QUALITY AND PROXIMITY: TRUE OR FALSE FRIENDS?

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Complex surgeries performed locally don't always rhyme with quality of care

Data analyses show that complex surgeries performed at a local level do not guarantee a sufficient level of quality. The low number of procedures performed, and consequently the surgeons' lack of practice, could explain higher rates of surgical revisions due to complications, of admissions in intensive care units, or even of deaths. For some surgical procedures to be performed, institutions need authorizations from their local health agency, that are based on thresholds set by institution and not by individual surgeon. As a result, some surgeons find themselves performing surgeries on an irregular basis in an institution who has been granted authorization for that specific surgery. Furthermore, the quality assessment system is compartmentalized and is conducted by healthcare institutions rather than by patient care teams or medical specialties. The link between certification, quality and funding is unclear. The implementation of good practice guidelines alone is insufficient to compensate for the lack of surgeons' practice.

A need for more clarity between the different levels of care and transparency for patients

If some patients desire complex surgical services close to home, being transparent about the incompatibility between complex surgeries in proximity and quality is essential. On the other hand, some patients incorrectly consider community-based care as dangerous and travel great distances for care that could have been provided nearby. It is therefore necessary to educate patients on the different existing levels of care so that they are respected and used appropriately and so that hospitals' overcrowdings are avoided.

Accessibility to care, a holistic approach promoting equity rather than equality

Reaching high-quality of any type of local healthcare service, anywhere in the country and for everyone is neither sustainable from medico-economic and human resources perspective, nor it is efficient. This proximity must be understood, not only in a geographical sense, but also in terms of accessibility. This means enabling everyone to have access to care, from prevention to treatment, according to their situation. Therefore, with the help of data, it is necessary to precisely target populations, their environment, and their health determinants, to offer a healthcare supply that is adapted to the local context.

This accessibility can be viewed from various perspectives: temporal accessibility (waiting times), financial accessibility (third-party payment), transport accessibility, social accessibility (people outside the healthcare system and outreach mechanisms). The aim is rather to reach equity of access to care than equality.

Paying health professionals: an incentive for community-based care and quality of care

The French healthcare system is primarily built on curative care and the current funding system in hospitals and private medicine practices promote the quantity of procedures performed rather than quality. It should evolve to give more incentives encouraging community-based care and quality of care, while enabling a shift towards a more efficient and prevention-based system. In this regard, innovative funding suggestions have been put forward: payment by results, funding according to the health status of a specific population area, funding promoting coordination between care teams and prevention, flat rate capitation for a specific medical condition or healthcare pathway, etc.

An evolution in task delegations to improve community-based care and quality of care

The Covid-19 health crisis has temporarily prompted task delegation. While there is currently a shortage of healthcare workers and a lack of task shifting between physicians and nurses, paramedical and medical professions are acquiring higher qualifications, such as advanced nursing practices. This evolution allows for a refocusing of medical resources on medical procedures where they can provide added value. However, doctors' concerns about potential loss of income due to the shifting of simple procedures is an obstacle and challenge the fee-for-service financing model. Furthermore, new technologies eliminate geographical barriers and enable the seeking of expertise elsewhere, giving physicians more time to maintain a link with patients and accompany them in their care pathway.

Coordination is key to proximity and quality of care

Quality and proximity of care imply that the different levels of care, to be effective, must be coordinated. The issue of proximity in rural areas has long been considered from the perspective of coordinated practice structures. Nowadays, territorial health communities (Communautés Professionnelles Territoriales de Santé – CPTS) are beginning to structure the private healthcare sector and territorial hospital groups (Groupements Hospitaliers de Territoire – GHT) facilitate coordination and resource sharing among hospital members. Faced with the closing of local healthcare institutions, a reorganization of the care pathway, in coordination with both the public and private sectors as well as hospitals and community-based care facilities, is necessary.

Local hospitals' evolution towards a "health city"

Where private healthcare facilities close due to a lack of procedures of an insufficient number of doctors, there is local political pressure to maintain the local hospitals, preventing these areas from becoming medical deserts. And yet, due to a lack of quality of these local facilities, many patients from these areas seek medical care elsewhere. Alternatives must be found through a regional approach, involving various stakeholders. Instead of closing them down, the aim is to transform them into local health centers, focusing on prevention and rehabilitation (including consultations, pre and post-operative care, rehabilitation, emergency services, etc.)