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NON-PROFIT HEALTH CARE: TAKING INSPIRATION FROM EUROPE

By Emmanuelle B. Faubert

In the public debate over health care, the private sector is usually understood as being made up of companies looking to make a profit. Around the world, however, the private sector encompasses non-profit as well as for-profit organizations. Non-profit organizations reinvest any profits to make improvements in the pursuit of their goals. They represent another alternative to centralized, government-controlled healthcare services.

NON-PROFITS IN CANADA AND EUROPE

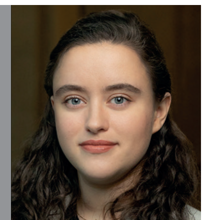
There are a large number of non-profit healthcare organizations and charities in Canada. When it comes to hospitals, however, things get blurry. Indeed, most Canadian hospitals are, at least on paper, non-profit corporations with their own boards.[1] Yet, they are so closely linked to governments, including in terms of their funding being conditional on standards set by the government, that they are completely dependent upon and controlled by the government for their everyday functioning. Not being independent, they cannot be considered truly private non-profits.

This is why the OECD, in its international healthcare statistics, considers all Canadian hospitals to be public, stressing that they are "controlled by government units." It stipulates that this applies to hospitals owned by non-government organizations, religious groups, or lay voluntary groups.[2] Statistics Canada uses a similar classification for non-profit hospitals, considering them to be part of the government sector.[3]

One measure of the presence of the non-profit hospital sector in a given country is the proportion of beds it accounts for. Whereas in Canada this figure is zero, it is 14% in France, 28% in Germany, and 100% in the Netherlands (see Figure 1).

These three European countries are of particular interest as each of them has things Canada can learn from. According to the

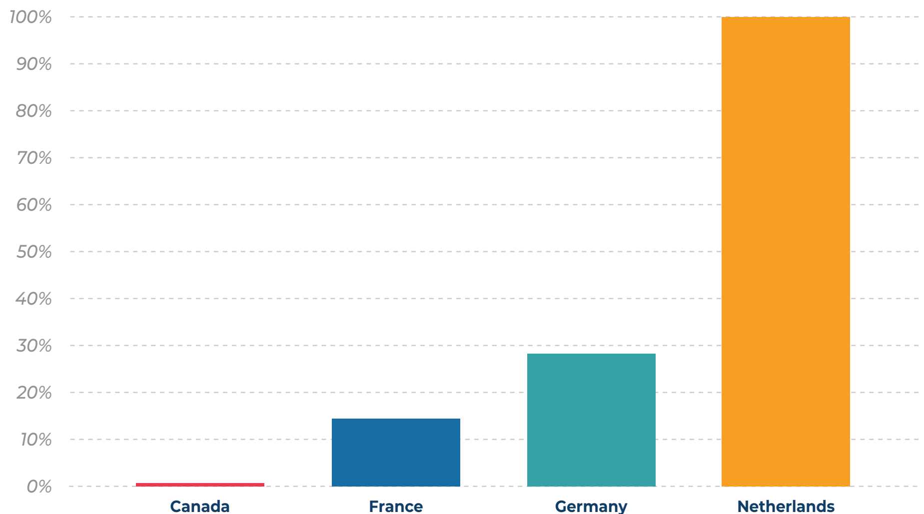
This Economic Note was prepared by **Emmanuelle B. Faubert**, Economist at the MEI. The MEI's Health Policy Series aims to examine the extent to which freedom of choice and entrepreneurship lead to improvements in the quality and efficiency of health care services for all patients.



Commonwealth Fund health care system rankings, each of these countries outperforms Canada when it comes to the provision of care. While Canada ranks 10th out of 11 systems studied in the overall ranking, France, Germany and the Netherlands rank 8th, 5th, and 2nd respectively.[4]

Figure 1

Proportion of hospital beds in non-profit hospitals, select countries



Source: OECDstats, Health, Health Care Resources, Hospital beds, consulted May 30, 2024.

MANAGEMENT OF OPERATIONS

While non-profit hospitals vary across Europe, some common characteristics distinguish them from Canadian hospitals. The first difference between them concerns the management of operations. Because independent hospitals and clinics are owned by legal entities outside of the government, they are subject to different rules. While technically non-profit hospitals in Canada are subject to all the same bureaucracy as the government system, European non-profit hospitals have more autonomy to manage their operations, and are largely self-governing.

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In Germany, while the government sets a general framework and conditions for delivering medical care, organization and financing are the responsibility of more regional associations. Many hospital policy decisions are made at the state rather than the federal level. The German Hospital Federation is an organization that represents all German hospitals, including non-profit ones, in health policy matters that are agreed upon with the insurer association and the medical doctors chamber. It is in charge of decision-making when it comes to hospital regulations, and also ensures the quality of care provision among its members.[5] This decentralized approach allows hospitals to have a bigger say in health care policies and regulations, ultimately giving them more control over their daily operations.

Similarly, while the Fédération hospitalière de France represents all French government-run hospitals in parliamentary debates, the Fédération de l'Hospitalisation Privée represents private hospitals and clinics, while the Fédération des Établissements Hospitaliers et d'Aide à la Personne represents non-profits.[6] The independence of non-profit hospitals gives them substantial freedom when it comes to self-governance and personnel management. Unlike French government-run hospitals that have to maintain uniformity across the country, non-profit hospitals are able to adapt their management to their own reality, both when it comes to administration and remuneration.[7] This freedom of management and organization allows them to better respond to the needs of their communities. The ability to adapt also lets them

specialize, and be recognized for the quality of care they provide.

In the Netherlands, national governmental involvement is limited, and all hospitals are non-profits.[8] While the government plays an important role in funding, regulating, and overseeing health care, the operation of the system itself is left in the hands of the private sector, relying heavily on market mechanisms and competition between insurers and providers.[9]

FUNDING METHODS

The second main difference is related to funding methods. In Canada, the vast majority of funding is through global government budgets.[10] Therefore, not only is hospital financing mostly dependent on the government (besides the role that hospitals' foundations may play), but financing is based on previous years' financial needs. This encourages less than optimal spending, as money not spent could be cut from future global budgets. It also makes every additional patient that comes through the doors of a hospital an additional burden on the hospital's budget, contributing to a rationing of resources and long waiting lists. Perversely, a well-run hospital with a good reputation will be penalized by attracting a greater volume of patients that it must treat on its fixed budget.

In contrast, activity-based funding, by rewarding efficiency and service quality, changes the incentive structures of health care facilities, encouraging them to treat a greater number of patients. While this funding method is gradually being implemented in Quebec, with 25% of hospital funding based on activity, this is not yet the case in the rest of Canada.[11] It is widely used in Europe, however, including by non-profit hospitals.[12]

In Germany, activity-based funding is used to fund inpatient treatments, covering all services and physician costs. Supplementary funding can be provided for specialized and expensive treatments.[13] Activity-based funding rates are based on statistical data and are applied to all patients, regardless of insurance provider or hospital type.[14] Funding for investments such as new buildings and equipment, however, is provided by the federal government.

France uses activity-based funding for all hospital medical services, both inpatient and outpatient.[15] Activity-based funding prices are fixed and determined yearly by the ministry of health based on annual cost data.[16] In 2024, financing is set to change to more of a mixed system, with activity-based funding for most standard activities, and mixed financing for acute care.[17]

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The Netherlands also uses a form of activity-based funding for both outpatient and inpatient care, although it is structured slightly differently.[18] While most activity-based funding rates can be negotiated between insurers and providers, 30% of them are fixed on a national level by the Dutch Health Care Authority. This particular method is supposed to encourage even more competition between insurers, as well as between health care providers for the other 70% of activity-based funding rates.

PRIVATE INSURANCE

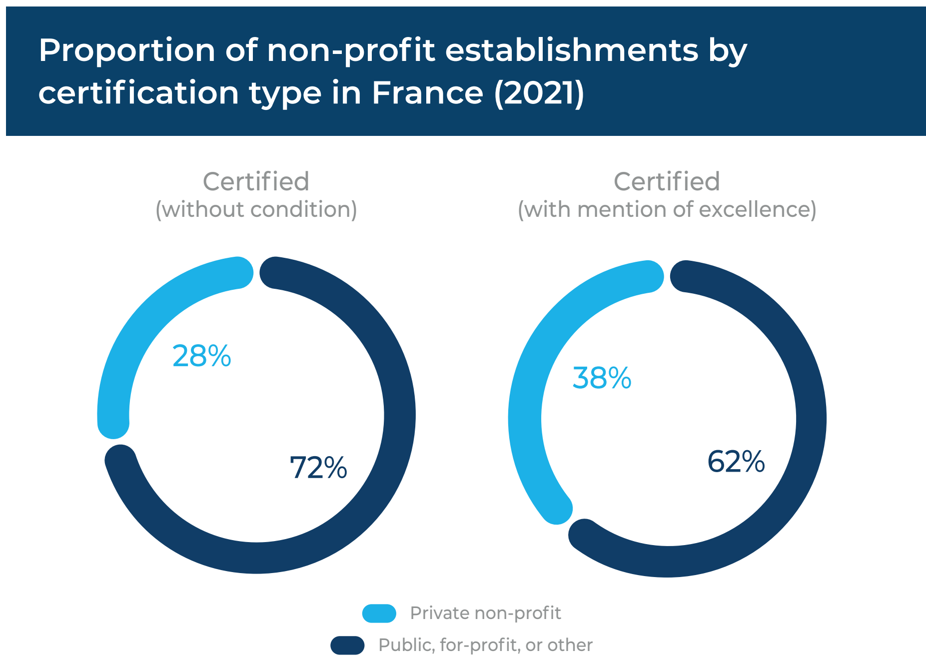
The third main difference concerns the insurance landscape and the existence of private co-payments. In Canada, all citizens are covered by their provinces' mandatory insurance plans. While additional insurance can be bought for health care services like dental care, optometry, medications, and other auxiliary services, "necessary medical care" is covered by the provincial insurance plans.[19] Duplicate insurance, which would allow Canadians to get insurance for services already covered by the provincial plans and which patients could use to pay for care received from private clinics, is banned in multiple Canadian provinces.[20] Medically required care also has to be delivered free of charge, with no co-payments, as these are banned by the *Canada Health Act*, which

further impedes the development of an autonomous private non-profit sector.[21]

When hospital care is paid for by insurers rather than by global government budgets, this increases the financial autonomy of private non-profit hospitals as they receive funding directly related to the care they provide, rather than predictions of needs based on previous years. Private insurance, whether complementary, duplicate, or global, also allows for even better coverage and flexibility, both for hospitals and for patients.

Figure 2

Proportion of non-profit establishments by certification type in France (2021)



Source: Haute Autorité de Santé, "Panorama de la qualité des établissements," consulted June 21, 2024, Author's calculations.

In Germany, people are covered by the basic government insurance plan, but those who are above a certain income threshold, self-employed, or civil servants can opt for typically more generous private insurance plans.[22] While state governments cover investments in infrastructure and equipment, health insurance funds cover treatment costs.[23] Although most care is fully covered, there are co-payments for some services, such as hospitalization, prescription drugs, and medical devices.[24]

> **For non-profit hospitals to truly play their beneficial role, government control over hospitals' activities must be loosened.**

In France, aside from some rare specific cases, all citizens must adhere to the government insurance program, which includes co-payments.[25] They are, however, able to take out additional voluntary health insurance, which 95% of the French population does. This can cover or reduce co-payments, including for hospitalization, as well as services like dental and vision care, which have minimal coverage under the government plan.

In the Netherlands, all insurers are private non-profit organizations. These insurers are in charge of concluding agreements with health care providers and hospitals, thus encouraging competition between providers. Private payments come mostly in the form of deductibles, which can be negotiated to change monthly premiums.[26]

LOOSENING TOP-DOWN CONTROL

Non-profit hospitals tend to outperform their government-run counterparts. For example, in France, they represent 27.8% of all hospitals certified without condition in 2021, but 38.3% of hospitals certified with a mention of excellence by the Haute Autorité de Santé, the government agency in charge of healthcare organizations[27] (see Figure 2). Considering that non-profit hospitals make up 28.8% of total hospital centres in France, the quality of the care provided by those hospitals is clear. The Institut Mutualiste Montsouris, a French non-profit hospital specialized in various serious and complex surgical services, is a good illustration of that high quality of care, with 21 specialties ranked among the best in

France.[28] Certified with mention of excellence, it is known for being the best hospital in France for prostate and lung cancers. This is only one of the many non-profit hospitals that provide top quality care to patients.

In order for non-profit hospitals to truly play their beneficial role of alternative healthcare providers in Canada, as they do in Europe, government control over hospitals' activities must be loosened. Governmental bodies should not micromanage non-profit hospitals, controlling centralized collective agreements, suppliers agreements, and consequently the way hospitals are run. Without sufficient autonomy, they become no different from hospitals run by the government.

Both for-profit and independent non-profit healthcare providers have a place in a universal health care system. Canadian decision-makers should look to European countries to see how embracing such diversity would lead to better healthcare results.

REFERENCES

1. Canadian Medical Association, Our focus, Public and private health care, Understanding public and private health care, consulted June 18, 2024; Government of Canada, "Canada's Health Care System, consulted July 9, 2024.
2. OECD, OECD Health Statistics 2023 – Definitions, Sources and Methods, Hospitals, Canada, Excel Spreadsheet.
3. Statistics Canada, "An Overview of the Non-Profit Sector in Canada, 2010 to 2020," July 5, 2022.
4. The Commonwealth Fund, Mirror, *Mirror 2021: Reflecting Poorly – Health Care in the U.S. Compared to Other High-Income Countries*, August 2021.
5. The German Hospital Federation, Mission and Objectives, consulted June 20, 2024.
6. La Fédération hospitalière de France, Notre histoire nos missions, February 22, 2022; Fédération de L'Hospitalisation Privée, Qui sommes-nous? consulted June 20, 2024; FEHAP, Qui sommes-nous? consulted July 25, 2024.
7. Le Sénat français, *Hôpital : Sortir des urgences – Rapport*, Report no. 587 (2021-2022), Vol. I, March 29, 2022.
8. OECD Library, *Towards an Integrated Health Information System in the Netherlands*, 2022, pp. 21-22.
9. Nadeem Esmail, *Health Care Lessons from the Netherlands*, Fraser Institute, June 2014, p. iv.
10. Government of Canada, *op. cit*., endnote 1.
11. Krystle Wittevrongel, "Activity-Based Hospital Funding in Alberta: Insights from Quebec and Australia" MEI, Economic Note, April 25, 2024.
12. The term Diagnosis-Related Group (DRG) is more commonly used in Europe.
13. Miriam Blümel and Reinhard Busse, "International Health Care System Profiles – Germany" The Commonwealth Fund, June 5, 2020.
14. Premier Healthcare Germany, "DRG Hospital Pricing System in Germany," consulted June 20, 2024.
15. Isabelle Durand-Zaleski, "International Health Care System Profiles – France," The Commonwealth Fund, June 5, 2020.
16. République Française, Fiches, Protection sociale, Le financement de la santé, Soins hospitaliers : T2A et autres modes de financement, January 11, 2024.
17. *Idem*.
18. Joost Wammes, Niek Stadhouders, and Gert Westert, "International Health Care Systems Profiles – Netherlands," The Commonwealth Fund, June 5, 2020.
19. Government of Canada, *op. cit*., endnote 1.
20. Maria Lily Shaw, "Lifting the Ban on Duplicate Private Health Insurance in Quebec," MEI, Economic Note, January 2023, p. 4.
21. Government of Canada, Health, Health system and services, Health care system, Canada Health Act - Frequently Asked Questions, Who is eligible for health care coverage in Canada? June 5, 2024.
22. Miriam Blümel and Reinhard Busse, *op. cit*., endnote 13.
23. The German Hospital Federation, *op. cit*., endnote 5; Bundesministerium für Gesundheit, Krankenhausfinanzierrung, consulted July 9, 2024.
24. *Idem*.
25. Isabelle Durand-Zaleski, *op. cit*., endnote 15.
26. Joost Wammes, Niek Stadhouders, and Gert Westert, *op. cit*., endnote 18.
27. This certification dates from 2021, and not all hospitals centres came up for certification that year. Other centres were graded in 2014. Only the hospitals certified in 2021 were taken into account in this Note. Haute Autorité de Santé, "Panorama de la qualité des établissements," consulted June 21, 2024.
28. L'Institut Mutualiste Montsouris, "21 spécialités classées parmi les meilleures de France dans le palmarès du Point," consulted June 21, 2024.

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