Cour des comptes

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Communication to the Senate Social Affairs Committee

CRITICAL CARE

The Covid-19 pandemic increased pressure on hospital critical care units – which prevent, diagnose and treat all forms of vital organ failure in critical patients whose prognosis is serious but potentially favourable – and increased the visibility of these units. The health crisis thus revealed structural difficulties in critical care units. The Court has reviewed the functioning of these units during the crisis and makes a series of recommendations to overcome the difficulties identified.

The health authorities were not prepared for the health crisis

With the onset of the Covid-19 pandemic, it became clear that the prevention of virulent pandemics likely to cause an influx of critical care patients had been overlooked in health crisis management systems, which were more focused on anticipating terrorist acts, handling an Ebola-type virus, etc. However, from mid-March 2020, a very rapid and wide-scale transformation of critical care beds and the creation from scratch of temporary critical care units increased the number of beds available from 5,080 in March to 10,133 on 15 May, before returning to 8,320 beds on 15 June 2020. This was made possible by the lasting postponement of non-emergency treatment nationwide, the consequences of which in terms of public health remain to be assessed, and by the mobilisation of a large number of reinforcements. While the period between two waves of the epidemic, in summer 2020, saw no decisions implementing structural change for critical care, the crisis management policy improved. For the second and third waves, the health authorities used the solutions tested during the first wave, but with more flexibility and on a more regionalised basis. This included postponing non-emergency treatment and regulating the medical systems and drugs needed for critical care. However, cooperation between the public and private sector, which overall worked well from the beginning of the health crisis, began to weaken.

The health crisis revealed the structural difficulties in this sector

The health crisis brought structural problems to light. The number of critical care beds has overall stabilised at around 5,000 since 2013 even though activity has continued to grow. People over 60 years of age represent two-thirds of patients in critical care units, and capacity has gradually deteriorated in relation to demographic changes. Healthcare professionals have responded by reducing the use of critical care and the average length of stays. Against this backdrop, the absence of an increase in the number of intern positions available for trainee doctors, the lack of specific critical care training for nurses, the non-recognition of the qualifications of allied health specialists, and difficult working conditions in units in which

nearly one in five patients dies, are also factors explaining why critical care capacity has stagnated. There are also marked regional inequalities in the provision of critical care.

Recommendations for improving the situation of critical care units

The Court makes twelve recommendations to:

- learn the lessons from the management of the crisis, in particular by measuring the consequences of the postponement of treatment, patient transfers and the renouncing of care during the first wave of the Covid-19 epidemic;

- reform the organisation of critical care, in particular by determining, at national level, indicators for monitoring scheduled and unscheduled critical care activity, or by computerising all critical care units and ensuring the interoperability of information systems;

- anticipate future critical care needs, in particular by increasing the number of intern positions open to trainee doctors in intensive and critical care medicine and anaesthesia-resuscitation, to take account of the increase in critical care needs.

Read the report

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