Hospital Payment Reforms in France

Why, how, and is it working?

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Outline and objective

- Overview of the health system in France
- Key features of the Hospital System
- Why and how DRGs came about
- Key features of the DRG system
- Assessment
Sorry this was not complete! I like to give a road map in a presentation and explain how the presentation is pitched in a sentence - I put something in the comments section but you can say something else or nothing.
French health system (1)

- Two-tier health insurance model that guarantees universal (since 2000) access to a comprehensive basket of goods and services
  - Public Social Health Insurance (SHI) provides comprehensive basic coverage and pays for three quarters of the total health expenditure
  - Optional complementary coverage: provided mostly by private non-profit insurers and covers about 15% of total health care costs. (Free complementary coverage available to the poorest and subsidy for the near-poor)

- Financial governance of the health system is shared between the government and health insurance funds
  - The government: sets annual financial targets to limit the expenditure of SHI (separate targets for ambulatory, hospital, social/long term care)
  - The SHI fund: defines the benefit baskets, sets tariffs for health professionals, regulates the prices of procedures, drugs and devices, and defines the levels of co-payment
French health system (2)

- Health care provision relies heavily on private providers
- Ambulatory care is mainly provided on a private, and usually solo, practice basis (but GP group practice is rapidly growing)
- Inpatient care is delivered by public, as well as for-profit and non-profit private hospitals
- More than 50% of all surgery and one fourth of obstetric care is provided by private-for-profit hospitals
- Patients can freely choose between public and private providers without requiring a referral
France has relatively good health outcomes.
But health expenditure is growing unsustainably

Total expenditure on health (% gross domestic product)
The Hospital System (1)
Overview

Hospital sector in broad financial terms
- Represents 44% of the consumption on medical goods and services
- 2/3 of this expenditure is incurred in public hospitals and 1/3 in private hospitals
- 90% of hospital expenditure is financed by SHI (5% by private insurers, 3% by households) – and the order of magnitude is comparable in public and private sector

Organization of sector
- Since 90ies, the tradition of top-down norm-based planning of the volume and distribution of inputs (hospitals, beds, specialized expensive equipment) slowly replaced by more autonomous decision-making at the regional level based on needs
- Since 2009, the newly created regional health authorities (ARS) are supposed to monitor and improve the territorial distribution and coordination of supply (public, private, from prevention to tertiary hospital care) and distribute resources accordingly
The Hospital System (2)

Activity (data from 2007)

- Traditional inpatient stays: 11.7 million stays
  - Acute care (10.2m) versus rehabilitation/long term care/psychiatric (1.5m)
  - Acute care represents 50% the beds
- Partial hospitalizations:
  - Day or night hospitalization (psychiatry), ambulatory surgery (13.3m),
  - Home-based hospice care (0.1m)
- Other hospital-based activities:
  - Outpatient visits (33m)
  - Emergency services (16.4m contacts)
  - Ambulatory treatments (16m “sessions”: chemo, dialysis, radiotherapy)
Overview of hospital activity, 2007

- **Inpatient care**
  - Rehabilitation (~1.6 millions)
  - Psychiatric
  - Acute care (10.2 millions)

- **Ambulatory**
  - Day hospitalisation
  - Night hospitalisation
  - Ambulatory surgery (13.3 millions)

- **External acts**
  - Outpatient visits (33 millions)
  - Outpatient treatments (dialysis & chemotherapy) (16 millions)

Alternatives to full hospitalisation
Other forms of hospitalization
Hospital System (3)
Public and private mix

- Public sector:
  - 65% of acute beds,
  - obligation to provide 24h emergency care, to accept all patients and participate to public health activities
  - Compete with private for surgery but remain reference for complex procedures

- Private for profit sector:
  - 25% of acute beds
  - provides nearly half of inpatient surgery and 70% of ambulatory surgery

- Private not-for profit: mostly medium LT care and comparable to public for acute care (hence not discussed further in this presentation)
Some comparisons

<table>
<thead>
<tr>
<th></th>
<th>France</th>
<th>EU members</th>
<th>CIS before 2004</th>
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<tbody>
<tr>
<td>Number of beds per capita</td>
<td>709</td>
<td>539</td>
<td>830</td>
</tr>
<tr>
<td>Number of acute beds per capita</td>
<td>360</td>
<td>360</td>
<td>793</td>
</tr>
<tr>
<td>ALOS per capital</td>
<td>5.75</td>
<td>6.71</td>
<td>10.78</td>
</tr>
<tr>
<td>Occupancy</td>
<td>76%</td>
<td>76%</td>
<td>85%</td>
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<tr>
<td>Acute admissions per 100 per year</td>
<td>16.5</td>
<td>15.5</td>
<td>20.8</td>
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Hospital payment system(1)
Historic perspective

Public sector:
- In 1983, per diem was replaced by Global Budget
- Around the same time, the idea of moving to DRGs payments was floated for the first time
- An information system was progressively set up, first on a voluntary basis among public hospitals to document their activity (1986)
- DRG Data (activity) mandated for all public hospitals since 1996 and increasingly used to adjust global budget

Private sector:
- Complex itemized billing consisting of per diems and several types of fees for services and fixed payments for inputs
Hospital Payment System (2)

Historic perspective

- Idea of moving to DRG-based payments was very controversial in 1990s, but there was a consensus on its merits in early 2000

- DRG based payment expected to
  - Increase the efficiency and fairness of funding (linked to activity, rather than historical costs)
  - Improve transparency of hospital activity and funding
  - Create a level-playing field between public and private sector (*read: increase competition*)
  - Contribute to modernizing management
Hospital Payment System (3)
Introduction of DRG-based system for acute care

• In 2002, the move to DGR-based payments was announced for an implementation in 2004/05
• Introduced progressively in public hospitals from 10% of payments in 2004, 25% in 2005 to 100% in 2008
• Private hospitals paid entirely by DRGs since 2005, but during a transition period (until 2012), the prices are adjusted to reflect each hospitals’ historic cost pattern to avoid large adjustments
Hospital Payment System (4)
All funding is not linked to DRG

- Public hospitals receive additional payments to compensate for specific ‘public missions’:
  - education, R&D, activities of general interest (e.g. developing prevention)
  - Investments in infrastructure (legal obligations)
- Cost of maintaining emergency care paid by fixed yearly grants + FFS taking into account the yearly activity of providers
- Restricted list of expensive drugs and medical devices is paid retrospectively (actual level of prescription)
  - Expenditure on these drugs & devices increased by 37% between 2005-2007
Payments based on DRGs

- In 2008 DRGs payments represent 56% of hospital expenditure

![Pie chart showing payment sources]

- 56%: DRG-based payment
- 27%: Lump-sum payments for "public missions" (teaching, emergency)
- 10%: Global Budgets (rehab, psychiatry, LT care)
- 6%: Additional Drugs and Medical Devices
- 16%: Other services
Outline

- Overview of the health system in France
- Key features of the Hospital System
- Why and how DRGs came about
- Key features of the DRG system (nuts and bolts)
  - DRGs
  - External quality control
  - Prices
  - Macro control
- Assessment
Diagnostic related groups (1)

- The grouping of diagnostic evolved over time
  - The 1986 version was inspired from the HCFA-DRG (450 DRGs)
  - Complications and co-morbidity were added as well as specific DRGs for ambulatory surgery and procedures
  - The latest and 11th version was introduced in 2009. It associates up to 4 degrees of severity to 606 “base cases” to make up a total of 2,297 DRGs (the previous version had a total of 784 DRGs)
  - The “severity” level depends on the type of co-morbidity associated with the main diagnosis, the LOS and in some cases the patients’ age (below 2, above 69)
Diagnostic related groups (2)

- The grouping is being developed and updated by an independent technical agency which uses data from:
  - the (now) national and unified, public and private hospital activity and diagnosis recording system
  - A cost database from a sample of 99 hospitals (private ones were introduced in 2006) which represent 13% of all stays
  - The costs per DRG is updated annually with a lag (2009 cost data was analyzed in 2010 and reflected in 2011 prices)
Diagnostic related groups (3)

- Within the hospital, the classification of patients is based on
  - administrative data (age, gender)
  - clinical information recorded by physicians:
    - primary and other diagnoses (ICD-10)
    - procedures undertaken (eg surgery)
- Clinical information is collected in each department the patient is admitted in and, upon discharge from that department, transmitted to a medical information department which consolidates and uses a software / algorithm to select the relevant DRG upon final discharge
- The medical information department conducts internal validity checks and audits (a software checks the consistency and plausibility of the information reported)
External quality control

- External audits are carried out by the health insurance fund and regional health authorities
- Main issues: Up-coding particularly for procedures carried out on an outpatient basis
- Between 2006-09, 77% of hospitals were audited at least once and among these half more than once
- 2009: 331 hospital controlled, 126,000 files reviewed, 42% had anomalies, half of hospitals had to give money back (aggregate €19m)

- Sanctions include reimbursement to SHI (vast majority of cases), penalties, and legal action
Price setting

- DRG prices (tariffs) are set annually at the national level based on average costs
- The objective is to have comprehensive DRGs which include all cost categories (capital costs are for the most part included)

**HOWEVER**

- Two different sets of tariffs:
  - Public (and PNFP): cover all costs linked to a stay
  - Private: Do not cover fees paid to doctors (paid on a FFS basis from the ambulatory care budget)
- Many other differences, eg “Off-DRG” capital allocation for public sector

**Price convergence** announced for 2012, now postponed till 2016
- Private hospitals lobbying heavily for this “to save French health system”
- Public hospitals claim that there are factor that they cannot control for reducing their costs (scope of services, size, inputs, etc.)
- Lack of transparency of hospital cost data is a problem
Macro-level price/volume control

- To contain hospital expenditure, macro expenditure-targets for acute care are set by the parliament (separate for public and private)
- If the actual growth in volume exceeds the target in year n, the MoH can, and does, adjust the tariffs down in year n+1
- This mechanism creates confusion and an extremely opaque environment for hospitals (to predict their revenues)
- Prices are set as a function of changes in global activity independent of individual hospitals
Evaluation (few official evaluations)

- Efficiency has not improved within hospitals (some transfer of activity across hospitals and mergers)
- MAIN PROBLEM: Opacity of the method for setting tariffs - severely criticized by Auditor General
  - resulting unpredictability of resources for hospitals which are only loosely linked to activity
  - Destabilizing and counterproductive
- Concerns about convergence between public and private
- Perverse incentives of actual macro-control mechanism
To Conclude

- Incentive system is ... complex
  - Incentive to up-code = yes!
  - Incentive to produce more? Not clear since the price might be adjusted downward in the next year
  - Incentive to be more cost-efficient? Autonomy on cost control remains limited in the public sector (staff salaries, hiring and firing). In 2007, 1 in 3 public hospital reported a deficit. (Private hospitals are doing better)
- No information about quality (yet)
- Inconsistency in overall regulatory framework: lack of purchasing capacity for regional health authorities
References

- EuroDRG Project: [http://www.eurodrg.eu](http://www.eurodrg.eu)
- *Health Policy Monitor* [http://hpm.org/](http://hpm.org/) (Or and Couffinhal on Hospital payment reforms)