HOW RESEARCH FINDINGS on factors influencing patients'cost of care in community nursing services for frail elderly led to a REFORM OF THE RESOURCE ALLOCATION METHOD in France

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PROBLEM DESCRIPTION

Demographic trends have led to an increasing need for social and health care for the frail elderly. Across Europe, in order to address the expected relative shortage of nursing homes, the development of services providing a comprehensive, coordinated and integrated range of personal and maintenance care for the frail elderly at home is encouraged.

In France, this is called the "maintaining at home" policy of which community nursing services (CNS) are a cornerstone. CNS provide care to 120,000 elderly at a cost of over € 1.3 billion per year, and their number is expected to rise rapidly.

However, financing problems exist: differences in patients' needs for care result in wide variations in cost per patient when services are funded on a simple per capita basis. CNS caring for very frail, highly demanding patients are therefore destined either to be bankrupted, to serve a smaller number of patients than they are paid for, or to cream skim new patients.

RESEARCH CONDUCTED

In 2007, the Ministry of Health (MoH) and the national health insurance (NHI) decided to conduct a cost study along with health services researchers (HSRers) to measure the cost of patient care and its variability and to identify factors that influence variations in cost. The study design was done in a collaborative manner by members of the NHI and of the MoH with the help of HSRers. The NHI and MoH local services collected the data. HSRers from the Paris health economics and health services research unit, a HSR unit, did the analysis.

The study was conducted on 2178 patients in 36 services. It used a micro-costing approach to estimate patient cost and hierarchical modelling to measure and to identify factors explaining variations in costs.

Findings show that elderly patients' cost of care ranges from one-tenth to three times the capitation lump sum while the average cost is below. The CNS financing problem is therefore mainly related to bad resource allocation mechanisms across services. Cost depends on 14 characteristics describing a patient's level of disease and of disability, and the informal (relatives, neighbours…) and formal (non-personal care services) help that they received beyond CNS.

POLICY IMPACT

As a consequence, the Paris health economics and health services research unit was asked by the MoH to develop a new resource allocation method that takes into account patients' needs to improve equity of financing across services and therefore efficiency of resource use. In collaboration with the MoH, HSRers set up a pilot committee that included policy makers, funding entities and researchers. The group met weekly over a four-month period. The objectives and the structure of the new financing model, as well as the factors taken into account, were therefore collectively defined.

The new resource allocation method includes a part covering overhead costs and a part covering the specific needs of a patient. The overhead cost is covered by a fixed lump sum per capita that varies with the number of patients cared for by the service. The cost of covering the specific needs of a patient is estimated with variables identified in the modelling analysis of the cost study. Moreover, many incentives or disincentives can be inserted to improve the use of the different types of services for frail elderly, such as better rewards for patients with high needs to postpone their entrance in nursing homes and low fees for light need patients favouring the intervention of basic support, non-personal care services.

This innovative method based on the evaluation of needs was approved by the heads of all the implicated institutions (direction of health and social affairs, direction of social security, national health insurance, the national fund for solidarity and autonomy) in a final meeting. It is currently being implemented and should improve the use of CNS and the efficiency of the overall system after January 2011. The Paris health economics and health services research unit is in charge of technical support for the implementation stage.

SUCCESS AND FAILURE FACTORS

SUCCESS FACTORS

The successful transformation of the HSR findings into policy actions was due to the involvement of both HSRers and all stakeholders (regulators: two departments of the MoH, and funding entities: national health insurance and the national fund for solidarity and autonomy) at every stage of the process: problem identification, problem solving, and the implementation stages. Moreover, representatives of community nursing services were included in the problem identification stage.

FAILURE FACTORS

Some failure factors can be identified at the implementation stage, including the relative slowness of the process. The cost study was initiated in 2007, results were available in late 2008, and the new resource allocation model was approved in December 2009. In 2010, the department in charge of the implementation was reformed. The head of the department and its main collaborators changed, leading to a break in the process for a few months. Newcomers had to be informed about the new allocation method. Because they did not participate in the collective decision making, there were questions and sometimes disagreements about the model, and new explanations were required. Finally, the minister changed in mid-March, and the new minister's approval will be required. This may result in additional delay and uncertainty.

CONCLUSION

The reform of the CNS resource allocation method is an example of evidence-based policy. It shows that collaboration at the early stages among regulators, funding entities and researchers enhanced the use of HSR results in decision making. However, it also shows that time and stability in the individuals participating in the development of the reform are major factors

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