

CHAPTER 2

Pharmaceutical policies

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FINANCING HOSPITAL CARE AND DRUGS IN FRANCE

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The French case-mix system of hospital payment was adopted in 2004 for public hospitals and in 2005 for the private-for-profit sector. Implementing this reform has increased competition between providers. Nevertheless, the State still regulates both prices and volumes.

How to apply the principles of pharmacoeconomics in a given country is to a certain degree dependent on how hospital care, including hospital drugs, are financed. This is far from uniform in Europe, and as such a more general review paper does not make much sense. Therefore the system in France, how it came into existence and how it is developing will be discussed. For more details the reader is referred to a more extensive report from Bellanger and Tardif [1]. The European Union, together with Austria, took the initiative to map in great detail how pharmaceuticals are being priced and reimbursed. Details can be found on the Pharmaceutical Pricing and Reimbursement Information website, which contains detailed reports from a growing number of EU countries (ppri.oebig.at).

A PUBLIC-PRIVATE MIX IN THE PROVISION OF ACUTE CARE

In France hospital care is mixed, but public facilities are dominant, with two thirds of all hospitals within the public sector. Public hospitals have a virtual monopoly on emergency treatment, high-level research and psychiatric care due to their institutional prerogatives. In practice, they also deal with elderly and socially disadvantaged patients. Furthermore, the public sector handles the bulk of major operations as well as life-threatening conditions. In contrast, the private-for-profit sector plays a major role in the provision of acute care. The larger clinics may have more than 250 beds dealing mainly with surgery and obstetrics. Their market share can be as high as 80% in the five most common surgical procedures. The French system is thus a mix of an entirely public system and a private sector which has, since the mid 1990s, operated with a very high degree of specialisation. Within a constrained environment and under economic pressures, private clinics have greater flexibility to respond rapidly to changes. In contrast, public hospitals have been reluctant to become involved in plans leading to a new share of activities. This is even the case when the Regional Hospital Agencies (RHAs), which are responsible for local, strategic health plans, have introduced tough new forms of partnerships [2].

A DRG-BASED PAYMENT SYSTEM

The aim of the French government in setting a prospective payment system (PPS) was to finance healthcare establishments in a consistent manner, regardless of their legal status. The system is based primarily on payments for diagnosis-related groups (DRGs), whereupon the healthcare provider receives a predetermined fixed payment to cover patient admission and care. Although the DRG classification has long been in place for data collection [3, 4], pricing per DRG is a major change compared with the global reimbursement system which was administered previously via the RHAs. For now, it is applied only to acute care (medicine, surgery and obstetrics). This new reimbursement system has been implemented in the public sector since 2004. Initially covering about 10% by value of acute hospital care, since January 2008 there has been complete coverage. Private-for-profit hospitals, on the other hand, have been funded entirely by the new system since March 2005. These hospitals were previously paid for their actual activity on the basis of regional prices, which showed large disparities. However, a transition period is in place, during which the national DRG prices will be adjusted for each provider based on their own historical costs and prices.

One of the objectives of the hospital reimbursement reform is to merge public and private financing systems by 2012. Currently two systems of tariffs still remain. One of the main reasons for this is the physician's payment. Whereas in the private sector they are paid for on a fee-for-service basis, in addition to the DRG tariff, in public hospitals the full costs of healthcare professionals are included in the DRG price.

FUNCTIONING OF THE CURRENT REIMBURSEMENT SYSTEM

The DRG-based payment system applies to acute care activity for all hospitals regardless of the modalities involved, i.e. inpatient and outpatient acute care, including home hospitalisation services and alternatives to inpatient dialysis. The payment unit is the hospital stay, from admission to discharge. The diagnosis codification allows the classification of stays in homogenous groups according to length of stay, diagnosis, procedures and severity of illness. The system of

CHAPTER 2

Pharmaceutical policies

classification includes 768 DRGs, of which 205 have comorbidities. The DRG classification algorithm is updated annually to take account of any changes in the practices and medical techniques used.

For the reimbursement of hospital stays, a nationally defined price is attributed to each DRG. Daily supplements are added to the DRG prices in some cases, such as neonatology, intensive care, continuous care and day-outliers (when a patient has a longer length of stay compared with other patients in that class of DRG). There are also some particular procedures such as abortion, radiotherapy and dialysis which are currently charged at specific national prices. Other sets of prices, tariffs per medical procedures, apply to outpatients admitted for emergencies and organ retrieval, both receive additional lump sum funding, as well as outpatient care. External activities, including medical procedures such as imaging, laboratory tests and consultations performed by consultants, are reimbursed on the basis of the common classification of medical procedures nomenclature and on tariffs applicable to ambulatory care.

A specific budget, MIGAC, also funds 'public utility missions'. These activities are defined by ministerial order and then allocated on a regional basis: teaching, research and innovation, other public welfare missions such as district emergency regulation centres, sperm and ovocyte banks, care dispensed to specific populations, therapeutic screening, paramedical schools and hospital activities promoted by contract with the RAHs.

Expensive drugs (currently 229) are also covered by separate payment, on a real cost basis, in addition to the DRG price. These drugs must be defined by ministerial order and/or by the National Union of Health Insurance Funds. They are funded on the basis of a maximum standard price – which is either the price declared by the industry or, if this price is questioned, the price fixed and published by the Committee for Medical Products [6]. Furthermore, hospitals are required by law to sign contracts with the Regional Hospital Agencies for "the proper use of expensive drugs and medical devices". In order to be fully reimbursed for the cost of these drugs, they have to agree with this contract, otherwise they will be compensated only up to 70% of their expenditure. Medical devices were first covered on this same basis until 2006, when they were included in the DRG prices.

STATE STEERS PRICES AND VOLUMES OF HOSPITAL CARE

In the French prospective payment system, prices are updated annually by the Ministry of Health. Although the

average cost per DRG, from a national data sample of 42 hospitals, is taken into account, the costs are also defined by a political decision process. To comply with an overall price-volume regulation principle, the Ministry may update prices once a year to meet the health insurance expenditure target. For example, an increase of inpatient activity (4%) during 2005 exceeded the estimated national budget targets (by 1%); therefore the Ministry decreased the DRG tariffs by 1% in 2006. This automatic reduction in tariffs applied to both public and private hospitals, even although the DRG pricing between the two is different. The increase in patient activity was partly due to the quantitative improvement of the DRG coding and is consistent with results observed in most other countries when PPS is introduced [4].

CONCLUSION

As this new system of healthcare finance and budgeting is still being implemented in France, it is not yet possible to see how effective it will be in achieving its goals [5]. Potential problems have still to be overcome, for example, under the new generation regional strategic health plans, the RHAs set hospital quantified objectives. These objectives will determine the location of the services and costly equipment and access to health care. However, setting this will restrain medical and surgical procedures which are not essential.

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