5. Funding methods in hospitals

Hello, I am Véronique Sauvadet. I am the head of the department for funding and economic analysis with the ATIH. What is the ATIH? The ATIH, or the Technical Agency for Information on Hospital care is a public administrative institution created in 2002 with the goal of collecting analyzing, compiling and publishing all information relating to health facilities and medico-social facilities. Among other things, the ATIH is tasked with putting in place the technical specifications of funding models for health facilities. This is what I will talk about throughout this video. In order to understand the current funding model for health facilities it is interesting to cast our minds back to the 1980s when health facilities were financed through a tool known as per diem, which was particularly inflationary. This was followed by a system of global budgeting lasting 20 years. To try and get around this problem of an inflationary system public authorities had to implement tools to understand what health facilities were doing both in terms of the services they provided and the costs of hospital treatment. This did not happen all at once. It took almost 20 years which was the whole period of global budgeting. We should note, however, that in 1994 there was a small development in the funding system based on what was called ISA points which was a composite index on hospital activity representing the early signs of the introduction of activity-based health care spending within the tools for health facility funding. The case-mix system arrived in 2004-2005 and that is what I am going to explain at length now. Before going into the details about the different facets of a case-mix system we must bear in mind that it exists within a framework meaning that health facility funding is structured within the framework of the ONDAM the national health insurance spending objective. This represents about 191 billion euros and is split up into five categories of objectives. Outpatient care takes up about 45-46% health facilities, so the hospital sector also covers about 45-46% then there is the medico-social sector the Regional Intervention Fund, or FIR and a final category for miscellaneous services. To fully understand the situation it must be noted that each of these broad categories – hospitals especially – are further divided into subcategories. There is the MCO spending objective which covers services in medicine, surgery and obstetrics there is the SSR spending objective for post-acute care and rehabilitation there are the ODAM and OQN spending objectives concerning psychiatric services and, finally, a fund to modernize public and private health facilities. We can go on. Looking even deeper, the subcategories each contain sub-subcategories because within each of the spending objectives for medicine, surgery and obstetrics there are several more subcategories. These are the cases which lead to the case-mix funding but there are also other things such as annual payment bundling or budgets for services of general interest and contract agreements. To properly understand this framework, we must bear in mind that it is not just a macro-level framework but also a micro-level one, subdivided into many other categories. Ultimately, when we can understand changes in the ONDAM and break it down into parts we can see how health facility fees progress. What are the overarching funding principles? So, what are the main principles behind health facility funding? Firstly, we need to understand what it is we want to finance – what are its specificities, its objectives and how funding should be measured: by stay, by day, or by service? Secondly, we must remember that health facility funding is based on the sector of activity. This should be clear from the framework where I mentioned medicine, surgery, obstetrics post-acute care or psychiatry: we work by sector of activity. We also have a larger, more structural logic with three types of funding.

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The first is directly linked to the activity and financed on a case-by-case basis the second is with bundled payments based on a series of cases which relies on what I would call long-term activity and the third is general budgets which are almost entirely unrelated to the activity. MCO funding principles Medicine, surgery and obstetrics is the sector of activity that has the widest range of funding mechanisms. A hospital stay in this sector is financed by a flat fee to which various surcharges can be added such as an extra daily rate if the patient went to the ICU or required continuous surveillance. There are also services not included in the stay such as very costly drugs or certain other medical devices. An annual bundled payment can also be added to this hospitalization fee. This is the case for the ER or for transplants or even for services that coordinate organ donation. In practice, for the ER this annual bundled payment is essentially fixed-rate funding to which a single service is added: either a hospital stay, at its regular rate or a trip to the ER with no subsequent hospitalization consisting of admitting and treating the patient in the ER. Remote services are also financed through bundled payments which is an important thing to bear in mind. Hospital-at-home services are funded per day and, as I mentioned before, MCO funding also includes elements not directly related to health care such as services of general interest which are financed by general budgets. That's it for MCO funding. SSR funding principles Within the sector of activity of post-acute care and rehabilitation funding tools are currently undergoing reform with some details still being ironed out. We should note however that SSR funding will share similarities with MCO funding such as surcharges for costly drugs or services of general interest. However, there will be other aspects that are specific to SSR such as rehabilitation equipment which will likely end up being part of a flat rate scheme. As for the activity it will be a new and innovative model as it will be a combination of a budget serving as a foundation which guarantees a minimum of financial resources and an activity-based supplement. This is therefore a mixture of budget and case-mix funding. Finally, we can combine MCO and SSR for an interdisciplinary tool which is financial incentives for quality improvement. This will allow funding to be awarded when a certain level of quality is reached or when quality has been improved. Psychiatric funding principles I will not spend much time on psychiatric services because this is a system that was set up in the 2000s. There is a budget for non-profit public and private facilities and a system of fees per day for clinics. Currently, the main goal of public authorities is to find new ways of awarding extra funding. The challenge will be to define the criteria for this. Over the last few minutes, I summarized for you the current model for health facility funding. There have been multiple and varied reports that sought to evaluate this current system in order to highlight both its advantages and its limitations. These limitations are particularly noticeable given the current intention to improve outpatient care and in light of the aging population. Tomorrow's challenge will be to make sure these funding models can adapt and be adapted in order to provide patients with coordinated treatment.