TITLE: New features for the French hospital Financial Incentive for Quality Improvement program (IFAQ)

Introduction

The hospital Financial Incentive for Quality Improvement program (IFAQ) has been launched in France in 2012 by the Ministry of Health and extended to all hospitals for acute care and home care in 2016 and for rehabilitation care in 2017. In 2018, France initiated the National Strategy for Healthcare System Change, which strengthened its Pay-For-Performance mechanisms. Under it, the amount dedicated to IFAQ will increase from €50M in 2018 to €1 billion in 2023 and the model will be extended to psychiatric hospitals.

Furthermore, IFAQ has been rebuilt. The France's Technical Agency for Information on Hospital Care (ATIH) under the direction of the Ministry of Health is overseeing the development and the implementation of the "new IFAQ". The purpose of this presentation is to outline the new features of IFAQ that have been implemented since 2019.

Methods

The main new features of the new IFAQ are (i) pay per indicator, (ii) dual integration of outcomes (level achieved and improvement) and (iii) model stratification by comparison group (CG).

Indicators are annually selected by the Ministry of Health as part of categories fixed by law such as Quality of care as perceived by patients or Quality of clinical care.

CG have been built to contain hospitals with similar activity (number of inpatient stays crossed with the degree of specialization).

For each indicator, a target level is defined independently from CG. In addition, a threshold for remuneration is determined per CG based on the outcome of the top 70% hospitals.

Per hospital and per indicator, the level of remuneration will be:

- Outcome equal or above the target level: 100%
- Outcome between the threshold of remuneration and the target level: 50% based on the distance to reach the target level + 50% based on the improvement over last year.
- Outcome below the threshold of remuneration: 50% based on the improvement over last year.

An overall level of remuneration is calculated for each hospital and the credits are allocated to them per CG, according to the economic volume they produced and how they performed on the indicators.

Results

New IFAQ has been implemented for 3 years now. It has been strongly impacted by Covid-19 pandemic as the collection of most indicators was suspended in 2020 and the economic volume of the hospitals was differently impacted depending on the CG.

Limitations of this model have been identified for the outcomes' integration of indicators based on automatic calculation from medico-administrative databases. Indeed, generally, these indicators need to be adjusted. The adjustment is then questioning (i) the interest of a stratification per CG and (ii) the method to determine the threshold of remuneration based on hospitals' outcomes by CG instead of on the deviation from the expected outcome estimated specifically per hospital based on its activity and patients' characteristics. An example will be displayed.

Conclusion

The new IFAQ is still adjusting and is being appropriated by hospitals. In the coming years, the Ministry of Health should anticipate the choice of indicators used for IFAQ to let time to hospitals to implement actions to improve their outcomes. In addition, ATIH will need to develop new indicators issued from medico-administrative databases and develop statistical methods to improve their use for the IFAQ program.