
The “Papy-boom”: A historical opportunity for French public hospitals

Robert Holcman

Conservatoire national des Arts et Métiers, Paris, France

Abstract The French public hospital system represents a major element in overall social security expenditure and ongoing reforms are having a significant impact on its financial equilibrium and the internal management of its activities. Nonetheless, the system has been unable to achieve the productivity objectives imposed on it. Significantly, staffing costs account for three quarters of its expenditure, yet most employees are civil servants who cannot be laid off easily. The only possibility for meaningful change in the size of its workforce may lie in the demographic revolution now affecting the French population, which will see half the present staff of public hospitals reaching retirement age within the next decade.

Keywords hospital, medical personnel, public expenditure, demographic aspect, retirement, France

95

The cost of the French public hospital system represents a major element of the country's overall social security expenditure. This fact has led to a spate of reforms within the public hospital system. Moreover, a combination of factors has created a generalised context wherein the emphasis is now placed on containing hospital expenditure. These factors include: a reduction of the French working-week to 35 hours (in hospitals as elsewhere); the spiralling increase in social protection

Address for correspondence: Professor Robert Holcman, Conservatoire national des Arts et Métiers, Professor of Economics and the Management of Health Services, 292 rue Saint-Martin, 75003 Paris, France. Email: robert.holcman@cnam.fr

expenditures (health and retirement) as a result of demographic ageing; the failure of France to respect the European Union’s Stability and Growth Pact, with resulting budgetary and financial constraints; and, finally, the more demanding attitudes of patients, their growing consumerism and increasing recourse to legal action against the medical establishment.

Over the last two decades, French public hospitals have had to adapt to an unprecedented degree. Accelerating technological progress calls for increasingly qualified staff and major changes in the organization of tasks. The emphasis on focused public health campaigns (for instance, on AIDS, hepatitis C and obesity) has further increased the pressure on health establishments that are already faced with demands for more sophisticated risk management based on more stringent quality controls and greater accountability.

At the same time, a new public hospital financial system has led to unprecedented budgetary restrictions, while new procedure-based methods of accounting provide strong incentives for increased productivity.

The need for tight control of expenditure and the more rational use of available resources underlines the overwhelming weight of staffing costs on overall hospital running costs. With approximately three-quarters of spending devoted to the remuneration of their staff, public health establishments can no longer afford to avoid this issue.

The problem is that the vast majority of French public hospital employees are civil servants, with career contracts. This basic fact has paralysed all attempts at rationalization made in recent years, no matter how strong the incentives for productivity. The social risk is so high that hospital decision-makers have been afraid to treat the size of their labour force as an adjustment variable.

Experience shows that, to date, the hospital system has not made the right decisions in terms of reducing costs, focusing on its core activities rather than on peripheral elements. Regardless, the coming decade will be crucial for the future of the French public hospital system: the retirement of the “Baby-boom” generation presents a window of opportunity for effecting major change in the composition and size of its labour force.

A brief description of the structure of the French social security system and the importance of public hospitals will be followed by a description of the special characteristics of the French hospital system compared with those of other industrialized countries. The article will demonstrate the crucial importance of staffing in the management of public health care establishments and consider why this issue has not yet been addressed. Finally, an estimate will be provided of the likely impact of demographic change on the hospital civil service and how this may provide a historical opportunity for the French public hospital system.

The French public hospital system and its reform

The four branches of French social security

Social security expenditure was €366 billion in 2005¹ (In 2005, €1.00 = US\$1.23 approx.), spread over four branches: work injury and occupational diseases (€11 billion); old-age and survivors (€15 billion); family (€52 billion); and health, maternity, disability and death (€148 billion).

Since 1996, expenditure has been controlled and monitored under the Social Security Finance Act approved annually by the French Parliament, which clearly defines health insurance expenditure as part of the “health-maternity-disability-death” branch, based on the *Objectif national des dépenses d’assurance maladie* (ONDAM) (National Public Health Expenditure Target). This target, which includes only those expenses covered by health insurance (excluding hospital co-payments covered by the patient, medical fees exceeding agreed tariffs covered under the system and non-reimbursable care), amounted to €135 billion in 2005 (de Kervasdoué, 2005).²

The National Public Health Expenditure Target should not be confused with the targets for the “health-maternity-disability-death” and “work injury and occupational diseases” branches. It includes expenses incurred by the compulsory basic schemes in Metropolitan France and the Overseas Departments; namely, for health care coverage (out-patient care and hospitalization expenses) for the risks of incapacity, maternity and work injury as well as for cash benefit coverage for the risks of incapacity and work injury. The work injury branch covers only expenses incurred in connection with temporary disabilities. Work injury pensions, daily maternity benefits, administration costs, health and social activities, fund health expenses, transfers and financial costs are excluded from this objective (Huteau, 2001).

It must be borne in mind that unemployment benefits are not included in French social security expenditure. However, a fifth branch, “dependence”, is soon to be added to the above-mentioned four.

Characteristics of the French hospital system

When compared with other countries, the French hospital system has a very high number of establishments distributed unevenly over the national territory, a very

1. Two reforms came into effect in 2005: the Health Insurance Turnaround Plan 2005-2007 and the full implementation of procedure-based invoicing. Expenditures included in the “Health Establishments” budget line have been extended to include spending in connection with the French Overseas Departments, as well as spending on private-sector consumer products that, until now, were included in the “urban care” budget line.

2. The objective for 2007 was €144 billion.

high proportion of total hospital expenditure is devoted to staff costs, and the public sector plays a dominant role.

A very high number of hospitals distributed unevenly

Life expectancy at birth is a figure that reflects the general state of health of the population. It is slightly above 79 years of age in France, i.e. the same as in Italy, slightly lower than in Spain and slightly higher than in Germany and the United Kingdom (78.5 years). This is significant when compared with the number of hospital beds available, of which France has 450,000. This is more than the United Kingdom and Italy, which both have approximately 240,000 beds, but far less than Germany, which has 700,000. However, the high figure for the latter may partly be explained by its population of 80 million compared with 60 million in France. In terms of the population, Germany has 8.6 beds per thousand inhabitants compared with 7.5 in France and 4.1 in the United Kingdom.

All sectors and activities combined (public, private for-profit and private non-profit), France has 2,900 health establishments compared with 3,500 in Germany, 1,400 in the United Kingdom and 1,300 in Italy. These figures are even more surprising when compared with national population figures: there are 4.8 establishments per 100,000 inhabitants in France, compared with 4.2 in Germany, 2.3 in the United Kingdom and 2.2 in Italy. Taking only public hospitals into account, 54 per cent have less than 200 beds, 16 per cent have between 400 and 800 beds and 7 per cent have more than 800 beds. Hospital facilities in France are thus fragmented as well as being concentrated in small and very small hospitals (OECD, 2006).

The distribution of hospitals throughout the national territory is not particularly rational. The total number of establishments and their size calls for a number of comments. First, the total number of hospitals in each French province or “*département*”, is almost completely determined by the number of small hospitals (less than 400 beds). With few exceptions (Paris, Val-de-Marne, Pas-de-Calais and Gironde for example), those *départements* with the largest number of hospitals are those with the highest number of hospitals with less than 400 beds. This is the case in the Nord, Loire-Atlantique and Rhône areas for example, which head the list of *départements* with the highest number of beds. The next comment is that there is an inverse ratio between the number and size of hospitals in *departments*. The lower the number of large establishments in a *département*, the higher the number of hospitals, as if number compensated for size (de Kervasdoué and Picheral, 2003).

A large but fragmented staffing structure

The first consequence of having a large but fragmented staffing structure is that France devotes more resources to health care in the hospital environment: 6 per cent

of its gross domestic product, compared with 3.8 per cent in Germany and 3.4 per cent in Italy. The explanation for this lies in a high number of hospital jobs as a result of the multiplicity of care structures throughout the country. France provides 1.2 million jobs in its hospitals, which is the same number as in Germany, although the latter has 20 million inhabitants and 250,000 hospital beds more than the former.

In spite of a high number of hospital staff, France — paradoxically — is a country with a low ratio of medical staff per hospital bed. The average number of medical staff per bed in acute care units in France is 1.64, compared with 2.03 in Germany, 3.07 in Italy, 3.57 in Spain and 6.5 in the United Kingdom. The situation as regards nursing staff is equally worrying: the average nursing staffing rate in France is 0.56 per bed, compared with 0.75 in Germany, 1.36 in Italy, 1.68 in Spain and 1.8 in the United Kingdom. Once again, these figures confirm the scattering of medical personnel over a particularly high number of health units (OECD, 2006).

The dominant role of the public sector

The public sector dominates the French hospital system. This is so despite the fact that another characteristic of the French system is the large number of private for-profit hospitals (20 per cent), particularly when compared with the United States (12 per cent), Germany (10 per cent) and the United Kingdom (10 per cent) (McKee and Healy, 2002; OECD, 2006).

The private sector is dominant in terms of the number of establishments, since the sector is characterised by fragmentation and small-sized structures (Table 2). The public hospital service, however, offers by far the largest number of beds. In addition to the 65 per cent belonging to the public sector itself, non-profit private establishments also provide a public hospital service (Table 2).

In 2003, 65.7 per cent of a total of 151,568 acute care beds were located in public hospitals. In 2004, 69.4 per cent of a total of 11.2 million admissions for acute care were treated in public hospital establishments.³ The public hospital service handled 69.7 per cent of all admissions in 2004,⁴ all areas combined.

The public sector also dominates the social and medico-social areas. The public hospital service is responsible for three-quarters of the beds available in follow-up and rehabilitation units. And it has a near-monopoly (98 per cent) of beds for long-term treatment.⁵

3. Public hospitals and private non-profit establishments that are financed as if they were public. These figures are taken from the Annual Statistics on Establishments (SAE) compiled by the Research, Assessment, Survey and Statistics Department of the French Ministry of Health.

4. See OECD, 2006.

5. See OECD, 2006.

Table 1. Social security expenditure by branch (in billions of Euros, 2005)

Health-maternity-disability-death	148
Including ONDAM (National Public Health Expenditure Target) mainly made up of:	135
Urban care	62
Public sector hospitals (*)	51
Private for-profit establishments	10
Work injury and occupational diseases	11
Old-age and survivors	155
Family	52
Total social security expenditure	366

(*) Public-sector hospitals and private establishments included in the public hospital network.

Table 2. Share of total care provided by public and private establishments

By number of establishments				
Public sector (33%)	Private sector (67%)			
	Non-profit (28%)		For-profit (39%)	
GA	GA (24%)	NQT (4%)	NQT	
PSH	PSH	PSH	Non-PSH	Non-PSH
Number of hospital beds (full numbers)				
Public sector (65%)	Private sector (35%)			
	Non-profit (15%)		For-profit (20%)	
GA	GA (13%)	NQT (2%)	NQT	
PSH	PSH	PSH	Non-PSH	Non-PSH

PSH: Part of the public-sector hospital network.

GA: Global allocation.

NQT: National quantified target.

It is the impact of the public hospital service on health insurance expenditure that makes this sector so important in financial terms. Within ONDAM, public hospital service expenditure (public hospitals and private non-profit establishments financed in the same way) amounts to €51 billion, compared with €62 billion for urban care (Table 1). In other words, the public hospital service accounts for 37.6 per cent of the ONDAM, 34.2 per cent of spending in the “health-maternity-disability-death” branch and 13.9 per cent of total social security expenditure.

Public hospital service expenditure represents 3 per cent of annual gross domestic product (GDP).

It is worth noting that it is the public health sector that takes on the most serious and complicated pathologies, and that any attempts to rationalize its activities and provide a budgetary framework — particularly in terms of the ongoing reform of public treatment centres — must take this fact into account.

Criteria for the classification of health establishments

Our first task is to distinguish between social, medico-social and health establishments, which are divided among these three categories depending on whether they provide only medical treatment, some medical treatment or no medical treatment.⁶ Health establishments provide only medical care; any other activities carried out within their confines are organized separately, particularly from a financial point of view. Medico-social establishments are primarily social establishments; they may also provide some medical care if the state of health of their patients makes it necessary, more intensive treatment being provided by the health sector. Finally, social establishments provide no medical treatment at all.

Social and medico-social establishments carry out a wide range of activities. They provide care for minors; special education and social or medico-social care for minors and young adults who are disabled or who have behavioural problems; sheltered workshops; occupational rehabilitation, reorientation and training; residential accommodation or home help for elderly people; residential care for handicapped adults; and accommodation, support or social assistance for persons or families in difficulty or distress, as well as for persons with addictions and so forth.

The term “hospital” is therefore used for health or medical establishments. Within the medical sector, activities are divided into three areas: medicine, surgery and obstetrics (MSO), also referred to as “acute care”; follow-up treatment and rehabilitation (FTR); and long-term treatment (LTT). Within the health sector, several criteria are used to classify health care establishments: the field and nature of their activities; the public or private sector; for-profit or non-profit; participation in the public service system; and method of financing.

Health establishments may be public or private. Generally speaking, the term “hospital” is used in France to refer to a public health establishment operating within a local community. However, not all private establishments are for-profit or commercial bodies. Private non-profit establishments may be run by associations, religious communities or social bodies such as mutual trust or sickness insurance funds. Such establishments that participate in the public hospital service are

6. See Balsan (2004) and Cueille (2005) for a typology of French public care establishments.

financed from public funds and are thus subject to the same management regulations as the public hospitals.

Private for-profit establishments are enterprises that are under private individual or corporate ownership. Their operational modes and methods of finance are those of private enterprises, and their objective is to make a profit.

Once the procedure-based invoicing system (see below) is fully operational,⁷ all health establishments — both public and private — will be subject to the same method of finance. Until then, health establishments will continue, at least in part, to be financed by two parallel but separate schemes, thus enabling a distinction to be made between establishments: those that receive global funding and those covered by the national quantified target (NQT).

Global funding consists of a lump sum allocated to public establishments and to the majority of private non-profit establishments, whether or not they form part of the public hospital service. For those establishments that do receive it, global funding represents a major part of their income. Only a few non-profit establishments continue to be financed through the NQT system (Table 2).

The NQT is a method of finance based on hospital admissions, which combines remuneration at a daily rate with procedure-based invoicing. Its aim is to control rising expenditure based on the volume of activity of the previous year. The expenditures of private for-profit establishments as well as those of about one hundred private non-profit establishments are subject to the NQT.

Several of the criteria for the differentiation of health establishments overlap. There is no fundamental link between holding a public or private status, method of finance and field of activity. However, as shown in Table 2, there is a high correlation between the public sector, involvement in the public hospital service and public finance. There is also a logical connection between private sector, profit-making, non-involvement in the public hospital service and the absence of public funding.

Public hospitals can also be grouped according to their size and sometimes their specialization: regional hospital centres are very large, and almost all of them are teaching hospitals; hospital centres are medium-sized; and local hospitals are small — the last two groups are not teaching hospitals, with the exception of hospital centres specializing in psychiatric treatment.

Hospitals in France can be divided into three main types (Table 3): public hospitals, teaching or otherwise; private establishments operating within the public hospital service; and private for-profit establishments (Chaleix and Mermilliod, 2005).

The public hospital service is by far the most important category. It is the importance of this sector within the French hospital system and its recurrent failure

7. The system is being implemented progressively. It represented 10 per cent of hospital budgets in 2004, 25 per cent in 2005, and 35 per cent in 2006.

Table 3. *The three major types of health establishment in France: Criteria*

	Public sector hospitals	Private establishments within the public hospital sector	Private for-profit establishments
Current financing (*)	Public (global allocation)	Public (global allocation)	Private (national quantified target)
Future financing (*)	Procedure-based invoicing		
Medical staff	Mainly salaried employees Self-employed staff in the local hospitals	Mainly salaried employees	Mainly self-employed staff
Non-medical staff	Mainly civil service	Private contracts	
Part of the public-sector hospital network	Yes	Yes	Only centres for the treatment of cancer
Training of medical students	Approx. twenty teaching hospitals	Only medical interns	No
Training of medical auxiliaries (nurses, nursing assistants, physiotherapists, etc.)	Some	No	
Emergency treatment	Some	Some	No

(*) A progressive transition from current to future methods of financing (procedure-based invoicing in all establishments) is under way; the current period is a transition phase between the two systems.

to respect budget allocations (Caussa, Fenina and Geffroy, 2003) that has led to the on-going reforms.

On-going reforms in the public hospital system

There are three kinds of on-going reform in the public hospital system: a new internal organizational structure; a new budgeting system; and new methods of finance.

Since 1 January, 2007, the activities of public hospitals have been divided into “clusters”. Previously, treatment was organized on the basis of departments with responsibilities divided according to the organs they treated — cardiology (heart), hepatology (liver, pancreas), respirology (lungs) etc. — or by one or more functions: gastroenterology (digestive system), orthopaedics (skeleton), rheumatology (articulations) and so forth. Under the “New Governance” system, departments are combined depending on the pathologies affecting patients. The “heart/lungs” cluster will thus combine the cardiology and respirology departments. The “head/neck” cluster will include the otolaryngology and stomatology departments. The combined aim is to facilitate the treatment and the path followed by the patient within the hospital by avoiding the passage from one department to another, to

pool resources and to involve medical staff in the management of public health establishments.

At the same time, a new budgetary system has been imposed on public hospitals: the statement of planned income and expenditure (SPIE). Under the previous scheme, the implementation of the annual budget was evaluated the following year, which meant that hospitals could overshoot their authorized budgets. By preventing overspending, the SPIE imposes financial logic in hospital management. Henceforth, resources (and therefore expenditure) will no longer be allocated according to activities; rather, it is available income that will condition expenditure and investments and therefore activities (Mercereau et al., 2005).

The aim of the new budgeting system is to estimate the risk of financial overshooting and to introduce sanctions upstream. Hospital managers must be able to produce an income and expenditure forecast for the current year at any time during the financial period in question. In the event of a significant and long-term difference between objectives and results, the administrative board of the hospital may call for an external audit and — if necessary — adopt a recovery plan at the request of the *Agence régionale de l’hospitalisation* (Regional Hospital Agency) responsible for the establishment.⁸

In the past, an operational deficit did not create a burden of debt that prevented the hospital making purchases and investments. Nowadays, the SPIE financial approach means that any operational deficit will reduce the funds available to the hospital and force its administration to find other ways of financing planned investments. In the words of those who developed the concept: “The SPIE will encourage well-balanced financial investments” (DHHO, 2005). With any budget system, equilibrium is the objective; however, thanks to the SPIE it has become a reality.

The third major area of reform introduced into the public hospital system concerns its method of finance. Until 2004, two-thirds of public hospital income took the form of a fixed allocation — the global payment — that was provided by the Ministry of Health regardless of the volume, nature and evolution of the hospital’s activities. The objective of the global payment was two-fold: to contain growth in hospital expenditure and to encourage hospitals to reflect on the best way to use the funds allocated, thus inciting higher productivity. The budget remained constant, which penalised the most dynamic and innovative establishments, those most active in the search for excellence. Still worse, the global payment encouraged inertia and the loss of technical skills within hospitals: an establishment which becomes increasingly less technical and thus spends less, is easier to manage on a constant budget.

8. Regional Hospital Agencies were created in 1996 to manage hospital programmes at the regional level and are responsible for dispensing the national budget allocated to public hospitals. They are therefore involved in the most important item of expenditure of the public hospitals, their staff.

Table 4. *Income and expenditure in health care establishments*

Groups or titles	Charges or expenditure	Products or income
1	Staff	Health insurance payments/ Procedure-based invoicing
2	Medical sector	Other products of hospital activities
3	Catering and accommodation	Other products
4	Amortization, general provisions and provisions for exceptional items	

Procedure-based invoicing is a promising reform. Its objective is to bring the current form of hospital financing, which is both unfair and ineffective, to an end and thus encourage increased productivity. From now on, French public hospitals will be financed on the basis of their activities. Each procedure, each act and each type of care has its own tariff and public funding for hospitals now⁹ depends on the procedures carried out and their corresponding tariffs.¹⁰

These are all major reforms that are having far-reaching effects on the activities and internal organization of public hospitals (Vincent, 2005 and 2006; Vasselle, 2006). They are exceptional in terms of the simultaneity and rapidity with which they have been implemented. These reforms provide strong incentives for health establishments to improve their productivity. The problem — particularly because their staffing structure is comprised mainly of hospital civil servants — is that public hospitals cannot compete on equal terms with the private sector.

Medical and non-medical staff costs in public hospital expenditure

French public hospital expenditure can be split up under four headings: staff costs; medical expenditure; general accommodation and catering; and financial costs (Table 4). Staff costs account for between 66 and 75 per cent of total expenditure while financial costs (amortization, general provisions and provisions for exceptional items) account for between 5 and 10 per cent of total expenditure. Medical and accommodation and catering costs account for 10 per cent and 15 per cent of total hospital expenditure, respectively. Staffing costs, therefore, represent up to 75 per cent of total hospital budgets, while spending directly connected with medical activities amounts to no more than about 10 to 15 per cent (Holcman, 2006a).

9. The transition from global allocations to procedure-based invoicing is gradually being phased in and the proportion of procedure-based invoicing in the financing of the hospitals increases every year.

10. For more information on how tariffs are applied in practice, see Fessler et al. (2003) and Fessler (2007).

Table 5. *Medical and non-medical staff in public health establishments (31 December 2002; except medical staff, 2003)*

Staff category	EFT*	Medical staff (per cent)	Non-medical staff (per cent)	Total (per cent)
Medical staff (2003)	53,340	9.1	—	7.2
Nursing staff	498,770	84.9	—	67.1
Medico-technical staff	35,306	6.0	—	4.7
Total medical and nursing staff	587,416	—	—	79.0
Administrative staff	59,910	—	38.4	8.1
Socio-educational staff	8,795	—	5.6	1.2
Manual and skilled labour	87,350	—	56.0	11.7
Total non-medical staff	156,055	—	—	21.0
Total	743,471	—	—	100.0

* EFT: Equivalent full-time staff.

Source: Cour des Comptes (2006).

In a recent report (2006), the “*Cour des Comptes*” (French Court of Auditors) indicated that 21 per cent of the staff of public health establishments were non-medical staff (Table 5). This is explained by the fact that hospitals usually employ manual labour. The problem lies in the overall volume of non-medical staff and the distribution of this type of staff within the sector. For instance, 38 per cent of the non-medical staff consist of administrative personnel. However, this category also includes medical secretaries, who account for 22,099 (37 per cent of the administrative personnel) out of a total of 59,910 staff in this category. Medical secretaries carry out most of their work in medical care departments and even though they are not part of the medical staff, they contribute enormously to their efficiency.

However, manual (skilled and non-skilled) workers make up more than half the non-medical staff; they are more than one and half times more numerous than medical staff, and two and a half times more numerous than medical technicians. Put frankly, this means that French hospitals employ more than two and a half times the number of staff for building and vehicle maintenance and gardening than they do to operate scanners and laboratory and MRI equipment.¹¹ Paradoxically, in spite of the plethora of maintenance workers, French public hospitals outsource more work every year to private enterprises to carry out tasks that could be done by their own maintenance services. This fact gives even more cause for concern. The explanation for this lies in high levels of trade union membership among the

11. Magnetic Resonance Imaging.

maintenance staff and their strict adherence to job demarcations: lock-smiths do not paint; carpenters do not mow lawns; plumbers do not fix masonry. High union membership among these staff members short-circuits any attempt at rationalizing their work (Holcman, 2006b).

The management culture of hospitals has been influenced by the need for specialists to deal with certain care situations, and this management principle has extended to the numerous sectors involved in hospital activities. The Ministry of Health (DHHO, 2004) has listed no less than 183 professions exercised by hospital civil servants spread over a very wide range — roofers, bricklayers, gardeners, designers, vehicle bodywork repairers — or even more exotic in a hospital environment: dressmakers, hairdressers, beauticians, floor and carpet-layers, landscape gardeners, film and video cameramen, graphic artists, and cultural advisers. Of the 183 listed professions, 135 have nothing to do with treatment.

In the past, hospitals had to deal with scarce resources. Today, the problem is one of rationing: the effect of the strict new budgeting scheme, the SPIE, is further exaggerated by the artificial staff shortage caused by the introduction of the 35-hour working week. The reduction of the working week has automatically led to a reduction in the number of hours worked by full-time staff. It has created a need for increased recruitment, which in turn has increased hospital expenditure (DRSES, 2003).

In this financial context, the public hospital system can no longer pretend that time has stood still and this way of managing human resources — or rather of failing to manage them — cannot continue. As but one measure, and based on the average annual cost of a hospital job (approximately €38,000), a reduction in the total number of staff equivalent to ten posts would cover the purchase price of a basic scanner each year.

Given the budgetary constraints imposed on the hospitals, funds that are used to cover staff costs must be subtracted from those available for new capital expenditure. For instance, the relatively reduced amount of bio-medical equipment available in France confirms that this budget line has been singularly reduced over a long period of time. Faced with the need to choose between various types of expenditure, hospital administrations have rationed the funds allocated to new capital expenditures: buildings, vehicles, bio-medical and computer equipment.

This is one of the reasons why France is ranked ninth among OECD countries for health expenditure in the hospital sector. The 3.6 per cent of GDP that it devotes to this sector compares with 4.1 per cent in the United States, 4.0 per cent in Austria, 3.0 per cent in Germany and 3.4 per cent in Italy. It lags far behind other countries in terms of bio-medical investment and facilities, with only 7.5 scanners per million inhabitants, in contrast to 15.4 per million inhabitants in Germany, 20.6 in Italy and 13.3 in Spain. The same is true of Remote Medical Imaging (RMI) equipment:

France has 3.2 per million inhabitants, compared with 4.9 in Germany, 5.0 in the United Kingdom, 10.2 in Italy and 7.7 in Spain (OECD, 2006).

In the past, hospitals have been responsible for all the tasks involved in their functioning, including laundry, catering, gardening, maintenance, and construction. The staff issue must be seen primarily in this light, but staff issues are frequently seen purely in terms of the employment of medical staff. This does not mean that the proportion of medical staff in the hospital care services is a taboo subject, particularly when comparing staffing levels in public and private establishments treating the same pathologies, but it does mean that this is not the first priority.

It is essential to reduce hospital staff but it must be understood why this has not been done before.

Addressing expenditure on staff costs

Setting aside the idea that public hospital administrators are incompetent — which is clearly not the case — the reason why the issue of expenditure on staff costs has not been addressed before is because it is both socially and sociologically sensitive.

Public hospital administrations see the simultaneous introduction of procedure-based invoicing and massive retirement as a window of opportunity for improving the efficiency and productivity of their establishments. In the meantime, however, the trade unions are focusing on obtaining guarantees that each and every post vacated by a retiring staff member will be filled, while the national health authorities seek to divert attention away from the hospital staffing issue by focusing their action on procedure-based financing.

The social risk

A particularity of the administration of the French public hospital system is that it is, at one and the same time, fragmented and highly centralized. It is fragmented in that there are approximately 1,300 hospitals of various sizes and types, each one led by an administration under a head of establishment. It is centralized in that the vast majority of hospital personnel consist of civil servants administered at the national level by the Ministry of Health; this includes medical practitioners working in hospitals, even though they cannot, strictly speaking, be defined as civil servants. In other words, the administration of health establishments — and in particular of the three-quarters of their expenditure devoted to staff costs — is in the hands of directors recruited by the mayors of the “*communes*” (municipalities) in which the hospitals are located. The staff members themselves, however, are managed at the national level. For instance, staff recruitment is based on competitive examinations wherein the number of available posts is decided by the Ministry of Health.

This means that the directors of public hospitals have everything to lose in a confrontation with a large proportion of the staff they are expected to manage if, at the same time, they are involved in a power struggle with the medical organization over which — and this is well worth repeating — they have little or no control in terms of recruitment. Doctors are in fact co-opted into the French public hospital system by their peers. In theory, the head of the establishment approves all recruitment, including that of doctors, through the head of human resources. In reality, the technological complexity of medical specialization is such that the recruitment process cannot be decided solely on the basis of the written job applications that are presented. Furthermore, heads of establishment who are not consulted and involved prior to recruitment, find themselves in an all-or-nothing situation, obliged either to go ahead with the recruitment or enter into conflict with the medical community of the hospital.

It is easy to understand why, under these conditions, heads of establishment are unwilling to enter into conflict with the non-medical staff directly under their management; as hospital directors managed at the national level by the Ministry of Health, they are also government medical employees. Their professional appraisal and resulting prospects of more or less rapid promotion largely depend on the social climate that they are able to preserve in the hospitals under their management.

A refusal to fill posts vacated following retirement would be viewed as provocation by many staff members — particularly those in the maintenance departments, where trade union membership is highest. In addition, the outsourcing of certain support tasks would increase spending in the short and medium term. Specifically, a temporary overlap between in-house and external teams would have to be financed until all the staff performing the tasks involved retired, leaving them to be carried out entirely by outside enterprises. The issue of staff spending therefore presents a social risk, as well as a risk based on the sociology of the management teams.

The sociology of management teams: Divided responsibilities for expenditure

The primary objective of a hospital is to take care of its patients and to participate in public health and safety campaigns. Secondary objectives may include teaching and research. Moreover, hospitals also — or perhaps above all — play the role of the most important employer in the local community and the most important client for local enterprises. This divergence is reflected in the division of responsibility for expenditure between members of the management team.

As indicated above, public hospital expenditure is split between four different financial sectors: staff costs (70 to 75 per cent of total expenditure); medical expenditure (10 to 15 per cent); general catering and accommodation costs (10 to 15 per

cent); financial costs (5 per cent). The staffing budget and related costs are administered by the head of human resources in close cooperation with the hospital’s general manager. This issue is of vital concern to both trade unions and staff representatives and is watched closely by joint bodies¹² within the management structure, as it is by the general manager. General accommodation and catering costs, mostly comprising heating, food, supplies, cleaning, are the responsibility of the head of purchasing and supplies — or, in a few cases, the head of finance. It is worth noting that certain medical supplies (for instance, prostheses, probes and implants) are included in the responsibilities of the latter category. Costs connected with equipment, investment and building are the responsibility of a director assisted by three (bio-medical, construction, computer) engineers. In some establishments, overall responsibility may lie with the relevant engineer (Holcman, 2007a).

The head of finance is left with the responsibility for the remaining items: medical expenses, the hospital treasury, and amortization and other financial provisions. Consequently, and in spite of the overwhelming importance of staff costs in hospital budgets and the maintenance in-house of activities that are peripheral in terms of the central mission of health establishments, this is why financial discussions frequently focus on the activities of the departments that provide treatment, which are often the first to come under financial pressure.

A hospital general manager who wishes to emphasise the need to reduce staff faces the risk of creating conflict within his or her own team — particularly between the head of human resources and the person responsible for finance — while at the same time, and in all likelihood, inciting trade union criticism. It is understandable that under these conditions the issue of hospital staffing is not given higher priority by hospital management. Nevertheless, this is also why every opportunity to reverse this situation is so precious. Significantly, one such opportunity now presents itself.

A historical opening

Demographic changes are having an enormous effect on the staff of the public hospital system and this trend will become even more marked in the coming decade. This is illustrated by demographic forecasts for the period up to 2015 (DHHO, 2003). From 1999 to 2015, the public hospital system will lose nearly 55 per cent of its current staff. During this period, the administrative sector will lose 57 per cent of its staff, the medico-technical sector 50 per cent, the care sector 56 per cent and the technical maintenance and manual sector 58 per cent (Table 6).

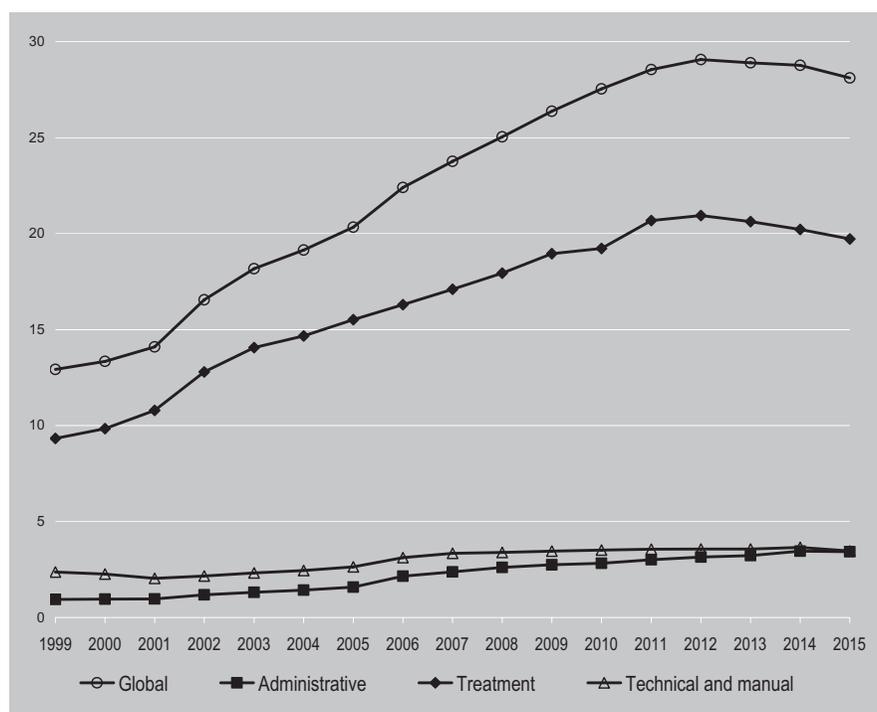
12. The management of government employees (evaluation, promotion, mobility, discipline etc.) is in the hands of a special body, the bi-partite administrative commission, composed equally of representatives of the administration and of elected staff representatives. Invariably, administrative commission recommendations are implemented by human resources departments.

Table 6. *Planned retirement of staff in the public hospital sector (1999-2015)*

Area of work	Planned retirement	Planned retirement (per cent)	Of total staff employed in 1999* (per cent)
Administrative	37,352	9.7	5.32
Medico-technical	15,437	4.0	2.20
Treatment	279,418	73.0	39.80
Manual and skilled labour	50,899	13.3	7.25
Total	383,106	100.0	54.57

* In 1999, the total number of government employees working in hospitals was 702,032.
Source: DHHO, 2003.

Figure 1. *Timing of departures on retirement — globally and by sector (in thousands)*



As shown in Figure 1, the absolute number of departures will reach its peak in 2012, with 30,000 staff retiring in that year, including 20,000 in the care sector alone. The highest number of departures in 2013 will be in the technical maintenance and manual sector while in 2014 it will be highest for the administrative sector. In other

Table 7. *Planned retirement among manual and skilled workers (1999-2015)*

	Planned retirement	Planned retirement (per cent)	Planned retirement among all employees in the professional category (per cent)
Total	50,899	100	—
<i>Including:</i>			
Maintenance staff	6,121	12.0	45
Skilled workers	26,717	52.5	55
Highly-skilled workers	8,410	16.5	78
Foremen	4,183	8.2	85

words, France has less than one decade to act upon this essential lever in hospital expenditure and in which to fully implement major hospital reforms: procedure-based invoicing, re-structuring of the establishments in clusters, and planned income and expenditure statements (SPIE).

The surplus of manual and skilled workers among French hospital staff makes their replacement with outside operators a top priority. No less than 60 per cent of these employees will retire between now and 2015 (Table 7). In order to guarantee continuing care and the continuity of hospital services, mobile and multi-skilled maintenance services will have to be maintained in each hospital. As indicated in Table 7, the groups of manual and skilled workers that will be most affected by retirement will be maintenance workers (12.0 per cent of this sector), skilled manual workers (52.5 per cent), highly-skilled workers (16.5 per cent) and foremen (8.2 per cent).

If we now take a look at the establishments where these changes will occur (Table 8), we can see that the hospital centres and regional hospital centres, which account for 55 per cent of the 1,084 public health establishments, employ 83 per cent of the civil servants employed in hospitals. In contrast, the specialized hospital centres and local hospitals, which constitute 41.5 per cent of the total number of establishments, employ 16.7 per cent. The highest number of retirees will therefore be drawn from a limited number of hospitals.

At the same time, a drop in the number of qualified doctors leaving university and the large number reaching retirement age will lead to a reduction in the number of doctors per 100,000 inhabitants at the beginning of this period. Their numbers will fall by about 15 per cent from 335 in 2002 to 283 in 2025, a level similar to that of the 1980s. The number of ophthalmologists, psychiatrists and ear, nose and throat specialists are those likely to be most affected (Bessière, Breuil-Genier and Darriné, 2004). As such, the fall in the number of general practitioners should be less marked.

Table 8. *Civil service hospital staff (CSHS), by type of establishment*

Type of establishments	Number of establishments	Establishments (per cent)	CSHS (per cent)
Regional hospital centres ¹	31	2.8	35.1
Hospital centres	563	52.0	47.8
Specialist hospital centres ²	97	8.9	11.9
Local hospitals	355	32.7	4.8
Other establishments	38	3.5	0.4
Total	1,084	100	100

¹ Almost all are also university staff, described as "CHRU" (Regional University Teaching Hospitals).

² Psychiatry.

Source: DHHO, 2003.

The difference compared with the situation that has prevailed up until now lies in the concentration of these changes, both in terms of time and space. Furthermore, the simultaneity of these demographic trends among the medical personnel — affecting both doctors and nursing staff — makes it difficult to synchronise the action that must be taken at the hospital level. As we have seen, the decentralization of decisions not to fill posts left vacant on retirement prevented such action at the local level. However, the concentration of departures over a limited period of time in a smaller number of establishments makes it easier to envisage the centralized management of departures and of decisions to recruit — or not — new staff. Centralized management of this kind could certainly be introduced through the "*Agences régionales de l'hospitalisation*" (regional hospital agencies).

There is thus nothing to prevent the creation of a fund to ease the transition period — not least when there is a temporary overlap between in-house teams and out-sourcing — or to prevent negotiation at the national level concerning the conditions for non-renewal of jobs vacated through retirement, which would make possible changes that cannot be realized at present at the local level. This alone would lead to substantial economies in French public hospitals, without jeopardizing the amount and quality of the care they provide; quite the contrary.

Conclusion

Taking all current and emerging challenges into account, the French public hospital system cannot continue to operate with a staff structure that dates back to the 1960s. One suggestion is for health establishments to consider the advisability of preserving the following activities in-house: cleaning; laundry; security; catering; beauty care (hairdressers, beauticians); transport; construction; the

maintenance of electrical and electronic systems and heating and plumbing installations; vehicle repairs; refuse collection; gardening; communication; cultural activities; computer development and data production; and ICT networks and telecommunications. In the long term it might also be worth considering whether it is worthwhile maintaining in-house facilities for increasingly technical functions such as purchasing and supplies, financial control and audit, treasury management and legal advice.

In the interim and while awaiting other possible developments, the means already exist within establishments to set about changing the relative importance of staff costs to other costs. Provided that current staff are guaranteed employment until they reach retirement age, and that mobile teams are created to provide round-the-clock technical support, it should be feasible to transfer tasks such as gardening, maintenance work and internal communications to outside companies. Many establishments have already out-sourced certain activities such as the preparation of meals or laundry. The question is why more has not been done?

The aim of this article is not to castigate certain types of staff or to suggest that civil servants should be denied the career contracts they have been guaranteed. The question is whether hospitals should still engage in multiple activities not directly linked with their overriding mission: the treatment of patients (Holcman, 2007b). The level of public expenditure on hospitals and the importance of the hospital system in terms of overall social security expenditure is such that these funds must be effectively deployed. Public hospitals offer an unequalled service; they provide direct and almost free access to the best medical care available in the country, since the best doctors in France practise within the public hospital network. However, current financial constraints are slowly suffocating the public hospital system. Only by finding more financial room for manoeuvre will it be possible to guarantee the long-term viability of this universal health service, which has rarely — if ever — been equalled in the industrialized world.

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