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Health Reform Monitor

# Control of hospitals and nursing homes in France: The 2016 reform may indirectly improve a dysfunctional system☆

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ABSTRACT

In France, the supervisory bodies require hospitals and nursing homes to undergo various control procedures. A stack of legislation and control measures has piled up, with no provision for their interconnection being included in any of the legislation. The purpose of the article is to point to the prospects for better control opened up by the legislation modernising the health system adopted on 26 January 2016. The reform will neither directly change the partitioning between the supervisory bodies preventing the sharing of information and the harmonisation of the practices in terms of control, nor change the internal partitioning within the supervisory body. But in hospitals, the reform will improve the interconnection of control of quality/control inspections/control of strategy using a common medical project and pooling certain cross-cutting functions, and implementing the control of quality for the new local hospital groupings as a whole. In nursing homes, the generalisation of multi-year aims and means contracts would allow a better interconnection of the control of strategy and the control of quality since it provides managers with the means of constructing projects for the evolution of their establishments over a period of time, and accompanies changes in the socio-medical offer to improve the provision of care. These changes would allow a more credible, coherent, useful, and equitable control.



## 1. Policy background

Various types of control have been imposed on hospitals and nursing homes since the 1990s, creating a stack of controls with no interconnection. This situation causes confusion and misunderstandings [1]. The purpose of this article is to demonstrate the positive impact the new legislation modernising the health system is expected to have on the various types of control (and the following timeline shows the evolution of demands in terms of control since 1996).

To do so, the first part of the article presents the main dysfunctions of control identified in an official report in 2013, and their consequences. The second part shows that other types of control were introduced after 2013, paradoxically without taking into account the conclusions of the report. The last part shows that, despite this situation, the legislation adopted on 26 January 2016 modernising the health system has resulted in changes and major improvements in the control of both quality and strategy.

## 2. Issues in adaptation and implementation: dysfunctions in the control of hospitals and nursing homes identified by an official report in 2013

A report by the French Inspectorate General of Social Affairs (*Inspection Générale des Affaires Sociales – IGAS*) in April 2013 highlighted a major problem: the abundance of control and the absence of any connection between the control of quality (carried out at the national level), the other supervisory inspections carried out at the local level, and the control of strategy carried out at the local level [2]. The IGAS refers to a stack of procedures with no strategic vision and no legibility, both within the supervisory bodies and at hospitals and nursing homes [2], which has resulted in a degree of reticence on the part of the establishments [3].

**The control of strategy** consists of checking achievement of the strategic objectives selected in the framework of the multi-year contract of aims and means (*contrat pluriannuel d'objectifs et de moyens – CPOM*) instituted by the Act of 22 July 2009. This contract is negotiated and signed by a hospital (compulsory procedure since 2009) or nursing home (optional procedure until 2016) and

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the supervisory body (the regional health agency (*Agence Régionale de Santé – ARS*)) for a five-year period. In return for a budget allocation, the establishment undertakes to achieve, over that period, a number of objectives allowing the implementation of the regional health project, guided by the supervisory body and drawn up on the basis of national policy on public health. In fine, establishment heads use a number of indicators to auto-supervise the CPOM and report the results obtained to the supervisory body. Eventually, if there is no justification for failing to perform commitments, the supervisory body may terminate the CPOM and recover all or part of the funding already paid out; it may even cancel anticipated financing [4]. It is therefore important to state here that the control of expenditure carried out in the context of the Diagnosis-Related Group (DRG) payment is completely different. The DRG payment system consists of checking that the funding of a hospital is in keeping with its medical activity whereas, for the CPOM, financial control is carried out in the more generalised framework of the control of strategy and also covers expenditure in connection with changes or developments in activities and the improvement of quality [5].

Regarding the **control of quality**, the indicators supplied by the establishments to the supervisory bodies are different: some are drawn up as part of the control of strategy (at the time of signing the CPOM) and are sent to the supervisory body (ARS, at the regional level), while others cover the control of quality and are sent to a different supervisory body at the national level [5] (*Haute Autorité en Santé pour les hôpitaux (HAS)* for hospitals, *Agence Nationale de l'Évaluation et de la qualité des établissements et services Sociaux et Médico-sociaux – ANESM* – for other establishments). Thus quality objectives are incorporated in the CPOM, but at the same time quality is covered by another independent control, which makes the control process more confusing and more cumbersome [4]. It should also be noted that the control of quality is not the same for both hospitals and nursing homes. The control of hospitals takes place every four to six years; it is carried out by independent experts on the basis of a two-part reference framework of quality norms drawn up by the supervisory body. The first part covers quality in terms of management and quality in terms of dealing with patients. If the results are not good, the supervisory body gives advice or expresses reservations, but the Act makes no provision for any sanctions. Nor may there be any connection between the DRG payment system and control of the quality of the care provided. As a result, a hospital may deliver lower quality care without its allocation of resources being affected [5,6]. The control of quality in nursing homes is provided for in the Act of 2 January 2002. It is carried out every seven years by independent experts and covers the pertinence of the activities and services delivered in relation to the people dealt with and to their needs (children, elderly people, dependent people, etc). The reference framework for quality norms is selected by the nursing home and validated by the supervisory body (ANESM). This is very important for nursing homes since the results of the control determine the renewal of their operational authorisations. If the results are bad, the nursing home may have to close; this is not the case for hospitals.

It should also be emphasised that hospitals and nursing homes are subject to **various "control inspections"** (*inspections-contrôles – IC*). Inspections are carried out if resources are being used inappropriately or if an activity is not being carried out properly (when it is thought that there are cases of physical abuse, for example). Control covers observance of the rules, such as the regulations introduced to combat nosocomial infections, and quality standards. An IC may lead the supervisory body to advise or impose action on the part of the hospital or nursing home (for example, the Health Insurance Funds may check that hospitals are using the DRG-based payments system properly [5,6]). And yet the results of inspections are almost never used, whereas they could add a further dimension to the control of strategy by influencing the choice of objectives included in the CPOM. This detrimental situation results in a wide range of differing practices within supervisory bodies at the regional level. While some supervisory bodies consider the control of quality and the various inspections to be partially interchangeable, and others feel that the reports on the control of quality may be used during an IC mission, others hold a contrary view [2].

## 3. Monitoring and outcomes: the consequences of the unsuitability of the control system in hospitals and nursing homes

The establishments themselves prefer to use the terms "assessment" and "evaluation" rather than "control", as professionals tend to be rather suspicious of the concept of control: it is often considered on a par with reporting back to the supervisory body with a view to sanctions rather than rewards. An illustration of this is the actual case of a nursing home which had its operational authorisation withdrawn following an inspection, even though it had only recently been renewed on the basis of the good results of an control of quality. The issue of the control of quality is a major one for nursing homes since their operational authorisation depends on it. Managers find it all the more difficult to understand why there is both an control of quality and an control of strategy when they have a number of points in common, although they are not interconnected, which explains why they are being challenged (Fig. 1).

The suspicion that control generates, its unnecessary repetitiveness, and the amount of time it takes up tend to make the players in the field reject them as management tools, as they often seem to be rigid, constricting and lacking in credibility. Their aims are not always understood, and their appropriation often takes the form of individual strategies. The very nature of the tools leads these same players to consider their activity no longer as something aimed at achieving "the common good" but rather as a form of "managerial logic", perceived as lacking in humanism and, often, as being pointless [8].

This feeling is further reinforced by the fact that the data produced by control is not always used correctly by the authority bodies, as the ARSs have problems handling the data as a result of serious internal partitioning [9].

It was this significantly flawed image of all the types of control that made the ANESM publish an opinion clarifying the objectives of the indicators devised as part of the control of quality. The opinion states that while it is important to listen to the opposition put forward by teams of professionals, control and the indicators it generates remain pertinent in supporting the quality system [7].

The dysfunctions presented in the previous section, and the consequences analysed above are summarized in Table 1.

## 4. Recent developments: constantly increasing amount of control but prospects for improvement thanks to the legislation adopted on 26 January 2016 modernising the health system

### 4.1. New ANAP dashboards

Despite the publication of this report in 2013, yet another supervisory body, a national agency in support of performance (*Agence Nationale d'Appui à la Performance – ANAP*), requires hospitals and nursing homes to maintain dashboards in order to ensure the control of performance. This new control is carried out completely separately from the other types of control analysed in the first part of this article [10]. For supervisory bodies, the aim is to gain a better knowledge of the services available in a given area; for establishments, the aim is to provide information for internal control

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