Strategies to control health care expenditure and increase efficiency: recent developments in the French health care system

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November 2011
In the recent years France has been more successful than previously in controlling the rate of growth of health care expenditure.

Examples of steps that have been taken:

- New mechanisms and governance to ensure the compliance with financial constraints
- Price regulation and efficiency gains as the main levers of the control of HC expenditure
- Innovations in collective agreements with HC professionals: example of the P4P scheme
A better control of health care expenditure in the recent years

Average annual growth rate of per capita expenditures (national currency unit)

<table>
<thead>
<tr>
<th>Country</th>
<th>Average Annual Growth Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switzerland</td>
<td>3.0%</td>
</tr>
<tr>
<td>Italy</td>
<td>5.0%</td>
</tr>
<tr>
<td>France</td>
<td>9.0%</td>
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<tr>
<td>Hungary</td>
<td>4.0%</td>
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<tr>
<td>Germany</td>
<td>2.0%</td>
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<tr>
<td>Belgium</td>
<td>6.0%</td>
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<tr>
<td>Austria</td>
<td>8.0%</td>
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<tr>
<td>Finland</td>
<td>10.0%</td>
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<tr>
<td>Sweden</td>
<td>12.0%</td>
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<tr>
<td>Ireland</td>
<td>14.0%</td>
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<tr>
<td>Luxembourg</td>
<td>16.0%</td>
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<tr>
<td>Israel</td>
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<tr>
<td>United States</td>
<td>20.0%</td>
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<tr>
<td>Canada</td>
<td>22.0%</td>
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<tr>
<td>Norway</td>
<td>24.0%</td>
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<tr>
<td>Denmark</td>
<td>26.0%</td>
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<tr>
<td>Spain</td>
<td>28.0%</td>
</tr>
<tr>
<td>United States</td>
<td>30.0%</td>
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<tr>
<td>Mexico</td>
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<tr>
<td>Slovenia</td>
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<tr>
<td>Netherlands</td>
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<tr>
<td>Iceland</td>
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<td>Czech</td>
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<td>New</td>
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<td>Korea</td>
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<td>Chile</td>
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<tr>
<td>Slovak</td>
<td>50.0%</td>
</tr>
<tr>
<td>Estonia</td>
<td>52.0%</td>
</tr>
</tbody>
</table>
1. **Mechanisms and governance to ensure the compliance with financial constraints** [1]

1. **1996 reform**

   The Parliament annually sets a projected target (ceiling) for health insurance spending for the following year, known as the national ceiling for health insurance expenditures (*objectif national des dépenses assurance maladie*);

   The target was met the first year (1997) but not the subsequent years.

2. **New steps taken in 2004 :**

   1. *alert committee* giving an independent advice on the forecasts
   2. if the ceiling is expected to be exceeded by more than 0,75%, **SHI has to propose measures** to make savings
   3. 6 months delay to implement tariffs increases
1. Mechanisms and governance to ensure the compliance with financial constraints [2]

3. New steps taken in 2008 and 2010 (report of a task force)
   1. New governance, better monitoring, increased intervention of the alert committee
   2. Threshold → 0,5%
   3. New tools: amounts set aside (part of hospital budgets), tariffs increased canceled in case of alert
Evolution of the annual ceiling (in absolute terms and growth rate) – the size of the circles indicate the amount of expenditure in excess (in blue) or below (in grey)
2. Main levers of the French control of health expenditure [1]

1. Regulation of prices
   - Drugs: price decrease of 11% in the last five years
   - Radiology: -9% between 2007 and 2011
   - Lab tests: -13% between 2008 and 2011
### Public expenditure - pharmaceuticals

<table>
<thead>
<tr>
<th>Month</th>
<th>Value</th>
<th>Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 99</td>
<td>0.90</td>
<td></td>
</tr>
<tr>
<td>Jan 00</td>
<td>1.10</td>
<td></td>
</tr>
<tr>
<td>Jan 01</td>
<td>1.30</td>
<td></td>
</tr>
<tr>
<td>Jan 02</td>
<td>1.50</td>
<td></td>
</tr>
<tr>
<td>Jan 03</td>
<td>1.70</td>
<td></td>
</tr>
<tr>
<td>Jan 04</td>
<td>1.90</td>
<td></td>
</tr>
<tr>
<td>Jan 05</td>
<td>2.10</td>
<td></td>
</tr>
<tr>
<td>Jan 06</td>
<td>2.30</td>
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</tr>
</tbody>
</table>

The chart shows an increase in both value and volume over time.

**Drugs:** Price reduction + slowdown of volume

### Public expenditure – laboratory tests

<table>
<thead>
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<tr>
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The chart shows an increase in both value and volume over time.

**Lab tests:** Price reduction, rapid growth of volume
2. Main levers of the French control of health expenditure [2]

1. Regulation of prices
   - Drugs: price decrease of 11% in the last five years
   - Radiology: -9% between 2007 and 2011
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2. Efficiency gains: slowdown of drug consumption, increase of generic substitution, development of ambulatory surgery (although our performance could be higher in these two fields), better control of sick leave expenditure,…
Efficiency gains

Annual growth 2006 – 2009, in standard units per inhabitant (data IMS health)

Generic substitution, 2004-2011

Number of sick days, 1997-2010
Numerous efficiency programs have been developed over recent years (role of NHI as purchaser of care in 2004, new Regional health agencies with broad responsibilities in 2009)

- academic detailing and information feedback to health care professionals to promote quality of care and efficient practices,
- development of guidelines,
- disease management programs,
- outreach campaigns towards patients, information, web services (choice of provider, promotion of prevention,…),
- prior authorisation for targeted hospitals (ambulatory surgery, rehabilitation,…),
- design of financial incentives for health care professionals (payment for performance),
- Promotion of cost-effective services for patients discharged from acute care hospitals, …
Combining tools to achieve results – 3 examples (1)

Improving the health status of diabetic patients & the quality of care, preventing complications

- P4P → guidelines on the follow up of diabetic patients
- Mass disease management program → patient driven strategy
- Development of therapeutic education (financing + supply)
Combining tools to achieve results – 3 examples (1)

Developing generic substitution

Collective agreement with pharmacists → Individual targets

Repeated visits of pharmacists with a low substitution rate by NHI representatives

Financial incentives for patients (threat of advancing drug costs)

+ alignment of margins (avoid perverse financial incentive)
Achievement: a rapid increase of generic substitution between 2004 and 2009

Visits by HI representatives and HI pharmacists targeted towards pharmacists with a low substitution rate + financial incentives for patients (third party payer)
Combining tools to achieve results – 3 examples (1)

Better use of physiotherapy in ambulatory care

- Guidelines
- Prior authorization linked to guidelines (thresholds)
- Control of professionals with excessive prescription
Variations in the average number of sessions of physiotherapy in ambulatory care for the same surgical procedures (carpal tunnel syndrome, hip replacement) : from 1 to 4

→ Prior authorisation above a threshold depending on the medical situation
2. Main levers of the French control of health expenditure [3]

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3. + increase in cost-sharing requirements (paid by complementary health insurance or patients) (about 1/5th of total savings in the last 5 years, according to the High Council on the future of health insurance)
3. Innovations in collective agreements with HC professionals

Negotiation of efficiency targets, performance measurement and benchmarking, academic detailing

HI practitioners (physicians, pharmacists, dentists) and HI representatives (since 2004) visit health professionals, giving them information on their practices and promoting efficient prescribing.

Examples of information feedback and tools for GPs
Some academic detailing efforts have been successful, e.g. statins

Expenditures on statins prescriptions

Beginning of the program

- Some academic detailing efforts have been successful, e.g. statins.
3. Innovations in collective agreements with HC professionals

- Development of a P4P component in the payment of physicians

- First pilot in 2009: CAPI (contrat d’amélioration des pratiques individuelles)
  - A new step: collective targets → individual targets → P4P (baseline = wide variations in practice)
  - Individual contracts, subscribed by GPs on a voluntary basis → 40% have subscribed
  - 16 indicators, mostly process measures, in 3 fields: Prevention (immunisation, cancer screening,…) / Follow up of chronic care patients (diabetes, hypertension) / Efficiency of drug prescription (prescription of generics)
3. Innovations in collective agreements with HC professionals

The baseline: Practice variability among French GPs

Distribution of French GPs according to % of their diabetic patients having 3 or more HBA1C tests during the year in the last 12 months - 40% for the average physician, target: 65%
3. Innovations in collective agreements with HC professionals

**Results after 2 years** (June 2011)

- **More improvement for contracting GPs** (statistically significant for all indicators) as compared to non contracting GPs

- For some indicators, the difference is important, e.g.:
  
  - **% of patients with 3 Hb1C controls per year**: + 7 points vs + 2 points for non contracting GPs (level achieved in June 2011: 47% on average vs 42%)
  
  - **% of statin prescription for diabetic patients with high cardiovascular risk**: + 5 points vs + 3 points (59% on average vs 56%)
  
  - **% prescription of generic PPIs**: +1 point vs -7 points
The 2011 Act on social security has allowed the contract to be integrated in the new collective agreement.

The agreement has been signed in July 2011 and P4P is now part of the basic remuneration of physicians.

New indicators have been developed, with:

- an emphasis on outcomes (level of Hb1C, blood pressure,…),
- and a new field “Practice organisation”: use of EMR, use of a software labelled by HAS for prescribing, electronic exchanges with NHI, information for patients, annual synthesis of the medical record

Although the scheme is more developed for GPs, it now includes specialists as well.
3. Innovations in collective agreements with HC professionals

Other collective agreements → selective contracting

- Professionals cannot set up their practice in the areas where the density is already very high
- They have incentives to set up their practice in underserved areas
- First profession involved = nurses, now physiotherapists
Conclusion

- France has succeeded in controlling health care expenditure in the recent years
- However there are still important efficiency gains that could be made in the system, as in all countries
- Development of new efficiency programs (better organisation, territorial levers with the Regional Health Agencies)
- Challenge of the professionalization of the health care system management, necessary to achieve our objectives
- Growing focus on the process of care - Need for more economic evaluation and health technology assessment