Cour des comptes

HOSPITAL EMERGENCY CARE : ADMISSION AND TREATMENT

Overcrowded emergency services and the need to reform the patient pathway

Communication to the social affairs committee of the national Assembly

November 2024

Executive Summary

The President of the National Assembly's Social Affairs Committee has asked the Court of Accounts to investigate hospital emergency departments and, more specifically, the effectiveness of the measures adopted under the "*Ma santé 2022*" action programme, adopted in June 2018, a programme supplemented in December 2019 by an action plan specific to emergency medicine, the *"Pacte de refondation des urgences",* developed in response to the particularly pressing difficulties encountered by healthcare facilities. This plan, comprising 12 measures, is the result of a report commissioned in June 2019 by the Government from Thomas Mesnier MP and Pierre Carli, Professor of Medicine.

This report provides an overview of the operation of emergency services (with the exception of emergency services specialising in psychiatry, obstetrics and paediatrics) and the implementation of this action plan.

A speciality mobilising five types of services to meet the need for permanent access

The role of emergency medicine is to treat anyone in need of urgent care, 24 hours a day, every day of the year. From a medical point of view, emergency medicine provides care for the first 24 hours for a sick or injured person and is not intended to keep patients longer than this period. It is carried out by three types of structures: the *"emergency medical services"* (Samu), which receive and regulate calls ; the *"mobile emergency and resuscitation structures"* (Smur), which travel to take charge of and transport people who have had an accident or are in medical distress, at the Samu's request ; and the *"emergency medicine structures"* , which receive patients and take charge of them in a health establishment.

At the end of 2023, two new components, provided for in the "*Pacte de refondation des urgences*", were added to the system: the *"*healthcare access services*"* (SAS), call centres able to respond to requests for unscheduled care in primary care, in addition to calls for hospital emergencies ; and the *"*emergency medicine units*"*, local emergency structures authorised to operate only part of the day but attached to a fully-fledged emergency department.

At the end of 2022, general and paediatric emergency medicine in France was provided by 694 structures, belonging to 624 health establishments, including 467 public establishments (75 % of emergency structures), 35 private not-for-profit establishments (5 %) and 122 private for-profit establishments (20 %), to which 100 call centres (Samu) and 388 Smur were attached. This distribution is determined by the activity authorisations issued by the State to health establishments. In 2022, emergency services recorded 20.9 million visits, a 6 % increase than in 2021 but 3% fewer than in 2019, the year before the health crisis.

Uncertain emergency care costs due to medical overlapsThe financial implications of emergency medicine cannot be measured directly and are partially based on estimates. It is true that the population-based allocation paid to establishments to cover the fixed costs of their emergency services, the billing of hospital stays in emergency departments and the allocation based on the quality of activity are known; the same is true of the lump sums paid by the health insurance scheme to health establishments and private practitioners based on emergency department visits not followed by hospitalisation and the individual lump sum billed to patients and their mutual insurance companies. However, the financing of emergency room visits, when followed by hospitalisation in another department of the establishment, overlaps with the billing of the stay in this other department; the share attributable to emergency rooms is therefore only an estimate. The total cost of emergency medicine is therefore estimated at €5,597 billions for 2023. After deducting the portion charged to patients and their mutual insurance

companies, the cost to the health insurance system is €5,312 billions, which represents 5.17% of the national healthcare expenditure target (Ondam) allocated to care in healthcare institutions in 2023.

A set of measures taken to tackle the deterioration in accessibility

Five years after the "*Ma santé 2022*" programme and, above all, almost four years after the "*Pacte de refondation des urgences*" and a major health crisis which, paradoxically, temporarily kept a significant proportion of users away from hospital emergency departments, the saturation of emergency facilities has resulted in the partial or total closure of many of them, due to insufficient staffing, industrial action linked to work overload, or serious undesirable events. As before the pandemic, emergency departments have once again become the focal point for most of the health system's shortcomings. As a system of last resort, in addition to real emergencies, emergency services are also in difficulty because they are used by patients who are unable to get an appointment with a doctor quickly, or by patients with chronic illnesses who are not under the care of a GP. Finally, people whose state of health requires them to be admitted to hospital, but who have not been admitted to the appropriate hospital department for their condition, also arrive at emergency departments.

A number of measures have been taken by the public authorities since 2022 to deal with this overcrowding, some of which affect the very principle of the public emergency service: that of being open at all times, with no possibility of refusal, regardless of the status, public or private, of the establishments providing this service.

Structural challenges arising from the interplay of two opposing demographic trends. These difficulties are due to two major phenomena that persist, converge, and are set to intensify over the next few years: the reduced accessibility of doctors over a large part of the country and the increase in demand for care due to the growth and ageing of the population. However, the measures taken to account for these changes, despite being fully documented and anticipated, are not commensurate with the necessary adjustments. When implemented, they encounter such obstacles, sometimes of a secondary nature such as procedures and approvals, that they are rendered ineffective (delegation of acts for example) or, initially mandatory, have become optional, such as the compulsory participation of doctors in ambulatory care duty. The financial incentives associated with these measures, which are insufficiently selective and more often than not only optional, have proven ineffective despite their cost.

The overuse of emergency services highlights, first and foremost, the shortcomings of measures aimed at improving access to primary care, particularly for elderly patients, or the reluctance to implement them, despite the declining number of doctors. Without more energetic action on this primary care offer (contractual agreements against partial practice in under-dense areas, coordination protocols and delegation of acts, coordinated practice, advanced practice nurses, transfer of acts, medical assistants, etc.), the other measures affecting emergency structures themselves will have only a marginal positive effect.

Regulation is a case in point. While the measures adopted have yielded some initial positive results, their full impact hinges on the ability to refer only those patients who genuinely require emergency care, i.e., providing others with an alternative consultation in the community, regardless of the format (doctor, coordinated care structure, on-call medical centre, advanced practice nurse, etc.).The success of this system is essential if people are to make systematic use of it before seeking emergency assistance.

Even if the influx of patients to emergency departments is reduced, this will only partially resolve the challenges specific to these services. The ability to discharge patients smoothly—particularly the elderly—has now become the central issue. Priority must therefore be given to ensuring appropriate care for elderly patients: expanding the use of proven strategies to prevent full-time hospitalisation (such as home hospitalisation, which also applies to nursing

homes) and facilitating direct admission to unscheduled hospitalisation rather than routing patients through emergency departments when their condition suddenly deteriorates.

Welcome but slow-moving reforms

At the end of an emergency, when post-emergency hospitalisation is absolutely necessary, it is essential to organisebed availability within the hospital and facilitate bed-sharing between public and private hospitals, with regional coordination under the supervision of regional health agencies (ARS) if necessary, to prevent unjustified waiting times at the end of an emergency.

The reform of financing offers promising prospects for improved management, provided that these measures are effectively implemented and monitored—something that is not currently the case. Within a strict national framework of fundamental principles, the scope for adaptation granted to the ARSs is valuable, but risks being undermined by additional central oversight that could limit its effectiveness.

Population-based funding aims to ensure that the fixed costs of emergency services are adequately covered by the health insurance system, reflecting the population served. The goal is to gradually bring emergency care services up to the standard deemed optimal in the regional health plan.

However, the allocation for quality improvements remains too limited to produce a significant impact. Within a constant financial envelope, a greater proportion of funds must be allocated to incentivising quality, with systematic monitoring of results, as the quality of care provided to patients must become a central priority.

Internal organisational measures to be continued

The shortage of emergency doctors is an aggravating factor in the mismatch between supply and demand. The reluctance of many practitioners for the practice of this speciality in hospitals stems partly from the demanding nature of the work -intensity, irregular working hours and frequent on-call duty- and partly from tensions and dysfunctions that disrupt daily operations with this practice, including the search for downstream beds and, increasingly, incidents of verbal and physical violence from patients or their companions.

Easing tensions within emergency departments is therefore essential to improving their attractiveness for both medical and paramedical staff, whose retention must be actively fostered.

At the same time, given the limited availability of medical professionals and the risk of destabilising primary care services, the unchecked proliferation of unscheduled care centres must be avoided. These centres do not serve as substitutes for general practitioners and are not integrated into the continuity of care system.

Progress continues in renovating buildings, optimising the spatial organisation of services, and enhancing staff and patient safety. While these improvements must not be delayed, they do not currently require additional acceleration, given the processes already in motion.

An imperative improvement in the collection and processing of activity and billing data

On the other hand, modernising and unifying data collection and processing systems—covering regulation, emergency room visits, activity-based funding, and the availability of beds and medical staff—is imperative. Public authorities, from the local to the national level, must have real-time visibility into both available and mobilised resources to anticipate foreseeable tensions. National and regional authorities must be equipped to allocate funding effectively, rigorously detect errors, and sanction any fraudulent data submitted in support of health insurance billing. To drive improvements in service quality and patient care, they must also rely on substantial quality-based funding, determined through representative indicators derived from reliable data. Serious adverse events occurring in emergency departments, which establishments are required to report, serve as key indicators of service quality. Their causes and the corrective measures taken must be published regularly.

A duty of transparency towards the public

The public, as the primary beneficiary of emergency services, will be more likely to use them appropriately if transparently informed about service activity levels, availability, and safety, alongside regulatory mechanisms. Ensuring easy public access to this information is therefore essential.

Recommendations

Coordinate the regulation of emergencies with the continuity of care in town, and simplify direct access to unscheduled hospitalisation

2. Coordinate the management of the teams of doctors involved in the permanent ambulatory care service with those who can be mobilised by the access to care service, to concentrate the service on the periods that best correspond to the needs of the population *(minister for health and access to care, Cnom).*
3. Systematise direct hospitalisation channels so that the elderly do not need to go through emergency departments and monitor their effectiveness *(minister for health and access to care).*
4. Establish a specific authorisation system for unscheduled care centres, integrating them into the framework for regulating the supply of care, into the care access services and into the continuity of ambulatory care *(minister for health and access to care)*.

Identify, distribute and mobilise available resources more easily and ensure safe discharge to hospitalisation

5. Establish precise medium-term requirements for doctors in emergency facilities *(minister for health and access to care).*
6. Extend territorial emergency teams throughout the country *(minister for health and access to care)*.
7. Continue, on an annual basis, the national survey on the management of beds downstream of emergency departments to check the performance of the bed scheduling function at the level of each establishment *(ministry of health and access to care, ANAP).*

Improve data reliability to ensure the quality and efficiency of emergency department activity

8. Complete the new version of the summary of emergency room visits, linking it to the information systems medicalisation programme to monitor activity and provide a basis for billing *(ministry of health and access to care, ATIH, Cnam).*
9. In order to facilitate the referral, care and follow-up of people arriving in accident and emergency departments, compare data from accident and emergency department attendance reports with: a) data recorded by Smur emergency services; b) data recorded by healthcare access services and the Samu-15 emergency call centres; c) data from the information systems medicalisation programme (*ministry of health and access to healthcare, ATIH*).
10. Systematically check the consistency between the statements made by establishments on the monitoring of healthcare activity and the emergency department figures used for billing purposes (*ministry of health and access to healthcare, ATIH, CNAM*).

Inform the public about the availability of emergency facilities and the quality of the service provided

11. Annually publish a national overview of serious adverse events associated with care in accident and emergency departments, reported by healthcare establishments (*HAS*).

12. Make data on emergency services available to users on a continuous basis, including the facilities open near their location, the waiting time observed in these facilities, the number of patients attending, the closure of facilities, etc. (*minister for health and access to healthcare*).