

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

By [G rard 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.

[\[1\]](#) 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? Reforming the reimbursement of care (3/4)

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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 third issue, presented here, concerns the reimbursement of health care, in particular long-term care, and the rise in physician surcharges.

The reimbursement of care by the French Social Security system currently varies with the severity of the illness: long-term care, which corresponds to more serious conditions, is fully reimbursed, whereas the reimbursement of routine care is tending to diminish due to a variety of non-reimbursed fixed fees and their tendency to rise. In addition to this structural upwards trend there is a rise in non-reimbursed doctor surcharges, which is reducing the share of expenditure financed by Social Security. As a result, the share of routine care covered by health insurance is limited to 56.2%, while the rate of reimbursement for patients with long-term illnesses (“ALD” illnesses in French) is 84.8% for primary care [1]. This situation has a number of negative consequences: it can lead people to forego certain routine care, with negative implications for the prevention of more serious conditions; and it increases the cost of supplementary “mutual” insurance that paradoxically is taxed to help compulsory insurance on the grounds of the high public coverage for long-term illness. Finally, it puts the focus on the definition of the scope of long-term illness, which is complicated since in order to draw up the list of conditions giving entitlement to full reimbursement it is necessary to consider both the measurement of the “degree” of severity and the cost of treatment. The issue of multiple conditions and their simultaneous coverage by health insurance under both routine care and long-term illness is a bureaucratic nightmare that generates uncertainty and expenditure on relatively ineffective management and controls.

This is why some suggest replacing the ALD system by setting up a health shield that would provide for full reimbursement of all spending above a fixed annual threshold. Beyond a

certain threshold of average out-of-pocket expenses (e.g. corresponding to the current “co-payment” level) after reimbursement by compulsory health insurance, which was about 500 euros per year in 2008[\[2\]](#)), Social Security would assume full coverage. A system like this would provide automatic coverage of the bulk of expenses associated with serious diseases without going through the ALD classification.

One could consider modulating the threshold of out-of-pocket expenses based on income (Briet and Fragonard, 2007) or the reimbursement rate, or both. This possibility is typically invoked to limit the rise in reimbursed expenses. This raises the usual problem of the support of better-off strata for social insurance when it would be in their interest to support the pooling of health risks through private insurance with fees proportional to the risk rather than based on income.

The establishment of a health shield system also raises the issue of the role of supplementary insurance. Historically mutual insurance funds “completed” public coverage by providing complete or nearly complete coverage of anything in the basket of care not reimbursed by basic health insurance (dental prostheses, eyeglass frames, sophisticated optical care, private hospital rooms, etc.). Today these funds function increasingly as “supplementary” insurance that complements public insurance for the reimbursement of health expenses on the whole (coverage of the patient co-payment, partial refund of doctor surcharges). The transition to a health shield system would limit their scope of reimbursement to expenses below the fixed threshold. It is often assumed that if mutual insurance were to abandon its current role of blind co-payment of care expenditures, it could play an active role in promoting prevention, for example, by offering differential premiums based on the behaviour of the insured [\[3\]](#). But where would their interests lie if the shield came to limit their coverage beyond the threshold not covered by public insurance? Even in the case of maintaining a

substantial “co-payment” beyond the threshold because of doctor surcharges, for example, they would undoubtedly remain relatively passive, and there would not be much change from the situation today, which isolates them from the bulk of coverage for serious and expensive diseases.

A system in which public insurance alone provides support for a clearly defined basket of care is surely better: this would require that the health shield increases with income, with the poorest households receiving full coverage from the first euro. If affluent households decide to self-insure for expenses below the threshold (which is likely if the latter is less than 1000 euros per year), the mutual insurance funds might withdraw almost entirely from coverage of reimbursements of routine care expenses. On the other hand, they could concentrate on the coverage of expenditures outside the field of public health insurance, which in practice would mean dental prostheses and corrective optics. They could intervene more actively than now in these fields to structure health care delivery and supplies. Their role as principal payer in these fields would justify delegating them the responsibility of dealing with the professions involved. However, this solution implies that a system of public coverage would be needed to give the poorest strata access to care not covered by the public insurance system (in a form close to France’s current CMU universal coverage system, which should however be extended and made more progressive). There is thus no simple solution to the question of the relationship between public insurance and supplementary private insurance.

The merger of the two systems should also be considered, which in practice means the absorption of the private by the public. This would have the advantage of simplifying the system as a whole, but would leave partially unresolved the question of defining the basket of care covered. It is quite likely that supplementary insurance would relocate to the margins of the system to support incidental expenses not covered by the

public system because they are deemed nonessential. The reimbursement of health costs should certainly remain mixed, but it is urgent to reconsider the boundaries between private and public, otherwise the trend towards declining public coverage will gain strength at the expense of streamlining the system and of equity in the coverage of health expenditures.

[\[1\]](#) In 2008. This is a level of coverage that excludes optical. Taking optical into account, the rate of coverage by health insurance falls to 51.3% (Haut Conseil pour l'Avenir de l'Assurance Maladie [High Council for the Future of Health Insurance], December 2011).

[\[2\]](#) HCAAM, 2011 (*ibid*).

[\[3\]](#) It is not easy to take into account the behaviour of the insured. Beyond the use of preventive examinations, which can be measured relatively easily, other preventive behaviours are difficult to verify. Another risk inherent in private insurance is that insurers “skim” the population: to attract “good” clients, coverage is provided of expenditures that are typical of lower-risk populations (for example, the use of “alternative” medicines), while using detailed medical questionnaires to reject expenditures for greater risks.