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The Private Sector Within A Public Health Care System: The French Example

In public policy matters, debates on the health care system are, beyond a doubt, those that cause the greatest controversy. In Quebec, as elsewhere in Canada, the issue of what role should be entrusted to the private sector in the provision of health care services is especially problematic. This is indicated by the strong reactions to the recently published report of the Task Force on the Funding of the Health System, chaired by Claude Castonguay, which some blamed for suggesting a greater participation of private providers as a way toward solving the health care system's problems.[1]

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The emotional reactions stirred by these debates on health care illustrate the scope of citizens' legitimate concerns with respect to a sector they justifiably regard as vital. However, the opposition of many interest groups and political factions to a more active role for private health care providers goes against the trend observed in nearly all developed countries, and it constitutes a serious obstacle to improving our own health care system.

A number of countries, facing health care challenges similar to ours, have undertaken reforms to improve the efficiency and productivity of their systems – decentralizing management, calling upon the private sector to provide care, and establishing mechanisms for competition between various providers. Contrary to widespread beliefs, these reforms have in no way threatened the goals of universality and accessibility to health care.

France is among the countries where the private for-profit sector plays a major role in the health care system, especially in hospital care. The French experience offers pertinent lessons regarding the appeal of letting private business play a role in supplying health care in Quebec and across Canada.

The private sector in the French hospital system

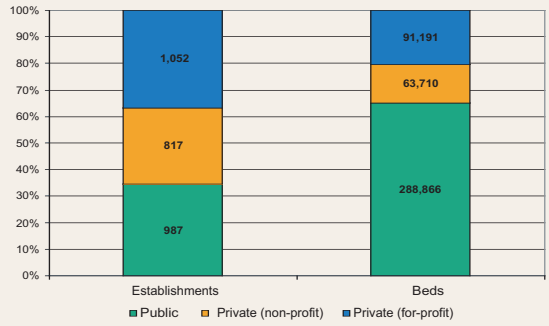
Private institutions occupy an indispensable place in France's hospital landscape. In 2005, there were 1,052 private for-profit establishments[2] in France, 37% of all health care establishments with hospital capabilities. They accounted for 91,191 beds for full hospital care, or 21% of the total.[3] This is about twice as much as the United States, where private for-profit establishments represented 15% of all hospitals and 12% of all beds.[4]

Private for-profit hospitals specialize above all in surgery and short-term care. Overall, these establishments look after about seven million patients each year and conduct nearly 60% of all surgeries.[5] For example, the for-profit private sector performs one digestive system surgery out of two, two cardiac surgeries out of five, three cataract surgeries out of four and three baby deliveries out of ten. With respect to looking after serious cases, the activity of private hospitals is comparable to that of the public sector,[6] especially outside university hospitals.

1. See, for example: Confédération des syndicats nationaux, "Rapport Castonguay : le privé n'est pas une pilule dorée", Special information bulletin no. 5, winter 2008; Louise-Maude Rioux-Soucy, "Levée de boucliers à gauche", *Le Devoir*, February 20, 2008, p. A3.
2. There were also 817 private non-profit establishments encompassing 63,710 beds.
3. French Ministry of Health, Youth and Sports, *Les établissements de santé : un panorama pour l'année 2005*, 2007, p. 15.
4. Private non-profit hospitals account for 51% of establishments and 59% of beds. National Center for Health Statistics, *Health, United States, 2007: With Chartbook on Trends in the Health of Americans,* U.S. Department of Health and Human Services, 2007, p. 364.
5. French Ministry of Health, *op. cit.*, footnote 4.
6. Marcel Boyer, *Le secteur privé dans un système de santé public : France et pays nordiques*, CIRANO, February 2008.

FIGURE 1

Distribution of health care establishments and hospital beds in France, based on legal status (2005)



Source: French Ministry of Health, *Les établissements de santé : un panorama pour l'année 2005*, 2007.

In the area of follow-up care and rehabilitation, 270 for-profit private clinics provide 22,910 beds with full hospitalization (25% of the total) and handle each year nearly 580,000 visits (24% of the total). In the psychiatric sector, 153 for-profit private clinics provide 10,875 beds for psychiatric hospitalization (19% of the total). The private for-profit sector also has a substantial presence in the area of emergency services: it manages 20% of establishments with emergency rooms and handles two million emergency room visits each year.

France has stood out over the years as a world leader in the area of private hospitalization. While the size of hospitals and the quality of services varies considerably from one establishment to the next, a recent study shows that mortality rates in private for-profit hospitals in France, after adjusting for the seriousness of cases, is lower than that of other establishments.[7] Moreover, the reputations of many private groups for innovation and medical expertise, as well as for the range and quality of services provided, speak for themselves. For example, Générale de Santé and Capio Group (majority owned by Italian and Swedish shareholders respectively) are major players in the provision of hospital care in France and export their expertise throughout Europe.

A mixed, universal and accessible system

This strong presence by the private for-profit sector in French health care does not mean that access to care is reserved only for those with the ability to pay.[8] In France, all legal residents wishing to obtain medical and hospital care are covered by the public health insurance system, one of the main branches of Social Security. Health insurance, financed mainly by contributions from employers (13.1% of gross payroll) and employees (0.75% of gross wages),[9] covers the entire French population, paying approximately three-quarters of health spending (and 92% of spending for hospitalization) with the rest assumed by supplemental health insurance bodies (mutual or private insurance companies and provident funds) or by patients themselves.

Since 2000, basic public health insurance has been supplemented by the complementary universal medical coverage program, covering all insured persons with incomes not above 8,644 euros per year, with no contribution required from them. Half of the program's 4.8 million beneficiaries who need hospital care choose to get it in private clinics.

The regular health insurance system handles the funding of health services mostly (85%) by reimbursing insured persons for the costs they have incurred. This reimbursement principle does not apply, however, to hospitalized patients or to beneficiaries of the complementary universal medical coverage program. There is thus no prior disbursement required from these patients: the health insurance system or supplemental insurance handles payment of the costs directly. Patients are required to pay only the amounts they are responsible for (the "patient contribution"[10] and, if applicable, a daily charge as well as supplements for personal comforts such as private rooms, telephone, television, etc.). In reality, these charges are looked after by the supplemental insurance plans with which patients are affiliated. About 92% of people in France have supplemental insurance.

Private for-profit establishments in France look after about seven million patients each year and conduct nearly 60% of all surgeries.

7. Carine Milcent, "Hospital ownership, reimbursement system and mortality rates", *Health Economics*, Vol. 14, No. 11, 2005, pp. 1151-1168.
8. Simone Sandier, Valérie Paris and Dominique Polton, *Health care systems in transition: France*, European Observatory on Health Systems and Policies, 2004.
9. Levies have been imposed on a broader base in recent years to take account of other types of income (investments, pension benefits, lottery or casino winnings, etc.). This is referred to as the "generalized social contribution". The remainder of health insurance funding comes essentially from indirect taxes on gasoline, tobacco, alcohol, gambling and pharmaceutical advertising.
10. Patient contributions, or co-payments, covering the amount not paid by health insurance, vary according to the type of care. They are higher for ambulatory care and drugs than for hospital care. However, not all patients are required to pay, including those with long-term conditions (diabetes, AIDS, cancer, psychiatric disease, disabling illnesses, etc.), victims of work accidents, pregnant women, handicapped children, etc. In 2006, health care costs paid directly by beneficiaries accounted for 8.6% of spending (2.7% for hospital care), with higher percentages applying to ophthalmology, orthopedics, dental care and drugs.

TABLE 1
Comparison of the French, Canadian and Quebec health care systems

INDICATORS	France	Canada	Quebec
DEMOGRAPHIC AND ECONOMIC			
Population 65 and over in 2007 (%)	16.5%	13.4%	14.4%
GDP per capita in 2006 (US$ PPP)	$31,001	$36,784	$30,697
HEALTH CARE SYSTEM			
Total health care spending (% of GDP, 2007)	11.1%	10.6%	11.3%
Total per-capita health care spending (US$ PPP, 2006)	$3,374	$3,326	$3,064
Annual growth in real per-capita health care spending, 1995 to 2005 (%)	2.3%	3.2%	4.0%
Doctors (per 1,000 inhabitants, 2005)	3.4	2.0	2.2
Nurses (per 1,000 inhabitants, 2006)	7.7	9.8	10.6
Magnetic resonance imaging devices (per million inhabitants, 2006)	4.6	6.0	7.3
Computed tomography scanners (per million inhabitants, 2006)	9.8	11.6	14.0
STATE OF HEALTH			
Life expectancy at age 65 – Women (2004)	22.0 years	21.0 years	21.0 years
Life expectancy at age 65 – Men (2004)	17.7 years	17.7 years	17.3 years
Infant mortality (per 1,000 births, 2004)	3.6	5.3	4.6
Avoidable mortality due to causes connected to health care (per 100,000 inhabitants, adjusted to the age structure, 2002-2003)	64.8	76.8	99.0

Sources: OECD, *Health at a Glance 2007*; OECD, *Health Data 2007*; Canadian Institute for Health Information, *National Health Expenditure Trends, 1975-2007*; Institut de la statistique du Québec, *Comparaisons internationales : tableaux comparatifs 2008*; Nolte and McKee, *op. cit.*, footnote 18.

Competition mechanisms and the quality of care

The French hospital system ensures not only universal access to care for all citizens, regardless of patients' financial means, but it does so without having to ration services through waiting lists, as is the case in Canada. It achieves this less through the size of medical personnel than through the mechanisms[11] that give establishments incentives to use available medical resources more fully so as to treat the greatest possible number of cases within the shortest time.

The French system is able to avoid waiting lists less through the size of medical personnel than through the competitive mechanisms that give establishments incentives to use available medical resources more fully.

The funding system for French hospitals offers this type of incentive. Since 2004, a new fee-for-service reimbursement system (T2A) has gradually replaced the historical funding system for public hospitals.[12] The implementation of an fee-for-service system now offers the advantage of enabling all hospitals to be reimbursed based on the number and complexity of cases they treat, unlike the funding method based on overall budgets. Hospitals with good results now are rewarded for their performance by getting more funds. The T2A system thus encourages establishments constantly to seek new ways of improving the quality of health services they provide to patients. An OECD study confirms that reimbursement systems of hospitals and specialists on a fee-for-service basis, are among the factors that help reduce waiting time for surgery.[13]

The logic underlying competition mechanisms is relatively simple. To the extent that patients have full freedom in choosing their health care providers, as is the case in France, they are more likely to turn away from establishments that provide mediocre services and go instead to those providing the best services.[14] For clinics that wish to generate profits, a patient is a source of added income. Private clinics and hospitals have no interest in neglecting quality of service to save on costs, for in the end poorer care means fewer clients and thus less income to cover the same fixed costs.

11. To learn more about the governance mechanisms of health care systems and an overview of international comparisons in this respect, see: Joanne Castonguay, Claude Montmarquette and Iain Scott, *Analyse comparée des mécanismes de gouvernance des systèmes de santé de l'OCDE*, CIRANO, February 2008.
12. In medicine, surgery, gynecology and obstetrics, and odontology. See: French Ministry of Health, *La tarification à l'activité en quelques lignes*.
13. Luigi Siciliani and Jeremy Hurst, "Explaining Waiting Times Variations for Elective Surgery across OECD Countries", OECD Economic Studies, No. 38, 2004.
14. The French also have a wide range of information and performance indicators enabling them to judge more effectively the quality of service provided by various hospitals. These include the *Plateforme d'information sur les établissements de santé : PLATINES* from the French Ministry of Health (http://www.platines.sante.gouv.fr) and *Les palmarès des hôpitaux et des cliniques* (http://hopitaux.lepoint.fr/index.php) from the magazine *Le Point*.

The performance of the French health care system

The French health care system has achieved a certain fame since being ranked first among 191 countries by the World Health Organization in a report published in 2000.[15] Despite any criticism that may be directed at this study and the problems inherent in comparing health care systems internationally, it should be noted that health indicators in France, like measures of satisfaction among the public with regard to the system itself,[16] are among the world's highest. For example, in terms of life expectancy at age 65 or infant mortality, France comes ahead of nearly every developed country, including Canada (and Quebec). According to a recent study, France ranks first in the world in the rate of avoidable mortality caused by deficient health care.[17]

France manages to attain better health care results than Canada or Quebec without really spending more per-capita or as a share of national income.

France manages to attain better health care results than Canada or Quebec without really spending more. In 2005, per-capita health care spending (adjusted for purchasing power parity) was US$3,374 in France, compared to US$3,326 in Canada and US$3,064 in Quebec. The share of national income devoted to health care is also comparable: it is lower across Canada (10.6%) than in France (11.1%) and Quebec (11.3%). These figures are misleading, however, insofar as the proportion of people 65 and over, who are more likely to require health care, is higher in France (16.5%) than in Quebec (14.4%) or across Canada (13.4%).

Although it is often stated that the main weakness of the French health care system is its high costs, international comparisons show that inflationary trends in health care spending in France in recent years are lower than elsewhere. In nearly all developed countries, public health care spending has kept rising since at least the mid-1990s at a faster pace than economic activity. However, a recent OECD report notes that health care spending in France was just 20% higher in 2005 than in 1995, whereas average spending in OECD countries had risen nearly 50%.[18] The average annual growth rate in real per-capita health care spending in France was 2.3% from 1995 to 2005, the lowest rate among OECD countries except for Germany.

Competition may well explain why spending growth has been held at a reasonable level in France despite the aging of its population. With health care establishments pushed constantly to seek ways of improving the quality of their services and to stand out from their competitors, they are forced to innovate and to find means of reducing costs. It is estimated that the private sector in France has costs 30% to 40% lower than the public sector for the same pathology.[19]

Conclusion

The French experience shows that a health care system, especially a hospital system, can be public and universal without health services being provided and insured almost exclusively by public sector bodies and establishments. In a system that respects patients and focuses on a continual search for performance, a diversified range of establishments, whether public, private non-profit or private for-profit is likely to ensure levels of flexibility and competition that end up greatly benefiting all citizens.

15. World Health Organization, *The world health report* 2000 – *Health systems: improving performance*. For a ranking of health care systems across Europe, the organization Health Consumer Powerhouse ranked France first in 2006 and third in 2007 and 2008. Canada was ranked 23rd in 2008. See: Health Consumer Powerhouse, *Euro-Canada Health Consumer Index 2008*.
16. European Commission, *Health and long-term care in the European Union*, Special Eurobarometer 283, December 2007.
17. Thus, the risk of a patient who suffers from an illness for which effective treatments exist and who dies for lack of receiving appropriate care within the required time is lower in France than in any other country. Ellen Nolte and Martin McKee, "Measuring the health of nations: updating an earlier analysis", *Health Affairs*, Vol. 27 (2008), No. 1, pp. 58-71.
18. Organization for Economic Cooperation and Development, *Health at a Glance 2007: OECD Indicators*, 2007.
19. See: Haut Conseil pour l'avenir de l'Assurance Maladie, *Analyse des coûts dans les établissements hospitaliers*, 2004, p. 10. The Haut Conseil pour l'avenir de l'Assurance Maladie does not state the potential causes of this cost differential and prefers to remain careful relative to its interpretation as long as the causes are not well-known.

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