, 1st Retina, 1st Brain aneurism, 2nd Strabismus, 2nd Cataracts, 3rd Glaucoma, 3rd Multiple sclerosis, 4th; etc.
Hôpital Foch, Suresnes	Bladder tumours, 2nd Prostate adenoma, 3rd Prostate cancer, 6th; etc.
Hôpital Saint-Joseph, Paris	Glaucoma, 1st Foot surgery, 3rd Varicose veins, 7th; etc.
Hôpital Saint-Joseph, Marseille	Renal calculi, 2nd Carotid surgery, 6th Bladder tumours, 7th; etc.
Clinique mutualiste, Saint-Étienne	Knee traumatology, 2nd
Polyclinique d'Hénin-Beaumont (groupe AHNAC)	Gall bladder, 3rd Varicose veins, 10th
Clinique mutualiste Jules-Verne, Nantes	Gall bladder, 2nd Prostate adenoma, 5th Urinary incontinence, 6th; etc.
Hôpital Sainte-Blandine, Metz	Varicose veins, 1st
Institut Curie	Breast cancer, 1st
Institut Gustave-Roussy	Breast cancer, 2nd ORL cancer, 2nd
Centre Oscar-Lambret	ORL cancer, 1st

Source: *Le Point*, 2009.

5. *Ibid.*
6. In this regard, see the article "Situation financière difficile : l'inquiétude des hôpitaux prives sans but lucrative," *Revue Francophone des Laboratoires*, January 2006, No. 378, p. 12.
7. See Denise Silbert et al., 2005, op. cit., pp. 50-51. See also Pierre Bauchet, "Observation sur le système français d'hospitalisation," *Comptes Rendu Biologies* 331, 2008, pp. 930-932. Other regulatory obstacles have also played a role in this regard. including laws facilitating the conversion of private non-profit hospitals into public hospitals, etc.
8. See *Report No. RM2007-053P*, "Tarification à l'activité et écarts du coûts du travail entre les établissements publics et PSPH," General Social Affairs Inspection, March 2007; calculations by the author.
9. *Ibid.*
10. See "Analyse des reports de charge dans les hôpitaux," Fédération Hospitalière de France, 2004, p. 3. Available at: http://www.fhf.fr/Informations-Hospitalieres/Dossiers/Gestion-Finances/divers-dossiers-ayant-des-incidences-financieres-et-budgetaires/analyse-des-reports-de-charges-2003/(language)/fre-FR.
11. See the Court of Auditors report, *La Sécurité sociale*, September 2007, p. 101. Available at: http://lesrapports.ladocumentationfrancaise.fr/BRP/074000560/0000.pdf. The Court also estimates that 26% of public hospitals did not pay the tax on salaries owed to the government at the required time and date, thereby deferring a tax charge of 86 million euros.

By accumulating past charges, some public establishments have found themselves in extreme situations. For example, the Hirson hospital centre (in Aisne department), a relatively small establishment, deferred more than 2.6 million euros from 2005 to 2006, amounting to "19% of operating expenses in the main budget."[12]

Deferral has enabled public hospitals to go more deeply into the red without having to make cost and staff cuts, which are unpopular at the local level. This practice has developed to the detriment of sound management of public establishments and has postponed looking after the imbalance in their accounts until some time in the future.

A total of nearly 2.2 billion euros was deferred between 2002 and 2005, with a peak of 713.6 million euros for all public establishments in 2004![13]

Unlike the situation at public hospitals, the appearance of deficits in the accounts of private non-profit hospitals generally requires cutting staff or finding ways of cutting costs elsewhere to get back into equilibrium. As explained by Patrick Hontebeyrie, director of the Centre chirurgical Marie Lannelongue (CCML): "The CCML was in deficit and could return to financial equilibrium in 2004 only at the cost of a 20% staff cut together with a sharp productivity increase plus 10% more services performed (...)."[14]

Private non-profit hospitals have a more flexible structure than public hospitals and greater responsiveness to their environment. However, in the French context of health care cost containment and inequality of treatment compared to public hospitals, this flexibility, paradoxically, turned into a handicap. It resulted in a diminution of the role they play in the health care system, in effect favouring the expansion and relative place of public hospitals.

For example, between 1998 and 2007, the reduction in the total number of beds (full hospitalisation) was 16.8% for private non-profit hospitals, compared to 6.5% for public hospitals.[15] This loss was only partly offset by an 11.9% rise in partial hospitalisation during this same period, whereas the corresponding figure for public hospitals was 25.6%.

The share of public establishments in hospital activities – in the numbers of entries, days or arrivals – also rose between 1998 and 2006 (see Table 3, p. 4). Private establishments' share, both for-profit and non-profit, declined in most cases.

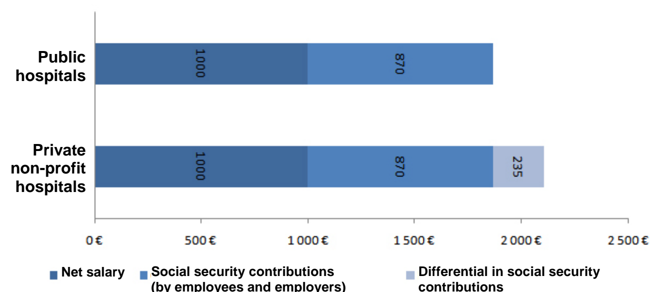
As a French specialist concluded, "PSPHs, French non-profit hospitals of general interest, responsible for public hospital service, have a less rigid structure than the rest of the public hospital sector and benefit from less costly management. Unfortunately, they are regressing because current regulations penalise them due to unfavourable regulatory measures."[16]

THE CASE OF ALSACE: AN EXCEPTION IN FRANCE

For historical reasons, the private non-profit hospitals have a much stronger presence in Alsace than elsewhere in France. The 1908 local association status, from German law, allows for an economic or even for-profit goal to be pursued, for example.[17]

Figure 2

Differential in social security contributions penalising private non-profit hospitals in the employment of medical staff



Source : General Social Affairs Inspection, 2007, *op. cit.*; calculations by the author.

In 2004, private non-profit hospitals accounted for 69 out of 121 establishments, or 57% of the total. Excluding the four largest establishments, private non-profit hospitals accounted for nearly half the total remaining capacity in the region (beds and places for short, medium and long stays and in psychiatry), compared to 44% for small and medium-sized public hospitals.

PRIVATE NON-PROFIT HOSPITALS IN THE NETHERLANDS: AN ASSET IN HEALTH CARE REFORM

The role played by private non-profit hospitals is traditionally even greater in the Netherlands. More than 90% of hospitals are private and non-profit.[18]

The case of the Netherlands also shows the dangers of public health care cost containment as well as the opportunity they provide in passing health care reform, like that initiated in 2006.[19]

Prior to this reform, private non-profit hospitals were feeling the full force of the results of cost containment conducted by the government. This state seizure of control – similar to what is under way in France – led to growing waiting lists for patients. In 2001, 244,000 people were ill and awaiting hospital care. The cost of waiting lists in terms of losses in well-being, income and productivity, as well as long-term handicaps, etc., have been estimated at 3.2 billion euros per year, or 6.1% of the country's total health care spending for that year!

The 2006 reform that was intended to resolve these problems gave insured persons the choice of subscribing to health coverage with a range of private insurers that went into competition. The public system's health insurance monopoly, which covered two-thirds of the population, was abolished. This is still a taboo area in France.

Health care professionals and private non-profit hospitals were given greater freedom to negotiate arrangements for the supply of health care and

12. *Ibid.*
13. Source: Ministry of the economy, finance and industry – General directorate of public accounts – Management accounts; calculations by the author. Deferral of net contributions, i.e., deductions from the carry-over of revenues, amounted to 472 million euros in 2004.
14. See Denise Silbert et al., 2005, *op. cit.*, pp. 47-48.
15. Sources: Direction de la recherche, des études, de l'évaluation et des statistiques (DREES), annual statistics on health care establishments, 1998 and 2007; calculations by the author.
16. Pierre Bauchet, 2008, *op. cit.*, p. 932.
17. See Denise Silber, 2005, *op. cit.*, Annexes 1 and 2, on the case of Alsace.
18. See André den Exter et al., Health systems in transition: Netherlands, European Observatory on Health Systems and Policies, WHO, 2004, p. 71.
Available at: http://www.euro.who.int/__data/assets/pdf_file/0006/95136/E84949.pdf.
19. See Valentin Petkantchin, "Health care reform in the Netherlands," Economic Note, Institut économique Molinari, 2010.
Available at: http://www.institutmolinari.org/health-care-reform-in-the,957.html.

Table 3

Change in respective shares of public and private establishments, 1998-2006						
	Public establishments		Private non-profit establishments		Private for-profit establishments	
	1998	2006	1998	2006	1998	2006
Number of full hospitalisation entries in						
Short-term care	61 %	64 %	9 %	8 %	30 %	28 %
Medicine	80 %	81 %	8 %	8 %	12 %	11 %
Surgery	43 %	44 %	9 %	8 %	48 %	47 %
Obstetrics	62 %	67 %	7 %	7 %	31 %	26 %
Number of days of full hospitalisation in						
Short-term care	63 %	69 %	9 %	8 %	28 %	23 %
Medicine	79 %	82 %	9 %	8 %	13 %	10 %
Surgery	43 %	49 %	10 %	9 %	47 %	42 %
Obstetrics	58 %	66 %	8 %	8 %	34 %	27 %
Number of arrivals in partial hospitalisation in						
Short-term care	38 %	40 %	10 %	10 %	52 %	50 %
Medicine	60 %	64 %	14 %	13 %	26 %	23 %
Surgery	9 %	12 %	8 %	8 %	83 %	80 %
Obstetrics	74 %	76 %	4 %	5 %	22 %	19 %

Source : Annual statistics on health care establishments, 1998, 2006 (metropolitan France); reproduced in the Report of the conciliation commission on hospital missions (Larcher report), 2008, p. 88.

fees for medical services.[20] They thus have an array of income sources and are no longer subject to the dictates of the public system monopoly and the public authorities as in France, where nearly 91% of hospital expenditures are financed by it.[21]

The reform, together with the responsiveness and flexibility of private non-profit hospitals, helped produce a reduction in waiting lists, which are no longer perceived as a problem by the general public. This reduction was achieved even with total health care spending rising less quickly after the reform, from 2006 to 2008 (+5.3% per year on average), than before it, from 1998 to 2005 (+7.6%).

CONCLUSION

Private non-profit hospitals provide a true alternative to public hospitals and are worth examining. In Alsace, they already occupy a large place in the provision of hospital care. In the Netherlands, the health care system relies heavily on them.

These establishments are among the most prestigious in France: they provide more flexible private management and avoid the rigidities that civil service status implies. However, a number of regulatory obstacles penalise these "public hospital service" players compared, in particular, to public hospitals.

In the face of repeated deficits and the degradation of public finances, politicians are attempting to reform the hospital and health care system in France. They should make a priority of removing these obstacles that are choking the development of private non-profit hospitals to the detriment of French patients.

20. A growing portion of medical services in the Netherlands is also left open to free negotiation, accounting for 34% of hospital expenditures in 2009. This share is expected to grow in the future.
21. Source: Direction de la recherche, des études, de l'évaluation et des statistiques (DREES), Health care accounts, 2009.

Valentin Petkantchin

Mr. Petkantchin holds a doctorate in economics and a master's degree in communications media and economics training from the University of Aix-Marseille III in France. Between 1996 and 2003, he was a research fellow at the Centre for Economic Analysis and a lecturer in economics at the faculties of applied economics and law at the same university. He is the author of several scientific publications and research papers on various topics. He was research director at the Montreal Economic Institute from January 2004 to May 2006. He joined the Institut économique Molinari in June 2006.

The **Institut économique Molinari** (IEM) is an independent, non-profit research and educational organization. Its mission is to promote an economic approach to the study of public policy issues by offering innovative solutions that foster prosperity for all.

Reproduction is authorized on condition that the source is mentioned.

Director General: Cécile Philippe
Design: Gilles Guénette

www.institutmolinari.org