Is our health system in danger? Reorienting the reform of health management (4/4)

By Gérard Cornilleau

Health is one of the key concerns of the French. Yet it has not been a major topic of political debate, probably due to the highly technical nature of the problems involved in the financing and management of the health care system. An OFCE note presents four issues that we believe are crucial in the current context of a general economic crisis: the last major concern about the health system is hospital financing. This underwent severe change in 2005 with the launch of the T2A system, which reintroduced a direct financial relationship between the activity of the hospitals and their financial resources. It has reinforced the importance and power of the "managers", which could give the impression that hospitals were henceforth to be regarded as undertakings subject to the dictates of profitability.

The reality is more complex, as the T2A system is aimed less at making hospitals "profitable" than at rationalizing the way expenditure is distributed among the hospitals by establishing a link between their revenue and their activity, as measured by the number of patients cared for weighted by the average cost of treating each patient. Paradoxically, the risk of this type of financing is that it could lead to a rise in spending by encouraging the multiplication of treatments and actions. In fact, the HCAAM report for 2011 (*op. cit.*) notes that the 2.8% growth in hospital fee-for-service expenditures in 2010 can be broken down into a 1.7% increase attributable to an increase in the number of stays and a 1.1% increase

attributable to a “structural effect” linked to a shift in activity towards better reimbursed treatments [1].

This development is worrying, and it could lead to a rise in hospital costs for no reason other than budget needs. The convergence of costs at private clinics and at government and non-profit hospitals is no guarantee against this tendency, as the incentives are not different for private clinics. Here we are reaching the limits of management by competition, even in a notional form, as its flaws are too numerous for it to be the only means of regulation and management.

Public hospitals also receive lump-sum allocations to carry out the general interest and training missions assigned to them. This lump-sum envelope represented approximately 14% of their actual budget in 2010 [2]. It provides funding for teaching and research in the hospitals, participation in public health actions, and the management of specific populations such as patients in difficult situations. Unlike reimbursements related to the application of the fee schedule, the amounts of the corresponding budgets are restrictive and easy to change.

Consequently, budget adjustments are often based on setting aside a portion of these allocations and revising the amounts allocated based on changes in total hospital expenditure. In 2010, for instance, the overrun of the spending target set for the hospitals that year, estimated at 567 million euros, resulted in a 343 million euro reduction in the budget allocated to the general interest mission, or an adjustment of about -4.2% from the original budget (HCAAM, 2011).

The regulation of hospital expenditure has tended to focus on the smallest budget share, which is also the easiest for the central authorities to control. While it is possible to revise the reimbursement rates of the T2A fee schedule, this takes time to affect the budget and the targets are harder to hit. The system for managing hospital budgets is thus imperfect,

and it runs the dual risk of uncontrolled slippage on expenditures governed by the T2A system and a drying up of the budget envelopes used to finance expenditures that do not give rise to any billing. There is no magic bullet for this problem: returning to the previous system of a total budget to finance total expenditure would obviously not be satisfactory when the T2A system has made improvements in the link between hospital activity and financing; nor is it acceptable to keep putting the burden of any budget adjustments solely on the budget envelopes of the general interest and investment missions, especially in a period of austerity. The general trend is to minimize the scope of the lump-sum funding envelope (Jégou, 2011) and to maximize the scope of fee-for-service charging.

Pricing is not, however, always perfectly suited to the management of chronic complex conditions. One could therefore ask whether, conversely, the establishment of a mixed rate system of reimbursement, including a component that is fixed and proportional, would not be more effective, while facilitating the overall regulation of the system as a whole by means of a larger lump-sum envelope. The fixed part could for example be determined on the basis of the population covered (as was the case in the old system of an overall budget). This development would also have the advantage of reducing the obsessive managerial spirit that seems to have contributed significantly to the deterioration of the working atmosphere in the hospitals.

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[1] The patients treated by the hospital are classified into a *Groupe Homogène de Malade* (GHM, a diagnosis-related group) based on the diagnosis. For each stay of a given patient, the hospital is paid on the basis of a fee set in the *Groupe Homogène de Séjours* (GHS, a stay-related group), which refers

to the patient's GHM and to the treatment that they receive. In theory this system can associate an "objective" price with the patient treated. In practice, the classification into a GHM and GHS is very complex, particularly when multiple pathologies are involved, and the classification process can be manipulated. As a result, it is impossible to determine precisely whether the shift towards more expensive GHS classifications reflects a worsening of cases, the manipulation of the classifications, or the selection of patients who are "more profitable".

[2] The credits, called "MIGAC" (for general interest missions and aid to contracting), came to 7.8 billion euros in 2010 out of total hospital expenditure in the "MCO" field (Medicine, Surgery, Obstetrics, Dentistry) of 52.7 billion; see HCAAM, 2011.

Is our health system in danger? Dealing with the shortage of doctors (2/4)

By Gérard Cornilleau

Health is one of the key concerns of the French. Yet it has not been a major topic of political debate, probably due to the highly technical nature of the problems involved in the financing and management of the health care system. An OFCE note presents four issues that we believe are crucial in the

current context of a general economic crisis: the second issue, presented here, concerns access to care, which could become more complicated due to a temporary reduction in the number of doctors.

The coming decline in the number of physicians, even if it is limited and temporary, runs the risk of developing medical deserts. Incentives exist to steer health professionals towards areas with a low medical density, but these are woefully inadequate, and the issue of more direct intervention is now on the agenda.[1] It will be difficult to avoid calling into question the complete freedom of doctors to install wherever they wish, which could result in a requirement for new physicians to go first to priority areas. But this would place a heavy burden on younger doctors, and inevitably involve some recompense. Would this mean accepting further increases in pay? To what extent? Should we allow further increases in physician surcharges ("dépassements d'honoraires")? The need for comprehensive negotiations with the profession is becoming clear: the past weakness of the *numerus clausus* restrictions on supply will lead for a while to some rationing in the supply of physicians; this reinforces the profession's market power at the very time when it is becoming necessary to call old compromises into question. Ideally, it would be desirable to negotiate an increase in the income of doctors in training against a reduction in surcharges and constraints on their locations (possibly compensated by specific premiums). But this won't work for generations who have just completed their studies. So the only way forward clearly involves a strong upgrade in prices for medical acts (or fixed fees if, as would be desirable, doctors' incomes were calculated less on acts and increasingly on the size of their patient base [2]) as a counterpart for their acceptance of constraints on location (compensated) and a reduction in surcharges. These changes would constitute an additional burden on the health insurance system, which could be justified at least partially by the development of good

practices. On the other hand, the increase in the individual remuneration of doctors will, for a few years, be partially offset by a reduction in their numbers.

The constraints of queuing should also encourage a better distribution of activity between physicians and a certain number of health technicians who can assist and even replace them in some situations (as is beginning to be the case in corrective optics). All these changes – the end of absolute freedom of installation, stricter regulation of surcharges, the sharing of medical activity with health technicians, the development of group work – are possible but would involve a major overhaul of the old compromise between the state and doctors. The main difficulty here is socio-political. To overcome it, we must also accept financial compensation for physicians, which will be difficult in a context of general rationing.

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[1] The HPST Act (Hospitals-Patients-Health-Regions) in July 2009 introduced a "public service commitment contract" that offers second-year medical students and interns an additional income of €200 per month for a commitment to move to a priority area for a period at least equal to the duration of the receipt of the aid, with a minimum of 2 years. 400 contracts were offered in 2010-2011 (200 to students and 200 to interns), but only 148 were signed (103 students and 45 interns). This very limited figure is clearly insufficient in view of the forthcoming problems with doctors locating to areas in difficulty.

[2] Since 2010, Health Insurance has established a "Contract for Improving Individual Practice" ("CAPI"), which provides a lump sum of up to €7,000 per year for physicians who agree to follow certain rules on care and prevention. This scheme introduces a form of pay for performance that is distinct from pay for medical acts, which is in addition to the very limited

pay related to the management of patients with a long-term illness (“ALD”) by the treating physicians (€40 per year and per patient).

Is our health system in danger? The financing of health insurance and the crisis (1/4)

By Gérard Cornilleau

Health is one of the key concerns of the French. Yet it has not been a major topic of political debate, probably due to the highly technical nature of the problems involved in the financing and management of the health care system. An OFCE note presents four issues that we believe are crucial in the current context of a general economic crisis : the first concerns the financing of health insurance, which is being undermined by a lowering of revenue due to the crisis; the second relates to access to care, which could become more complicated due to a temporary reduction in the number of doctors; the third involves the poor management of changes in the way reimbursement is divided between social security and complementary health insurance organisations in the context of a rise in non-reimbursed expenses (in particular higher

surcharges by doctors); and finally, the fourth problem concerns hospital management, which has experienced major disruptions by the introduction of charges on this activity.

The financing of health insurance: A new source to explore

The crisis has further intensified the difficulty of financing health insurance, which is feeding concern about the sustainability of the health system and about public responsibility for healthcare costs. However, an analysis of the main trends in spending and financing shows that in the event of a return to a "normal" macroeconomic situation, the financial difficulties should be contained and only a limited structural effort would be needed to achieve a balanced situation; the initial deficit is relatively small (about 0.6 GDP of the total deficit, which is divided roughly into two equal halves of 0.3 point for the structural deficit and 0.3 point for the cyclical deficit), and there are only moderate prospects for a further rise in spending (with an increase in the expenditure / GDP ratio of around 0.1 percent of GDP a year). An increase in the CSG wealth tax and realistic efforts to control spending (of around 1 to 2 billion euros per year relative to the spontaneous trend) should be sufficient to ensure the financial sustainability of the system.

If the macroeconomic climate remains very bad for a long time, the health insurance deficit could increase, in which case the issue of cutting expenditure could be posed more acutely. There would then be two options: either to accept a new increase in the deficit, as only a radical change in European policy would solve the issue of funding; or to put off a return to growth, which would mean adjusting the financial configuration of health insurance. Three variables could be used to adjust the accounts: to shift spending downwards; to raise taxes; or to lower reimbursements. In the bleak scenario of a halt in growth, it is likely that governments would seek to make use of these three variables. It is difficult to envisage a downward trend in spending at a time when needs

will be increasing due to population growth and aging, and the spontaneous trend is already moderate. It would be possible to increase charges, but this would compete with tax increases to finance other government spending. As for lowering reimbursement rates, it would be difficult to do this uniformly when coverage of expenditure on primary care physicians is already very low.

The only path that has not yet been taken is means-testing reimbursement, which would lead to a large increase in the financial co-payments of the wealthiest households. This would undoubtedly reduce the deficit, but it would weaken the system, as public care would become increasingly expensive for the wealthier strata, which would lead them to support moves towards a private insurance system that excluded any redistribution between rich and poor.