

**The French National Authority for Health's approach for improving the global management of patients with chronic diseases**

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**Objective:**

A French 2004 law deeply transformed the management of chronic diseases. We present here the experience of the French National Authority for Health (HAS) in developing recommendations for both patient management and reimbursement conditions of their expenses.

**Methods:**

The French national health insurance system defined a list of 30 pathological conditions (named ALDs), mostly chronic diseases. All the patients meeting pre-defined criteria are eligible for 100% coverage of the healthcare expenses directly generated by their disease(s). Given the high growth rate of beneficiaries, adjustment strategies for improved efficiency, quality and cost effectiveness have become mandatory. Since 2005, the HAS has been in charge of providing scientific and financial evidences as a decision aid for general practitioners (GPs) and the national health insurance system.

For each ALD, the following three outputs are elaborated by a work group comprised of experts in the relevant field, GPs and patient representatives: 1) Medical criteria of entry; 2) evidence-based operational protocols describing an ideal clinical pathway for optimal management; 3) the list of corresponding medical and paramedical services and products. Validation occurs after field-testing for relevance, feasibility and acceptability by all categories of users. In parallel to that scientific work, a financial assessment is performed in order to calculate residual average out-of-the-pocket expenses for patients.

The ministry of health is then passing a law on the criteria of entry while operational protocols are used for establishing individualized programs of care proposed by GPs, approved by health insurance medical advisors, and endorsed by each patient (new regulation enforced since end of 2005).

**Results:**

The review of nine conditions was prioritized: diabetes, chronic hepatitis, severe high blood pressure, severe chronic respiratory failure, severe heart failure, coronary disease, multiple sclerosis, chronic ischemic arteriopathies, and disabling stroke. The first three have been completed.

The conclusions of this one year experience are fourfold:

- Need of a slight refining of the methods for developing recommendations (increased involvement of GPs and other stakeholders in the validation process);
- Reshaping of the ALD list (e.g. Consider cardiovascular risks all together and not severe high blood pressure separately);
- New definition of entry criteria in order to ensure a better equity of both care for patients and attention to diseases;
- Difficult precise assessment of actual costs incurred by health insurers, given the current configuration of databases. There is therefore, uneasy matching with a theoretical financial estimation of the proposed new protocols.

**Conclusions:**

By allowing to adapt clinical practice guidelines to the complexity of individual situations, the HAS new approach reflects a move from a population scale towards an individual level in the management of chronic diseases. However, whether this will result in a better quality of follow up, efficiency and efficacy remains to be documented by adequate outcome studies.

In the mandatory modernization process of chronic condition management, the production of updated protocols and recommendations should be properly articulated with the following three other important changes underway: development of an electronic personal medical record; increased patient's responsibility for his/her own healthcare; regulatory pivotal role of GPs as coordinators of individualized healthcare programs.