Hospital payment reform in France

OECD, Nov. 22, 2011

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Hospital payment reform in France

Activity -based payments for acute hospital care, introduced by Social security financing Act for 2003, with progressive implementation from 2004.

Before, 2 payment methods:

- Global budgets for *public hospitals and not-for-profit private hospitals* fulfilling some "obligations", based on past spending + growth rate;
- "fee-for-service" for *for-profit hospitals* with per diem for the hospital and fees for doctors. Per diem were set by negotiation between ARH and hospital associations at regional level.

Both subject to macro-envelops defined each year by the Parliament and the government.

Sources for the whole presentation:
- Ministère de la santé, Rapport 2010 au Parlement sur la T2A
- Or & Couffinhal (2011) Hospital Payment Reforms in France : Why, how, and is it working?, Presentation.

Hospital payment reform: objectives

Tarification à l'activité (**T2A**), implemented with **three objectives**:

- Enhance transparency and fairness in hospital funding by linking payments to activity;
- Create a level-playing field between public and private sector with a unique price for a given service;
- Increase the efficiency of individual providers and of the system.
- (NOT to increase activity)

- Scope: Acute hospital care (MCO), dialysis and hospitalisation at home, i.e only a share of hospital financing (≈ 60%)

Source: Or & Couffinhal (2011) Hospital Payment Reforms in France : Why, how, and is it working?

Hospital payment reform: implementation

"Public" and "private" sectors treated differently

For public and private hospitals formerly financed by global budget (69% of acute care admissions):

- Progressive implementation of T2A: 10% of activity in 2004, raised to 50% in 2007 and 100% in 2008;
- Price per GHS (French equivalent of DRG) is all inclusive

For private hospitals formerly paid by per diem (31% of acute admissions)

- One-step implementation in 2005
- Physicians' fees not included in DRG prices

Price convergence between sectors initially planned for 2018.

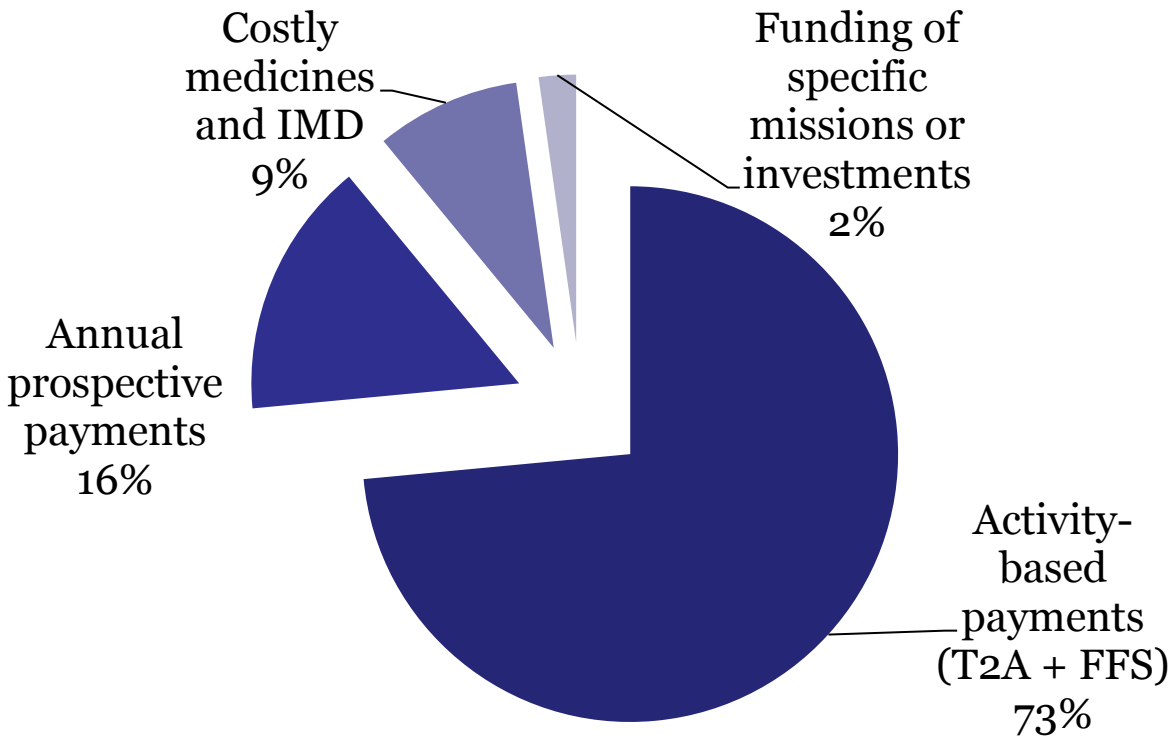
- Progressive implementation (e.g. in 2010, unique price for 21 GHM and "close prices" for 14)

Hospital financing mix

- **T2A** (DRG –based payments);
- **Fee-for-service** for outpatient care;
- **Annual prospective payments** for specific activities, such as emergency services, and organ transplantation;
- **Retrospective payments for very-costly drugs** and implementable medical devices (whose prices are regulated)
- **Financing of missions of general interest and "contracts" (MIGAC)**, such as teaching, specific contribution to public health plans (e.g. reference centres for cancer or palliative care) or investments, new activities, or help to achieve a balanced budget.

Mix of hospital financing in 2010

(for activities and hospitals financed through T2A)



Source: Ministère de la santé et des Sports, Rapport 2010 au Parlement sur la T2A.

Definition of DRG prices

- National **study on costs** on sample of public and private hospitals (ENCC, lead by ATIH)
- Definition of a **Resource-based relative value scale** with relative costs for each DRG
- Consideration of the **macro-economic budget constraint and predicted volumes**

➔ Definition of "initial" prices per DRG

- Introduction of **economic incentives** to encourage the development of activities (e.g. cancer care, palliative care, ambulatory surgery)

➔ "Reference prices" for each DRG

- Consideration of individual hospitals' situations to establish "hospital-specific prices" smoothing the impact on hospitals revenues but converging each year to the reference price

➔ Final price/DRG for each hospital (expected to converge in 2012 to single price for each sector)

Impact of macro-level spending cap on prices

Macro-level price/volume control

- Macro expenditure-targets for acute care are set by the parliament (separate objectives for “public” and “private”)
- If actual growth in spending exceeds the target in year n, the MoH can, and does, adjust the tariffs down in year n+1
- Prices are set as a function of changes in global activity independent of individual hospitals

Impact of T2A reform

On activity (trend 2008-2009)

- Slight increase in number of admissions (+1.36% in 2009)
  - More marked for ambulatory care (+3.14%)
- Reduction in total number of days (i.e. slight reduction of ALOS)
- Impact of specific incentives, e.g.:
  - Ambulatory surgery increased by 13%
  - Reduction in palliative care (due changes in coding)

Impact on hospital spending

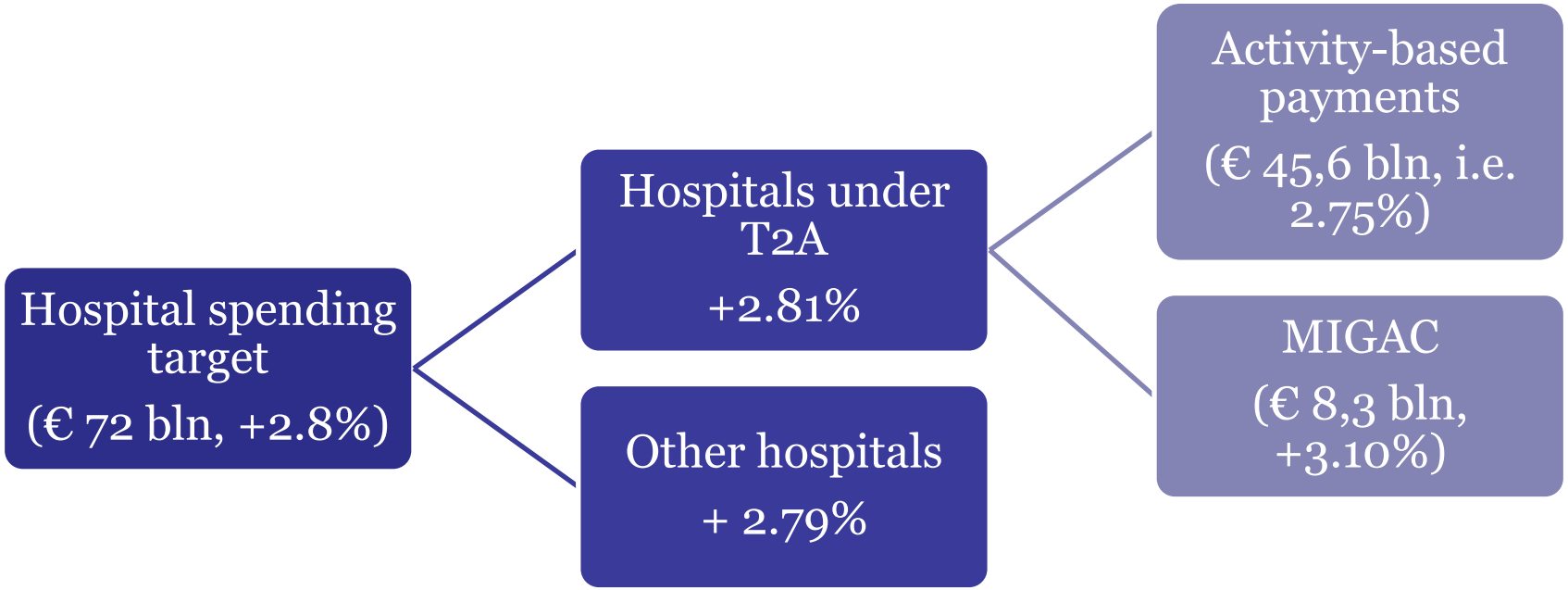
Years	Objective	Actual spending	Excess	Actual growth (% over last year)
1997	43.4	43.3	-0.1	1.0
1998	44.2	44.1	-0.1	1.8
1999	45	44.9	-0.1	1.7
2000	46.2	46.3	0.1	3.2
2001	47.8	48	0.2	3.6
2002	50.2	51.2	1.0	6.3
2003	53.6	54	0.4	5.5
2004	56	56.4	0.4	4.5
2005	60.9	61.7	0.8	4.4
2006	63.7	63.5	-0.2	3.0
2007	65.7	65.3	-0.4	3.0
2008	67.7	67.7	0.0	3.9
2009	69.6	70	0.4	3.6
2010	71.2	70.84	-0.4	2.0

Impact of T2A reform

On financial situation of hospitals

- Revealed low-productivity of some hospitals
- Worsened the financial situation of many hospitals (also due to "relatively low" national spending growth objectives)
  - ⇨ contracts with ARS to achieve balanced budgets (with the possibility for ARS to take over administrative power in case of failure) [national objective set in 2008 to achieve balanced budgets in all hospitals]

Spending targets for 2011 and impact on prices/DRG



Activity paid by T2A:

Predicted growth of volumes: +2.4%

⇨Average price changes:

-0.83% for « public » hospitals prices

-0.05% in « private » hospitals prices