

Hospital Financing in France

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The French health care system is arguably the most complicated of the European (and Canadian) systems described in this report. Its system includes universal, compulsory social insurance, significant patient cost-sharing, and supplementary insurance on the financing side, and public providers combined with a sizable number of private providers on the supply side. Overlaying both the public and private sectors are strong governmental controls at all levels of government (11).

Almost the entire population (99 percent) is covered by the statutory health insurance scheme, which is part of France's social security system. Statutory health insurance expenditures account for over 70 percent of national health expenditures in France. The scheme is administered by social security sickness funds (*Assurance Maladie de la Sécurité Sociale*). A person's occupation generally determines membership in a particular fund. There is one large fund for salaried workers (CNAMTS), which accounts for nearly 80 percent of the compulsorily insured and about 15 smaller funds cover other workers. The government provides insurance for low income people. Contributions for sickness fund insurance are income-related and shared by employers and employees or paid directly to the relevant fund by nonsalaried or self-employed individuals (11).

Social insurance provides both cash benefits (e.g., sick pay) and benefits in kind (e.g., ambulatory care, hospital care). Depending on the patient's financial circumstances, the patient may be required to pay coinsurance or copayment amounts; for instance, patients may have to pay 20 percent of the cost of hospital services (the *ticket modérateur*) and a daily flat rate contribu-



tion that is currently 50 francs.¹ Employers sometimes provide supplementary insurance for their employees through mutual fund organizations (*mutuelles*) to cover patient cost-sharing amounts and a few benefits not covered by the social insurance scheme. Individuals may also purchase private supplementary insurance. *Mutuelles* and private insurance payments account for about 8 percent of national health expenditures.

France's sickness funds are quasi-autonomous, non-governmental organizations; there are national, regional, and local organizations of these funds. They are subject to national and local management by employer associations and trade unions. They are also closely regulated by the central government; in particular, contribution rates, fee schedules, and pharmaceutical prices are controlled by the central government (11).

Patients can consult any medical practitioner for primary care, and can choose to go to either a public or private hospital. Money follows the patient in the case of private hospitals, but public hospitals are subject to prospectively fixed budgets. Compared with the other European countries in this study and Canada, French patients have relatively large cost-sharing requirements. Patient out-of-pocket payments currently account for about 17 percent of national health expenditures; however, cost-sharing for hospital services is fairly small with only about 4 percent of hospital expenditures financed directly by patients (11).

Similar to many other countries, the containment of health expenditures is a major concern in France. Hospital care represents half of national health expenditures, making the hospital sector a primary target of France's cost-containment efforts. Recent reforms have concentrated on effectively controlling sickness fund insurance payments to private hospitals by extending governmental regulation over that sector, and by creating a new balance between the private and public sectors to harmonize their development

within an overall program designed to control health spending. Also similar to many other countries, France's health reforms are moving in the direction of making individual hospital budgets based more on each hospital's level of activity and less on historical costs.

STRUCTURE OF THE HOSPITAL SECTOR

France has a mixture of public, private nonprofit, and private for-profit hospitals. Public hospitals tend to be large and well equipped; private hospitals tend to be smaller and to specialize in elective surgery, obstetrics, or long-term care. In 1990 there were 1,072 public institutions; they constituted only 28 percent of all French hospitals, but provided almost two-thirds of total hospital beds, hospital days, and inpatient admissions (tables 4-1 and 4-2). By law, a public institution is a corporate body governed by public law and is responsible for providing a specific public service. Public institutions have full legal status, their own assets and resources, and full legal autonomy. They are, however, subject to various forms of public supervision and financial control. Public hospitals cannot waive their obligations, defined in the Act of December 31, 1970, to:

- provide diagnosis, treatment, and (in particular) emergency care to their patients and those referred to them, including necessary inpatient care;
- contribute to the training of medical and paramedical (nonmedical) staff; and
- participate in medical and pharmaceutical research and health education.

In 1989 the private hospital sector included 2,721 institutions, constituting 72 percent of all hospitals but accounting for only one-third of the total hospital beds, patient days, and inpatient admissions in France in that year (tables 4-1 and 4-2). The private sector is divided into a private for-profit or commercial sector with 1,515 institu-

¹The exchange rate in January 1994 was approximately \$USO.17 to F1 .00.

TABLE 4-1: Hospital Shares in France, by Category of Hospital^a

Category of hospital	Percent of total hospitals	Percent of beds
Public	28	65
Nonprofit, PSPH	12	11
Private nonprofit, non-PSPH	19	5
Private for-profit refit	40	19

^aData for public hospitals are for 1990; data for private hospitals are for 1989.

SOURCES: Documents Statistiques, "Les Etablissements d'Hospitalisation Privée en 1989," Enquete EHP 1989, SESI no. 121, Juillet 1991, Documents Statistiques, "Les Hopitaux Publics en 1990, Resultats H80," SESI no. 154, Septembre 1992

tions and a private nonprofit sector with 1,206 institutions. For-profit hospitals are privately funded and subject to the rules of commercial and civil law. Private nonprofit hospitals are run by voluntary organizations, religious orders, employee representatives, mutual fund associations, and social security funds. They are similar to public institutions in that they do not attempt to maximize profits, and their surplus revenues are invested to further their health care objectives.

Private institutions are managed by individuals or a legal entity. They make many of their own management and investment decisions, and their services are governed mainly by market forces, although they are subject to certain government constraints. Fees charged by private institutions are controlled and subject to formal agreements. Increases in the number of beds and high-cost equipment are controlled by the health map (*carte sanitaire*), described later, and require formal au-

TABLE 4-2: Hospital Beds and Inpatient Days, by Category of Hospital^a

	Public		PSPH		Public and PSPH	
	Beds	Hospital days (in 1,000s)	Beds	Hospital days (in 1,000s)	Beds	Hospital days (in 1,000s)
Medicine	105,393	29,243	13,879	3,918	119,272	33,161
Surgery	61,282	14,827	8,986	2,315	70,268	17,142
Obstetrics/gynecology	17,337	4,101	1,393	356	18,730	4,458
Medium-stay	42,127	11,943	19,921	5,386	62,048	17,329
Long-stay	63,711	22,289	1,877	638	65,588	22,927
Psychiatry	68,600	18,669	12,733	3,921	81,333	22,590
Total	358,450	101,071	58,789	16,535	417,239	117,607
	Private for-profit		Private nonprofit		Total private	
	Beds	Hospital days (in 1,000s)	Beds	Hospital days (in 1,000s)	Beds	Hospital days (in 1,000s)
Medicine	14,753	2,039	3,943	1,242	18,696	3,282
Surgery	50,820	17,123	4,675	1,484	55,495	18,607
Obstetrics/gynecology	10,083	3,084	882	254	10,965	3,338
Medium-stay	18,123	5,646	15,672	4,525	33,795	10,171
Long-stay	436	140	2,037	722	2,473	862
Psychiatry	13,405	4,767	1,960	637	15,365	5,404
Total	107,620	32,800	29,169	8,865	136,789	41,664

^aData for public hospitals are for 1990; data for private hospitals are for 1989.

SOURCES: Documents Statistiques, "Les Etablissements d'Hospitalisation Privée en 1989," Enquete EHP 1989, SESI no. 121, Juillet 1991, Documents Statistiques, "Les Hopitaux Publics en 1990, Resultats H80," SESI no. 154, Septembre 1992.

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theorization. Additionally, the medical activities of private hospitals are supervised by the sickness insurance funds' medical officers.

Private institutions are allowed to participate in the public sector, although to date only some of France's private nonprofit hospitals (467 in 1988) have asked to be incorporated into the public hospital service. These hospitals, called PSPH hospitals, are governed by rules similar to those for public hospitals. There are thus two general categories of hospitals in France: public and PSPH hospitals, and private institutions that do not participate in the public hospital sector.

Financing methods and operating arrangements vary greatly between the public and private hospital sectors. Public and PSPH hospitals are governed by the principles of public accounting, whereas private for-profit hospitals are commercial undertakings that attempt to maximize their surplus revenues. Reform legislation passed in July 1991 and currently being implemented is designed to create a new balance between the private and public sectors and to harmonize their development within an overall program to control health expenditures. The reforms formally recognize that public and private hospitals perform the same basic functions. In the future, the two categories of hospitals will share equal responsibility for ensuring public health through common provisions that affect all types of hospitals. Furthermore, the reforms seek to strengthen and encourage cooperation between public and private hospitals (5).

At present, a statutorily insured patient in France can go to either a public or private hospital, although in practice the decision is usually made by the patient's physician. When the choice is a personal one, it tends to reflect the hospital's geographical proximity, its reputation, or other personal preferences. Under the 1991 reforms, patients' freedom to choose a physician or hospital became an even more integral part of the health care system in France than it was under previous health care legislation.

Many hospitals in France have short-, medium-, and long-stay beds as well as psychiatric beds. It is difficult, if not impossible, to determine the proportion of hospital care in France that is devoted to short-term acute care treatment; therefore, this chapter deals with the French hospital sector as a whole. Purely residential institutions, such as nursing homes, are excluded from data cited herein, however.

PHYSICIANS

In public and PSPH hospitals, the medical staff includes residents or interns, who are physicians in training, and hospital practitioners, who are full-time or part-time with a salaried established post (*titulaire*) or a salaried, nonestablished post (*non-titulaire*). Table 4-3 provides a breakdown of hospital physicians in private and public hospitals in 1989 and 1990. The central government controls the growth of salaries and the number of hospital staff in public hospitals.

TABLE 4-3: Hospital Physicians^a

		Public	PSPH	Private for-profit	Private nonprofit	Total
Salaried practitioners	Full-time	27,913	2,614	596	525	31,675
	Part-time	39,962	4,250	851	2,047	47,110
Nonsalaried practitioners	Full-time		32	8,883	495	9,410
	Part-time		762	22,151	1,912	24,825
	Occasional		590	12,976	1,496	15,062
Salaried residents	Full-time	22,019	1,655	248	236	24,158
	Part-time		233	328	90	651
Nonsalaried residents	Full-time		22	15	11	48
	Part-time			164	8	172

^aData for public hospitals are for 1990; data for private hospitals are for 1989.

SOURCES: Documents Statistiques, "Les Etablissements d'Hospitalisation Privée en 1989," Enquête EHP 1989, SESI no. 121, Juillet 1991; Documents Statistiques, "Les Hôpitaux Publics en 1990, Résultats H80," SESI no. 154, Septembre 1992.

In certain circumstances hospital physicians are authorized to treat private patients in public hospitals through consultations or the use of public service beds for private patients. In such cases the physician receives a fee from the patient, which may be reimbursed by the patient's insurance company. Income from private fees may not exceed 30 percent of a physician's total income and the number of beds that can be used for private patients may not exceed 8 percent of all public service beds.

Public hospital physicians often confer with office-based private practice physicians (*médecins libéraux*). Whether or not payment for the consultation is included in the hospital's global allocation of funds (discussed further below) depends on the regularity of the consults. Any physician in an office-based practice may be consulted on an occasional basis by a hospital physician. Payment is rendered according to the service or consultation performed and falls outside the hospital's global allocation. Hospitals regularly call on some physicians in private practice (called affiliated practice physicians) who are paid a fee per service provided. These fees are included in the hospital global allocation.

There are no salaried physicians in rural hospitals and any private physician may consult there subject to authorization. In these cases the physician may ask patients who are not covered by sickness funds to pay an agreed-upon fee. For patients with sickness fund coverage, the physician may claim 85 percent of the local daily charge per day; for patients qualifying for social assistance, the physician is paid 50 percent of the departmental medical assistance charge. In these two cases the hospital retains 10 percent of fees received.

In certain circumstances nonsalaried physicians operate clinics in public institutions. They are paid on a fee-for-service basis; the level of fees is agreed upon directly with the patient. Physicians pay 10 percent of their fee income to the hospital, which uses the proceeds for improving their stock of medical equipment.

Thus, in public or PSPH hospitals, most payments to medical staff are included in the operating section of the budget and are taken into ac-

count in determining the hospital's global allocation. Exceptions to this are fees paid to physicians practicing in rural hospitals and in hospital clinics, and fees received by hospital physicians as part of their private practice.

In private for-profit hospitals, physicians are nearly always paid on a fee-for-service basis and patients are reimbursed by their insurance companies. Nevertheless, an increasing number of private institutions are taking the opportunity to invest in staff (particularly medical staff) by offering the best-trained personnel attractive remuneration packages, particularly in comparison with what the public sector can offer. Physicians' fees in private hospitals are set according to a national fee schedule, but their incomes, other staff incomes, and the number of staff hired are not regulated by government.

HOSPITAL OPERATING COSTS

■ Financing Model

There are two distinct methods of financing hospital operating costs in France. Public and PSPH hospitals are paid largely through a prospectively fixed budget. Private non-PSPH institutions are paid a daily (per diem) rate for their services; inpatient physician and ancillary services are paid for on a fee-for-service basis.

Public Hospitals

Since 1984-85, public and PSPH hospitals have been subject to a global allocation scheme established by the prefect of the district in which they are located and determined within the framework of federal guidelines. The global allocation scheme replaced a system of controlled rates of increase in per diem prices for public and PSPH hospitals (11). Under the new scheme each hospital receives an annual global allocation to cover the portion of its costs that is paid for by the sickness funds. Hospitals also charge daily rates (*tarifs journaliers de présentations*) to cover that part of a hospital stay not provided for in the global allocation. Daily charges are established for several purposes. Federal and local governments pay a daily charge for patients on social assistance. The

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daily charge is also used to determine patient cost-sharing amounts for patient copayments (*ticket modérateur*) and daily flat-rate payments (paid either by the patient or by a supplementary insurance company), and it constitutes the charge for patients who have no insurance coverage.

Hospital Budgets

The hospital budget sets forth estimated expenditures and revenues for the coming year. This budget, like that of any public administrative institution, must conform to certain public accounting principles. It has two sections, as described below:

- The operating section deals with current activities, including the day-to-day running of the hospital and financial management.
- The investment section deals with operations leading to an increase in durable capital assets requiring depreciation (other than stocks), such as permanent capital, real estate and tangible property, stocks and securities, deposits and sureties, and physical supplies.

Expenditures that require authorizations for the operating section of the budget are divided into three groups:

1. expenditures relating to the external purchase of goods and services,
2. staff or personnel-related expenditures, and
3. all other types of expenditures.

A public or PSPH hospital's operating revenue is derived from the following sources:

1. the global allocation described below;
2. income from services (e.g., via daily rate charges or fees);
3. grants, donations, and legacies to be used for operating purposes;
4. other surplus income unrelated to operational activities;
5. income from reserves;
6. the value of liabilities reduced by expire or lapse; and
7. the value of any repairs undertaken or surplus produced by the institution itself (e.g., pharmaceutical products made by the hospital's laboratory).

Appended Budgets

Current expenditures on certain activities and services (e.g., blood transfusion centers, mobile emergency services, data processing centers) must be included in appended budgets. Operating costs are funded from both general and appended budgets.

Authorized expenditures for the coming year must take into consideration the average rate-of-increase guidelines established by the central government's ministries of the economy, budget, health, and social security. The average rate of increase for hospital expenditures is based on general economic trends—in particular, forecasted changes in prices and wages—and on national health and social policies. The guideline rate was 4.2 percent in 1990.

Determination of the Global Allocation

Although a hospital receives a small amount of revenues in addition to the global allocation and daily charges, these two elements are essential to a hospital's ability to provide services. The global allocation is designed to provide enough funds to cover that part of the hospital's expenses that will be paid for by the sickness insurance funds. It represents the difference between total operating costs as set forth in the authorized general and appended budgets and expected hospital revenues other than the global allocation itself, so as to ensure that the hospital's budget will be balanced after taking into account surpluses or deficits from previous years. Annual increases in a hospital's global allocation are based on the federal guideline rate of increase and the hospital's forecasted level of activity.

Patient copayment and daily flat-rate contributions, repayments by mutual fund associations and private insurance companies for their members' expenses, and payments for patients covered by medical or social assistance are not included in the global allocation; they are billed according to the daily service charges established for individual patients.

The global allocation covers costs relating to inpatient care, day and night care in the hospital,

outpatient care,² psychiatric care, legal abortions, mobile emergency care units, and long-term care institutions for the elderly.

Determination of Daily Charges

The partial nature of the global allocation makes it necessary to establish a system of charges (tariffs) to recover expenses not paid for through the global allocation. Daily service charges determine the amounts to be paid by federal or local governments, patients, or any organization providing supplementary coverage. Daily service charges are calculated for different types of services by dividing the estimated total costs of each type of service by the estimated number of patient days for each type, after adjusting costs for offsetting receipts and for any previous year's surplus or deficit that has been carried forward.³

Service charges are calculated for inpatient care (including specialist and nonspecialist services, services relating to expensive specialties, and medium- and long-term services), day and night care, and home care services. There are also three possible short-term charges for medicine, surgery, and expensive specialties. Because individual hospitals have different budget levels and estimated numbers of patient days for various types of services, daily service charges vary by hospital. In contrast, flat-rate charges for outpatient care and for legal abortions apply uniformly throughout France. Box 4-1 describes the different parties involved in hospital management and supervision, and offers more details on the determination of global allocations and daily rates.

Budget Adjustments

Except in the case of a budget revision, the global allocation is paid on the basis of the amount initially provided for, regardless of the hospital's actual level of activity. If the number of patient days is lower than estimated, the hospital's income (insofar as it relates to its global allocation) remains unaltered.

If a hospital can show that there has been a significant and unforeseen change in its financial circumstances or medical activity leading to a substantial increase in the hospital's costs during the current year, changes to the budget (e.g., an increase in authorized revenues to meet higher-than-anticipated expenses) may be approved. Additionally, in urgent cases the hospital's director may transfer appropriations between the first two groups of authorized expenditures in the general budget and the appended budgets during a financial year. These transfers may not, however, increase or reduce authorized expenditures within these groups by more than 10 percent, reduce appropriations designed to cover unavoidable costs (e.g., social security contributions or taxes), or commit the institution to expenditures beyond the current financial year.

End-of-year surpluses in the hospital's administrative account resulting from more efficient management (e.g., expenses are less than forecasted for the same or higher level of service delivery) are assigned to a compensation reserve account. Such reserves may be used to cover subsequent years' deficits or assigned to another reserve account that can be used to finance operations or investments that do not increase operating

²Actually, only part of the cost of outpatient care is taken into account in calculating the global allocation. In particular, the allocation relating to this area covers the cost of supplying drugs for which the sickness insurance funds are statutorily responsible. It is estimated that on average, 50 percent of outpatient costs are covered by the global allocation. The remainder has to be covered by the patient through a copayment or by a third-party payer other than the patient's sickness fund.

³An excerpt from the decree of Aug. 11, 1983, section 32, states specifically that "[t]he estimated cost price shall be equal to total operating expenditures, comprising:

- a) direct costs, that is the costs of services belonging to a particular category of charges, excluding the cost of medical treatment, goods and other medical services;
- b) the cost of medical treatment, goods and services on the basis of their purchase price or, failing that, of their cost price;
- c) other costs included in the operating section of the general budget which are not covered by their own resources, divided among the different categories of charges in proportion to the estimated number of days for each category;
- d) where appropriate, that part of the previous financial year's deficit which has been carried forward."

BOX 4-1: Hospital Management in France

Hospitals are managed by a board made up of locally elected representatives (of which the mayor of the municipality concerned is the chairperson), representatives of the social security system, representatives of the hospital's medical and nonmedical staff, and a director who is responsible for implementing the policies developed by the board and approved by representatives of the State. The board's director also authorizes expenditures and issues revenue orders, appoints nonmedical staff, and is the hospital's legal representative.

The supervisory role exercised by public authorities in the budget-making process places strict limits on the degree of managerial autonomy enjoyed by public and affiliated hospitals. Administrative supervision of public and PSPH hospitals operates at every level:

- at the national level through the Hospital Department of the Ministry of Health;
- at the regional level through the prefect of the region (appointed by the government), assisted by the regional Department for Health and Social Services (DRASS); and
- at the district level through the prefect of the district (also appointed), assisted by the district Department for Health and Social Services (DDASS).

The social security system, which is the principal source of funds for hospitals, has no formal supervisory responsibilities but only the right of oversight. Its role has been strengthened over time, however. Social security sickness funds have contributed to the development of hospital policy at the national and local levels through representation on various associations and through their significant oversight rights for financial and medical matters. Additionally, supervisory authorities must consult representatives of sickness funds when drawing up hospital budgets. Furthermore, at the request of the sickness funds, hospital directors must submit quarterly expenditure commitment statements and provide information on staffing. The sickness funds also partially supervise medical decisions, which can mean that a sickness fund would refuse to pay the cost of treatment or would modify the financial terms of a hospital admission that it deemed unjustified or inappropriate. The sickness funds monitor all hospital medical activities but (except with regard to nonpayment of services) exercise a passive form of supervision, as the funds' concerns are not backed up by any sanctions (3).

Financial monitoring of hospitals is the responsibility of the district Department for Health and Social Services; the social security funds, which receive the quarterly expenditure statements; and the hospital accountant (an official of the public treasury service) who ensures that spending commitments comply with relevant legislation and regulations and that the necessary appropriations have been made.

costs in subsequent years. Priority is given to financing services that have contributed to the surplus. Surpluses that do not result from improved management (e.g., if services are lower than forecasted levels or the surplus arises from daily charges or outpatient care) are transferred to a compensation reserve account to cover operating costs in future years.

Any deficits in the administrative account are covered by drawing on the compensation reserve

account. If the reserve is not sufficient, the deficit amount is figured into the budget of two years later or can be spread over the following two financial years by adding it to the hospital's operating costs.

Sickness Fund Payments

Each sickness insurance fund in a given hospital's catchment area pays the so-called pivot fund (or main fund in the area) its share of the hospital's

BOX 4-1 (Cont'd.): Hospital Management in France

The budgetary process is relatively long, reflecting the desires of various categories of hospital staff to be involved in the hospital's planning and the strict supervision exercised by external authorities. The director or director-general of the hospital is responsible for preparing and submitting budget proposals, taking account of the previous and current years' activities. Assisted by hospital departments, the director determines the level of expenditure that is essential for the hospital's operations. The draft budget is then submitted to a joint consultative committee and a medical staff committee for comment. Budget proposals are adopted by the hospital's board (*conseil d'administration*), which must express a formal opinion on the director's figures. Budget proposals are then sent to administrative authorities and the regional sickness insurance fund for salaried employees, where they are available for comment.

Hospital budgets, global allocations, and daily service charges are determined by administrative supervisory authorities by January 1 of the relevant year. With the exception of the Paris hospital service (responsibility for which devolves on the Minister of Health), the prefect of the district is responsible for establishing global allocations for the district's public hospitals. This responsibility also involves a critical response to hospitals' budget proposals to ensure that each institution can meet its obligations. The prefect is empowered to increase income and expenditure estimates for hospitals whose estimates it considers too low and to remove or reduce items that it considers unnecessary or too high—taking account of local health care needs and the federal guideline rate for average increases in hospital expenditures (4). Prefects' decisions are made only after consultations with the social security funds. The opinions of the social security funds and the medical supervisory bodies are recorded by the regional sickness insurance fund.

The district prefect notifies the hospital, the regional sickness fund for salaried employees, and the fund responsible for paying the global allocation (the "pivot" fund) or main sickness insurance fund in the area) regarding the final determination of daily service charges and the global allocation, together with the hospital's approved budget.

The hospital's director is the principal authorizing officer for the budget and maintains a formal record of expenditures. The director submits quarterly accounts (upon request) to the prefect. At the end of each quarter, the director also submits a chart to the prefect showing the current number of hospital staff.

global allocation.⁴ At the end of the financial year, the national sickness insurance fund for salaried employees draws up a statement of contributions required from each fund based on the number of days provided to the fund's members (weighted according to coefficients that account for the different daily costs of hospital care provided, which are determined by a joint ministerial order). Before June 1 of the following budget year, a committee for the apportionment of hospital global al-

locations must reach a unanimous decision on the final contribution from each sickness fund, taking into account the statement drawn up by the national sickness insurance fund (8).

Recent Reforms

Although the 1991 health reforms did not alter the basic method of global allocations, major changes to the budgetary process were introduced. Under this legislation (whose implementing regulations

⁴ Under the 1991 reform legislation, the pivot sickness fund makes an initial payment of 60 percent of the global allocation to the hospital on the twenty-fifth day of the month, then 15 percent on the fifth of the following month, and the balance on the fifteenth day of the following month.

were unpublished as of this writing), the budgetary process will start earlier in the year, budget negotiations will be faster and more streamlined, management will be more flexible, and the hospital board will have more autonomy particularly with regard to day-to-day matters (e.g., staffing, loans, internal organization), which will no longer be subject to the district prefect's prior approval. There will be closer cooperation between the authorizing officer and the accounting officer. New provisions will also be made for the investment of and return on funds. Moreover, it will be possible to revise a hospital's global allocation in the course of a financial year to reflect changes in the current volume of services provided as long as it is related to greater patient needs.

Another important innovation included in the 1991 reforms and currently being experimented with in several hospitals is the determination of charges based on the identification of homogeneous patient groups (*groupes homogènes de malades*), which are in turn based on U.S. diagnosis-related groups (DRGs) (5).

Private Hospitals

Private for-profit and nonprofit institutions that do not participate in the public hospital sector operate on a fee-for-service basis, although fees are usually regulated by the central government's health ministry. An agreement between hospitals and their regional sickness funds fixes the amount of money that the funds will reimburse patients in the coming year. Private hospitals accept a certain number of service obligations (inpatient days and hospital admissions) to sickness fund patients in exchange for guaranteed reimbursement from the funds. If a private hospital has a surplus when it closes its accounts, it is free to distribute that surplus to shareholders or to reinvest the surplus funds. If it has an operating loss, the social security fund does not become involved in any way to cover the deficit.⁵

Daily Rates and Fees

Private hospitals' payments are based on negotiated daily rates that comprise a charge for hotel-type services and nonmedical personnel services (e.g., nurses, social workers, therapists), fees for operating and delivery room services, pharmaceutical fees, and fees for physician services. Patients usually pay physicians' fees directly and are then partially reimbursed by their sickness fund. In the past physicians have been paid separately from the hospital's charges, but physician payment is increasingly being included in the same schedule as the costs for a hospital stay. One advantage of folding in physician payments is that all payments made by the sickness fund for a patient's hospital stay are included in a single document that provides the fund with an overview of total hospital costs.

Physicians' services are reimbursed according to a national fee schedule classified as K, Kc, B, and Z (for diagnostic activities, surgery, biological analyses, and imaging, respectively). One K is worth approximately 12 francs, and one Kc is worth about 13 francs. Reimbursement for physician or surgeon services is supplemented by an operating or delivery room fee (FSO) paid to the hospital. The FSO varies according to region and category of hospital and by levels of K.

Private hospital per diem rates for hotel-type and non-medical staff services are based on a classification of the hospital's specialty and quality ranking. Since 1973 the classification system has assigned points to an individual hospital for each of the following five areas (in order of significance for rate setting):

1. medical services,
2. nonmedical staffing,
3. technical equipment,
4. hotel facilities, or
5. a combination thereof.

Depending on the total number of points obtained, a hospital is classified as A, B, C, D, or E,

⁵ The agreement setting forth the responsibilities of all the parties concerned was drawn up by the Ministry of Health between 1975 and 1978 and approved by the Ministry in 1978.

each of which has a particular set of rates per specialty. The classification is decided by the regional prefect after consultation with a joint committee that includes representatives of sickness funds and health care providers.

A total of 800 points is required for category A classification, which indicates consistently high performance; rates fall as a hospital's classification moves from category A to E. Hospitals and clinics classified within each category have the same level of rates wherever they are located in the region. Hospitals have an incentive to invest in technologies, equipment, and staff to improve their ranking to receive higher per diem rates. The process of ranking hospitals is fairly rapid, and a hospital may even have its ranking changed retrospectively. For several years, per diem rates have been regulated and subject to authorized annual increases, expressed in either absolute amounts or percentage terms.

Operating room fees are directly linked to a hospital's rate category. Similarly, the pharmaceutical fee, formerly based on actual costs, is now becoming more uniform. Charges and fees are thus subject to limits and linked to the number of inpatient days delivered by the hospital. There are also government controls on the number of admissions and on the number of authorized beds in private hospitals.

Despite these measures to limit private hospital rates and the number of services, the total volume of medical services provided by private hospitals has not been brought under control. In response, the regional sickness funds require private hospitals to supply information on their activities from which averages and comparisons among hospitals are made. Hospital profiles are also drawn up to identify potential abuses. These profiles serve only as indicators of service provision, however, and are not used as instruments for setting limits or preventing abuses.

As an additional monitoring tool, regular checks of hospital practices are conducted to prevent bad practices. If any are identified, a preliminary letter is sent to the director of the hospital asking for remedial action. If the problem is serious or has occurred before, the hospital's manager

is required to make the hospital's case before a committee of administrators of the regional sickness funds. A warning or reprimand may be sent or, after a complex review procedure, the hospital's classification may be downgraded. The ultimate sanction (for which there must be serious grounds) is abrogation of the sickness funds' agreement; costs are no longer paid in advance, and the daily charge is paid at three-quarters of the previous level. Although not applied frequently, these sanctions have had some effect (17).

Supervision

A group of sickness fund physicians supervises agreements between private hospitals and sickness funds that pertain to private hospital staffing levels, current pharmaceutical regulations, standards for operating rooms, and standards regarding the size of patient rooms. A compulsory annual statistical survey of private hospitals must also be provided to regional sickness fund organizations, making it possible to identify any possible problems in a range of areas. The standards and adherence to them have a direct effect on charges for services.

Health Reforms

Although the 1991 health reform act initially retains the principle of fees and rates for private hospital services, the legal framework and the financial basis of for-profit institutions have been altered. The tripartite system, involving the state, sickness funds, and hospitals, may gradually become the norm in the private sector as it has already been for some time in the public sector. The state could become involved in contractual relations regarding the volume of services that have hitherto been the concern only of hospitals and sickness funds.

There are no plans at this time to introduce a global allocation scheme for the private sector. Instead, there is a global ceiling on private hospital expenditures by the sickness funds, subject to a guideline rate of annual increase in this ceiling agreed on between the state and the other two traditional partners in the private hospital sector.

TABLE 4-4: Sources of Financing for Hospital Operating Expenses, by Hospital Sector, 1991

Source	Public and PSPH		Private		Total	
	Million francs	Percentage of total public and PSPH operating expenses	Million francs	Percentage of total private hospital operating expenses	Million francs	Percentage of total operating expenses
Sickness insurance funds	179,778	90.0	52,886	83.4	232,664	88.5
Individuals and private insurance	13,116	6.6	7,848	12.4	20,964	8.0
Mutual fund associations	3,023	1.5	2,329	3.7	5,352	2.0
Federal or local authorities	3,508	1.8	342	0.5	3,850	1.5
Total expenses	199,425		63,405		262,830	

SOURCE: Centre de Recherche d'Etude et de Documentation en Economic de la Sante (CREDES) Programme Eco-Sante, 1990 and 1991.

This ceiling is allocated among regions and by month and may not be exceeded.

The 1991 legislation requires that private institutions analyze their activities, develop an assessment policy, and implement information systems (similar to *programmed medical des systemes d'Information, or PMSI*). It also makes the submission of annual forecasts of activity to the sickness funds a precondition for setting rates or for concluding rate agreements. The implementation of a cost accounting system and a medical information system were intended to lead to a DRG-type of charge system by the end of 1993. An experiment using this new approach was introduced in obstetrics-gynecology units and in volunteer institutions for other specialties beginning on July 1, 1992 (5).

■ Sources of Funds

The social security sickness funds pay for the lion's share of hospital care in France; they funded 90 percent of public and PSPH hospital operating expenses and over 83 percent of private hospital operating costs in 1991 (table 4-4). Private insurance, mutual fund associations, and individual out-of-pocket payments accounted for a fairly small share of hospital costs (10 percent), even for private hospitals (16.1 percent). These figures reflect sickness fund patients' freedom to choose

either a public or a private hospital, and private insurers' and mutual fund associations' minor roles in the French health care system of mainly providing supplementary insurance.

The relatively small part that private hospitals have in France's system is reflected by their share of total hospital expenditures. In 1991, three-fourths of all hospital spending was for care provided in public and PSPH hospitals; the other fourth was for private hospital care (table 4-4).

Federal and local authorities pay hospitalization costs for patients who receive state medical or social assistance. These payments, financed through general revenues, funded 1.5 percent of hospital expenses in 1991 (table 4-4). (Foreign patients who are not residents of France must pay their own hospital bills although there are international agreements between France and certain countries allowing payments to be made through official channels.)

■ Allocation of Operating Funds

Public Hospitals

Public hospital operating costs were F139 billion in 1988, representing 87.8 percent of aggregate hospital expenditures (which includes capital expenditures) (table 4-5). The largest single item (F90.1 billion, or 65 percent of operating costs)

TABLE 4-5: Operating Funds in Public Hospitals, 1988

Operating costs	Million francs	Percentage of total	Operating revenues	Million francs	Percentage of total
Staff	90,140	64.9	Global allocation	118,074	81.0
Pharmaceuticals, medical services	12,792	9.2	Service charges	9,631	6.6
Hotel facilities	8,473	6.1	Daily flat rate contributions	1,877	1.3
Repairs, maintenance	3,753	2.7	Outpatient care	2,543	1.7
General management	3,490	2.5	Donations, contributions	219	0.2
Mortgages	2,737	2.0	Sales of products	469	0.3
Other	17,451	12.6	Other	13,121	9.0
Total	138,836		Total	145,934	

SOURCES: Ministère de l'Economie des Finances et du Budget, Direction de la Comptabilité Publique, Les Finances du Secteur Public Local, Hôpitaux Publics 1983-1988.

was for hospital staffing costs. (It is not possible to distinguish between medical and nonmedical personnel costs.) Expenses for pharmaceuticals and medical services accounted for 9 percent of hospital operating costs in 1988; hotel-type services made up 6.1 percent, repairs and maintenance 2.7 percent, and management and transport 2.5 percent (table 4-5).

Public hospital operating revenues were nearly F146 billion in 1988, of which the global allocation represented 81 percent, total daily service charges accounted for 6.6 percent, total daily flat-rate contributions were 1.3 percent, and outpatient care charges accounted for 1.7 percent of hospital operating income (table 4-5) (10).

Private Hospitals

In contrast to public and PSPH hospitals, there are no systematic statistics on the revenues or costs of private institutions. A 1985 study by the *Centre d'Etudes des Coûts et des Revenus (CERC)* estimated the operating costs of private hospitals and clinics in 1980 at F11.7 billion. Fifty-five percent of this was spent on staff; 17.4 percent on purchases; 17.2 percent on repairs, supplies, and external services; 4 percent on depreciation and provisions; 2.3 percent and 6.4 percent on other costs (1).

Operating Expenditures

Total hospital operating expenditures (which include both operating and capital spending) were F263 billion in 1991, equaling 3.9 percent of the gross domestic product (GDP) and 40.7 percent of national health expenditures (NHE). Hospitals' share of NHE has fallen over the past decade, which was 44.9 percent in 1980, but hospital expenditures as a share of GDP have increased, starting at 3.6 percent in 1980. These trends indicate that health care spending in France has commanded a greater share of the country's financial resources over the past decade, although the hospital sector has contributed less to this trend than have other sectors of France's health care system.

Approximately three-fourths of aggregate hospital outlays went to public and PSPH hospitals in 1991—slightly less than in 1980, when the public sector accounted for 78 percent of hospital spending (2).

HOSPITAL CAPITAL COSTS

Located as they are in a rapidly changing sector that is strongly affected by technological progress, and faced with growing patient demands for the latest technology and more patient amenities, all hospitals are increasingly sensitive to competition and have strong incentives to invest. In contrast to

the private sector, public and PSPH hospital investments are subject to certain financial constraints, although they also benefit from special public assistance.

The private sector is facing increasing competition, and its level of required investment is becoming more and more onerous; thus hospitals in this sector find it necessary to seek new investors. Few figures are available on private sector hospital investment, and most of the information in this section relates only to the capital investments of public and PSPH hospitals. Where appropriate, legislation concerning the investment process and current trends are discussed.

■ Relationship of Capital and Operating costs

In 1988 the aggregate budget for French public hospitals was approximately Fbillion158, which represented the purchase of goods and services. These costs may be either operating or investment costs, as follows:

- The operating section of the budget includes all consumable goods and services that are short-term; such expenditures relate to day-to-day supplies and to upkeep and maintenance.
- The investment section includes expenditures that are intended either to maintain a capital good beyond its budgeted life or to purchase new capital (3).

The investment section regularly receives transfers from the operating budget through provisions and depreciation accounts. Such accounts represent the depreciation of assets with a view to replacing them; depreciation is recorded as an income item in the investment section and as a cost item in the operating section. Depreciation costs are taken into account in determining the global allocation and daily service charges.

Private for-profit hospitals and certain private nonprofit institutions, even if they participate in the public hospital service, are not entitled to direct reimbursement of depreciation costs because the government is concerned about preventing the accumulation of private wealth at the expense of

the sick. Such institutions may, however, receive a remuneration equivalent to 3 percent of their capital (based on the nonamortized value of their assets, where necessary after revaluation). In addition, fixed assets in such institutions are almost never the property of the hospital but are rented. The depreciation of these assets is included in the rent, which is an operating cost.

Hospitals that receive a global allocation are allowed to include interest payments on investment loans as part of their operating costs. This option does not extend to the repayment of loan principals, which are included in the investment section of their budgets.

Another way in which operating and capital costs are related in French public and PSPH hospitals is through the allocation of operating fund surpluses. Under certain circumstances (discussed above), surpluses in the operating section can be used to finance investments that are not expected to increase operating costs in ensuing years. Moreover, any surplus in the appended budget is allocated to the purchase of equipment for hospitals (e.g., blood transfusion centers or computer centers), to other hospital capital investment, or to reduce operating costs in succeeding years.

The impact of capital costs on future operating costs is determined informally. Some hospital boards draw up program budgets as a means of improving quality of forecasting and planning, and assisting management by highlighting the overall impact of an activity in operational *and* investment terms. Activities examined may cover energy saving programs, computerization and major equipment, or hospital buildings.

■ Capital Financing Model

Investments in new construction, new major medical equipment, or replacement equipment in the public sector can be financed by depreciation (applied to tangible assets such as hospital plant and equipment) or amortization (applied to intangible assets such as insurance policies). In the hospital sector, however, this is inadequate due to the rate of technological innovation, and other funding sources are often required.

TABLE 4-6: Capital Expenditures and Income in Public Hospitals (1975, 1986, 1988) (in millions of francs)

Expenditures	1975	1986	1988	Percentage of 1988 total
Direct expenditures	3,722	8,842	13,456	69.9
Tangible assets	812	4,059	5,723	29.7
Real estate investments	169	434	3,171	16.5
Construction	2,741	4,349	4,562	23.7
Indirect expenditures	884	3,464	5,801	30.1
Total expenditures	4,606	12,306	19,257	100.0
Income	1975	1986	1988	Percentage of 1988 total
Subsidies, grants	985	1,707	1,583	7.6
Loans	2,533	3,521	4,545	21.8
Depreciation	1,513	6,989	7,702	36.9
Fixed assets			4,181	20.0
Other income	244	946	2,845	13.6
Total income	5,275	13,163	20,856	100.0

SOURCES: Ministère de l'Economie des Finances et du Budget, Direction de la Comptabilité Publique, Les Finances du Secteur Public Local, Hôpitaux Publics 1983-1988.

Self-Financing

Hospitals obtain some of their funds from internal sources, such as the sale of real estate and tangible assets (a fairly unimportant source) and depreciation, which accounted for 37 percent of hospitals' investment funds in 1988 (table 4-6). Since the mid-1980s, depreciation funds have increased in importance because of trends in the structure of investments and thus their patterns of depreciation. The decline in the acquisition of land and buildings and of repairs with a long (often 30 years) depreciation period and the increase in tangible acquisitions with a short (around 5 years) depreciation life has significantly increased depreciation income and thus the level of self-financing.

Subsidies

Hospitals obtain a portion of their investment funds from several external sources that may be free or may incur a cost. State subsidies—which normally vary between 5 and 40 percent of a hospital's investment funds, depending on the institution's capacity for self-financing—and subsidies from local authorities are free. More than half the subsidies received by hospitals come from the

state. Of local authority funding, the regions are the most important source of assistance, followed by the districts and municipalities (*communes*). In 1988, subsidies accounted for 7.6 percent of aggregate investment income (table 4-6).

Loans

The sickness funds have been authorized to make interest-free loans to hospitals, which are required to repay only the principal amount. For loans that incur a cost, hospitals normally call on banks for public authorities (*Caisse des Dépôts et Consignations* and the *Caisse d'Aide à l'Équipement des Collectivités Locales*). Hospitals may also borrow from other banks or even, with ministerial approval, from the financial market (i.e., debenture loans). Such loans represented 21.8 percent of aggregate investment income in 1988 (table 4-6) (3).

Today, state subsidies and sickness insurance fund loans play less of a role in hospital investment financing than they have in the past. Hospitals' own resources now constitute a key element of their capital finances. They even appear to be gaining in importance, given a slight trend toward

a reduced level of debt and a refocusing of investment; that is, investment now seems to be geared toward the acquisition of biomedical equipment, which in turn generates a higher level of depreciation. If sufficiently short periods of depreciation are allowed, a high level of debt generates considerable resources for investment. In fact, hospitals that have borrowed at high rates have not been penalized at all; rather, they have benefited from a budgetary bonus, as the financial costs associated with a high level of depreciation form part of the base from which the initial budget is calculated (9).

Financing from loans is restricted to 60 percent of the estimated cost of an investment. Institutions are required to meet the other 40 percent of the cost (as well as any associated additional operating costs) from their own financial resources. To help cover such costs, hospitals sometimes receive an additional allocation over and above the federal guideline rate for updates to global allocations, although experience shows that this does not occur often. Other internal sources include the use of surpluses arising from improved management. In contrast to the private sector, such decisions are subject to the approval of supervisory authorities (17).

Private Hospitals

Private hospitals (often called clinics) are free to use their profits for investment or to redistribute them to shareholders. Private for-profit clinics have traditionally been owned by physicians. It has become increasingly difficult, however, for clinics to finance investments in new major equipment from their own resources, which they need to keep up with technological progress and the demands of competition (14). Clinics face a difficult problem of finding outside investors mainly because in most cases there is no guarantee that the investment will be profitable. In recent years this “crisis” in the private sector has resulted in a transformation of the structure of such hospitals, which are increasingly passing from the status of a family business to that of a limited company belonging to a major financial group. Large French compa-

nies (e.g., Paribas, Suez, Lyonnaise des Eaux) and foreign companies have invested in chains of clinics in search of profits (17).

Determining Capital Requirements

The entire French health care system (both public and private health institutions) is subject to formal health sector planning (15). In general, public hospitals are subject to the provision of public law that governs public works and the placing of public work contracts. Commercial institutions must operate according to private law, which allows them to determine their own investment procedures within the limits of the law. Health care legislation in 1970, however, stipulated that repair programs and projects relating to the creation, extension, or transformation of public and private hospitals would be subject to authorization arrangements. Authorization is forthcoming only if a scheme complies with the health map (*carte sanitaire*).

Health Maps

The foundation for health sector planning in France is the health map. The health map forms the reference point for public authorities in all decisions relating to the level of public and private hospital construction of new buildings, additions of hospital beds, or the acquisition of major medical equipment (15). It is based on a recognition that the private sector must operate alongside the public sector, as the latter is unable to meet all public health care needs. The aim is to meet those needs satisfactorily at the lowest cost by a rational allocation of capital resources.

The health map, drawn up by the Ministry of Health after consultation with regional and national health resources committees (12) was designed to meet three objectives: 1) to control the rapid growth of the hospital sector, 2) to correct regional disparities, and 3) to coordinate public and private sector development. To accomplish these aims, the health map establishes the boundaries of health sectors and regions. Each health sector is a geographical area of about 30,000 to 40,000 inhabitants centered on a hospital with a certain

minimum level of technical facilities. There are currently 21 regions divided into 284 health sectors. The health map also establishes the nature, extent, and location of health facilities of national importance or designed to serve several health regions. For each type of facility, the health map for the particular sector or region concerned specifies the buildings and major items of required equipment. Plans are detailed after an analysis of local and regional needs. The health map also includes an inventory of existing or authorized buildings and a continuously updated record of major items of medical equipment.

Each region draws up its health map in light of directives issued by the Ministry of Health. The work is then submitted for review to sector and regional hospital groups and the regional committee for health and social resources. This is followed by an examination of the health map at the federal level. The Ministry then adopts the provisions of each map after seeking the opinion of the national committee for health and social resources.

This approach, it should be noted, is very broad and general with indicators of need established for major areas of activity (e.g., medicine, surgery, obstetrics-gynecology, medium stays). It is not based on epidemiological or population-based data (2,4).

The Act of December 31, 1970, requires all public and private institutions to secure authorization from the administrative authorities for new buildings or extensions of existing ones with compulsory reference to the health map. (The map's indicators of beds per specialty represent ceilings that may not be exceeded.) The Act also makes it obligatory to obtain prior approval for conversions of hospital facilities, the merging of hospitals, or the installation of major medical equipment.

The prefect is responsible for issuing authorizations after consulting the Regional Health and Social Resources Committee, except in the case of decisions of national importance; these are the responsibility of the Health Minister of the central government after consultation with the National Health and Social Resources Committee.

Reforms

The reforms initiated by the 1991 legislation maintain the health map but substantially broaden its scope with the addition of a new document: the health organization scheme. Both the maps and the schemes are to be drawn up on the basis of the measurement of needs in the population and their changes, with regard to demographic data and technical progress in medicine, following a quantitative and qualitative analysis of existing care provision.

In carrying out this task, the ministers responsible for health and social security (in the case of national and inter-regional maps and schemes) and the regional prefects (in the case of their regional and sub-regional equivalents) will be assisted by health organization committees at national and regional levels. To reflect the need for assessment, each regional health organization committee will have a committee on regional medical assessments of hospitals.

The scope of health planning has been broadened by the health organization scheme to gradually break down the boundaries between inpatient hospital care and outpatient ambulatory care and to develop plans to rationally diffuse particularly expensive or sensitive medical activities associated with ambulatory care. The legislation is concerned with the type of care provided, not with the physical structure of the buildings or the legal context in which the care takes place. Alternatives to hospitals are taken into account (particularly ambulatory surgery) by establishing an equivalence between hospital beds and the number of places providing alternatives to hospital care.

Under the new legislation, public hospitals are also authorized to collaborate with public and private legal bodies, including those at the international level. In connection with these activities, they may sign agreements and participate in inter-hospital syndicates and public and financial consortia. The creation of such consortia enables health institutions to pool their operational or investment resources to undertake activities that their individual resources would not allow. To

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achieve greater uniformity of the two hospital sectors, the new legislation also provides for all care institutions and providers to be subject to the same authorization arrangements. The overall aim is to simplify and decentralize the administrative procedures for securing capital investment authorizations.

The reforms also introduce a hospital plan which sets out (particularly in the context of the medical plan) each institution's objectives with regard to medical and nursing atmospheres, social policy, training, management, and information systems. The plan, which must be compatible with the objectives of the health organization scheme, identifies all the resources in terms of buildings, staff, and equipment that the hospital requires to achieve its objectives. It is developed for a period of up to five years (5).

Traditional Public Hospital Investments (16)

In any major hospital and even those of average size, new buildings and expansion of existing facilities form part of an overall medium-term (10- to 15-year) program. Three types of projects may be identified: 1) those of national significance, for which the ministry is responsible; 2) capital projects that are unique to a region and for which the regional prefect is responsible; and 3) capital projects that are the responsibility of the district prefect, who gives approval in view of the overall resources allocated to each district.

Because most investments are carried out with state assistance, investment priorities are spelled out in the national economic and social development plans, which effectively determine the allocation of financial resources set aside for the different sectors of public investment. Receipt of state subsidies for new capital investment is contingent on the proposed investments' inclusion in the plan.

Any building and major medical equipment investment project must pass through several stages (e.g., purchase of a site, initial preliminary design, final proposal) each of which must be approved by the hospital board after they have been considered by the hospital's medical staff committee and the

joint technical committee. Each stage is subject to final approval by the supervisory authority.

- The financial appraisal of the project is accompanied by a financing scheme. The financing rules are as follows:
- When state funding is provided, it is always equal to 40 percent of the capital expenditure qualifying for subsidy.
- Local authorities may also contribute to this assistance, bringing the rate of subsidy above 40 percent.
- The balance is met by the hospital from its own resources, by loans from the *Caisse des Depots et Consignations* or the *Caisse 'Aide a l'Equipement des Collectives Locales*. In the case of investments that do not receive state funding, the proportion of the cost met from borrowing may not exceed 60 percent.

The different categories of equipment and materials subject to approval are care units equipment, ancillary care and technical medical equipment, and equipment for general services.

In 1974 a national center for hospital equipment (CNEH) was established that reports to the Ministry of Health. It has responsibility for considering problems associated with the functioning of hospitals. The rules governing the financing of the provision of medical equipment are the same as those relating to the building process.

Under the new legislation the supervisory authority will monitor only the legality of contracts entered into by hospital directors. Such contracts will come into force as soon as they are received by the prefect's office.

Private Hospital Investment

Once a private hospital decides to adopt new technologies, provide new services, or expand its hospital beds, it can acquire the necessary physical and staff resources and place them at their patient's disposal, thus putting them to profitable use more quickly than the public sector. Private hospitals can also more quickly provide the resources required to meet an existing need. If an investment turns out to be profitable after the facili-

ties are in place, they can be adjusted to a certain extent by the constant redeployment of resources (particularly of staff), as there are few statutory constraints. Private hospitals face no major impediments to increasing and modernizing their facilities as soon as a decision has been made (17).

■ Capital Expenditures

Capital expenditures do not correspond to a single year's costs and may figure into the calculation of more than just one year's global allocation and charges. In 1988, capital expenditures of public hospitals equaled F19.3 billion, or 12.2 percent of aggregate hospital expenditures. This represents a more than threefold increase over 1975. (Expenditures for different capital investments are given in table 4-6.) Since 1975 the structure of direct investment expenditure has changed, with the proportion funding real estate investments (e.g., construction of new hospital wings) falling from 78.2 percent in 1975 to 57.5 percent in 1988. There has been an equivalent rise in investment in other capital assets.

Total investment income in 1988 was F20.9 billion (shown by funding source in table 4-6). This amount represents a corresponding threefold increase in investment income over 1975. Over the last decade, the proportion of capital expenditures paid for from internal funds has tended to increase, while the proportion met by grants, and especially by loans, has declined (table 4-6) (13).

FUTURE DIRECTIONS

The containment of health expenditures is a major concern in France. The costs of hospital care represent half of national health expenditures, making the hospital sector a primary target of France's cost containment efforts. The hospital sector has always expanded without much control, and its evolution has been marked by the constant need for an urgent response to perpetually growing demand. The urgent nature of hospital care has often taken precedence over economic rules of efficiency and better management. Prior to 1971, hospitals would present their bills to the sickness insurance funds after having satisfactorily treated

patients. The funds would not hesitate to pay their share of expenses, and little attention was given to detailed analyses of hospital bills. Only in the 1970s did national economic conditions demand closer scrutiny of the economics of hospital care. By the end of the 1970s, containment of hospital costs had become a high-priority issue and the primary goal of all reforms aimed at reducing health expenditures since then.

Understandably, it is the public hospital sector that has been most influenced by cost-containment reforms. In 1983, prospective budgeting became the standard in this sector. Its purpose was to control spending by imposing guideline growth rates for hospital spending. However, the determination of budgets across hospitals takes no consideration of changes in activity or volume of services demanded from individual hospitals but merely applies a predetermined increase rate (the federal guideline rate) to the previous year's budget. Budgets are based on historical levels of expenditure, and rates of increase are determined centrally, with little scope for local deviation (11).

The medical program information system (PMSI) was created to achieve a financing system more reflective of an individual hospital's activity and to encourage continuous evaluation. This program systematically produces a standardized discharge form at the completion of each patient's hospital stay and enters the form's data into a patient database. The system allows for detailed analysis of hospital activity to enable comparisons of patient volume among departments or hospitals and to detect morbidity trends. The PMSI was implemented as an initial move toward developing a DRG-type system of homogeneous patient groups and incorporating this classification system into the hospital financing scheme. Implementation of the PMSI is proving to be complex and involved, however, and the full achievement of a DRG-based system in France remains a long-term objective.

A large gap still exists between the public and private hospital sectors in France. The allocation of funds to each sector is based on different mechanisms, and despite the sickness insurance funds' increasing control over the private sector, cost

containment efforts for this sector have not been very successful. A serious shortcoming of the present financing scheme is that private institutions have an incentive to increase the number of medical procedures to compensate for rigidly imposed fees and daily rates.

The 1991 health reform legislation in France is designed to extend government control over the private sector and to narrow the gap between the public and private sectors. The legislation redefines hospitals according to general guidelines, thus providing the private sector with the same "public interest" mission as the public sector. The reform also emphasizes the complementary role of the public and private sectors. Private hospitals are not yet paid through a global allocation scheme, but growth in expenditures for private hospital services are capped under the reforms. Additionally, the PMSI is planned to be extended to the private sector, and current experimentation with a DRG-type system is in place for some special services. Now that the philosophy underlying the DRG system is being tested in the public hospital sector, a relatively smoother implementation of the DRG system in the private sector is likely.

Implementation of the necessary structural arrangements to achieve the objectives of recent reforms will be a long-term task. Both private and public hospitals face new obligations, including maintaining medical records that are readily available for consultation by the patient or the patient's physician, evaluating professional practice, reorganizing health care, analyzing service activity, and implementing information systems that document different conditions and modes of care and treatment (5).

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Hospital Financing in France

by Marie-José Sourty-Le Guellec

4

The French health care system is arguably the most complicated of the European (and Canadian) systems described in this report. Its system includes universal, compulsory social insurance, significant patient cost-sharing, and supplementary insurance on the financing side, and public providers combined with a sizable number of private providers on the supply side. Overlaying both the public and private sectors are strong governmental controls at all levels of government (11).

Almost the entire population (99 percent) is covered by the statutory health insurance scheme, which is part of France's social security system. Statutory health insurance expenditures account for over 70 percent of national health expenditures in France. The scheme is administered by social security sickness funds (*Assurance Maladie de la Sécurité Sociale*). A person's occupation generally determines membership in a particular fund. There is one large fund for salaried workers (CNAMTS), which accounts for nearly 80 percent of the compulsorily insured and about 15 smaller funds cover other workers. The government provides insurance for low income people. Contributions for sickness fund insurance are income-related and shared by employers and employees or paid directly to the relevant fund by nonsalaried or self-employed individuals (11).

Social insurance provides both cash benefits (e.g., sick pay) and benefits in kind (e.g., ambulatory care, hospital care). Depending on the patient's financial circumstances, the patient may be required to pay coinsurance or copayment amounts; for instance, patients may have to pay 20 percent of the cost of hospital services (the *ticket modérateur*) and a daily flat rate contribu-



tion that is currently 50 francs.¹ Employers sometimes provide supplementary insurance for their employees through mutual fund organizations (*mutuelles*) to cover patient cost-sharing amounts and a few benefits not covered by the social insurance scheme. Individuals may also purchase private supplementary insurance. *Mutuelles* and private insurance payments account for about 8 percent of national health expenditures.

France's sickness funds are quasi-autonomous, non-governmental organizations; there are national, regional, and local organizations of these funds. They are subject to national and local management by employer associations and trade unions. They are also closely regulated by the central government; in particular, contribution rates, fee schedules, and pharmaceutical prices are controlled by the central government (11).

Patients can consult any medical practitioner for primary care, and can choose to go to either a public or private hospital. Money follows the patient in the case of private hospitals, but public hospitals are subject to prospectively fixed budgets. Compared with the other European countries in this study and Canada, French patients have relatively large cost-sharing requirements. Patient out-of-pocket payments currently account for about 17 percent of national health expenditures; however, cost-sharing for hospital services is fairly small with only about 4 percent of hospital expenditures financed directly by patients (11).

Similar to many other countries, the containment of health expenditures is a major concern in France. Hospital care represents half of national health expenditures, making the hospital sector a primary target of France's cost-containment efforts. Recent reforms have concentrated on effectively controlling sickness fund insurance payments to private hospitals by extending governmental regulation over that sector, and by creating a new balance between the private and public sectors to harmonize their development

within an overall program designed to control health spending. Also similar to many other countries, France's health reforms are moving in the direction of making individual hospital budgets based more on each hospital's level of activity and less on historical costs.

STRUCTURE OF THE HOSPITAL SECTOR

France has a mixture of public, private nonprofit, and private for-profit hospitals. Public hospitals tend to be large and well equipped; private hospitals tend to be smaller and to specialize in elective surgery, obstetrics, or long-term care. In 1990 there were 1,072 public institutions; they constituted only 28 percent of all French hospitals, but provided almost two-thirds of total hospital beds, hospital days, and inpatient admissions (tables 4-1 and 4-2). By law, a public institution is a corporate body governed by public law and is responsible for providing a specific public service. Public institutions have full legal status, their own assets and resources, and full legal autonomy. They are, however, subject to various forms of public supervision and financial control. Public hospitals cannot waive their obligations, defined in the Act of December 31, 1970, to:

- provide diagnosis, treatment, and (in particular) emergency care to their patients and those referred to them, including necessary inpatient care;
- contribute to the training of medical and paramedical (nonmedical) staff; and
- participate in medical and pharmaceutical research and health education.

In 1989 the private hospital sector included 2,721 institutions, constituting 72 percent of all hospitals but accounting for only one-third of the total hospital beds, patient days, and inpatient admissions in France in that year (tables 4-1 and 4-2). The private sector is divided into a private for-profit or commercial sector with 1,515 institu-

¹The exchange rate in January 1994 was approximately \$USO.17 to F1 .00.

TABLE 4-1: Hospital Shares in France, by Category of Hospital^a

Category of hospital	Percent of total hospitals	Percent of beds
Public	28	65
Nonprofit, PSPH	12	11
Private nonprofit, non-PSPH	19	5
Private for-profit refit	40	19

^aData for public hospitals are for 1990; data for private hospitals are for 1989.

SOURCES: Documents Statistiques, "Les Etablissements d'Hospitalisation Privée en 1989," Enquete EHP 1989, SESI no. 121, Juillet 1991, Documents Statistiques, "Les Hopitaux Publics en 1990, Resultats H80," SESI no. 154, Septembre 1992

tions and a private nonprofit sector with 1,206 institutions. For-profit hospitals are privately funded and subject to the rules of commercial and civil law. Private nonprofit hospitals are run by voluntary organizations, religious orders, employee representatives, mutual fund associations, and social security funds. They are similar to public institutions in that they do not attempt to maximize profits, and their surplus revenues are invested to further their health care objectives.

Private institutions are managed by individuals or a legal entity. They make many of their own management and investment decisions, and their services are governed mainly by market forces, although they are subject to certain government constraints. Fees charged by private institutions are controlled and subject to formal agreements. Increases in the number of beds and high-cost equipment are controlled by the health map (*carte sanitaire*), described later, and require formal au-

TABLE 4-2: Hospital Beds and Inpatient Days, by Category of Hospital^a

	Public		PSPH		Public and PSPH	
	Beds	Hospital days (in 1,000s)	Beds	Hospital days (in 1,000s)	Beds	Hospital days (in 1,000s)
Medicine	105,393	29,243	13,879	3,918	119,272	33,161
Surgery	61,282	14,827	8,986	2,315	70,268	17,142
Obstetrics/gynecology	17,337	4,101	1,393	356	18,730	4,458
Medium-stay	42,127	11,943	19,921	5,386	62,048	17,329
Long-stay	63,711	22,289	1,877	638	65,588	22,927
Psychiatry	68,600	18,669	12,733	3,921	81,333	22,590
Total	358,450	101,071	58,789	16,535	417,239	117,607
	Private for-profit		Private nonprofit		Total private	
	Beds	Hospital days (in 1,000s)	Beds	Hospital days (in 1,000s)	Beds	Hospital days (in 1,000s)
Medicine	14,753	2,039	3,943	1,242	18,696	3,282
Surgery	50,820	17,123	4,675	1,484	55,495	18,607
Obstetrics/gynecology	10,083	3,084	882	254	10,965	3,338
Medium-stay	18,123	5,646	15,672	4,525	33,795	10,171
Long-stay	436	140	2,037	722	2,473	862
Psychiatry	13,405	4,767	1,960	637	15,365	5,404
Total	107,620	32,800	29,169	8,865	136,789	41,664

^aData for public hospitals are for 1990; data for private hospitals are for 1989.

SOURCES: Documents Statistiques, "Les Etablissements d'Hospitalisation Privée en 1989," Enquete EHP 1989, SESI no. 121, Juillet 1991, Documents Statistiques, "Les Hopitaux Publics en 1990, Resultats H80," SESI no. 154, Septembre 1992.

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theorization. Additionally, the medical activities of private hospitals are supervised by the sickness insurance funds' medical officers.

Private institutions are allowed to participate in the public sector, although to date only some of France's private nonprofit hospitals (467 in 1988) have asked to be incorporated into the public hospital service. These hospitals, called PSPH hospitals, are governed by rules similar to those for public hospitals. There are thus two general categories of hospitals in France: public and PSPH hospitals, and private institutions that do not participate in the public hospital sector.

Financing methods and operating arrangements vary greatly between the public and private hospital sectors. Public and PSPH hospitals are governed by the principles of public accounting, whereas private for-profit hospitals are commercial undertakings that attempt to maximize their surplus revenues. Reform legislation passed in July 1991 and currently being implemented is designed to create a new balance between the private and public sectors and to harmonize their development within an overall program to control health expenditures. The reforms formally recognize that public and private hospitals perform the same basic functions. In the future, the two categories of hospitals will share equal responsibility for ensuring public health through common provisions that affect all types of hospitals. Furthermore, the reforms seek to strengthen and encourage cooperation between public and private hospitals (5).

At present, a statutorily insured patient in France can go to either a public or private hospital, although in practice the decision is usually made by the patient's physician. When the choice is a personal one, it tends to reflect the hospital's geographical proximity, its reputation, or other personal preferences. Under the 1991 reforms, patients' freedom to choose a physician or hospital became an even more integral part of the health care system in France than it was under previous health care legislation.

Many hospitals in France have short-, medium-, and long-stay beds as well as psychiatric beds. It is difficult, if not impossible, to determine the proportion of hospital care in France that is devoted to short-term acute care treatment; therefore, this chapter deals with the French hospital sector as a whole. Purely residential institutions, such as nursing homes, are excluded from data cited herein, however.

PHYSICIANS

In public and PSPH hospitals, the medical staff includes residents or interns, who are physicians in training, and hospital practitioners, who are full-time or part-time with a salaried established post (*titulaire*) or a salaried, nonestablished post (*non-titulaire*). Table 4-3 provides a breakdown of hospital physicians in private and public hospitals in 1989 and 1990. The central government controls the growth of salaries and the number of hospital staff in public hospitals.

TABLE 4-3: Hospital Physicians^a

		Public	PSPH	Private for-profit	Private nonprofit	Total
Salaried practitioners	Full-time	27,913	2,614	596	525	31,675
	Part-time	39,962	4,250	851	2,047	47,110
Nonsalaried practitioners	Full-time		32	8,883	495	9,410
	Part-time		762	22,151	1,912	24,825
	Occasional		590	12,976	1,496	15,062
Salaried residents	Full-time	22,019	1,655	248	236	24,158
	Part-time		233	328	90	651
Nonsalaried residents	Full-time		22	15	11	48
	Part-time			164	8	172

^aData for public hospitals are for 1990; data for private hospitals are for 1989.

SOURCES: Documents Statistiques, "Les Etablissements d'Hospitalisation Privée en 1989," Enquête EHP 1989, SESI no. 121, Juillet 1991; Documents Statistiques, "Les Hopitaux Publics en 1990, Resultats H80," SESI no. 154, Septembre 1992.

In certain circumstances hospital physicians are authorized to treat private patients in public hospitals through consultations or the use of public service beds for private patients. In such cases the physician receives a fee from the patient, which may be reimbursed by the patient's insurance company. Income from private fees may not exceed 30 percent of a physician's total income and the number of beds that can be used for private patients may not exceed 8 percent of all public service beds.

Public hospital physicians often confer with office-based private practice physicians (*médecins libéraux*). Whether or not payment for the consultation is included in the hospital's global allocation of funds (discussed further below) depends on the regularity of the consults. Any physician in an office-based practice may be consulted on an occasional basis by a hospital physician. Payment is rendered according to the service or consultation performed and falls outside the hospital's global allocation. Hospitals regularly call on some physicians in private practice (called affiliated practice physicians) who are paid a fee per service provided. These fees are included in the hospital global allocation.

There are no salaried physicians in rural hospitals and any private physician may consult there subject to authorization. In these cases the physician may ask patients who are not covered by sickness funds to pay an agreed-upon fee. For patients with sickness fund coverage, the physician may claim 85 percent of the local daily charge per day; for patients qualifying for social assistance, the physician is paid 50 percent of the departmental medical assistance charge. In these two cases the hospital retains 10 percent of fees received.

In certain circumstances nonsalaried physicians operate clinics in public institutions. They are paid on a fee-for-service basis; the level of fees is agreed upon directly with the patient. Physicians pay 10 percent of their fee income to the hospital, which uses the proceeds for improving their stock of medical equipment.

Thus, in public or PSPH hospitals, most payments to medical staff are included in the operating section of the budget and are taken into ac-

count in determining the hospital's global allocation. Exceptions to this are fees paid to physicians practicing in rural hospitals and in hospital clinics, and fees received by hospital physicians as part of their private practice.

In private for-profit hospitals, physicians are nearly always paid on a fee-for-service basis and patients are reimbursed by their insurance companies. Nevertheless, an increasing number of private institutions are taking the opportunity to invest in staff (particularly medical staff) by offering the best-trained personnel attractive remuneration packages, particularly in comparison with what the public sector can offer. Physicians' fees in private hospitals are set according to a national fee schedule, but their incomes, other staff incomes, and the number of staff hired are not regulated by government.

HOSPITAL OPERATING COSTS

■ Financing Model

There are two distinct methods of financing hospital operating costs in France. Public and PSPH hospitals are paid largely through a prospectively fixed budget. Private non-PSPH institutions are paid a daily (per diem) rate for their services; inpatient physician and ancillary services are paid for on a fee-for-service basis.

Public Hospitals

Since 1984-85, public and PSPH hospitals have been subject to a global allocation scheme established by the prefect of the district in which they are located and determined within the framework of federal guidelines. The global allocation scheme replaced a system of controlled rates of increase in per diem prices for public and PSPH hospitals (11). Under the new scheme each hospital receives an annual global allocation to cover the portion of its costs that is paid for by the sickness funds. Hospitals also charge daily rates (*tarifs journaliers de présentations*) to cover that part of a hospital stay not provided for in the global allocation. Daily charges are established for several purposes. Federal and local governments pay a daily charge for patients on social assistance. The

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daily charge is also used to determine patient cost-sharing amounts for patient copayments (*ticket modérateur*) and daily flat-rate payments (paid either by the patient or by a supplementary insurance company), and it constitutes the charge for patients who have no insurance coverage.

Hospital Budgets

The hospital budget sets forth estimated expenditures and revenues for the coming year. This budget, like that of any public administrative institution, must conform to certain public accounting principles. It has two sections, as described below:

- The operating section deals with current activities, including the day-to-day running of the hospital and financial management.
- The investment section deals with operations leading to an increase in durable capital assets requiring depreciation (other than stocks), such as permanent capital, real estate and tangible property, stocks and securities, deposits and sureties, and physical supplies.

Expenditures that require authorizations for the operating section of the budget are divided into three groups:

1. expenditures relating to the external purchase of goods and services,
2. staff or personnel-related expenditures, and
3. all other types of expenditures.

A public or PSPH hospital's operating revenue is derived from the following sources:

1. the global allocation described below;
2. income from services (e.g., via daily rate charges or fees);
3. grants, donations, and legacies to be used for operating purposes;
4. other surplus income unrelated to operational activities;
5. income from reserves;
6. the value of liabilities reduced by expire or lapse; and
7. the value of any repairs undertaken or surplus produced by the institution itself (e.g., pharmaceutical products made by the hospital's laboratory).

Appended Budgets

Current expenditures on certain activities and services (e.g., blood transfusion centers, mobile emergency services, data processing centers) must be included in appended budgets. Operating costs are funded from both general and appended budgets.

Authorized expenditures for the coming year must take into consideration the average rate-of-increase guidelines established by the central government's ministries of the economy, budget, health, and social security. The average rate of increase for hospital expenditures is based on general economic trends—in particular, forecasted changes in prices and wages—and on national health and social policies. The guideline rate was 4.2 percent in 1990.

Determination of the Global Allocation

Although a hospital receives a small amount of revenues in addition to the global allocation and daily charges, these two elements are essential to a hospital's ability to provide services. The global allocation is designed to provide enough funds to cover that part of the hospital's expenses that will be paid for by the sickness insurance funds. It represents the difference between total operating costs as set forth in the authorized general and appended budgets and expected hospital revenues other than the global allocation itself, so as to ensure that the hospital's budget will be balanced after taking into account surpluses or deficits from previous years. Annual increases in a hospital's global allocation are based on the federal guideline rate of increase and the hospital's forecasted level of activity.

Patient copayment and daily flat-rate contributions, repayments by mutual fund associations and private insurance companies for their members' expenses, and payments for patients covered by medical or social assistance are not included in the global allocation; they are billed according to the daily service charges established for individual patients.

The global allocation covers costs relating to inpatient care, day and night care in the hospital,

outpatient care,² psychiatric care, legal abortions, mobile emergency care units, and long-term care institutions for the elderly.

Determination of Daily Charges

The partial nature of the global allocation makes it necessary to establish a system of charges (tariffs) to recover expenses not paid for through the global allocation. Daily service charges determine the amounts to be paid by federal or local governments, patients, or any organization providing supplementary coverage. Daily service charges are calculated for different types of services by dividing the estimated total costs of each type of service by the estimated number of patient days for each type, after adjusting costs for offsetting receipts and for any previous year's surplus or deficit that has been carried forward.³

Service charges are calculated for inpatient care (including specialist and nonspecialist services, services relating to expensive specialties, and medium- and long-term services), day and night care, and home care services. There are also three possible short-term charges for medicine, surgery, and expensive specialties. Because individual hospitals have different budget levels and estimated numbers of patient days for various types of services, daily service charges vary by hospital. In contrast, flat-rate charges for outpatient care and for legal abortions apply uniformly throughout France. Box 4-1 describes the different parties involved in hospital management and supervision, and offers more details on the determination of global allocations and daily rates.

Budget Adjustments

Except in the case of a budget revision, the global allocation is paid on the basis of the amount initially provided for, regardless of the hospital's actual level of activity. If the number of patient days is lower than estimated, the hospital's income (insofar as it relates to its global allocation) remains unaltered.

If a hospital can show that there has been a significant and unforeseen change in its financial circumstances or medical activity leading to a substantial increase in the hospital's costs during the current year, changes to the budget (e.g., an increase in authorized revenues to meet higher-than-anticipated expenses) may be approved. Additionally, in urgent cases the hospital's director may transfer appropriations between the first two groups of authorized expenditures in the general budget and the appended budgets during a financial year. These transfers may not, however, increase or reduce authorized expenditures within these groups by more than 10 percent, reduce appropriations designed to cover unavoidable costs (e.g., social security contributions or taxes), or commit the institution to expenditures beyond the current financial year.

End-of-year surpluses in the hospital's administrative account resulting from more efficient management (e.g., expenses are less than forecasted for the same or higher level of service delivery) are assigned to a compensation reserve account. Such reserves may be used to cover subsequent years' deficits or assigned to another reserve account that can be used to finance operations or investments that do not increase operating

²Actually, only part of the cost of outpatient care is taken into account in calculating the global allocation. In particular, the allocation relating to this area covers the cost of supplying drugs for which the sickness insurance funds are statutorily responsible. It is estimated that on average, 50 percent of outpatient costs are covered by the global allocation. The remainder has to be covered by the patient through a copayment or by a third-party payer other than the patient's sickness fund.

³An excerpt from the decree of Aug. 11, 1983, section 32, states specifically that "[t]he estimated cost price shall be equal to total operating expenditures, comprising:

- a) direct costs, that is the costs of services belonging to a particular category of charges, excluding the cost of medical treatment, goods and other medical services;
- b) the cost of medical treatment, goods and services on the basis of their purchase price or, failing that, of their cost price;
- c) other costs included in the operating section of the general budget which are not covered by their own resources, divided among the different categories of charges in proportion to the estimated number of days for each category;
- d) where appropriate, that part of the previous financial year's deficit which has been carried forward."

BOX 4-1: Hospital Management in France

Hospitals are managed by a board made up of locally elected representatives (of which the mayor of the municipality concerned is the chairperson), representatives of the social security system, representatives of the hospital's medical and nonmedical staff, and a director who is responsible for implementing the policies developed by the board and approved by representatives of the State. The board's director also authorizes expenditures and issues revenue orders, appoints nonmedical staff, and is the hospital's legal representative.

The supervisory role exercised by public authorities in the budget-making process places strict limits on the degree of managerial autonomy enjoyed by public and affiliated hospitals. Administrative supervision of public and PSPH hospitals operates at every level:

- at the national level through the Hospital Department of the Ministry of Health;
- at the regional level through the prefect of the region (appointed by the government), assisted by the regional Department for Health and Social Services (DRASS); and
- at the district level through the prefect of the district (also appointed), assisted by the district Department for Health and Social Services (DDASS).

The social security system, which is the principal source of funds for hospitals, has no formal supervisory responsibilities but only the right of oversight. Its role has been strengthened over time, however. Social security sickness funds have contributed to the development of hospital policy at the national and local levels through representation on various associations and through their significant oversight rights for financial and medical matters. Additionally, supervisory authorities must consult representatives of sickness funds when drawing up hospital budgets. Furthermore, at the request of the sickness funds, hospital directors must submit quarterly expenditure commitment statements and provide information on staffing. The sickness funds also partially supervise medical decisions, which can mean that a sickness fund would refuse to pay the cost of treatment or would modify the financial terms of a hospital admission that it deemed unjustified or inappropriate. The sickness funds monitor all hospital medical activities but (except with regard to nonpayment of services) exercise a passive form of supervision, as the funds' concerns are not backed up by any sanctions (3).

Financial monitoring of hospitals is the responsibility of the district Department for Health and Social Services; the social security funds, which receive the quarterly expenditure statements; and the hospital accountant (an official of the public treasury service) who ensures that spending commitments comply with relevant legislation and regulations and that the necessary appropriations have been made.

costs in subsequent years. Priority is given to financing services that have contributed to the surplus. Surpluses that do not result from improved management (e.g., if services are lower than forecasted levels or the surplus arises from daily charges or outpatient care) are transferred to a compensation reserve account to cover operating costs in future years.

Any deficits in the administrative account are covered by drawing on the compensation reserve

account. If the reserve is not sufficient, the deficit amount is figured into the budget of two years later or can be spread over the following two financial years by adding it to the hospital's operating costs.

Sickness Fund Payments

Each sickness insurance fund in a given hospital's catchment area pays the so-called pivot fund (or main fund in the area) its share of the hospital's

BOX 4-1 (Cont'd.): Hospital Management in France

The budgetary process is relatively long, reflecting the desires of various categories of hospital staff to be involved in the hospital's planning and the strict supervision exercised by external authorities. The director or director-general of the hospital is responsible for preparing and submitting budget proposals, taking account of the previous and current years' activities. Assisted by hospital departments, the director determines the level of expenditure that is essential for the hospital's operations. The draft budget is then submitted to a joint consultative committee and a medical staff committee for comment. Budget proposals are adopted by the hospital's board (*conseil d'administration*), which must express a formal opinion on the director's figures. Budget proposals are then sent to administrative authorities and the regional sickness insurance fund for salaried employees, where they are available for comment.

Hospital budgets, global allocations, and daily service charges are determined by administrative supervisory authorities by January 1 of the relevant year. With the exception of the Paris hospital service (responsibility for which devolves on the Minister of Health), the prefect of the district is responsible for establishing global allocations for the district's public hospitals. This responsibility also involves a critical response to hospitals' budget proposals to ensure that each institution can meet its obligations. The prefect is empowered to increase income and expenditure estimates for hospitals whose estimates it considers too low and to remove or reduce items that it considers unnecessary or too high—taking account of local health care needs and the federal guideline rate for average increases in hospital expenditures (4). Prefects' decisions are made only after consultations with the social security funds. The opinions of the social security funds and the medical supervisory bodies are recorded by the regional sickness insurance fund.

The district prefect notifies the hospital, the regional sickness fund for salaried employees, and the fund responsible for paying the global allocation (the "pivot" fund) or main sickness insurance fund in the area) regarding the final determination of daily service charges and the global allocation, together with the hospital's approved budget.

The hospital's director is the principal authorizing officer for the budget and maintains a formal record of expenditures. The director submits quarterly accounts (upon request) to the prefect. At the end of each quarter, the director also submits a chart to the prefect showing the current number of hospital staff.

global allocation.⁴ At the end of the financial year, the national sickness insurance fund for salaried employees draws up a statement of contributions required from each fund based on the number of days provided to the fund's members (weighted according to coefficients that account for the different daily costs of hospital care provided, which are determined by a joint ministerial order). Before June 1 of the following budget year, a committee for the apportionment of hospital global al-

locations must reach a unanimous decision on the final contribution from each sickness fund, taking into account the statement drawn up by the national sickness insurance fund (8).

Recent Reforms

Although the 1991 health reforms did not alter the basic method of global allocations, major changes to the budgetary process were introduced. Under this legislation (whose implementing regulations

⁴ Under the 1991 reform legislation, the pivot sickness fund makes an initial payment of 60 percent of the global allocation to the hospital on the twenty-fifth day of the month, then 15 percent on the fifth of the following month, and the balance on the fifteenth day of the following month.

were unpublished as of this writing), the budgetary process will start earlier in the year, budget negotiations will be faster and more streamlined, management will be more flexible, and the hospital board will have more autonomy particularly with regard to day-to-day matters (e.g., staffing, loans, internal organization), which will no longer be subject to the district prefect's prior approval. There will be closer cooperation between the authorizing officer and the accounting officer. New provisions will also be made for the investment of and return on funds. Moreover, it will be possible to revise a hospital's global allocation in the course of a financial year to reflect changes in the current volume of services provided as long as it is related to greater patient needs.

Another important innovation included in the 1991 reforms and currently being experimented with in several hospitals is the determination of charges based on the identification of homogeneous patient groups (*groupes homogènes de malades*), which are in turn based on U.S. diagnosis-related groups (DRGs) (5).

Private Hospitals

Private for-profit and nonprofit institutions that do not participate in the public hospital sector operate on a fee-for-service basis, although fees are usually regulated by the central government's health ministry. An agreement between hospitals and their regional sickness funds fixes the amount of money that the funds will reimburse patients in the coming year. Private hospitals accept a certain number of service obligations (inpatient days and hospital admissions) to sickness fund patients in exchange for guaranteed reimbursement from the funds. If a private hospital has a surplus when it closes its accounts, it is free to distribute that surplus to shareholders or to reinvest the surplus funds. If it has an operating loss, the social security fund does not become involved in any way to cover the deficit.⁵

Daily Rates and Fees

Private hospitals' payments are based on negotiated daily rates that comprise a charge for hotel-type services and nonmedical personnel services (e.g., nurses, social workers, therapists), fees for operating and delivery room services, pharmaceutical fees, and fees for physician services. Patients usually pay physicians' fees directly and are then partially reimbursed by their sickness fund. In the past physicians have been paid separately from the hospital's charges, but physician payment is increasingly being included in the same schedule as the costs for a hospital stay. One advantage of folding in physician payments is that all payments made by the sickness fund for a patient's hospital stay are included in a single document that provides the fund with an overview of total hospital costs.

Physicians' services are reimbursed according to a national fee schedule classified as K, Kc, B, and Z (for diagnostic activities, surgery, biological analyses, and imaging, respectively). One K is worth approximately 12 francs, and one Kc is worth about 13 francs. Reimbursement for physician or surgeon services is supplemented by an operating or delivery room fee (FSO) paid to the hospital. The FSO varies according to region and category of hospital and by levels of K.

Private hospital per diem rates for hotel-type and non-medical staff services are based on a classification of the hospital's specialty and quality ranking. Since 1973 the classification system has assigned points to an individual hospital for each of the following five areas (in order of significance for rate setting):

1. medical services,
2. nonmedical staffing,
3. technical equipment,
4. hotel facilities, or
5. a combination thereof.

Depending on the total number of points obtained, a hospital is classified as A, B, C, D, or E,

⁵ The agreement setting forth the responsibilities of all the parties concerned was drawn up by the Ministry of Health between 1975 and 1978 and approved by the Ministry in 1978.

each of which has a particular set of rates per specialty. The classification is decided by the regional prefect after consultation with a joint committee that includes representatives of sickness funds and health care providers.

A total of 800 points is required for category A classification, which indicates consistently high performance; rates fall as a hospital's classification moves from category A to E. Hospitals and clinics classified within each category have the same level of rates wherever they are located in the region. Hospitals have an incentive to invest in technologies, equipment, and staff to improve their ranking to receive higher per diem rates. The process of ranking hospitals is fairly rapid, and a hospital may even have its ranking changed retrospectively. For several years, per diem rates have been regulated and subject to authorized annual increases, expressed in either absolute amounts or percentage terms.

Operating room fees are directly linked to a hospital's rate category. Similarly, the pharmaceutical fee, formerly based on actual costs, is now becoming more uniform. Charges and fees are thus subject to limits and linked to the number of inpatient days delivered by the hospital. There are also government controls on the number of admissions and on the number of authorized beds in private hospitals.

Despite these measures to limit private hospital rates and the number of services, the total volume of medical services provided by private hospitals has not been brought under control. In response, the regional sickness funds require private hospitals to supply information on their activities from which averages and comparisons among hospitals are made. Hospital profiles are also drawn up to identify potential abuses. These profiles serve only as indicators of service provision, however, and are not used as instruments for setting limits or preventing abuses.

As an additional monitoring tool, regular checks of hospital practices are conducted to prevent bad practices. If any are identified, a preliminary letter is sent to the director of the hospital asking for remedial action. If the problem is serious or has occurred before, the hospital's manager

is required to make the hospital's case before a committee of administrators of the regional sickness funds. A warning or reprimand may be sent or, after a complex review procedure, the hospital's classification may be downgraded. The ultimate sanction (for which there must be serious grounds) is abrogation of the sickness funds' agreement; costs are no longer paid in advance, and the daily charge is paid at three-quarters of the previous level. Although not applied frequently, these sanctions have had some effect (17).

Supervision

A group of sickness fund physicians supervises agreements between private hospitals and sickness funds that pertain to private hospital staffing levels, current pharmaceutical regulations, standards for operating rooms, and standards regarding the size of patient rooms. A compulsory annual statistical survey of private hospitals must also be provided to regional sickness fund organizations, making it possible to identify any possible problems in a range of areas. The standards and adherence to them have a direct effect on charges for services.

Health Reforms

Although the 1991 health reform act initially retains the principle of fees and rates for private hospital services, the legal framework and the financial basis of for-profit institutions have been altered. The tripartite system, involving the state, sickness funds, and hospitals, may gradually become the norm in the private sector as it has already been for some time in the public sector. The state could become involved in contractual relations regarding the volume of services that have hitherto been the concern only of hospitals and sickness funds.

There are no plans at this time to introduce a global allocation scheme for the private sector. Instead, there is a global ceiling on private hospital expenditures by the sickness funds, subject to a guideline rate of annual increase in this ceiling agreed on between the state and the other two traditional partners in the private hospital sector.

TABLE 4-4: Sources of Financing for Hospital Operating Expenses, by Hospital Sector, 1991

Source	Public and PSPH		Private		Total	
	Million francs	Percentage of total public and PSPH operating expenses	Million francs	Percentage of total private hospital operating expenses	Million francs	Percentage of total operating expenses
Sickness insurance funds	179,778	90.0	52,886	83.4	232,664	88.5
Individuals and private insurance	13,116	6.6	7,848	12.4	20,964	8.0
Mutual fund associations	3,023	1.5	2,329	3.7	5,352	2.0
Federal or local authorities	3,508	1.8	342	0.5	3,850	1.5
Total expenses	199,425		63,405		262,830	

SOURCE: Centre de Recherche d'Etude et de Documentation en Economic de la Sante (CREDES) Programme Eco-Sante, 1990 and 1991.

This ceiling is allocated among regions and by month and may not be exceeded.

The 1991 legislation requires that private institutions analyze their activities, develop an assessment policy, and implement information systems (similar to *programmed medical des systemes d'Information, or PMSI*). It also makes the submission of annual forecasts of activity to the sickness funds a precondition for setting rates or for concluding rate agreements. The implementation of a cost accounting system and a medical information system were intended to lead to a DRG-type of charge system by the end of 1993. An experiment using this new approach was introduced in obstetrics-gynecology units and in volunteer institutions for other specialties beginning on July 1, 1992 (5).

■ Sources of Funds

The social security sickness funds pay for the lion's share of hospital care in France; they funded 90 percent of public and PSPH hospital operating expenses and over 83 percent of private hospital operating costs in 1991 (table 4-4). Private insurance, mutual fund associations, and individual out-of-pocket payments accounted for a fairly small share of hospital costs (10 percent), even for private hospitals (16.1 percent). These figures reflect sickness fund patients' freedom to choose

either a public or a private hospital, and private insurers' and mutual fund associations' minor roles in the French health care system of mainly providing supplementary insurance.

The relatively small part that private hospitals have in France's system is reflected by their share of total hospital expenditures. In 1991, three-fourths of all hospital spending was for care provided in public and PSPH hospitals; the other fourth was for private hospital care (table 4-4).

Federal and local authorities pay hospitalization costs for patients who receive state medical or social assistance. These payments, financed through general revenues, funded 1.5 percent of hospital expenses in 1991 (table 4-4). (Foreign patients who are not residents of France must pay their own hospital bills although there are international agreements between France and certain countries allowing payments to be made through official channels.)

■ Allocation of Operating Funds

Public Hospitals

Public hospital operating costs were F139 billion in 1988, representing 87.8 percent of aggregate hospital expenditures (which includes capital expenditures) (table 4-5). The largest single item (F90.1 billion, or 65 percent of operating costs)

TABLE 4-5: Operating Funds in Public Hospitals, 1988

Operating costs	Million francs	Percentage of total	Operating revenues	Million francs	Percentage of total
Staff	90,140	64.9	Global allocation	118,074	81.0
Pharmaceuticals, medical services	12,792	9.2	Service charges	9,631	6.6
Hotel facilities	8,473	6.1	Daily flat rate contributions	1,877	1.3
Repairs, maintenance	3,753	2.7	Outpatient care	2,543	1.7
General management	3,490	2.5	Donations, contributions	219	0.2
Mortgages	2,737	2.0	Sales of products	469	0.3
Other	17,451	12.6	Other	13,121	9.0
Total	138,836		Total	145,934	

SOURCES: Ministère de l'Economie des Finances et du Budget, Direction de la Comptabilité Publique, Les Finances du Secteur Public Local, Hôpitaux Publics 1983-1988.

was for hospital staffing costs. (It is not possible to distinguish between medical and nonmedical personnel costs.) Expenses for pharmaceuticals and medical services accounted for 9 percent of hospital operating costs in 1988; hotel-type services made up 6.1 percent, repairs and maintenance 2.7 percent, and management and transport 2.5 percent (table 4-5).

Public hospital operating revenues were nearly F146 billion in 1988, of which the global allocation represented 81 percent, total daily service charges accounted for 6.6 percent, total daily flat-rate contributions were 1.3 percent, and outpatient care charges accounted for 1.7 percent of hospital operating income (table 4-5) (10).

Private Hospitals

In contrast to public and PSPH hospitals, there are no systematic statistics on the revenues or costs of private institutions. A 1985 study by the *Centre d'Etudes des Coûts et des Revenus (CERC)* estimated the operating costs of private hospitals and clinics in 1980 at F11.7 billion. Fifty-five percent of this was spent on staff; 17.4 percent on purchases; 17.2 percent on repairs, supplies, and external services; 4 percent on depreciation and provisions; 2.3 percent and 6.4 percent on other costs (1).

Operating Expenditures

Total hospital operating expenditures (which include both operating and capital spending) were F263 billion in 1991, equaling 3.9 percent of the gross domestic product (GDP) and 40.7 percent of national health expenditures (NHE). Hospitals' share of NHE has fallen over the past decade, which was 44.9 percent in 1980, but hospital expenditures as a share of GDP have increased, starting at 3.6 percent in 1980. These trends indicate that health care spending in France has commanded a greater share of the country's financial resources over the past decade, although the hospital sector has contributed less to this trend than have other sectors of France's health care system.

Approximately three-fourths of aggregate hospital outlays went to public and PSPH hospitals in 1991—slightly less than in 1980, when the public sector accounted for 78 percent of hospital spending (2).

HOSPITAL CAPITAL COSTS

Located as they are in a rapidly changing sector that is strongly affected by technological progress, and faced with growing patient demands for the latest technology and more patient amenities, all hospitals are increasingly sensitive to competition and have strong incentives to invest. In contrast to

the private sector, public and PSPH hospital investments are subject to certain financial constraints, although they also benefit from special public assistance.

The private sector is facing increasing competition, and its level of required investment is becoming more and more onerous; thus hospitals in this sector find it necessary to seek new investors. Few figures are available on private sector hospital investment, and most of the information in this section relates only to the capital investments of public and PSPH hospitals. Where appropriate, legislation concerning the investment process and current trends are discussed.

■ Relationship of Capital and Operating costs

In 1988 the aggregate budget for French public hospitals was approximately Fbillion158, which represented the purchase of goods and services. These costs may be either operating or investment costs, as follows:

- The operating section of the budget includes all consumable goods and services that are short-term; such expenditures relate to day-to-day supplies and to upkeep and maintenance.
- The investment section includes expenditures that are intended either to maintain a capital good beyond its budgeted life or to purchase new capital (3).

The investment section regularly receives transfers from the operating budget through provisions and depreciation accounts. Such accounts represent the depreciation of assets with a view to replacing them; depreciation is recorded as an income item in the investment section and as a cost item in the operating section. Depreciation costs are taken into account in determining the global allocation and daily service charges.

Private for-profit hospitals and certain private nonprofit institutions, even if they participate in the public hospital service, are not entitled to direct reimbursement of depreciation costs because the government is concerned about preventing the accumulation of private wealth at the expense of

the sick. Such institutions may, however, receive a remuneration equivalent to 3 percent of their capital (based on the nonamortized value of their assets, where necessary after revaluation). In addition, fixed assets in such institutions are almost never the property of the hospital but are rented. The depreciation of these assets is included in the rent, which is an operating cost.

Hospitals that receive a global allocation are allowed to include interest payments on investment loans as part of their operating costs. This option does not extend to the repayment of loan principals, which are included in the investment section of their budgets.

Another way in which operating and capital costs are related in French public and PSPH hospitals is through the allocation of operating fund surpluses. Under certain circumstances (discussed above), surpluses in the operating section can be used to finance investments that are not expected to increase operating costs in ensuing years. Moreover, any surplus in the appended budget is allocated to the purchase of equipment for hospitals (e.g., blood transfusion centers or computer centers), to other hospital capital investment, or to reduce operating costs in succeeding years.

The impact of capital costs on future operating costs is determined informally. Some hospital boards draw up program budgets as a means of improving quality of forecasting and planning, and assisting management by highlighting the overall impact of an activity in operational *and* investment terms. Activities examined may cover energy saving programs, computerization and major equipment, or hospital buildings.

■ Capital Financing Model

Investments in new construction, new major medical equipment, or replacement equipment in the public sector can be financed by depreciation (applied to tangible assets such as hospital plant and equipment) or amortization (applied to intangible assets such as insurance policies). In the hospital sector, however, this is inadequate due to the rate of technological innovation, and other funding sources are often required.

TABLE 4-6: Capital Expenditures and Income in Public Hospitals (1975, 1986, 1988) (in millions of francs)

Expenditures	1975	1986	1988	Percentage of 1988 total
Direct expenditures	3,722	8,842	13,456	69.9
Tangible assets	812	4,059	5,723	29.7
Real estate investments	169	434	3,171	16.5
Construction	2,741	4,349	4,562	23.7
Indirect expenditures	884	3,464	5,801	30.1
Total expenditures	4,606	12,306	19,257	100.0
Income	1975	1986	1988	Percentage of 1988 total
Subsidies, grants	985	1,707	1,583	7.6
Loans	2,533	3,521	4,545	21.8
Depreciation	1,513	6,989	7,702	36.9
Fixed assets			4,181	20.0
Other income	244	946	2,845	13.6
Total income	5,275	13,163	20,856	100.0

SOURCES: Ministère de l'Economie des Finances et du Budget, Direction de la Comptabilité Publique, Les Finances du Secteur Public Local, Hôpitaux Publics 1983-1988.

Self-Financing

Hospitals obtain some of their funds from internal sources, such as the sale of real estate and tangible assets (a fairly unimportant source) and depreciation, which accounted for 37 percent of hospitals' investment funds in 1988 (table 4-6). Since the mid-1980s, depreciation funds have increased in importance because of trends in the structure of investments and thus their patterns of depreciation. The decline in the acquisition of land and buildings and of repairs with a long (often 30 years) depreciation period and the increase in tangible acquisitions with a short (around 5 years) depreciation life has significantly increased depreciation income and thus the level of self-financing.

Subsidies

Hospitals obtain a portion of their investment funds from several external sources that may be free or may incur a cost. State subsidies—which normally vary between 5 and 40 percent of a hospital's investment funds, depending on the institution's capacity for self-financing—and subsidies from local authorities are free. More than half the subsidies received by hospitals come from the

state. Of local authority funding, the regions are the most important source of assistance, followed by the districts and municipalities (*communes*). In 1988, subsidies accounted for 7.6 percent of aggregate investment income (table 4-6).

Loans

The sickness funds have been authorized to make interest-free loans to hospitals, which are required to repay only the principal amount. For loans that incur a cost, hospitals normally call on banks for public authorities (*Caisse des Dépôts et Consignations* and the *Caisse d'Aide à l'Équipement des Collectivités Locales*). Hospitals may also borrow from other banks or even, with ministerial approval, from the financial market (i.e., debenture loans). Such loans represented 21.8 percent of aggregate investment income in 1988 (table 4-6) (3).

Today, state subsidies and sickness insurance fund loans play less of a role in hospital investment financing than they have in the past. Hospitals' own resources now constitute a key element of their capital finances. They even appear to be gaining in importance, given a slight trend toward

a reduced level of debt and a refocusing of investment; that is, investment now seems to be geared toward the acquisition of biomedical equipment, which in turn generates a higher level of depreciation. If sufficiently short periods of depreciation are allowed, a high level of debt generates considerable resources for investment. In fact, hospitals that have borrowed at high rates have not been penalized at all; rather, they have benefited from a budgetary bonus, as the financial costs associated with a high level of depreciation form part of the base from which the initial budget is calculated (9).

Financing from loans is restricted to 60 percent of the estimated cost of an investment. Institutions are required to meet the other 40 percent of the cost (as well as any associated additional operating costs) from their own financial resources. To help cover such costs, hospitals sometimes receive an additional allocation over and above the federal guideline rate for updates to global allocations, although experience shows that this does not occur often. Other internal sources include the use of surpluses arising from improved management. In contrast to the private sector, such decisions are subject to the approval of supervisory authorities (17).

Private Hospitals

Private hospitals (often called clinics) are free to use their profits for investment or to redistribute them to shareholders. Private for-profit clinics have traditionally been owned by physicians. It has become increasingly difficult, however, for clinics to finance investments in new major equipment from their own resources, which they need to keep up with technological progress and the demands of competition (14). Clinics face a difficult problem of finding outside investors mainly because in most cases there is no guarantee that the investment will be profitable. In recent years this “crisis” in the private sector has resulted in a transformation of the structure of such hospitals, which are increasingly passing from the status of a family business to that of a limited company belonging to a major financial group. Large French compa-

nies (e.g., Paribas, Suez, Lyonnaise des Eaux) and foreign companies have invested in chains of clinics in search of profits (17).

Determining Capital Requirements

The entire French health care system (both public and private health institutions) is subject to formal health sector planning (15). In general, public hospitals are subject to the provision of public law that governs public works and the placing of public work contracts. Commercial institutions must operate according to private law, which allows them to determine their own investment procedures within the limits of the law. Health care legislation in 1970, however, stipulated that repair programs and projects relating to the creation, extension, or transformation of public and private hospitals would be subject to authorization arrangements. Authorization is forthcoming only if a scheme complies with the health map (*carte sanitaire*).

Health Maps

The foundation for health sector planning in France is the health map. The health map forms the reference point for public authorities in all decisions relating to the level of public and private hospital construction of new buildings, additions of hospital beds, or the acquisition of major medical equipment (15). It is based on a recognition that the private sector must operate alongside the public sector, as the latter is unable to meet all public health care needs. The aim is to meet those needs satisfactorily at the lowest cost by a rational allocation of capital resources.

The health map, drawn up by the Ministry of Health after consultation with regional and national health resources committees (12) was designed to meet three objectives: 1) to control the rapid growth of the hospital sector, 2) to correct regional disparities, and 3) to coordinate public and private sector development. To accomplish these aims, the health map establishes the boundaries of health sectors and regions. Each health sector is a geographical area of about 30,000 to 40,000 inhabitants centered on a hospital with a certain

minimum level of technical facilities. There are currently 21 regions divided into 284 health sectors. The health map also establishes the nature, extent, and location of health facilities of national importance or designed to serve several health regions. For each type of facility, the health map for the particular sector or region concerned specifies the buildings and major items of required equipment. Plans are detailed after an analysis of local and regional needs. The health map also includes an inventory of existing or authorized buildings and a continuously updated record of major items of medical equipment.

Each region draws up its health map in light of directives issued by the Ministry of Health. The work is then submitted for review to sector and regional hospital groups and the regional committee for health and social resources. This is followed by an examination of the health map at the federal level. The Ministry then adopts the provisions of each map after seeking the opinion of the national committee for health and social resources.

This approach, it should be noted, is very broad and general with indicators of need established for major areas of activity (e.g., medicine, surgery, obstetrics-gynecology, medium stays). It is not based on epidemiological or population-based data (2,4).

The Act of December 31, 1970, requires all public and private institutions to secure authorization from the administrative authorities for new buildings or extensions of existing ones with compulsory reference to the health map. (The map's indicators of beds per specialty represent ceilings that may not be exceeded.) The Act also makes it obligatory to obtain prior approval for conversions of hospital facilities, the merging of hospitals, or the installation of major medical equipment.

The prefect is responsible for issuing authorizations after consulting the Regional Health and Social Resources Committee, except in the case of decisions of national importance; these are the responsibility of the Health Minister of the central government after consultation with the National Health and Social Resources Committee.

Reforms

The reforms initiated by the 1991 legislation maintain the health map but substantially broaden its scope with the addition of a new document: the health organization scheme. Both the maps and the schemes are to be drawn up on the basis of the measurement of needs in the population and their changes, with regard to demographic data and technical progress in medicine, following a quantitative and qualitative analysis of existing care provision.

In carrying out this task, the ministers responsible for health and social security (in the case of national and inter-regional maps and schemes) and the regional prefects (in the case of their regional and sub-regional equivalents) will be assisted by health organization committees at national and regional levels. To reflect the need for assessment, each regional health organization committee will have a committee on regional medical assessments of hospitals.

The scope of health planning has been broadened by the health organization scheme to gradually break down the boundaries between inpatient hospital care and outpatient ambulatory care and to develop plans to rationally diffuse particularly expensive or sensitive medical activities associated with ambulatory care. The legislation is concerned with the type of care provided, not with the physical structure of the buildings or the legal context in which the care takes place. Alternatives to hospitals are taken into account (particularly ambulatory surgery) by establishing an equivalence between hospital beds and the number of places providing alternatives to hospital care.

Under the new legislation, public hospitals are also authorized to collaborate with public and private legal bodies, including those at the international level. In connection with these activities, they may sign agreements and participate in inter-hospital syndicates and public and financial consortia. The creation of such consortia enables health institutions to pool their operational or investment resources to undertake activities that their individual resources would not allow. To

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achieve greater uniformity of the two hospital sectors, the new legislation also provides for all care institutions and providers to be subject to the same authorization arrangements. The overall aim is to simplify and decentralize the administrative procedures for securing capital investment authorizations.

The reforms also introduce a hospital plan which sets out (particularly in the context of the medical plan) each institution's objectives with regard to medical and nursing atmospheres, social policy, training, management, and information systems. The plan, which must be compatible with the objectives of the health organization scheme, identifies all the resources in terms of buildings, staff, and equipment that the hospital requires to achieve its objectives. It is developed for a period of up to five years (5).

Traditional Public Hospital Investments (16)

In any major hospital and even those of average size, new buildings and expansion of existing facilities form part of an overall medium-term (10- to 15-year) program. Three types of projects may be identified: 1) those of national significance, for which the ministry is responsible; 2) capital projects that are unique to a region and for which the regional prefect is responsible; and 3) capital projects that are the responsibility of the district prefect, who gives approval in view of the overall resources allocated to each district.

Because most investments are carried out with state assistance, investment priorities are spelled out in the national economic and social development plans, which effectively determine the allocation of financial resources set aside for the different sectors of public investment. Receipt of state subsidies for new capital investment is contingent on the proposed investments' inclusion in the plan.

Any building and major medical equipment investment project must pass through several stages (e.g., purchase of a site, initial preliminary design, final proposal) each of which must be approved by the hospital board after they have been considered by the hospital's medical staff committee and the

joint technical committee. Each stage is subject to final approval by the supervisory authority.

- The financial appraisal of the project is accompanied by a financing scheme. The financing rules are as follows:
- When state funding is provided, it is always equal to 40 percent of the capital expenditure qualifying for subsidy.
- Local authorities may also contribute to this assistance, bringing the rate of subsidy above 40 percent.
- The balance is met by the hospital from its own resources, by loans from the *Caisse des Depots et Consignations* or the *Caisse 'Aide a l'Equipement des Collectives Locales*. In the case of investments that do not receive state funding, the proportion of the cost met from borrowing may not exceed 60 percent.

The different categories of equipment and materials subject to approval are care units equipment, ancillary care and technical medical equipment, and equipment for general services.

In 1974 a national center for hospital equipment (CNEH) was established that reports to the Ministry of Health. It has responsibility for considering problems associated with the functioning of hospitals. The rules governing the financing of the provision of medical equipment are the same as those relating to the building process.

Under the new legislation the supervisory authority will monitor only the legality of contracts entered into by hospital directors. Such contracts will come into force as soon as they are received by the prefect's office.

Private Hospital Investment

Once a private hospital decides to adopt new technologies, provide new services, or expand its hospital beds, it can acquire the necessary physical and staff resources and place them at their patient's disposal, thus putting them to profitable use more quickly than the public sector. Private hospitals can also more quickly provide the resources required to meet an existing need. If an investment turns out to be profitable after the facili-

ties are in place, they can be adjusted to a certain extent by the constant redeployment of resources (particularly of staff), as there are few statutory constraints. Private hospitals face no major impediments to increasing and modernizing their facilities as soon as a decision has been made (17).

■ Capital Expenditures

Capital expenditures do not correspond to a single year's costs and may figure into the calculation of more than just one year's global allocation and charges. In 1988, capital expenditures of public hospitals equaled F19.3 billion, or 12.2 percent of aggregate hospital expenditures. This represents a more than threefold increase over 1975. (Expenditures for different capital investments are given in table 4-6.) Since 1975 the structure of direct investment expenditure has changed, with the proportion funding real estate investments (e.g., construction of new hospital wings) falling from 78.2 percent in 1975 to 57.5 percent in 1988. There has been an equivalent rise in investment in other capital assets.

Total investment income in 1988 was F20.9 billion (shown by funding source in table 4-6). This amount represents a corresponding threefold increase in investment income over 1975. Over the last decade, the proportion of capital expenditures paid for from internal funds has tended to increase, while the proportion met by grants, and especially by loans, has declined (table 4-6) (13).

FUTURE DIRECTIONS

The containment of health expenditures is a major concern in France. The costs of hospital care represent half of national health expenditures, making the hospital sector a primary target of France's cost containment efforts. The hospital sector has always expanded without much control, and its evolution has been marked by the constant need for an urgent response to perpetually growing demand. The urgent nature of hospital care has often taken precedence over economic rules of efficiency and better management. Prior to 1971, hospitals would present their bills to the sickness insurance funds after having satisfactorily treated

patients. The funds would not hesitate to pay their share of expenses, and little attention was given to detailed analyses of hospital bills. Only in the 1970s did national economic conditions demand closer scrutiny of the economics of hospital care. By the end of the 1970s, containment of hospital costs had become a high-priority issue and the primary goal of all reforms aimed at reducing health expenditures since then.

Understandably, it is the public hospital sector that has been most influenced by cost-containment reforms. In 1983, prospective budgeting became the standard in this sector. Its purpose was to control spending by imposing guideline growth rates for hospital spending. However, the determination of budgets across hospitals takes no consideration of changes in activity or volume of services demanded from individual hospitals but merely applies a predetermined increase rate (the federal guideline rate) to the previous year's budget. Budgets are based on historical levels of expenditure, and rates of increase are determined centrally, with little scope for local deviation (11).

The medical program information system (PMSI) was created to achieve a financing system more reflective of an individual hospital's activity and to encourage continuous evaluation. This program systematically produces a standardized discharge form at the completion of each patient's hospital stay and enters the form's data into a patient database. The system allows for detailed analysis of hospital activity to enable comparisons of patient volume among departments or hospitals and to detect morbidity trends. The PMSI was implemented as an initial move toward developing a DRG-type system of homogeneous patient groups and incorporating this classification system into the hospital financing scheme. Implementation of the PMSI is proving to be complex and involved, however, and the full achievement of a DRG-based system in France remains a long-term objective.

A large gap still exists between the public and private hospital sectors in France. The allocation of funds to each sector is based on different mechanisms, and despite the sickness insurance funds' increasing control over the private sector, cost

containment efforts for this sector have not been very successful. A serious shortcoming of the present financing scheme is that private institutions have an incentive to increase the number of medical procedures to compensate for rigidly imposed fees and daily rates.

The 1991 health reform legislation in France is designed to extend government control over the private sector and to narrow the gap between the public and private sectors. The legislation redefines hospitals according to general guidelines, thus providing the private sector with the same "public interest" mission as the public sector. The reform also emphasizes the complementary role of the public and private sectors. Private hospitals are not yet paid through a global allocation scheme, but growth in expenditures for private hospital services are capped under the reforms. Additionally, the PMSI is planned to be extended to the private sector, and current experimentation with a DRG-type system is in place for some special services. Now that the philosophy underlying the DRG system is being tested in the public hospital sector, a relatively smoother implementation of the DRG system in the private sector is likely.

Implementation of the necessary structural arrangements to achieve the objectives of recent reforms will be a long-term task. Both private and public hospitals face new obligations, including maintaining medical records that are readily available for consultation by the patient or the patient's physician, evaluating professional practice, reorganizing health care, analyzing service activity, and implementing information systems that document different conditions and modes of care and treatment (5).

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