Cour des comptes

CRITICAL CARE

Communication to the Senate Social Affairs Committee

Abstract

The health authorities were not prepared for the health crisis

All other things being equal, the Covid-19 pandemic caused a crisis which, as with poliomyelitis in the 1950s, required an inventive, emergency response to a highly contagious disease with serious or fatal consequences and for which no treatment was available. Whereas for around ten years from the start of the 2000s, health authorities and health facilities had prepared for the possibility of an influenza-SARS[1]-MERS[2] pandemic, even providing for a temporary doubling of critical care capacity and the gradual postponement of non-emergency treatment, current mechanisms for managing exceptional, extensive and diverse health crises (anticipation of terrorist acts, Ebola-type viruses, etc.) overlooked the prevention of virulent pandemics likely to create widespread respiratory distress and a surge in patients requiring critical care. The health authorities waited too long before assessing the situation. From mid-March 2020, however, 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 from 5,080 in March to 10,133 on 15 May, before returning to 8,320 beds on 15 June 2020. Although only some regions were severely affected by the epidemic, this transformation 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 very large number of reinforcements, including doctors and nurses working in anaesthesia and intensive care, among others.

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 in a bid to avoid causing a significant "healthcare backlog" by postponing non-emergency treatment, possibly without justification, in the event of a second wave. For the management of 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, increasing critical care capacity and regulating the medical systems and drugs needed for critical care. The regionalised management of the

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[1] Severe Acute Respiratory Syndrome-related coronavirus.
[2] Middle East Respiratory Syndrome–related coronavirus.

crisis management can make it more difficult to assess the relevance and chronology of decisions made with regard to the impact and spread of the epidemic. Since the epidemic was more widely spread across the country than during the first wave and as the postponement of non-emergency treatment was neither generalised nor sustainable, the mobilisation of reinforcements was naturally more difficult than in the first wave, not to mention the exhaustion of medical staff. Fewer patient transfers were made. Cooperation between the public and private sector, which overall worked well from the beginning of the health crisis, began to weaken.

While the needs arising during the Covid-19 pandemic cannot be used as a benchmark for the scaling of critical care provision over time, the health crisis brought to light many structural problems which had not been analysed as a whole by the government authorities or in public debate for twenty years. These included the slow but constant deterioration in capacity with regard to demographic changes, a lack of modularity, insufficient regional coordination and computerisation, major tensions on human resources and an inadequate method of financing.

The health crisis revealed structural difficulties in the sector

Under a reform carried out in 2002, the provision of care was concentrated by grouping a large number of beds in technical platforms in a smaller number of establishments. This was an initiative by the public authorities, acknowledged by all medical sectors, to build larger teams and units better able to ensure the quality and safety of care and adapt to often considerable fluctuations in activity.

However, the number of critical care beds has overall stabilised at around 5,000 since 2013 while activity has continued to grow. Indeed, given the ageing of the population and the increasing prevalence of chronic diseases, critical care activity has risen in line with the growth in the proportion of the population aged over 60. This is not surprising since this population segment accounts for two-thirds of the patients treated by these services. This decline in capacity with regard to demographic changes took place quietly, with a marked decrease in the length of stays in critical care units automatically leading to an increase in the length of stays in the main post-critical care units – constant care units (USCs).

Therefore, critical care provision gradually became increasingly inadequate, and healthcare professionals responded by reducing the use of critical care and the average length of stays. The progress made in critical care, surgery and the introduction of new interventional radiology techniques also mitigated the effects of the fall in capacity. This inadequacy is explained by the poorly funded nature of critical care, which does not encourage hospital managers to open new beds even though there is, in essence, no alternative to critical care. Unfavourable medical demographics, which have not been reversed by increasing the number of intern positions available for trainee doctors, as well as the lack of specific critical care training for nurses, the non-recognition of the qualifications of allied health professionals, and difficult working conditions in units in which nearly one in five patients dies, are also factors explaining why critical care capacity has stagnated.

In addition, the critical care sector, where there is a major gap between strict regulatory requirements for critical care units and the near absence of regulations for constant care units, has gradually become more fragmented: constant care units isolated from critical care areas dominate, while the private sector has focused on the critical care needed to develop surgical activities, which receive the most funding. This fragmentation has led to a form of disorganisation in critical care in the regions. There are also marked regional inequalities in the provision of critical care. Inequalities in the use of critical care show the same

regional differences. Neither hospital planning, nor the grouping of regional hospitals, which are too small and do not incorporate the provision of private care, were able to provide a response before the health crisis of 2020.

Recommendations

Learn the lessons from the management of the crisis:

Recommendation No. 1: *Review national and regional arrangements for managing exceptional health crises by updating them in light of the current pandemic and seeking to identify possible blind spots (DGS, SGMAS, DGOS);*

Recommendation No. 2: *Assess the consequences on public health of the postponement of treatment, patient transfers and the renouncing of care during the first wave of the Covid-19 epidemic (DGS, SPF);*

Recommendation No. 3: *Maintain achievements regarding the anticipation of needs and the monitoring of medical equipment and drugs stocks. Establish a reserve corps of critical care providers and put in place procedures to ensure the attractiveness and sustainability of this system (DGOS, DGS, SPF).*

Reform the organisation of critical care:

Recommendation No. 4: *Determine the criteria allowing a constant care unit (USC) to remain isolated, create a regional network of these USCs and a critical care unit and establish lasting coordination of critical care that can include public and private structures (DGOS, ARS, CNP);*

Recommendation No. 5: *Determine, at national level, indicators for monitoring scheduled and unscheduled critical care activity and ensure that the regional health authorities (ARS) consider these results in their analysis of requests for critical care authorisations or renewals (ARS, DGOS);*

Recommendation No. 7: *Test the identification of "post-critical care" beds for the most affected treatments, which will receive constant enhanced medical and non-medical care, to ensure seamless and regular provision of post-critical care throughout the week and the year (DGOS, CNP);*

Recommendation No. 10: *Review the technical operating conditions of critical care units to modernise them and improve their modularity (DGOS, CNP);*

Recommendation No. 11: *Computerise all critical care units, ensure the interoperability of information systems to facilitate the creation of a national critical care database to ensure better patient journeys and ongoing monitoring of the activity of these units (DGOS, CNP);*

Recommendation No. 12: *Review the critical care funding model to cover the cost of this care, for which there is no alternative for patients (DGOS).*

Anticipate future critical care needs:

Recommendation No. 6: *Assess, with the assistance of the National Professional Councils for intensive and critical care medicine, anaesthesia-resuscitation and perioperative medicine, the impact of population ageing on critical care needs, taking into account the impact of medical progress and long-term prevention policies and increasing critical care provision accordingly (DGOS, DGS, SPF, HAS);*

Recommendation No. 8: *Increase the number of positions open to trainee doctors in intensive and critical care medicine and anaesthesia-resuscitation, to take account of the increase in critical care needs, in particular for medical resuscitation, and demographic pressure on anaesthesia and to continue to benefit from the versatility of anaesthesia-resuscitation specialists (DGOS, SGMAS);*

Recommendation No. 9: *Review the initial training plan for general care nurses by integrating specific theoretical and practical training modules for critical care and acknowledging the skills acquired with a recognised qualification as a resuscitation nurse, which is not mandatory to practise in this area (DGOS).*