6. The Véran report: advantages and limits of T2A

Hello, I am Véronique Sauvadet, head of the department for funding and economic analysis with ATIH, the Technical Agency for Information on Hospital care. I will give you some technical insight into the solutions put forward in reports on the funding mechanisms and the evaluation of health care facilities. There are many such reports issued by various institutions: the General Inspectorate of Social Affairs (IGAS), the General Inspectorate of Finance (IGIF) and the Senate, via the Social Security Assessment and Monitoring Mission (MECSS). The last report was issued by Olivier Véran. The advantages of T2A: These reports highlight several advantages of case-mix (T2A) funding, i.e. the funding mechanism in place for the last 10 years. Namely, it has helped in developing medico-economic approaches and in fine-tuning knowledge on how health care facilities operate. Case-mix funding, coupled with budget and accounting reforms, brought about a management control framework. It also helped establish a form of equity among facilities and territories, as these funding mechanisms and pricings are nationwide. The limits of T2A : Reports show T2A has limits. First, T2A is mostly based on previous hospital activity. Therefore, it may be tempting to perform unnecessary clinical procedures for profit. Second, with case-mix funding, quality of care is seldom taken into account. This is another limit of T2A. Specific needs of certain populations are also rarely thought about. While population-based approaches were implemented such as taking into account precariousness and local hospitals, but these efforts are not yet sufficient. Concerns were also raised on the references chosen to set T2A, therefore regarding losses of efficiency and effectiveness in the system. Lastly, another important limit is the compartmentalization of funding mechanisms within hospitals and between sectors of activity – due to specific mechanisms i.e. MCO, SSR, psychiatric and medico-social care – and in outpatient care and among the various actors. Yet, public health issues such as aging populations, or the spread of chronic diseases, require funding mechanisms that will not hinder the coordination of patient care Limit 1: the reference for setting T2A Today, this reference is mostly determined according to average care costs. There may be other references, such as constructed costs, which are based on medico-economic calculations made by experts and specialists. Another reference could be efficiency costs: instead of looking at averages, one could form a sample group of facilities that are deemed efficient and see how much they charge. However, both constructed and efficiency costs are complicated to implement. Efficiency must first be defined, and indicators are needed to observe and measure costs in these facilities. Limit 2: compartmentalized funding. On this matter, Article 35 of the 2018 PLFSS or French Social Security Financing Bill introduced an interesting experiment involving innovative systems. The idea is to set aside all existing funding mechanisms and foster the emergence of innovative systems and foster comprehensive patient care. This 2018 PLFSS article is based on a very pragmatic, empirical approach and a bottom-up approach. That means defining frameworks, specifications, launching calls for proposals to which stakeholders can respond, and assessments based on empirical evidence in order to generalize or broaden the use of such funding mechanisms. These mechanisms work in two ways: one involves bundled payments, i.e. per each episode of care, that will generally apply to specific care for which a number of services will be provided. Ultimately, the strength of these new mechanisms lies in flat-rate financing, which covers all necessary services for patient care such as surgery, regardless of who coordinates the care, so that these services are paid for..

There are other approaches and mechanisms especially abroad, that experiment with incentives to share the cost of care. In this case, a group of stakeholders collaborates to meet the health care needs of entire populations, e.g. senior citizens within a territory. In any case, regarding funding mechanisms, one take into account incentives. There must be returns on stakeholders' investments. Quality of care indicators must also be taken into account, to make sure that coordinated patient care responds to the demand for care in its entirety. Article 35 thus offers an important perspective on stakeholders' funding mechanisms. Quality of funding mechanisms and its indicators Quality is a delicate matter. How should funding mechanisms take quality into consideration, without relying solely on economic performance? This is a concern in evaluating funding mechanisms. Many foreign experiments rely on P for P, i.e. payment for performance. Financial incentives to improve quality (IFAQ) were introduced in France, but IFAQ remains relatively modest, representing only 40 million euros. IFAQ incentives apply to quality of care and developments in said quality. Still, this is a closed-loop mechanism. To move beyond such mechanisms in financing models, stakeholders are now calling for quality indicators to be reinforced and be made more robust and more reliable. How? By combining two mechanisms. Today, quality indicators are decent process indicators. It is important to acknowledge the recent efforts to develop these indicators. We now have more than 40. What this mechanism lacks is performance indicators that focus on clinical outcomes of patient care, such as indicators on mortality, issues linked to hospital readmissions, rehospitalizations, or even complications. It is technically very difficult to apply these indicators, as they are based upon patients. So patient characteristics must be forgone by implementing standardization methods that can be used for comparison. Public authorities have substantial room to participate in developing such indicators, which are not yet available for direct use in financing models.