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The Implementation and Pitfalls of Health Care Spending Targets in France

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Abstract

In France a National Objective for Health Insurance Spending (ONDAM) is annually voted by the Parliament since 1996 and is divided into four sub-groups corresponding to a category of care. We describe how the initial diversity in providers' payment rules conducted to particular regulation procedures for each of them. We then show how the failure of this initial regulating model forced the Health Authorities to converge on a single price regulation procedure since 2000. Preoccupation of the French Health Authorities is now to identify spontaneous determinants of health care expenditures growth rate and to adjust resources to the ONDAM level.

Introduction

The sharp increase of French health care expenditures dates back to the mid 1970s. Boosted by day payments, hospital spending grew to 54.9% of overall health expenditures in 1982. This is the reason why the Health Authorities introduced an annual, global budget for public hospitals in 1983. It was successful in slowing hospital expenditure growth rate, which passed from an annual average rate of 8% before 1983 to 4% thereafter (Caussat and Fenina and Geffroy , 2003) (Redmon and Yakoboski 1995).

Encouraged by the effectiveness of budget regulation, the French health authorities decided to spread this financing method to other health producers. In the early 1990's, several agreements were signed by health care professionals with the French public health insurance funds, fixing an annual, global budget for the national spending in each category of care (nurses, physiotherapists, private medical laboratories, private hospitals ...). Global budget caps were therefore, like in many other countries, (Poterba, 1994) (Van de Ven, 1995) (Mougeot and Naegelen, 2005) viewed as the central instrument for slowing the growth of health spending (Hirtzlin, 2006)

This mechanism was fully completed in 1996, when the Parliament voted, for the first time, a National Objective for Health Insurance Spending (ONDAM). It is an annual ceiling for overall public health insurance expenditure (Flori and Hirtzlin, 2000). The ONDAM can be viewed as a prospective spending limit, devoted to public health care provision (e.g. €134.9 billion for 2005). Out-of-pocket and private insurance payments, representing 23.4% of overall health care spending, are not included. The ONDAM target level of one year was based on spending in an initial (or base) year (i.e. 1996) and an estimated growth for health care expenditure, including the changes in the costs of inputs used to produce health care (in practice this was essentially growth in salaries paid in public hospitals) plus expenditures that result from changes in laws and regulation. Once the overall budget is set, it is divided into four sub-groups representing categories of spending: outpatient care (i.e. general practitioners, specialists, nurses, drug delivery, dentists, and physiotherapists), public hospitals (divided in 22 regional sub-budgets), private for-profit hospitals and care for handicapped and elderly people. Each of the sub-groups has its own target level and, for outpatient care, each professional category has to adjust its spending to its target level. A different spending

growth rate is attributed to each sub-group, by considering if the sub-group exceeded the target the year before or not, and by evaluating new public health objectives

The aim of this paper is to highlight the diversity of payment rules initially adopted in 1996 for each category of provider in order to stay under its sub-group target (section 1). Section 2 shows why the initial payment rules were abandoned in 2000 to converge on a unique price adjustment rule derived from Germany's approach. In Section 3, we discuss the opportunity to calculate the ONDAM level as a sustainable growth rate for health spending.

1- The initial diversity in providers' regulation rules

Let us consider that a global sub-budget (\mathbf{B}) is allocated for year t to one type of providers.

Global budgeting for public hospitals is dating from 1983 and was not modified under the ONDAM process. Volume and price were lumped together to calculate the annual prospective budget. The payment rule implemented for public hospitals was based on a monthly prospective budget. Each month ($j=1$ to 12) one-twelfth of its budget (\mathbf{b}) was paid to each hospital. Thus, if an overall hospital budget of size \mathbf{B} is allocated for one year t to n hospitals; their payment rule can be summarized by the *Equation 1* below:

$$(Equation 1) \quad B_t = \sum_{i=1,t}^n \sum_{j=1}^{12} b_{ij,t}$$

For outpatient providers and private hospitals the adequate regulation tool to stay under the sub-budget limit was more difficult to find. They are self employed and strongly attached to fee-for-service payments. Patients pay producers and are partially reimbursed by the statutory Health Insurance system. As fee-for-service was maintained within the ONDAM, the compatibility with the annual budget limit could not be reached by means of budget plus prospective payment mechanism (thanks to capitation payments for example). So it had to be ensured by other regulative procedures.

To simplify, let us assume that there is one price (p) and one activity measured by a volume (q). Some health care providers have negotiated a pay-back agreement which can be summarised in *Equation 2 below*:

$$(Equation 2) \quad B_t = \sum_{i=1}^n p_t * q_{i,t} - a \sum_{i=1}^n r_{i,t}$$

As they receive fees-for-service, providers' overall expenditures are calculated by multiplying price (p) by volume (q). The equilibrium with B_t was obtained through a reimbursement r . If spending was under the budget limit, the reimbursement went to providers. a was a negotiated coefficient between 0 and 1. When a is less than 1 and when $r > 0$, the equilibrium with B_t is not possible.

Physicians and medical laboratories had initially adopted this agreement. The pharmaceutical industry had negotiated a level for a which was far below 1.

Other health care providers had negotiated a pricing update mechanism that incorporated spending targets. Fees were adjusted upwards or downwards depending on whether t spending had fallen below, or exceeded the budget. Thus the equilibrium should be considered for a 2 year minimum period as shown in *Equation 3*.

$$(Equation 3) \quad B_t + B_{t+1} = \sum_{i=1,t}^n p_t * q_{i,t} + \sum_{i=1,t+1}^n p_{t+1} * q_{i,t+1}$$

With $p_{t+1} < p_t$ when $\sum_{i=1,t}^n p_t * q_{i,t} > B_t$

And $p_{t+1} > p_t$ when $\sum_{i=1,t}^n p_t * q_{i,t} < B_t$

If the global budget ($B_t + B_{t+1}$) was not reached after two years, fees (*i.e.* P_{t+2} to P_{t+n}) went down and so on. Thus p could tend to zero if the global budget was always exceeded. This rule was applied to nurses, physiotherapists, dentists, private hospitals and social health care.

2-Converging on a single price regulation procedure

All these providers' payment rules within the ONDAM were implemented for the first time in 1997. The system was considered as a success because overall public health expenditure (€89.32 billion) was under the global budget cap (€89.45 billion). By applying the pay-back agreement shown in Equation 2, the public health insurance reimbursed €1372 to each general practitioner, because their expenditures was under the global sub-budget which had been allocated to them. Specialists, who exceeded their sub-budget for 1997, negotiated a new reimbursement procedure summarized in equation 4:

$$(Equation 4) \quad B_{t+1} - \sum_{i=1}^n r_{i,t} = \sum_{i=1}^n p_{t+1} * q_{i,t+1} - \sum_{i=1}^n r_{i,t+1}$$

This meant that specialists got a global budget for year t+1 which was reduced by the amount they were supposed to reimburse in year t.

The initial success was quickly interrupted in 1998. Spending by physicians exceeded their global budget and they refused to reimburse the Public Health Insurance. Physicians even turned against the Health Insurance system, by bring legal action before the Council of State and before the Constitution Council to denounce reimbursement agreements. These judicial bodies ruled in the physicians' favour. They motivated their decision by the illegality of the reimbursement procedure (Evin, 2002). Physicians were considered as collectively responsible and had to pay a fixed amount in proportion of the overall exceeding; so everyone in the group was punished for what could be interpreted as the excesses of only some of them. This was considered as incompatible with the French constitutional principles.

Thus, the government modified the rules for outpatient professionals. It adopted a single price regulation method for all of them. But because price regulation shown in *Equation 3* had very little chance of being compatible with the global budget, when fee adjustment was applied the year after the excess, France used a floating price mechanism from 2000 to 2002 which was inspired by Germany (Benstetter and Wambach, 2006) and that can be summarized in *Equation 5*.

$$(Equation 5) \quad B_t = \sum_{i=1,t}^n p_t * q_{i,t}$$

While
$$p_t = \frac{B_t}{\sum_{i=1}^n q_{i,t}}$$

In 1993, Germany implemented health care reform legislation which strengthened the global budgeting of physicians. German physician expenditure was capped, thanks to a point-system. At the end of each quarter, the global budget for all physicians is divided by the sum of points submitted by all physicians for reimbursement. This determines the point (price) value *pt*.

In France, price regulation was supposed to be more efficient if a way could be found to adjust prices level immediately to global spending. Fees were supposed to be revised twice a year (in April and September) according to the spending level that was reached. Unfortunately, the public health insurance system was not able to proceed to price adjustment so quickly, due to uncertainty in statistical data about real spending.

If the mechanism had been strictly applied, price regulation would have been compatible with global budget. Nevertheless, if volumes of care are steadily increasing, the point value drops and there is a risk of physicians' bankruptcy, because *pt* could be nearly equal to zero. This problem could be solved if physicians are guaranteed that the fee value could not fall below a pre-determined value (Benstetter and Wambach, 2006).

In France, price flexibility was moderated by providers' negotiations. Fees were not automatically reduced when expenditures exceeded this target. So regulation through the ONDAM target and global sub-budgets progressively lost its utility. The ONDAM was no longer considered as a regulatory device and had become a simple tool for health care expenditure forecasting (Evin, 2000). The consequence was that the government progressively lost control on health care spending. The average annual health expenditure growth rate accelerated, passing from 2.8% during 1996-1999 period, to 6.1% during 2000-2002 period (Hirtzlin, 2003).

A renewed soft regulation process based on "mutual confidence" emerged in 2002 and is still in use in 2006. The public Health Insurance authorities sit down with producers to adopt a regulatory approach that is acceptable to them. Contract terms usually balance an upper level for fees with changes in prescription patterns (e.g. less drug prescriptions, less home visits by physicians etc.). Determining budgets is no longer a matter of choosing quantitative criteria and applying financial penalties but a matter of interaction between public health insurance

and stakeholders. Thus physicians are supposed to adopt self-regulation and virtuous behaviour. But whatever the merits of a regulatory procedure based on ethical codes and good professional practices, it is doubtful it will be successful without introducing an efficient tool to regulate the overall spending. Historically, physician self-regulation has not been particularly successful in controlling the behaviour of individual physicians nor in France neither in other countries (Jacobson, 2001). Indeed, there is no substantial evidence of physicians' ability to respect their contract, even on key points (e.g. generic drug prescriptions are still lower than the level recommended in the agreement).

Rather than just finding tools for regulating finance, the major preoccupation of the French Health Authorities since 2003 has been to identify determinants of health care expenditures growth rate.

3- Determining a sustainable growth rate for the ONDAM

Sustainability of the ONDAM level was only be assessed in France, in 2003. The Health Minister ordered a report in 2003 (Coulomb, 2001) to determine what data are actually linked to health care expenditure growth. Several indicators were identified. First, demographic factors are explaining one percentage point of the health care expenditure growth rate (i.e. 0.46 percentage points due to French population growth, and 0.54 percentage points due to ageing). Technical progress is responsible for 1.5 percentage points, and health care expenditures are assumed also to be linked to the GDP growth rate. Finally, other data may explain annual fluctuations, such as an epidemics, changes in social behaviours, health reforms etc. The report concluded that the ONDAM growth rate should be adjusted to these parameters: that meant an increasing of health care expenditures of 4 to 6% per year.

This method is very similar to the Sustainable Growth Rate calculation used by Medicare for physicians' fee payments in the United States (GAO, 2005) (GAO, 2002). The Sustainable Growth Rate system was created in the United States by the Balanced Budget Act of 1997. Its objective is to moderate spending of Medicare, the Federally financed program for the elderly. Over time, the SGR system has been revised but its main principle remains. When physician services exceed a pre-defined spending target, fee updates are reduced. Thus spending increases caused by volume are corrected by fee moderation. The SGR is the product of the estimated percentage change in four elements: (1) input prices for physician services, (2) the average number of Medicare beneficiaries in the traditional fee-for-service (FFS) program, (3)

National economic output, as measured by inflation-adjusted GDP per capita (4) expected expenditures for physician services resulting from changes in Laws or Regulation.

The advantage of these formulas is to introduce explicitly a volume indicator (beneficiary numbers) and to compensate growth of production costs for physicians instead of implicitly adjusting fees to public hospitals wage growth rate which has no link to outpatient services constraints. The method also has the advantage of recognising that health care provision should be compatible with the GDP per capita growth rate. As health care is financed in France by taxes on the gross national revenue, this is a coherent way to link health spending growth to the overall wealth of the country. Nevertheless a question still remains unsolved. As physicians consider that demand is increasing more quickly than the GDP growth rate, the SGR system's allowance should be increased regularly.

Conclusion

Although the global budget was supposed to be an efficient tool to restrict public health care expenditures in France, outpatient regulation has failed. Governmental control over physicians' overall spending and activity has been rejected and outpatient activity has been very lightly regulated since 2002. Up to now, the health authorities have officially maintained the ONDAM as a target but its growth rate is now calculated by considering multiple pressures (from patients and producers) existing on public health care spending.

Price flexibility is still presented as the main regulatory tool. The price role has even been introduced for public hospitals. Per case payments through Diagnosis Related Groups (DRG) classification have progressively been replacing hospitals' global budgets since 2005. From now on, if all public hospitals exceed the overall sub-budget devoted to hospital activities, DRG unit prices will be reduced in the following year (Cash, 2004)

So the regulator must deal with the issue of whether future health care can be publicly financed. Two options are possible: 1) increasing taxes and accepting that health care will be a major part of public finances in the future. A French Senate report (Vasselle, 2003) has shown that if there is a two point gap between the growth rate of GDP and health care costs then public health care expenditures will represent 16% of the GDP in 2040. 2) Reducing the package of care which is financed through public funds. For example, France is cutting the list of drugs that are reimbursed within the ONDAM. The latest health care reform in 2004,

combines these two options, but direct regulation of producers using global budgets and strict financial constraints has been definitively abandoned.

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