HealthManagement
Promoting Management and Leadership

Volume 10, Issue 4 / 2008 - Privatisation

Lethal Treatment for Public Hospitals

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The Shock of T2A

Funding healthcare by T2A (activity-based fees) has replaced the funding of hospitals via the general budget established in 1983. The goal of the general budget was to limit expenses by restricting activity. The main criticisms of the general budget were its injustice vis-à-vis private clinics, which were not subject to the general bud get, and its unsuitability for the activity since it offered a “peculiar advantage” to well-funded hospitals and penalised less well-funded hospitals experiencing growth in their activity. The result has there fore been a transition from a deflationary system to a potentially inflationary system by “activity-based” payment.

The end goal of the system, as well as its ultimate corruption, is revealed by the assertion of a total convergence of public and private care by 2012, even though, as recognised by the director of the Minister’s office and health advisor to the President of France, the structure of healthcare for public hospitals and private clinics is fundamentally different. This difference extends to the medical salaries included in hospital costs, even though medical fees and social security subsidies for medical insurance are not included in the costs of private clinics.

In practice, as confirmed by expected losses at 29 of the 31 CHUs (university hospitals), the T2A financing system was developed in favour of private clinics, to the detriment of public hospitals. Thanks to T2A, the turnover of private clinics has risen by 9%. The Générale de Santé, which owns 180 clinics, has paid EUR 420 million to its shareholders while the deficit of public hospitals exceeded EUR 350 million and next year is expected to exceed EUR 400 million.

French private clinics are currently undergoing in-depth restructuring, a trend that has resulted in interest from inter national investment funds such as Blackstone that seek returns of 15- 20%. In certain regions, private clinics already have a monopoly. At the same time, charging healthcare fees in excess of what social security will reimburse is becoming increasingly common, paving the way for supplementary insurance.

Functioning of T2A

To succeed in organising a system characterised by activitybased payment, it was necessary to quantify this activity, which led to the adoption of a reductionist approach involving the use of codes. Some 10,000 different pathologies were classified into 750 “homogenous” hospital stay codes, which are therefore very heterogeneous. Average benchmark measures were chosen based on a very opaque, highly criticised methodology, in particular as regards pathologies that are highly specialised or that are almost exclusively treated in hospitals, such as leukaemia or very intensive care. Very benign pathologies mainly treated in private clinics were placed in the same homogeneous groups as serious pathologies that are mostly treated in hospitals. T2A does not take into account emergencies or highly specific activities in specialised centres.

Impact of T2A

T2A is going to force hospitals to change the way they are organised, i.e. to “increase their productivity”, by reducing their headcounts. According to the French Hospital Federation, the only way for the system to break even will be to find 20,000 redundancies, even though no one dares to talk about this! Hospitals are also going to have to change the way they are structured by adopting financial profitability criteria corresponding to the activity of private clinics, i.e. surgery and simple treatment acts (surgery for varicose veins, cataracts, hip replacements, pacemaker, etc.), to the detriment of activities deemed unprofitable (therapeutic prevention and education, chronic illnesses, multiple pathologies and dependencies). This means that complementarity will be replaced by competition. Dialysis machines are already working at their full capacity and Paris hospitals are attempting to win “market shares” in orthopaedic surgery and cataract surgery. Hospitals will lose their unique characteristics and, in so doing, their appeal.

Hospitals must be in a position to provide care 24 hours a day. This means that there must always be free beds to satisfy an acute need (epidemic of bronchiolitis, heat wave, etc.). Unlike a clinic, a hospital cannot aim for a 100% occupancy rate. A failure to finance 15-20% of empty places would be like paying firemen only when there is a fire! For the same reason, a certain percentage of hospitalisations cannot be anticipated. Yet, for the exact same pathology, an unscheduled admission costs roughly 60% more than a scheduled admission.

Thus, in order to cope with this situation, it will be necessary to pay hospital surgeons the same way as their private clinic peers are paid: by medical act, at the risk of destabilising teamwork. This restructuring will be managed by directors who will have become businessmen. They may come from the private sector, be hired on private contracts at

non-public hospital salaries, and return to the private sector after a few years, if they so wish. Moreover, both doctors and administrative staff will likely be entitled to a share in profits, thereby creating a conflict of interests inconsistent with medical ethics and the spirit of public service.

Reform Principles

There are two dominant thoughts behind this reform of public hospitals:

as is the case in most countries, this involves the calling into question of the supposedly inefficient public services. The

government's aim is to achieve at least partial privatisation, introduce competition and "make work more flexible", in order to reduce costs. This market-based approach is tantamount to merchandising medicine. It reflects a misunderstanding of

the evolution of medicine, an approach that only looks at things in terms of technical progress and acute illnesses (according to Claude Le Pen, a healthcare economist, "caring for a sick person and fixing a car is the same thing").

The other characteristics of the evolution of the healthcare system, i.e. the increase in chronic illnesses requiring comprehensive, multi-professional, multidisciplinary care and therapeutic education, are excluded from the analysis or marginalised with the illusion of a transfer of coverage to non-hospital or nonmedical "community" resources (patient associations, NGOs, call centres, etc.). The US system based on private insurance, despite its numerous failings, has become a reference for decision makers' analysis of the situation.

Conclusion

The organisation and funding of the healthcare system should be analysed in these two ways: acute disease and treatment acts on the one hand and comprehensive care for persons with chronic illnesses, on the other.

There is an urgent need to limit T2A to what it is suitable for and to rethink hospital financing before T2A has turned the entire system's structure upside down by transforming hospitals into private clinics (for profit or notfor-profit) on the one hand and into modern homes for the disabled, on the other.

Published on : Fri, 22 Aug 2008