Funding of the healthcare system and healthcare providers in France – an introduction

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General Organization of the Social Security System

- Farmer Social Security System (MSA)
  - Health
  - Pensions
  - Family
  - Recovery of Social security contributions

- Social Security for employees and independents
  - Family Allowances (CNAF)
  - Pensions (CNAV)

- Special schemes for certain non-agricultural salaried workers

- National Union of Health Insurance Funds
  - National public health insurance (CNAM)

- Complementary health insurance companies
### Health expenditures

- **Total:** 203.5 billions €
  - **Hospital care:** 94.5 billions € (46.4%) including 73 billions for the public sector
  - **Outpatient care:** 55 billions € (27%) including 22.6 billions for physicians
  - **Pharmaceuticals:** 32.7 billions € (16.1%)
  - **Other medical goods:** 16 billions € (spectacles, prosthesis, bandages, …) (7.9%)
  - **Transport of patients:** 5 billions € (2.5%)

### Where does the money come from? (2017)

- **Social contributions:** 164.6 billions €
  - Social contributions: 93.3 billions €
  - Generalized social contribution (CSG): 71.2 billions €
- **Taxes:** 31 billions €
- **Financial products:** 4 billions €

### Social security debt in general

- **Remaining debt:** 105 billions € (at the end of 2018)
- **Expected last year of debt reimbursement:** 2024
Health expenditure per capita (2017)


StatLink  http://dx.doi.org/10.1787/888933835345

- **Public payers**: 78.1% (94.5% of hospital care)
- **Complementary insurance**: 13.4% (74.2% of optical care)
  ≈ 97% of French people have a complementary health insurance policy
- **State programs**: 1.5%
- **Patients**: 7%

Share of total health spending financed by out-of-pockets payments (2016)
# General Characteristics of Payment System in France

An annual Social security budget law (PLFSS) with a specific target for public health insurance expenses (ONDAM)

**Public** (civil servants or not) and **private health providers** (independants or employees)

A payment scheme different for each type of provider

### Different levels / layers of price regulation:

- Ministry of Health
- National public health insurance (CNAM)
- Regional health authority (ARS)
- A specific regulator for medicines and medical devices: the Economic committee for health products (CEPS)

### Tools of regulation:

- Regulation of hospital prices by the Ministry of Health
- Regulation by contracts for outpatient professionnals: negotiation between CNAM and health professionnals representatives / for one health profession or different types of group practices
- **Disease management programs**

Lower co-payments for patient affected by a serious illness (ALD)
### How do we pay for public hospitals?

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
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<tbody>
<tr>
<td>Inpatient day, then global payment, then diagnosis related groups (T2A)</td>
<td>(since 2004)</td>
</tr>
<tr>
<td>Fee-for-services : Based on 2 300 diagnosis related groups</td>
<td>(bundled of activities - GHS)</td>
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<td>Additional payments for expensive drugs and medical devices</td>
<td>(liste en sus de la T2A)</td>
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<td>Lump sump payments (per patient and/or for the activity on an annual basis)</td>
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<td>Performance payment : Contract for improving the quality and efficiency of care (CAQES)</td>
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<td>Payments exclusively by patients and/or complementary insurers</td>
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<tr>
<td>Buildings and equipment investment aids</td>
<td>+</td>
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Historically a payment scheme only based on fee-for-services

Since 2008 evolution toward an ever more mixed model rewarding quality, cooperation and the functioning of the practice

Current payment model

Fee-for-services (medical consultation and technical acts)

- **Medical consultation**:
  - Amount depending of specialty (25 € for general practitioners)
  - Higher rates for complex patients, emergency visits (+ 15 €), follow-up of elderlies and young childs, …
  - Dedicated rates for teleconsultation acts
- **Technical acts**: Rate depending of specialty and technicity (mainly performed by specialists)

**Annual bonus for moderate fee-for-services rates** (OPTAM - Moderate Rate Practice Option)
- Only for certain physicians
- Average rate of overrun compared to the standard price
- Share of visits performed at the standard price
HOW DO WE PAY FOR PHYSICIANS IN OUTPATIENT CARE?

Lump sum payments:

- Risk adjusted capitation lump sum (more than 15 000 € per year per physician)
  - Patient with a serious illness
  - Patient over 80
  - Patient 7 to 79 years old without serious illness
  - Patient over 80 and with a serious illness
  - Child: 0 to 6 years old

- Lump sum for informatic equipment and use of webservices

Bonus for physicians who settle in area with few health providers ("medical deserts")

Performance payment: Payment for Public Health Objectives (ROSP)

For the time being only for certain specialty (and not yet at hospital): General practitioners, cardiologists, gastroenterologists, endocrinologists

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HOW DOES PAYMENT FOR PUBLIC HEALTH OBJECTIVES (ROSP) WORK? (FOR GP)

Different sets of indicators corresponding to various type of actions

Distribution of points in 2019: 940 points and 29 indicators

- Follow-up of chronic diseases: 220 points (8 indicators)
- Disease prevention and health promotion: 390 points (12 indicators)
- Medicines prescription efficiency: 330 points (guidelines) (9 indicators)

2016: 1000 points

Efficiency of non-medicines prescriptions

Distribution of points in 2019:

Follow-up of chronic diseases: 220 points

Disease prevention and health promotion: 390 points

Medicines prescription efficiency: 330 points

Reward: 1 point = 7 euros

On average: 4 500 € per general practitioner per year

Instance of a ROSP indicator

Share of patients aged 65 and over vaccinated against seasonal flu / Target ≥ 75% / Reward: 20 pts
# How do we pay for Pharmacists?

**Historically a fee based on a margin on drugs sold** (with different levels of margins according to prices thresholds)

Since 2009, introduction of several lump sum payments and payment for performance. Now, new pharmaceutical acts

## Current payment model

### Degressive margin on medicines delivered

### Performance payment : Payment for Public Health Objectives (ROSP)

Instance of indicators: generic substitution rate, stability of the generics brand delivered, computer and software equipment and use, prescriber identity mention (RPPS), participation in a primary care team, …

### Fee-for-service payments:

- Night and week-end opening compensation (payment for each out-of-hours opening day)
- Dispensation fee: lump sum per box (1 to 3 €) and for complex prescriptions (0,5 € more for prescriptions for more than 5 products),
- Accompanying patients on antivitamin K oral anticoagulant, on inhaled corticosteroids, on direct oral anticoagulants (AOD), on chemotherapy, polymedictaed elderly patients, … (50 € / year / patient),
- Opening of personal electronic health records (DMP) (1€ per opening)
- Patient medication assessment (20 to 60 € per year per patient)
- Vaccination
A fund to foster organizationnal innovation: Experiments « Article 51 » and Strategic Council for innovation in health organization

- Central idea: Allowing projects to not follow classic payment schemes and regulations
- Two kinds of projects:
  - Projects designed by professionnals or local authorities
  - National calls for proposals to test new models
- National appraisal before authorization
- Systematic assessments of impacts (efficacy, efficiency, patient experience and quality of life, …)
- Generalization of best practices identified

A Government plan to:

- Pay more for the quality and performance and not only for services
- Incentivize health professionnals to work in care teams
- Gradually implement harmonized payment models structures for all professionnals

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**Bundled Payment**

To test a pooled payment of actors for an episode of care (upstream, during and after hospitalization or just, or just for a part of the care process).

**IPEP : Collective incentive for shared care and population health**

Professionnels collectively engage to target regarding quality, efficiency, and access for a group of people and share bonus if they reach the targets. A payment additional to classic ones. No penalty if targets are not achieved.

**PEPS : Team payment**

Collective risk-adjusted capitation with free repartition between professionnels. A single payment for the patient's care for a given pathology. Replaces traditional payments. Paid to a structure for all professionals.
The expected result of payment models reform

2018

Hospital
- Public: Fee-for-service, Lump sum
- Private: Fee-for-service, Lump sum

Rehabilitation facilities
- Public: Fee-for-service, Lump sum
- Private: Per diem price, Lump sum

Physicians
- GPs: Fee-for-service, Lump sum
- Specialists: Fee-for-service, Annual budget

Psychiatry
- Public: Annual budget
- Private: Per diem price

Inpatient / Outpatient

2022

Combined payments
- To incentivize quality and relevance of care and to improve patient experience

Shared incentives
- New coding system
- Bundled payment
- Follow-up of chronic diseases
- Population based payment / Lump sum payments

Quality

Common regulation and assessment

Article 51 experiments

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A Step by Step Evolution of All Payment Models

Lump sum payments for diabetes and heart failure at hospital

Lump sum payments for other chronic illness at hospital

Lump sum payments for diabetes (physicians and nurses)

New quality incentive payments / New physicians assistants to take over simple tasks

Classification of medical acts update

Fee negotiation

DRGs update

New coding system for rehabilitation activities

New coding system for « hospital at home » activities

Experiment of an incentive for hospitals which orient patients that don’t need urgent care toward outpatient professionals

Technical work on a new payment model

Design of a new model

Implementation

Design and implementation of new quality oriented indicators

New model to fund expensive drugs and medical devices at hospital

New models for rehabilitation care and « hospital at home »

Bundled payments

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## The Health Plan 2018 – 2022 is going to bring lots of changes

Apart from new payments and experiments, this plan is going to bring:
- More capacity to train health professionnals
- A bunch of new digital health services
- New organizations models (CPTS, proximity hospitals, delegation of tasks, …)
- More IT capacities with a digital hub for health data

## But it could not be enough …

- Medical shortages will be long to solve
  - In certain areas there will no longer be healthcare providers in few years …
- Aging reinforce needs
- Tomorrow’s patients and health professionnals will have new aspirations and needs
- Technology is going to change healthcare practices in a number of ways

## Solutions ?

- Toward a more decentralized approach ?
- Increased autonomy and financial liabilities for professionnals ? (ACOs ?)
- Radical change in access to care thanks to telehealth ?
…
Thank you for your attention!
Population coverage for a core set of services (2016)

Private health insurance coverage (2016)

OECD / EUROPEAN UNION 2018
Structure of the CSBM in 2018

- Soins hospitaliers: 46.4%
- Médicaments: 16.1%
- Soins de ville: 27.0%
- Autres biens médicaux: 7.9%
- Transports sanitaires: 2.5%

Motors of the growth in value of the CSBM

Source: DREES, comptes de la santé.

CSBM: Consumption of care services and medical goods