

8.4 FRANCE

8.4.1 Health care organisation in general^{hh}

The French health care system is a centralised mixed system combining elements of various organizational models:

- It is a publicly funded system characterized by freedom of choice and unrestricted access for patients and freedom of practice for professionals;
- The organizational model is built on health insurance funds and strong state intervention. It is complex and pluralistic in its management, with co-management by the state and the health insurance funds.
- It combines public and private health insurance, which finance the same services by the same providers for the same populations;
- It combines public and private care, including private for-profit hospitals;

8.4.1.1 Health insurance

The financial management of health care in France is mainly regulated through the statutory health insurance as a branch of the wider social security. It covers the entire population of France. The health insurance system, offers wide-ranging reimbursement in the fields of preventive, curative, rehabilitative, and palliative care.

There are three main schemes within the statutory health insurance system: a general (employees in commerce and industry and their families), an agricultural scheme for farmers and their families and a scheme for self-employed people. In 2004 an insurance fund was established specifically for dependent elderly people. In 1999 universal health insurance coverage (CMU) was established on the basis of residence in France (99.9% coverage for medical expenses).

The health insurance is compulsory and covers all households regardless of health status, income, number of persons, etc. It provides a somewhat uniform field of reimbursement, with the “basket of goods and services” covered by the insurance funds being identical for all the statutory schemes, and a same reimbursement rate for the three main insurance schemes (since 2000).

Health benefit catalogues are drawn up at national level with the whole range of goods and services reimbursed by the statutory scheme. The reimbursement of goods and services depends on their inclusion in defined lists, identified through advice of ad hoc scientific commissions and agencies, such as the former National Agency for Accreditation and Evaluation in Health Care (ANAES)- the current haute autorite de santé (HAS), checking for the effectiveness and/or safety of these procedures and the conditions under which they need to be performed.

More selection is occurring in the insured services delivered by private sector profession in their own practices or in private for-profit hospitals. Services dispensed in public hospitals or private not-for-profit hospitals are mainly the subject of implicit definition since they were paid for by a global budget.

8.4.1.2 Health care policy-making and organisation

The French health care system is a very centralized model, with an important role for the regions. Regions are responsible for the factual organization and execution of health

^{hh} This paragraph is mainly based on the report “health systems in transition: France, WHO, 2004.

care policy, while the central authorities define the policy and operational framework. (see Appendix to chapter 8)

8.4.1.3 *Financing*

The financing model is subject to important reforms. The Social Security Act of 2003 (Loi de financement de la sécurité sociale, LFSS) changed the inpatient acute care funding rules, but implementation is still in progress. The nomenclature for physicians' procedures, the CCAM, applies from that date to both private and public hospitals. The reform will also change the remuneration schemes of inpatient and outpatient care.

- Services provided in inpatient or outpatient acute care will be financed through a payment-per-case system for all hospitals (700 Groupes Homogènes de Malades (GHM), considering co-morbidities and a nationally fixed tariff (Groupe Homogène de Séjours, GHS).
- Outpatient procedures will be paid on a fee-for-service basis
- Organ retrieval and emergency services by annual lump sum payments.

Physicians are always paid separately and directly on a fee-for-service basis, except in public hospitals, where tariffs include specialists' salaries.

- **France has a publicly funded system characterized by freedom of choice and unrestricted access for patients and freedom of practice for professionals.**
- **France has a compulsory insurance system, but a large proportion of the population has private (complementary or supplementary) insurance.**
- **France is a centralized model, but has delegated a lot of operational responsibilities to the regions. The “regional hospital agencies” (ARH) are responsible for hospital planning (for both public and private hospitals), financial allocation to public hospitals and adjustment of tariffs for private for-profit hospitals.**
- **The SROS (Schéma Régional d’Organisation Sanitaire) is the regional planning tool for health care provision. The SROS provides the regional hospital agencies (ARH) with a framework for granting authorizations, approving proposals submitted by institutions and negotiating contracts.**
- **Services provided in inpatient or outpatient acute care will be financed through a payment-per-case system for all hospitals (700 Groupes Homogènes de Malades (GHM), corrected for co-morbidities and a nationally fixed tariff (Groupe Homogène de Séjours, GHS).**

8.4.2 The organisation of the rehabilitation sector

8.4.2.1 *The underlying conceptual ideas*

Rehabilitation is conceptually organised around three levels of care^{161, 162}

- The specialized level of care has to answer very specific needs of a particular group of patients within a region. At this level specialised “reference” centres are identified, in charge of advanced medical and paramedical care. These services fall under the responsibility of a physician, and medical and paramedical team with specific competencies for the pathology
- A second level is created for high needs or specific care needs requiring particular competences. This level is typically foreseen for the non-complex neurological pathologies (such as MS and stroke) and for geriatric care.

- The “low” level is created for general multidisciplinary rehabilitation and medical care, generally attached to hospital services and typically foreseen for short term rehabilitation, often in close collaboration with the SSR.

A specific regulation of 1997 defines five functions of technical and support tasks for continuous care or rehabilitation:

- limit the impairments through rehabilitation,
- somatic and psychological rehabilitation through intensive treatment or teaching compensatory techniques, education of the patient (and his peers),
- follow up in after care and control of pain
- taking initiatives for reintegration in society.

These principles have to be realised through the development of a continuity of care model (filiales de soins).

The organization of the rehabilitation sector has a clear regional orientation. Four geographical levels are distinguished, conceptually closely related to the notion of “filiales de soins”. They aim at serving people as close as possible to their home, integrating them into daily life as far as possible:

- The interregional or regional level: on the interregional level services are responsible for highly specialised care for pathologies with low incidence/prevalence (e.g. burn units, visual deficits or auditive deficits), but for which specific technology and infrastructure is needed.
- On the regional level, specialised centres, using particular technologies, having an adapted infrastructure and competences but for which also the idea of accessibility for people of the region is taken into account.
- The “intermediate” level, is defined as the less specialized rehabilitation services, clearly serving the people from a geographically near area. It are services not requiring very specific technologies or infrastructure.
- The local level (niveau de proximité) is the alternative form of hospital services, offering medical and rehabilitation care at home.

The regulations “soins de suite et de readaptation” (SSR) form the framework for middle-long term rehabilitation services (moyen séjours) are as follows. As a general principle, the SSR aim at patients coming from acute or post-acute settings or other SSR, and are primarily aimed at social reintegration for those people in need of a global medical-rehabilitation for deficiencies or impairments, in need of a medical follow up, or in need of functional rehabilitation. They are conceptualized as the “in-between-services” between acute hospital environments and the home care setting (or long term care facilities). There are “general” SSR and SSR specializing in geriatrics, cardiology and nutrition¹⁶³. The agenda for the SSR is centrally set by means of circular letters (circulaires) (lettre circulaire DH/EO4/97 n°841 du 31 décembre 1997 relative aux orientations en matière d'organisation des soins de suite ou de réadaptation ; la lettre circulaire DHOS/03/DGAS/AVIE n°2003-257 du 28 mai 2003 relative aux missions de l'hôpital local (notamment dans son paragraphe « Développer l'hospitalisation en soins de suite et de réadaptation »). In 2005 HAS/ANAES has published a report on the state of the art of SSR, in which the roles and missions of different services are clearly described.

8.4.2.2 *Rehabilitation facilities*

Rehabilitation can take form in intramural settings (hospitals, specialized rehabilitation and nursing facilities), in ambulatory form (day hospitals) or in home care, depending on the clinical status of the patient. The most important post-acute facilities are university based rehabilitation units, general hospital rehabilitation units and rehabilitation centresⁱⁱ

- The mission of MPR (medicine physique et réadaptation) in university hospital centres is focused on teaching, research and expertise highly specialised rehabilitation and has to participate in networks of care.
- MPR services within hospitals are polyvalent rehabilitation services not necessarily involved in highly specialised rehabilitation
- Rehabilitation centres are specialised and polyvalent facilities often reference centres for specific pathology groups, and also expected to participate in networks of care. Teaching and research can be part of their mission

Due to historical reasons, France has an uneven geographical distribution of rehabilitation centers. For this reason units for rehabilitation in acute hospitals (both in Centres Hospitaliers, and almost always in Centres Hospitalier Universitaires) play an important role in rehabilitation in the different regions. They focus on the medical and paramedical issues of rehabilitation.

The services for medical rehabilitation (medicine physique et réadaptation MPR) are specialized rehabilitation units generally linked to hospitals, and often with a day care function.

The reforms prepared in the mid 1990 aim at guaranteeing a regional, needs based approach, and developing a more smooth patient flow. Through the “filières de soins”, these hospital services are urged to collaborate with other inpatient and home care facilities, for other dimensions of rehabilitation care. Through these models, one hoped to reduce lengths of stay in inpatient settings, manage the issue of waiting lists, and coordinate the services offered to the needs of the patients.

An important rather new “French” development is the development of the “hôpital a domicile”, delivering medical and rehabilitation services, for people returned home. Not all regions have this service available, but it is a type of service that is developed more and more.

For those people unable to (immediately) return home after the post-acute phase, different types of long term-care facilities are available: (Unités de soins de longue durée, maison d'accueil spécialisée (MAS) foyer d'accueil médicalisé (FAM) and « établissement hébergeant des personnes âgées dépendants », (EHPAD)).

8.4.2.3 *Indication setting in rehabilitation*

For some types of treatment, such as physiotherapy and spa treatment, the prescription from a physician does not provide the status for reimbursement. Coverage by statutory health insurance is subject to the prior authorization (entente préalable) of the physicians advising the health insurance funds, after examination of the patient's case history and a possible interviewing of the patient. However, France is not using a systematic model of indication setting: the indication setting is left to the clinical authority of individual physicians.

8.4.2.4 *Financing of the institutions*

Rehabilitation facilities are falling under the hospital financing regulations. Public and most private non profit hospitals receive a prospective global budget defined by AHR (taking into account historical budgets, relative costs per DRG and priorities in the

ⁱⁱ <http://www.anmsr.asso.fr/anmsr00/crf/intro.html>

SROS). Individual hospitals and the AHR work according to a model of contracting, defining the tasks and commitments of the hospital (quality of care, efficiency, activities,..) Private hospitals have a topic oriented billing system, independent of the fees to paid for the physicians. As a result, prices do vary enormously per region and between hospitals.

8.4.3 Quality

The “charte de qualité en médecine physique et de réadaptation” is used as a formal quality agreement and as a complement to different regulations defining the constituent norms of rehabilitation services. But this agreement is mainly limited tot a formal statement.

In general one could say that France is mainly reflecting on the conceptual and “principles” level about quality. Several documents are being prepared, but no real quality models or indicators as a collective instrument are implemented. The principles proposed are not to be considered as quality tools in the technical meaning of the word.

The quality policies and approaches in rehabilitation are getting inspiration from the CARF accreditation methodology. A working group has been developing criteria for rehabilitation care for different “locomotor” pathologies (“Critères de prise en charge en médecine physique et de readaptation”).¹⁶² The text of the working group is considered as an important reference document in France for the rehabilitation approach for different pathologies.

The infrastructural and equipment characteristics of the facilities (as a condition for quality rehabilitation) are being summarised tooⁱⁱ

Different “circulaires” have been developed identifying the expected level of quality and the norms for treatments (e. g. Circulaire n° 2004-280 du 18 juin 2004 relative à la filière de prise en charge sanitaire, médico-sociale et sociale des traumatisés crâniocérébraux et des traumatisés médullaires ; Circulaire n° 2003-517 du 3 novembre 2003 : relative à la prise en charge des accidents vasculaires cérébraux) ;

Rules of accreditation apply to the institutions providing Rehabilitation Care. The ANAES- “manuel d’accreditation des établissements de santé”, (with a chapter on SSR) sets some organizing principles, and focuses on patients rights. It also introduces the idea of using functionality scales, but this issue has to be developed further

For the institutions providing SSR as a segment of their activity, a specific section in the accreditation reports offers an overall appreciation of these services. The accreditation is however not using specific indicators.

In general, accreditation is used to be more structure oriented, but slowly quality standards started to be integrated. Most of the emphasis has been on hospital acquired (nosocomial) infections, there are some specific norms (process oriented) and objectives. However, real quality assessment tools are not used yet.

In order to develop follow-up systems, some regions very recently started to develop (epidemiologic) registration systems, including a follow up of patients.

Rehabilitation is conceptually organised around three levels of care: a specialized level for very specific needs of a particular group of patients within a region. A second level is created for high needs or specific care needs requiring particular competencies. The “low” level is created for general multidisciplinary rehabilitation and medical care, generally attached to hospital services and typically foreseen for short term rehabilitation.

ii http://www.syfmer.org/referentiel/qualite_mpr/syfcharte04.html

- **The organisation of the French rehabilitation sector has a clear regional orientation. Four geographical levels are distinguished: interregional, regional, intermediate and local level.**
- **The regulations “soins de suite et de readaptation” (SSR) form the framework for middle-long term rehabilitation services.**
- **Rehabilitation can take form in intramural settings (hospitals, specialized rehabilitation and nursing facilities), ambulatory (day hospitals) or home care, depending on the clinical status of the patient.**
- **France is not using a systematic model of indication setting: the indication setting is left to the clinical authority of individual physicians.**
- **Rehabilitation facilities are falling under the hospital financing regulations.**
- **France is mainly reflecting on the conceptual and “principles” level about quality. Several documents are being prepared, but no real quality models or indicators as a collective instrument are implemented.**

8.4.4 Example: Stroke

The approach of stroke rehabilitation fits into the model of the SSR (“soins de suite et de réadaptation”). The organisation model should hold the notion of integrating the activities of different services and developing “chains of care”.

A circular letter (“circulaire”) was endorsed in november 2003 for the treatment and rehabilitation for people with stroke (Cirulaire n°2003-517 du 3 novembre 2003 relative à la prise en charge des accidents vasculaires cérébraux). The circular letter describes the formal conditions, and creates opportunities within the SROS, to develop facilities for taking care of stroke patients close to home (hôpitaux de proximité).

An Anaes-study has focused on the different aspects of treatment of stroke patients. The study focuses on clinical guidelines, including post-acute rehabilitation¹⁶⁴ This report is not paying a lot of attention to organizational matters in stroke rehabilitation, except that some infrastructural issues are mentioned. A major recurrent recommendation is that networks of care services have to be developed in order to provide integrated care.

In August 2005 the HAS-ANAES has launched an evaluation tool-kit for assessing the scope of care offered for stroke patients. The tool-kit aims at supporting the services in doing auto-evaluations and improving the quality of care. It is supposed to steer the future quality assessments of stroke services.

8.4.5 Example: Multiple Sclerosis

Rather recently, an assessment has been made analyzing the state of the art of MS-related topics in France¹⁶⁵

As is the case in many other countries, MS and the particular needs of MS-patients, make the organisation of rehabilitation for this group of patients a particular issue In general terms the treatment and follow up of MS patients in France is very heterogeneous.

Only in few regions, specific initiatives have been set up to coordinate the treatment and care of MS-patients. Since 2001, some regional networks are formally recognized as MS-care networks (“reseau de soins sclerose en plaques (SEP)”), and others are in preparation. The major network-aim is to offer different kinds of (para)medical and social care in a coordinated way, as close as possible to the patient.

Some regions are (at this stage) not covered at all by a formal network of care. Moreover, there is a great disparity between the existing networks in the number of participating patients. The operational conditions of these networks are very dissimilar,