2010 Irdes Workshop
on Applied Health Economics and Policy Evaluation

Comparing Productivity in French Public and Private Hospitals

Brigitte Dormont and Carine Milcent

DISCUSSION

by

Matteo Lippi Bruni

University of Bologna

24-25 June 2010

The 2010 IRDES Workshop on Applied Health Rconomics and Policy Evaluation
24-25 June 2010 – Paris – France
www.irdes.fr/Workshop2010

- The paper encompasses highly debated topics:
  - Role of payment systems
  - Relative efficiency of different providers
    - Do ownership structure matters?
  - Estimation issues
    - How to measure hospital efficiency?
- It also addresses relevant policy issues:
  - Are different payments for the same treatments between the public and the private sector justified?
  - Do more generous tariffs for the public sector prevent the latter from becoming more efficient?

Policy implications for the French case

- My first suggestion is to **clarify** better the **link** between the (expected) **empirical results** and the current **French policy debate**.
- Data used in the empirical analysis cover the period 1998-2003.
- Different payment mechanism were in place
  - Global budget for public hospitals (soft budget)
  - Retrospective payment scheme for private hospitals
- How informative are the results for the present situation based on a prospective payment system (PPS)?
  - If the payment mechanism has an impact on efficiency, after more than five are the relative performances of the different groups of hospitals still the same?
  - Or should we expect them to have changed as a consequence of the introduction of the new payment system? ….

Convergence up or down?

"Convergence in payments", as supported by private lobbies, seems to imply that tariffs for the private sector should increase

but…..

even if the public sector would emerge as "inefficient", what would be the rational of extending such (inefficient) payment schedule to the private sector?

A few institutional clarifications

- Do public hospitals receive **additional payments** other than those implied by PPS to finance services such as 24hrs access?
- According to the authors' view, the present work allows to draw conclusions on the potential impact of payment convergence, that is a change in the PPS system
- The **role of PPS** wouldn't be better evaluated by comparing efficiency **before and after the reform** in reimbursement system occurred in 2004?
  - If ownership matters for efficiency, we expect this to depend on the different sets of incentives (and constraints) under which public and private providers operate.
  - Why not exploiting the change in incentives that follows the establishment of PPS for getting insights on relative efficiency?

Hospital choice?

- In order to understand what is the potential of PPS to increase competition between facilities, the reader should have information on how the choice of the hospital takes place for (elective) treatments
  - Is the patient referred to the hospital by a GP?
  - Can the patient freely choose between Pub-FP-NFP facilities?
  - Does the choice of the provider has implications on the out-of-pocket expenses of the patient?
    - i.e. hospital care is entirely free of charge at the point of demand?

Teaching Hospitals

- How are TH reimbursed?
- I expect them to display relevant peculiarities wrt the rest of public facilities
  - Staff patients composition, etc…
- Moreover, their objective function partially differs from the rest of the sample
- I wonder whether a dummy variable is sufficient to control for all potentially confounding factors.
  - Interactions?
- Are the empirical results robust to the exclusion of TH?

Results- Length of stay

- **Model 4**
  - As far as I understand **LOS** is included as additional proxy for (otherwise unobserved) differences in the severity of case mix.
  - In the empirical literature LOS is recognised as being largely the result of hospital choice through accurately designed discharge policies
    - i.e. there is evidence that hospitals react to changes in the reimbursement mechanism by varying average LOS
  - Isn't this variable highly at risk of being **endogenous**?
  - Take two groups of hospitals identical in any respect apart from LOS. Does the group with longer LOS emerges as relatively more efficient in the analysis?

Results- severity & mortality

- How is severity measured?
  - I assume that you take "*severity 1*" as the baseline case omitted in the estimations
- Is severity increasing from 1-3?
  - If so, the signs of the severity coefficients seem to contrast with "mortality"
- More fundamentally… is it appropriate to include mortality as a control variable?
  - This would imply that mortality rates are exogenous, whereas we expect them to be the outcome of a (complex) sets of factors over which hospitals (hopefully) have some degree of control.

Results-Inefficiency

- The final results show that:
  - public hospital of medium and large size do not display higher level of inefficiency with respect to private hospitals, once production and patients characteristics are taken into account
  - Small public hospitals appear as relatively more inefficient wrt private ones
    - especially in Model 1
- Maybe **geography matters**….
  - Are small public hospital, rural hospital?

- In that case, lower productivity rates would be "justified" as the presence of a rural hospital increases accessibility in remote areas
  - Unexploited production capacity works as option value in this case.
- Can you include information on hospital location and/or on the installed capacity in the district where each hospital operate?