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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.

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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 a 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 a control of quality and a 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

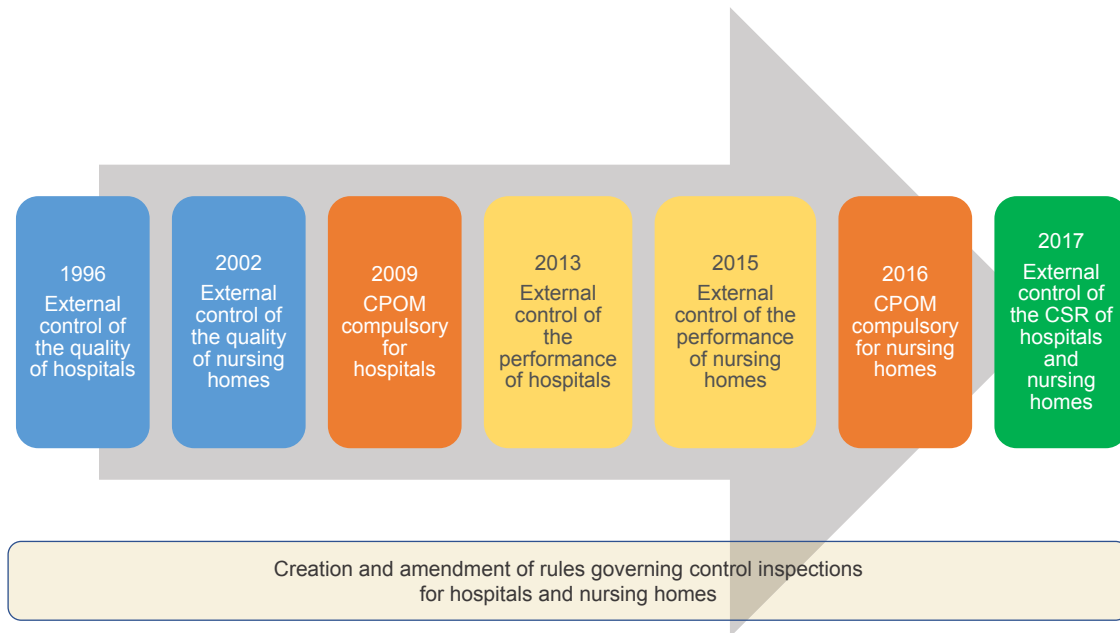


Fig. 1. Timeline of the introduction or amendment of quality controls in French hospitals and nursing homes.

Table 1
Main dysfunctions in the control of hospitals and nursing homes.

Dysfunctions	Consequences
Partitioning between the supervisory bodies preventing: <ul style="list-style-type: none"> -the sharing of information connected with the various types of control, -harmonisation of the practices of the supervisory bodies in terms of control. Internal partitioning within the supervisory body, causing: <ul style="list-style-type: none"> - difficulties in using the data produced by the various types of control, - an inability to link the control of strategy and the ICs. Control inspections (ICs) connected with the DRG payment system carried out separately from the control of the quality of care and medical treatment. Control of strategy and control of quality are carried out separately, whereas the control of strategy incorporated quality objectives. Control of strategy carried out separately from the ICs (since the content of the CPOM is chosen and supervised separately from the results of the ICs).	Control considered unnecessarily repetitive, lacking in credibility, often pointless and inequitable (by the people in charge of hospitals and nursing homes). Control of quality deemed cumbersome, partly unnecessarily repetitive with regard to control of strategy CPOM objectives selected and supervised separately. Control of strategy considered incoherent since it takes no account of the ICs.

and allow benchmarking between establishments. For hospitals, the ANAP developed a dashboard in 2013 comprising 68 indicators divided into five categories: the activity, the quality of practices, organisational performance, use of human resources, and finance. Nursing homes have been required to use a different dashboard since 2015; this comprises 337 indicators, broken down into four groups: provision of treatment and accompaniment for their residents, human and material resources, finance and budget, and objectives.

Since 1 June 2017, the ANAP also proposes a corporate social responsibility (CSR) dashboard for nursing homes and hospitals. This dashboard is not compulsory, but it enables those establishments which so wish to draw up an inventory in every area of CSR (social, society, environment, economic) [11].

All these indicators are valuable and allow both the administration of the establishment by its management team and the control of the establishment by the supervisory bodies. Once again, however, the indicators proposed by the ANAP are disconnected from the other administrative indicators and may seem unnecessarily repetitive (supplied by the control of quality, the ICs and the control of strategy via the CPOMs).

Acts, reforms and initiatives analysed (above and in the second section) make it possible to list the convergences and particularities

of control tools in hospitals and nursing homes (Tables 2 and 3). There are two convergences (hospitals and nursing homes are both subjected to ICs and control of CSR), and many particularities:

- control of strategy is compulsory since the Act of 22 July 2009 in hospitals, but only since the Act of 26 January 2016 in nursing homes;

- there is a single reference framework for quality standards for all hospitals, while each nursing home may choose its own reference framework for quality norms; if results are bad, a nursing home may have to close, but this is not the case for hospitals;

- ANAP dashboard includes only 68 performance indicators for hospitals, compared to 337 for nursing homes."

Despite these additional forms of control, the legislation modernising the health system allows a glimpse of possibilities for rationalising and improving the control system. The Act comprises 227 Articles, focusing on three areas: prevention, access to treatment, and the rights and safety of patients. The Act has attracted attention from the media and the general public mainly because it deals with issues of major importance to society: experimental opening of safe injecting rooms to reduce risks connected with the use of drugs, introduction of nutrition information on food packaging to combat obesity and diabetes, introduction of neutral packaging for cigarettes (with no logo and no possibility of

Table 2
Convergences of control tools.

Hospitals and nursing homes	Supervisory body	Legislation
IC: inspections and control in connection with physical abuse, nosocomial infections, DRG payment, etc. Control of CSR: 32 indicators connected not only with the social, society, economic and environmental aspects of CSR, but also with purchasing and the governance of CSR	ARS and other supervisory bodies (labour inspectorate, etc.) ANAP	Dozens of Acts over more than 30 years 2017

Table 3
Particularities of control tools.

Arrangements for the control of hospitals	Supervisory body concerned	Year of implementation	Arrangements for the control of nursing homes	Supervisory body concerned	Year of implementation
Control of strategy (via the CPOM): control of financial objectives, improvement in quality, etc.	ARS	Compulsory since the Act of 22 July 2009	Control of strategy (via the CPOM): control of financial objectives, improvement in quality, etc	ARS	Compulsory since the Act of 26 January 2016
Control of quality: single reference framework for quality standards for all public and private hospitals in France If the results are bad, the hospital remains open.	HAS	Compulsory since the Orders of 24 April 1996	Control of quality: each nursing home may choose its own reference framework for quality norms If the results are bad, the nursing home may have to close	ANESM	Act of 2 January 2002
Control of performance: 68 indicators	ANAP	2013	Control of performance: 337 indicators	ANAP	2015

advertising), introduction of the possibility of class actions in the health field, etc. What we are interested in here is above all two less visible but nevertheless major changes in the organisation of the health system that affect the control of hospitals and nursing homes.

4.2. Better interconnection of control of quality/ICs/control of strategy thanks to the new local hospital groupings (groupements hospitaliers de territoire – GHT)?

The GHT is an innovation introduced by the Act of 26 January 2016 with a view to improving the quality of patient care and rationalising the use of resources. To achieve this, the hospitals in a given area are required to define a shared strategy for providing patient care, using a common medical project and pooling certain cross-cutting functions (information systems, purchasing, training, etc). GHTs are compulsory for public hospitals, and optional for private hospitals. Each GHT is headed by one of its member hospitals.

Each establishment retains its own CPOM; there is no single CPOM for hospitals in a given GHT. Nevertheless, it is likely that the GHT will achieve a better interconnection of the control of quality and the control of strategy. Indeed the major consequence of the GHTs is the implementation of control of quality for the GHT as a whole from 2020 onwards (and no longer for each establishment separately, as is the case at present). Some GHTs have decided to anticipate the new rule, and 26 commitment agreements (*conventions d'engagement*) have already been signed with the supervisory body (HAS) to date (involving 66 hospitals) [12]. Carrying out a joint control of quality (Article L 6132-4 of the Act of 26 January 2016) makes it possible to replace a logic of competition among hospitals by a territorial logic based on a federated hospital system, which other hospitals may join if they wish.

The coercive and negative perception of control is thus attenuated in favour of a more collaborative, positive perception. The people in charge of the hospitals recognise in this new form of control of quality a real ability to create or develop synergies and links among the professionals at the various hospitals. As a result, hospitals and their quality departments are starting to carry out work

on defining and implementing a common quality and risk management system on the scale of the GHT. This total reorganisation of the system for the control of quality affects the control of strategy, which points to the hope of a better interconnection of the various processes.

4.3. Better interconnection between the control of quality and the control of strategy thanks to the multi-year aims and means contracts?

The multi-year aims and means contracts (*contrats pluriannuels d'objectifs et de moyens* – CPOMs) are no longer optional; they are now compulsory for nursing homes. About 9 000 nursing homes will have to sign their CPOM with their supervisory bodies before 2022. Not only may the same CPOM be signed by a number of nursing homes belonging to the same group (a large association, for example, or a private commercial group); it may also be signed by partners such as a school (in connection with projects for caring for handicapped children, for example).

The report drawn up by the independent experts carrying out the control of quality at each nursing home could provide a particularly valuable basis for defining the objectives of the CPOM and hence the strategy of each signatory nursing home for the following five years. In this respect, the CPOM indeed becomes a major tool in the control of strategy, but its generalisation also makes it possible to envisage the control of quality on the scale of a group of establishments rather than on that of a single establishment.

As a result, the generalisation of CPOMs will 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, by providing a multi-year framework for objectives and funding,
- it accompanies changes in the socio-medical offer to improve the provision of care, accompaniment, and the logic of the route followed by patients.

5. Conclusion

An IGAS report published in 2013 denounced the pile-up and incoherence of control procedures in hospitals and nursing homes. Paradoxically, since 2013, the requirements made of controls have increased constantly. But at the same time, the legislation adopted on 26 January 2016 offers a glimpse of prospects for improvement with the introduction of a better interconnection between the control of quality/other ICs/the control of strategy.

The 2016 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, nor change the DRG payment system. But in hospitals the reform will allow a better interconnection of control of quality/ICs/control of strategy using a common medical project and pooling certain cross-cutting functions (information systems, purchasing, training, etc.) and the most important, implementing the control of quality for the GHT as a whole (and no longer for each establishment separately, as is the case at present). These changes will allow a more useful and less cumbersome control of quality. Also, in nursing homes the generalisation of multi-year aims and means contracts will 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 (by providing a multi-year framework for objectives and funding), and accompanies changes in the socio-medical offer to improve the provision of care, accompaniment, and the logic of the route followed by patients.

It would be difficult to transfer the control system to another country, but the lessons to be drawn from experience of the system can be applied anywhere in the world. Indeed many researchers have demonstrated the influence of the control system on the strategy adopted by an organisation [13–15]. They stress the need for interaction and discussion among the stakeholders if the control is to be useful and pertinent for decision-making on strategies (both by the people in charge of the establishments and by the supervisory bodies) [16,17]. This was really not the case in France until 2016, when the legislation modernising the health system at last raised some hope not only of better dialogue among the various supervisory bodies and the establishments, but also of a better interconnection of the various ICs and the control of strategy.

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