Activity based payment in France

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The French hospital system is characterized by a wide choice of public and private providers. More than one third of all inpatient care and 56% of all surgery are provided by private for-profit hospitals. Patients can choose freely between public and private hospitals. Activity based payment (ABP) was first introduced in 2004/ 2005 to pay for acute care services (including home hospitalization) with the objectives of improving efficiency; creating a 'level playing field' for payments to public and private hospitals; improving the transparency of hospital activity and management; and improving quality of care. Before the ABP, two different funding arrangements were used to pay public and private hospitals. Public and most private not-for-profit hospitals had global budgets, mainly based on historical costs, while private for-profit hospitals had an itemized billing system with different components: daily tariffs covering the cost of accommodation, nursing and routine care; and separate payments for each diagnostic and therapeutic procedure carried out, with separate bills for costly drugs and physicians' fees. The implementation of ABP has been progressive. In public hospitals, the share of all activities paid by the ABP has increased gradually each year: from 10% in 2004 to 25% in 2005 and reaching 100% in 2008. Private for-profit hospitals have been paid entirely by the ABP since February 2005. A transition period is in place until 2012, where 'national prices' are adjusted for each provider, taking into account its own historical costs/prices.

Patient classification

Under the ABP system, the income of each hospital is linked directly to the number and case-mix of patients treated as defined in terms of homogeneous patient groups (GHM, *Groupe Homogène des Malades*). The classification system used in France was inspired by the US Health Care Financing Group classification (HCFA-DRG) but adapted to the French system. Assignment of patients to GHM is based on the primary diagnosis as well as on any surgical interventions provided. Data on age, length of stay and mode of discharge (death, transfer) are used to define case severity. The current version (v11) of the GHM classification, which was introduced in January 2009, accounts for 2291 groups compared with 784 in the previous version.

Price setting

The GHM prices (tariffs) for each service are set annually at the national level based on average costs. Nevertheless, there are two different sets of tariffs: one for public (including private-non-profit) hospitals and one for private for-profit hospitals. The initial objective of achieving price convergence between the two sectors in 2012 was recently pushed back to 2018. Cost calculation methods underlying the prices and what is included in the price differ between the public and private sectors. The tariffs for public hospitals cover all of the costs linked to a stay (including medical personnel, all the tests and procedures provided, etc.), while those for the private sector do not cover medical fees paid to doctors (which are paid on a feefor- service basis) and the cost of biological and imaging tests (eg. scanners,) which are billed separately.

All funding is not linked to ABP

Public hospitals (and private hospitals participating in so called 'missions') receive additional payments to compensate for specific 'public missions', including: education, research and innovationrelated activities; activities of general public interest such as meeting national or regional priorities (e.g. developing preventive care); and the financing of investments in infrastructure contracted with the Regional Hospital Agencies. The costs of maintaining emergency care and related activities are paid by fixed yearly grants, plus a fee-for-service element taking into account the yearly activity of providers. Finally, a restricted list of expensive drugs and medical devices is paid retrospectively, according to the actual level of prescriptions made. The expenditure on these drugs and devices increased by 37% between 2005 and 2007.

Efficiency in question

Between 2004 and 2007, the financial situation of public hospitals deteriorated generally, while that of private hospitals improved.[1] In 2007, one out of every three public hospitals was in deficit, with a total budget deficit of about €500 million. Public hospitals seem to have difficulty in reducing their costs despite an increase in their activity. In terms of productivity improvements, the situation is unclear. Overall, both public and private hospitals appear to have reacted to ABP by increasing their activity in 2005, the year of its introduction. In public hospitals, both inpatient and day cases have increased by 1.5% and 5% respectively, while in the private sector there seems to be a shift from inpatient to ambulatory surgery with a 3% reduction in inpatient care and a 9.5% increase in day cases. However, it is not clear how much of this rise in ambulatory activity represents an increase in efficiency, and how much is due to miscoding or over-supply of services. The external audits by the Health Insurance Funds revealed that some of this increase was due to ‘up-coding’ of ambulatory consultations. In 2006, the Ministry of Health issued a decree providing a more strict definition of ‘ambulatory stays’. Subsequently, the overall number of day cases fell by 8% in 2007 (4% and 10% in the public and private sectors, respectively).

Macro-level control of volume and price

In order to contain the level of hospital expenditure, national level expenditure targets for acute care (with separate targets for the public and private sector) are set by Parliament. If the actual growth in volume exceeds the target, prices subsequently go down. Because the increase in activity in 2005 was higher than the targets set, the government reduced GHM prices by 1% in 2006. Subsequently, overall activity went down about 3.5 % in 2007, but it is difficult to say how much of this was in reaction to the decline in GHM prices. Nevertheless, this macro-level regulatory mechanism creates confusion and an extremely opaque environment for hospitals where it is not possible to predict market trends and prices. GHM prices are set as a function of global changes in hospital activity, independent of costs and their evolution at the individual hospital level. Thus, some hospitals may experience a reduction in their revenues even if their own level and range of activities have remained unchanged but there has been a global rise in activity which has led to a fall in GHM prices.

Lack of information on impact

No national evaluation is yet available on the effects of ABP on measurable outcomes such as activity rates, readmissions and throughput (length of stay, etc.). But a recent report by the Auditor’s Office (*Cour de comptes*) concludes that ABP has become a very opaque mechanism of control for hospital managers and the follow up of hospital resources (revenues) is not adequate. The report also criticizes the ambiguous process of fixing GHM prices because it is not always clear what is included in the price and what is not. Overall, expenditure on hospital activity which is not linked to the GHM escalated between 2005 and 2007: expenditure for expensive drugs and medical devices increased by 37% and other daily supplementary payments by 21%, against a 4% increase in GHM related expenditure.

Conclusion

So far, activity based payment in France does not appear to have achieved any of its stated objectives in terms of improving efficiency, transparency and fairness of funding and quality. Cost data is missing to identify efficient providers, to understand the differences in medical practices and to monitor any changes in behaviour of the various actors. Quality indicators such as readmission and mortality rates are not available either. The playing field is not much fairer since the GHM prices do not cover the same cost items in public and private hospitals and extra-GHM payments are still opaque. Better monitoring is required on hospital expenditure that falls outside of the GHM system. Moreover, the macro-level volume-price control mechanism appears to be counter-productive or ineffective. A contractual approach giving individual providers clear volume and quality signals could improve efficiency.

REFERENCES 1. Mission T2A (2009), *Rapport d’activité du Comité d’évaluation de la T2A*, DREES, September 2009.

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