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Accessibility of healthcare - France

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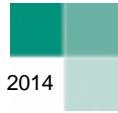
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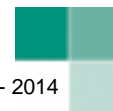
ANED 2014 Task 4 - Accessibility of Healthcare

Country: France

Author(s): Martial Meziani

The [Academic Network of European Disability experts](#) (ANED) was established by the European Commission in 2008 to provide scientific support and advice for its disability policy Unit. In particular, the activities of the Network will support the future development of the EU Disability Action Plan and practical implementation of the United Nations Convention on the Rights of Disabled People.

This country report has been prepared as input for the synthesis report on [Access of healthcare](#) in European Countries.



1 Accessibility of Medical records which Patients are Entitled to Access

1.1 Obligations and Standards

1.1.1 Mandatory/Binding Accessibility Requirements applicable to Medical Health Records

In matters of medical records, in France, there are two principles: the right to direct access to medical records and medical confidentiality. In principle, Articles L. 1111-7 and R. 1111-1 of the Public Health Code specify that everybody has the the right to directly access his or her own medical records.

Article R 4127-71 of the Public Health Code states that the records must be kept in a locked place. A medical file has to be legibly written to facilitate consultation. Since the law dated March 13, 2000, e-health medical records have had the same legal value as paper records. All electronic health records have to be notified to the CNIL (National Commission for Data Protection and Liberties). In the case of Data Protection Law violation, the guilty person shall be liable to 5 years' imprisonment and a fine of 300,000 euros.¹

Full access is restricted in some cases. In case of psychiatric hospitalisation without consent of the patient, the presence of a practitioner designated by the applicant can be required. Similarly, adults under tutorship do not have direct access to their own medical records. The tutor is the only person, as legal representative, authorized to access the file, even if he or she has to inform the person.²

In the case of refusal to provide the medical records, the complainant may bring the case before the CADA (National Commission for access administrative records) within one month, if this is a public or private institution which provides a public service. This period may be extended to two months, if there is no response.³

This application allows the resolution of the complaint without making a referral to the court. The CADA gives a notification based on the law of July 17, 1978 and on the administrative jurisprudence. If the notification is in favour of providing the medical records, the administration must inform the CADA if the records will effectively be provided ,within one month.

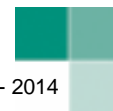
¹ Article 226-13 of Penal Code.

<http://www.legifrance.gouv.fr/affichCodeArticle.do?idArticle=LEGIARTI000006417945&cidTexte=LEGI TEXT000006070719>.

² Article R. 1111-1 of Public Health Code.

<http://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006072665&idArticle=LEGIARTI000006908128&dateTexte=&categorieLien=cid>.

³ AP-HP, UNAPEI (2007) Les Guides de l'AP-HP. Personnes vulnérables et domaine médical. Quels sont leurs droits ? http://www.aphp.fr/handicap/files/2012/04/personnes_vulnerables.pdf.



If the institution or company is not part of public service, the person must enter the internal commission. Against a private practitioner, the complainant can send a complaint form to the French National Medical Order or the Civil Court. The complainant can also refer to the CNIL which acts as a go-between with the private practitioner.⁴

In case of psychiatric hospitalization without consent, the procedure is different. The patient or the psychiatric service sends an application to the Departmental Psychiatric Hospitalisation Commission, whenever there is a disagreement between the patient and medical staff to consult the medical records. This commission has to assess the situation of the patient in terms of respect of human rights.

There is another kind of restriction. All the documents cannot be disclosed to the patient. According to the decree of March 5, 2004, personal notes must not be stored, reused or exchanged. Only formal writings contributing to the medical diagnosis must be transmitted⁵. Further, the collected information from a third party, or not used in the process diagnosis can not be transmitted.

1.1.2 Technical Accessibility Standards or Guidance relating to Medical/Health Records

Article R 1111-2, of the Public Health Code⁶ specifies the technical procedure for access to medical records. The applicant must submit a written or oral request. The medical record is disclosed within eight days. This period can be extended to two months if the medical information is more than five years old. There are two kinds of transmission: consulting on the spot or sending copies of medical records. The same article specifies that the transmission has to be made according to the patient's understanding abilities, no further details.

Article 1111-7, of the Public Health Code states that the presence of a third person while consulting the file may be recommended by the practitioner. This proposal can be made when there is a risk for the patient in cases of psychological weakness or if a severe diagnosis has not yet been disclosed.

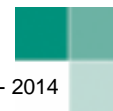
After consulting the records, support is organized if necessary, by the practitioner, a family member or any other person who has no conflict of interest. If the medical records are sent, the practitioner has to attach a cover letter and suggest a medical consultation.

⁴ <http://vosdroits.service-public.fr/particuliers/F12211.xhtml>.

⁵ Appeal Administrative Court of Appeal, Paris, September 30, 2004.

<http://www.legifrance.gouv.fr/affichJuriAdmin.do?idTexte=CETATEXT000007444841>.

⁶ <http://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006072665&idArticle=LEGIARTI000006908131&dateTexte=20120619>.



1.1.3 Litigation or Other Publicly Documented Complaints about Inaccessible Medical Records

Although the laws do not provide specific penalties for non-compliance, the professional cannot ignore a patient's request or miss the deadline. The administrative court of appeal⁷ recognized the moral damage for the patient, in the case of non-transmission. In a court ruling of September 14, 2012, the Regional Court ruled against a practitioner to pay a 500 euro fine, for a delay in the transmission of medical records.⁸

Other referrals have been made to the State Council. The State Council rejected the hospitalised psychiatric patient appeal.⁹ The patient requested his medical records. After the denial of psychiatric service, the patient sent an application to the CADA, before referring to the Administrative Court. During the investigation, the hospital called on the Departmental Psychiatric Hospitalisation Commission, which authorized access if a practitioner of the patient's choice was present during the consultation. Even if the patient does not think he needs this support, the State Council justified the need for practitioner support because patient was under tutorship.

There were also other debates, particularly around the DMP (Personal Medical Record) which is managed by the patient. The DMP aims to facilitate cooperation between health professionals, as well as the patient's control in the access to his own medical records by the different practitioners.

At the beginning, there were debates about the role of the DMP. Thus, the National Ethics Council¹⁰ highlighted that many professionals saw the DMP as a document to share medical records. However, it seems difficult for them, because the patient decides who has access to the different medical records saved in the DMP.

The National Ethics Council reported discussions between associations, professionals and other concerned persons. Thus, at the beginning of the project, the DMP was supposed to be a shared medical record only for the professionals. Patients did not have access to the DMP. Today, the DMP can only be created with the informed consent of the patient. He can also directly add documents himself or herself.

⁷ <http://www.legifrance.gouv.fr/affichJuriAdmin.do?oldAction=rechJuriAdmin&idTexte=CETATEXT00022057037&fastReqId=1298895455&fastPos=1>.

⁸ <https://www.macsf.fr/vous-informer/organisation-des-soins/dossier-du-patient/transmission-du-dossier-medical-au-patient.html>.

⁹ <http://www.legifrance.gouv.fr/affichJuriAdmin.do?oldAction=rechJuriAdmin&idTexte=CETATEXT00020868503&fastReqId=776126006&fastPos=1>.

¹⁰ Conseil Consultatif National d'Ethique (2008) Avis n°104. Le « dossier médical personnel » et l'informatisation des données de santé. http://www.ccne-ethique.fr/sites/default/files/publications/avis_104.pdf.



The French National Medical Order has noted technical problems with the DMP. The DMP is only available via a specific website, and not all patients have internet access. The Order considers that it is creating new barriers and inequalities in access of healthcare.¹¹ There also is the question of the patient's computer skills. If he or she is not able to go on the web on their own, he or she will need a third party to have access to the DMP.¹² Thus, the Order is considering how to respect medical confidentiality.

1.2 Accessibility of Medical Records in Practice

1.2.1 Extent of Accessibility

Though policy makers permitted direct access to medical records, they have not provided official monitoring tools. Thus, complaints are accessible via reports or court decisions.

Moreover, even if the management of medical records in healthcare facilities and medical offices is constrained, the medical-social institutes have to manage personal files and not only medical records. There is a heterogeneity of practices that are "sometimes incompatible with the quality requirements of the medical-social services".¹³

The medical records management process is rarely integrated into commitments to improvement. Medical-social services do not have the same objectives, because they often have different kinds of patients.¹⁴

Thus, there is no official national guidance.¹⁵ However, there are many internal standards. A first guidance program was released to measure the management of records from several points of view: local policy patients' record, promotion of the accessibility of patient's record, access conditions, specific and lawful treatment of medical writings.

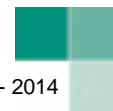
¹¹ Conseil National de l'Ordre des Médecins (2005). Questions sur l'informatisation des dossiers médicaux, le partage et l'hébergement des données.
<http://www.conseil-national.medecin.fr/sites/default/files/dmp.pdf>.

¹² Conseil National de l'Ordre des Médecins (2005). Questions sur l'informatisation des dossiers médicaux, le partage et l'hébergement des données.
<http://www.conseil-national.medecin.fr/sites/default/files/dmp.pdf>.

¹³ Direction Générale de l'Action Sociale (2007). Guide pour les établissements sociaux et médico-sociaux. Le dossier de la personne accueillie ou accompagnée. Recommandations aux professionnels pour améliorer la qualité. <http://www.social-sante.gouv.fr/IMG/pdf/dossierpersac.pdf>.

¹⁴ Direction Générale de l'Action Sociale (2007). Guide pour les établissements sociaux et médico-sociaux. Le dossier de la personne accueillie ou accompagnée. Recommandations aux professionnels pour améliorer la qualité. <http://www.social-sante.gouv.fr/IMG/pdf/dossierpersac.pdf>.

¹⁵ Direction Générale de l'Action Sociale (2007). Guide pour les établissements sociaux et médico-sociaux. Le dossier de la personne accueillie ou accompagnée. Recommandations aux professionnels pour améliorer la qualité. <http://www.social-sante.gouv.fr/IMG/pdf/dossierpersac.pdf>.



As regards healthcare facilities, records management is largely computerised. The Ministry of Health gives licenses to various health data hosting systems. These standards cover patient and professional identification, interoperability and security system¹⁶. Interoperability is the ability of computer systems to exchange information. All this refers to the issues about the computerisation of medical records in France. The most important issues are medical confidentiality and the health data hosting systems' abilities to allow the interoperability. In this context, the DMP aims to promote the patient's access to medical records.

1.2.2 Good Practice Examples

We have not found examples of good practice on access of medical records. Any additional protocol seems to have been created at the local level. However, to facilitate access of medical records, the National Health Authority achieved a report to improve it.¹⁷

The National Health Authority recommends provision of a welcome booklet to provide rules on access to medical records in medical-social institutes and medical offices. In healthcare facilities, this information is contained in a specific chapter in a welcome booklet.¹⁸ These recommendations for health professionals are only reminders about the law.

In matters of accessibility, the DMP completely changes the proceedings, because it is the patient himself who gives access to medical records to the practitioners, for when they did not make the examinations themselves.¹⁹ However, the DMP is not widespread yet. Although the the law of August 13, 2004 created the DMP, a back up plan was launched in 2011 to strengthen this kind of tool. Currently, 500,000 DMPs have been created in France.²⁰

1.3 Ongoing Developments

1.3.1 Commitments to Improvement

Since 2012, a national strategy has required the computerisation of medical data and the development of the DMP. This is the Digital Hospital Programme.²¹ As regards

¹⁶ ASIP Santé (2013). Présentation du Répertoire National des Référentiels.

<http://esante.gouv.fr/services/referentiels/presentation-du-repertoire-national-des-referentiels-rnr/presentation-du>.

¹⁷ Haute Autorité de Santé (2005). Recommandations pour la pratique clinique. Accès aux informations concernant la santé d'une personne - Modalités pratiques et accompagnement.

http://www.has-sante.fr/portail/upload/docs/application/pdf/Acces_Info_sante_Dec_2005.pdf.

¹⁸ Article R .1112-9 of the Public Health Code.

<http://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006072665&idArticle=LEGIAARTI000006908169&dateTexte=&categorieLien=cid>.

¹⁹ <http://www.dmp.gouv.fr/>.

²⁰ <http://www.dmp.gouv.fr/nb-dmp-par-region>.

²¹ <http://www.sante.gouv.fr/le-programme-hopital-numerique.html>.

the DMP, Article L1111-14, of the Public Health Code specifies that each insured person has a DMP, even if there is no legal obligation to create it.²² Article L1111-15, of the Health Public Code specifies that each health professional ought to indicate the therapeutic information at every consultation and hospitalization in the DMP.²³ The DMP received the "2011 year of patients' rights" label.²⁴ Awarded by the Ministry of Health, the label was intended to promote the patients' rights.²⁵ In this context, the communicating cancer file (DCC)²⁶ was integrated into the DMP. The DCC is a tool designed to allow healthcare coordination in the case of cancer treatment. Currently, the DCC has been implemented in 17 French regions.²⁷

1.3.2 Campaigns (eg by DPOs) or Calls (eg in academic publications) for Accessible Medical Records

Regional deployments support the national plans for e-health, with which DMPs are associated. In this way, Regional Health Agencies implement the national health policies²⁸. To this end, 'ASIP Santé' Agency (Shared Health Computer Systems Agency)²⁹ supports the Regional Health Agencies in the development of telemedicine and shared information systems. ASIP Santé can also support hospitals and medical-social institutes.

1.4 Additional Information about the Accessibility of Medical Records

No additional information.

²² <http://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006072665&idArticle=LEGIARTI000020889189&dateTexte=&categorieLien=cid>.

²³ <http://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006072665&idArticle=LEGIARTI000020890573&dateTexte=>

²⁴ http://www.sante.gouv.fr/IMG/pdf/Fiche_recapitulative_label.pdf.

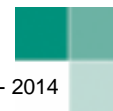
²⁵ <http://www.dmp.gouv.fr/>.

²⁶ <http://www.e-cancer.fr/soins/parcours-de-soins/dossier-communicant-de-cancerologie>.

²⁷ ASIP Santé (2011). DMP. Dossier de presse. http://esante.gouv.fr/sites/default/files/DMP_Dossier_de_presse_NOV_2011.pdf.

²⁸ ASIP Santé (2011). DMP. Dossier de presse. http://esante.gouv.fr/sites/default/files/DMP_Dossier_de_presse_NOV_2011.pdf.

²⁹ <http://esante.gouv.fr/asip-sante>.



2 Communications Between Medical Staff and Disabled Patients

2.1 Obligations and Standards

2.1.1 Mandatory/Binding Accessibility Requirements applicable to Relevant Communications

Communication between medical staff and patients is based on the right to medical information for each patient. Disabled persons' rights are firstly based on common rights, even if the disabled persons law acknowledges the importance of specific communication to facilitate accessibility.

In the case of communication between medical staff and disabled people, the implementation of accessibility firstly is for sensory, mental and cognitive disabilities.

Thus, the patients' rights law³⁰ specifies the right to be informed regardless the host institution.³¹ Further, Article 3 of the Rights and Freedoms Charter allowed in medical-social institutes³² states that the patient must receive understandable and appropriate information. To this end, the patient can call a qualified person, chosen in a list established by the the State Department representative and the President of the Departmental General Council.

2.1.2 Technical Accessibility Standards or Guidance relating to Relevant Communications

For technical accessibility, in matters of sensory disabilities, there are financial supports useful for healthcare. Firstly, deaf persons benefit from support of 30 hours per month to employ sign-language interpreters.³³ This support does not exist for people with mental or cognitive disabilities.

For the Ministry of Health,³⁴ deafness implies an adapted, appropriate and supported reception in the healthcare service. Thus, the Ministry has developed measures for deaf people to improve their access to healthcare. Special healthcare reception units have been opened in several regions.³⁵ Currently, there are 12 special healthcare reception units in France for deaf persons. The Ministry of Health has released a

³⁰ <http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000227015>.

³¹ Article L. 1111-2 of Health Public Code.

<http://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006072665&idArticle=LEG IARTI000006685758&dateTexte=&categorieLien=cid>.

³² http://www.social-sante.gouv.fr/IMG/pdf/EXE_A4_ACCUEIL.pdf.

³³ Fricotté, L. (2014) *Guide Néret : Droit des personnes handicapées 2014*. Wolters Kluwer France : Paris.

³⁴ <http://www.sante.gouv.fr/qualite-de-la-prise-en-charge-des-usagers-dans-les-etablissements-de-sante-prise-en-charge-des-patients-sourds.html>.

³⁵ <http://www.sante.gouv.fr/IMG/pdf/guide.pdf>.

methodological guidebook to open new special healthcare reception units and offer different recommendations.

In this guidebook, the first objective is to provide a personalised service. The information has to be based on the patient's communication skills. For example, if the patient practices sign-language, the meetings have to be conducted in sign-language. The medical care must also be adapted to the patient. The patient can be supported by a person of trust all along the meetings.³⁶ The practitioner may also be supported by another team member, with the informed consent of the patient. The practitioner ensures the patient's understanding himself.

The special healthcare reception units have other missions, such as the monitoring of social demand, requiring the presence of a social worker. The social worker establishes links with the concerned services in accordance with the wishes of the deaf person. These units also can help clarify a situation between patient and health professionals.

As regards communication between medical-social team and patient, The ANESM (National Agency for the Assessment and Quality of Social and Medical-social Institutions)³⁷ specifies that communication has to be adapted, using images or tactile objects.³⁸

For hospitals, the National Health Authority³⁹ encourages the "use (of) support devices [...] especially when the situation requires a support to permit the understanding of the healthcare proposal". Another report⁴⁰ highlights the need to determine the problems of understanding and the autonomy of the patient as early as possible.

2.1.3 Litigation or Other Publicly Documented Complaints about Inaccessible Communications with Medical Staff

In a case of failure of the practitioner's obligation to give appropriate medical information, the French High Court of Appeal⁴¹ judged that a practitioner had caused moral damage. The assessment of compensation for moral damage can range from 1 euro up to several thousand euros.⁴²

³⁶ <http://www.legifrance.gouv.fr/affichCodeArticle.do?idArticle=LEGIARTI000006685773&cidTexte=LEGITEXT000006072665>.

³⁷ ANESM (2013). L'accompagnement à la santé de la personne handicapée. Analyse de la littérature http://www.anesm.sante.gouv.fr/IMG/pdf/Analyse_Litterature_Juillet_2013.pdf.

³⁸ http://www.moteurline.apf.asso.fr/IMG/pdf/12-15_CDrom_Unapei-.pdf.

³⁹ Haute Autorité de Santé. (2009). Audition publique. L'accès aux soins des personnes en situation de handicap. http://www.has-sante.fr/portail/upload/docs/application/pdf/2009-01/audition_publice_acces_soins_personnes_handicap_22_23102008.pdf.

⁴⁰ INPES, CNSA. (2010). Recherche qualitative exploratoire Handicap – Incapacité – Santé et Aide pour l'Autonomie. http://www.inpes.sante.fr/professionnels-sante/pdf/RHISAA_Vol_1.pdf.

⁴¹ https://www.courdecassation.fr/jurisprudence_2/premiere_chambre_civile_568/573_3_16447.html.

⁴² <http://www.alliancejuris-media.com/2013/01/default-dinformation-du-praticien-et-sanction/>.

However, this kind of litigation is rare, even if there are many testimonies indicating barriers in matters of communication. Testimonies specify that it can be difficult to mobilize professionals.⁴³

Thus, the methodological guidebook for deaf persons in matters of communication⁴⁴ presents testimonies of the communication difficulties between practitioners and deaf patients. The National Health Authority noted that the lack of availability is aggravated by a demographic decline of practitioners.⁴⁵ Another barrier seems to be the disconnection between health and medico-social services.⁴⁶ Thus, if communication between patient and medical staff is important, the communication between different services can have a significant impact on communication with the patient.

The same report shows that people with intellectual disabilities complain about the failure of others to listen to them. Their legitimate and explicit demands may not be heard. Moreover, too often, practitioners speak to the family member and not directly to the patient.⁴⁷

For UNAPEI, a French association for persons with intellectual disabilities, there are two reasons behind these problems: a misunderstanding of disability and the consequences of the disability. Thus, for Lagier,⁴⁸ the patient's communication difficulties hinder the analysis of many symptoms, leading to diagnostic mistakes, multiplication of examinations and inappropriate treatments.

Thus, the perception of health of persons with intellectual disabilities is not often seen from the point of view of accessibility issues, but from that of internal communication difficulties. Moreover, reports seem more concerned with other partners than the patient in terms of cooperation. The disabled patient may be absent. Therefore, we can question his decision-making.

⁴³ ANESM (2013). L'accompagnement à la santé de la personne handicapée. Analyse de la littérature http://www.anesm.sante.gouv.fr/IMG/pdf/Analyse_Litterature_Juillet_2013.pdf.

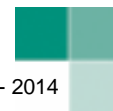
⁴⁴ <http://www.sante.gouv.fr/qualite-de-la-prise-en-charge-des-usagers-dans-les-etablissements-de-sante-prise-en-charge-des-patients-sourds.html>.

⁴⁵ Haute Autorité de Santé. (2009). Audition publique. L'accès aux soins des personnes en situation de handicap. http://www.has-sante.fr/portail/upload/docs/application/pdf/2009-01/audition_publicque_acces_soins_personnes_handicap_22_23102008.pdf.

⁴⁶ Haute Autorité de Santé. (2009). Audition publique. L'accès aux soins des personnes en situation de handicap. http://www.has-sante.fr/portail/upload/docs/application/pdf/2009-01/audition_publicque_acces_soins_personnes_handicap_22_23102008.pdf.

⁴⁷ Haute Autorité de Santé. (2009). Audition publique. L'accès aux soins des personnes en situation de handicap. http://www.has-sante.fr/portail/upload/docs/application/pdf/2009-01/audition_publicque_acces_soins_personnes_handicap_22_23102008.pdf.

⁴⁸ Lagier, P. (2011). *Assurer le parcours de santé des personnes handicapées mentales*. Symposium « Geront Expo – Handicap Expo », pp. 12-16.



2.2 Accessibility of Communications with Medical Staff in Practice

2.2.1 Extent of Accessibility

UNAPEI and ANESM point out the difficulties people with intellectual disabilities meet in everyday life.⁴⁹ Communication difficulties are stronger when expressing needs. The anxiety generated by bad experiences of healthcare or pain treatment may lead to other difficulties.⁵⁰

If lack of time is another kind of barrier,⁵¹ it also appears that professionals have a misunderstanding of the way of thinking, expressing themselves and communicating of people with sensory or intellectual disabilities.⁵² It also happens that disability is ignored especially in the case of invisible disability.⁵³

In a study of 2005, general practitioners in the South of France reported feeling uncomfortable during the medical consultation. 8.2% report that they were uncomfortable with mental disability, while 21.6% were it with physical disability.⁵⁴ Finally, 62.8% of general practitioners in the region reported being misinformed.⁵⁵

2.2.2 Accessibility in the Training courses of Medical Staff

⁴⁹ UNAPEI (2012). Livre Blanc de l'UNAPEI. Pour une santé accessible aux personnes handicapées mentales.

http://www.unapei.org/IMG/pdf/Livre_Blanc_Unapei_Pour_Une_sante_accessible_aux_personnes_handicapees_mentales.pdf ; ANESM (2013). L'accompagnement à la santé de la personne handicapée.

Analyse de la littérature http://www.anesm.sante.gouv.fr/IMG/pdf/Analyse_Litterature_Juillet_2013.pdf.

⁵⁰ UNAPEI (2012). Livre Blanc de l'UNAPEI. Pour une santé accessible aux personnes handicapées mentales.

http://www.unapei.org/IMG/pdf/Livre_Blanc_Unapei_Pour_Une_sante_accessible_aux_personnes_handicapees_mentales.pdf ; ANESM (2013). L'accompagnement à la santé de la personne handicapée.

Analyse de la littérature http://www.anesm.sante.gouv.fr/IMG/pdf/Analyse_Litterature_Juillet_2013.pdf.

⁵¹ Aulagnier M., Gourheux J.-C., Paraponaris A., Garnier J.-P., Villani P., Verger P. (2004). La prise en charge des patients handicapés en médecine générale de ville libérale : une enquête auprès d'un panel de médecins généralistes en Provence Alpes Côte d'Azur, en 2002. *Annales de réadaptation et de médecine physique*, 47: 98-104.

⁵² ANESM (2013). Personnes handicapées. Recommandations de bonnes pratiques professionnelles. L'accompagnement à la santé de la personne handicapée.

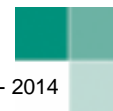
http://www.anesm.sante.gouv.fr/IMG/pdf/ANESM-RBPP-Accompagnement_sante-Juillet_2013.pdf.

⁵³ ANESM (2013). Personnes handicapées. Recommandations de bonnes pratiques professionnelles. L'accompagnement à la santé de la personne handicapée.

http://www.anesm.sante.gouv.fr/IMG/pdf/ANESM-RBPP-Accompagnement_sante-Juillet_2013.pdf

⁵⁴ Aulagnier M., Gourheux J.-C., Paraponaris A., Garnier J.-P., Villani P., Verger P. (2004). La prise en charge des patients handicapés en médecine générale de ville libérale : une enquête auprès d'un panel de médecins généralistes en Provence Alpes Côte d'Azur, en 2002. *Annales de réadaptation et de médecine physique*, 47: 98-104.

⁵⁵ Aulagnier M., Gourheux J.-C., Paraponaris A., Garnier J.-P., Villani P., Verger P. (2004). La prise en charge des patients handicapés en médecine générale de ville libérale : une enquête auprès d'un panel de médecins généralistes en Provence Alpes Côte d'Azur, en 2002. *Annales de réadaptation et de médecine physique*, 47: 98-104.



Article 1110 of The Public Health Code states that professionals have to attend vocational training, concerning welcoming and supporting disabled people and breaking news about disability. The literature shows a lack of training, however. To cope with the need for training for deaf people, an academic degree entitled "saying it in sign-language" was created in 1998. Other elements can be found on this issue in the Report « Access to healthcare », under question 9: Training / awareness programmes.

2.2.3 Good Practice Examples

In matters of communication there are many initiatives from associations. For example, Handisoins 86⁵⁶ is a local healthcare service created to support disabled persons. This service makes the connection between this kind of patient and the rest of the healthcare system, especially for disabled persons with communication difficulties. The service is composed of a practitioner, two nurses and a secretary.

In addition, Public Hospitals of Paris (AP/HP) has released a Toolkit for hospital emergencies.⁵⁷ Originally created for parisian emergencies and to communicate with people with intellectual disabilities, the toolkit is also used for other services. Although more than 600 toolkits have been sent to various medical services, we can note that the toolkit is free only for Parisian hospitals.

On another issue, a medical care home has developed an adapted questionnaire for its residents. The questionnaire focuses on residents' knowledge of their rights. It has been disseminated to residents allowing to them to establish a collective diagnosis.

Another medical-care home has used a guidebook,⁵⁸ to translate legal texts relating to disabled persons' health rights for persons with intellectual disabilities. Further, support for reading and understanding has been proposed to the residents.

In 2012, four local associations created the Health Passport⁵⁹ to facilitate the access to healthcare. The Health Passport provides specific information on the communication of the patient (simple words, sign-language, pictograms). The Health Passport also indicates if the person is able to stay alone for care, gives information on the patient's diseases, their treatments as well as the precautions to be taken. The Health Passport summarises lifestyle, reaction to pain, adaptation and understanding abilities of the patient.

⁵⁶ <http://handisoins86.free.fr/handisoins86.php?page=accueil>.

⁵⁷ <http://www.aphp.fr/handicap/kit-de-communication-avec-les-patients/>.

⁵⁸ ANESM (2013). Personnes handicapées. Recommandations de bonnes pratiques professionnelles. L'accompagnement à la santé de la personne handicapée.

http://www.ansm.sante.gouv.fr/IMG/pdf/ANESM-RBPP-Accompagnement_sante-Juillet_2013.pdf.

⁵⁹ <http://www.sante.gouv.fr/facilite-l-acces-aux-soins-des-personnes-en-situation-de-handicap-mental.html>.



2.3 Ongoing Developments

2.3.1 Commitments to Improvement

In matters of commitments to improvement, ANESM notes that medical-social institutes support more people with severe or complex disabilities.⁶⁰ To deal with difficulties in expressing needs, the agency also recommends specific methods of communication such as Makaton, PECS, speech synthesis system or pictogram associations.

2.3.2 Campaigns (eg by DPOs) or Calls (eg in academic publications) for Accessible Communications with Medical Staff

To promote the expression of needs, INPES (National Agency for Health Education) and CNSA (National Solidarity Office for Autonomy)⁶¹ recommend creating favourable conditions for communication by asking open questions and paying attention to paralinguage (quality and rhythm of voice, non-verbal communication). Further, UNAPEI and AFNOR (National Agency of Certification and Standardisation) has released a specific guidebook with pictograms.⁶² In 1998, the association created the S3A pictogram (Reception, Support and Accessibility Symbol),⁶³ to promote accessibility for persons with intellectual disabilities.

2.4 Additional Information about the Accessibility of Communications with Medical Staff

No additional information.

⁶⁰ ANESM (2013). Personnes handicapées. Recommandations de bonnes pratiques professionnelles. L'accompagnement à la santé de la personne handicapée.

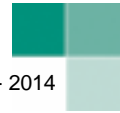
http://www.anesm.sante.gouv.fr/IMG/pdf/ANESM-RBPP-Accompagnement_sante-Juillet_2013.pdf.

⁶¹ https://www.google.fr/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0CCEQFjAA&url=http%3A%2F%2Fwww.cnsa.fr%2F&ei=GHOBVNXBMor2UNGYg9gP&usq=AFQjCNH_zh5X6f4g76PQJvv3gLUyCO-IAw.

⁶² UNAPEI (2012). Guide pratique de la signalétique et des pictogrammes.

http://www.unapei.org/IMG/pdf/Unapei_Guide_pratique_signalétique_et_pictogrammes.pdf.

⁶³ <http://www.unapei.org/le-pictogramme-s3a-symbole-d.html>.



3 Generic Health-Related Information

3.1 Obligations and Standards

3.1.1 Mandatory/Binding Accessibility Requirements applicable to Generic Health Information

We can consider that the obligations for information for the general population refer to health promotion and health education, as defined by the World Health Organisation. ANESM legitimates health and public policies through the promotion of health.⁶⁴ On the other hand, the disabled persons and patients' rights laws present the principles of access of healthcare, particularly in matters of health education and health promotion.

To this end, INPES was created. This agency aims to inform and educate both the general public and health professionals.

3.1.2 Technical Accessibility Standards or Guidance relating to Generic Health Information

INPES is a public institution created by the patients' rights law of March 4, 2002. This agency has the responsibility to implement prevention and health education policies. The public health policy law of August 9, 2004 expanded these initial missions to the management of urgent or exceptional situations with collective public health consequences and in trainings for health education.

INPES programs are developed by internal multidisciplinary teams, from the public health policies objectives. The agency has several types of tools: studies, research, communication, information, educational materials and support of local initiatives.

As previously mentioned, literature emphasises the difficulties for people with disabilities in recognising their problems in matters of health. Thus, recommendations and actions aim to educate people with disabilities to improve their access to healthcare.

3.1.3 Litigation or Other Publicly Documented Complaints about Inaccessible Generic Health-Related Information

We did not find much litigation or complaints about inaccessible generic health-related information. We just can argue that awareness and prevention campaigns are not

⁶⁴ ANESM (2013). Personnes handicapées. Recommandations de bonnes pratiques professionnelles. L'accompagnement à la santé de la personne handicapée.
http://www.anesm.sante.gouv.fr/IMG/pdf/ANESM-RBPP-Accompagnement_sante-Juillet_2013.pdf.

completely accessible. For ANESM, national campaigns are rarely tailored to people with cognitive, intellectual, psychological or sensory disabilities.⁶⁵

In other words, issues related to health education seem difficult to take into account for professionals. They do not think they are legitimate especially as regards sexual life.⁶⁶

3.2 Accessibility of Generic Health Information in Practice

3.2.1 Extent of Accessibility

In matters of accessibility of generic health information, people with disabilities are not particularly well informed nor do they have much health education compared with the general population.⁶⁷ For example, medical-social teams restrict their actions to routine care, while these institutes are often geographically isolated, making access to public information more difficult.⁶⁸

To facilitate access to public information, INPES implemented think tanks with users and professionals to create understandable tools for all, whilst working on lexical accessibility.⁶⁹ INPES "preferred to use simple French, avoiding anglicisms, metaphors, puns, technical languages and abstract ideas".⁷⁰ To facilitate easy reading for visually impaired persons, work on contrast and color coding was done. A clear text on a dark background was favoured. Illustrations and examples greatly help understanding. Furthermore, theoretical concepts are illustrated.

During the Prevention Days,⁷¹ INPES presented the agency's actions for disabled persons.⁷² The Agency implemented devices for primary prevention, such as a pregnancy and alcohol prevention campaign, a hearing risks prevention campaign, or an accidents prevention campaign. INPES also implemented specific disability information tools, such as guidelines on childhood deafness, depression, poor vision and dyslexia. Further, INPES also supports specific actions in medical-social institutes, such as education workshops for emotional and sexual life.

⁶⁵ ANESM (2013). Personnes handicapées. Recommandations de bonnes pratiques professionnelles. L'accompagnement à la santé de la personne handicapée.

http://www.anesm.sante.gouv.fr/IMG/pdf/ANESM-RBPP-Accompagnement_sante-Juillet_2013.pdf.

⁶⁶ ANESM (2013). Personnes handicapées. Recommandations de bonnes pratiques professionnelles. L'accompagnement à la santé de la personne handicapée.

http://www.anesm.sante.gouv.fr/IMG/pdf/ANESM-RBPP-Accompagnement_sante-Juillet_2013.pdf.

⁶⁷ http://www.actif-online.com/fichiers/articles/art_zucman_402_403.pdf.

⁶⁸ http://www.actif-online.com/fichiers/articles/art_zucman_402_403.pdf.

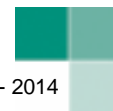
⁶⁹ <http://journees-prevention.inpes.fr/sites/default/download.php?file=sites/default/files/4-ALLAIRE.pdf>.

⁷⁰ https://www.google.fr/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0CCQQFjAA&url=http%3A%2F%2Fjournees-prevention.inpes.fr%2Fsites%2Fdefault%2Fdownload.php%3Ffile%3Dsites%2Fdefault%2Ffiles%2F3-PANIEZ%2520BD.pdf&ei=znGBVNn9M8PkUr7OAg&usq=AFQjCNFHnsf2I1M_20DPdyNtnqycDOqYg

⁷¹

<http://journees-prevention.inpes.fr/>.

⁷² <http://www.inpes.sante.fr/>.



Another aspect is the partnership between CNSA and INPES. These agencies have funded research to analyse problems, expectations and practices of health, to identify barriers, analyse perception, knowledge and access to information and educational health.

INPES and CNSA also conducted a study on the quality of health for disabled persons⁷³ and another one on persons who are affected by sensory impairments.⁷⁴ There was also quantitative research-such as on deaf persons' perceptions and behaviors relating to health.⁷⁵

Public Information tools have also been adapted with working groups. Further, specific tools have been designed particularly dealing with health emergencies, emotional and sexual life, nutrition and vaccination.

3.2.2 Good Practice Examples

At the local level, we can give a few examples. The *Epidaure* Association has implemented an action to encourage people to stop smoking among disabled persons.⁷⁶ Other initiatives also focus on emotional and sexual life⁷⁷ or also on oral and dental hygiene,⁷⁸ in different regions.⁷⁹ There are also initiatives for persons with intellectual disabilities⁸⁰ in the fields of health promotion and health education. Nurses and educators lead a workshop to enable young people to express and locate their pain with appropriate tools, like pictograms. In these workshops, booklets have been developed.⁸¹

3.3 Ongoing Developments

3.3.1 Commitments to Improvement

To improve the access to healthcare, ANESM recommends identifying users' needs in matters of health education in discussion groups combining users, families and professionals at a local level.⁸² The professionals could assess needs. At the same

⁷³ http://www.inpes.sante.fr/etudes/besoins_handicap.asp.

⁷⁴ <http://www.inpes.sante.fr/pdv/pdf/etude-pdv.pdf> ;

<http://www.inpes.sante.fr/CFESBases/catalogue/pdf/1399.pdf>.

⁷⁵ <http://www.inpes.sante.fr/CFESBases/catalogue/pdf/1505.pdf>.

⁷⁶ http://www.inpes.sante.fr/jp/cr/pdf/2013/3_-_STOEBNER_DELBARRE.pdf.

⁷⁷ http://www.inpes.sante.fr/jp/cr/pdf/2013/4_-_THON.pdf.

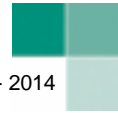
⁷⁸ http://www.inpes.sante.fr/jp/cr/pdf/2013/5_-_WILLAUME.pdf.

⁷⁹ <http://www.rhapsodif.com/dyn/>.

⁸⁰ <http://www.inpes.sante.fr/jp/cr/pdf/2011/session3/Presentation-Persiani.pdf>.

⁸¹ Anesm (2013) Expression, communication, participation et exercice de la citoyenneté. Qualité de vie en MAS et en FAM. Volet 1. http://www.anesm.sante.gouv.fr/IMG/pdf/ANE-Handicapes-Qualite_de_vie_en_MAS-FAM_volet_1_-Juillet_2013.pdf.

⁸² ANESM (2013). Personnes handicapées. Recommandations de bonnes pratiques professionnelles. L'accompagnement à la santé de la personne handicapée. http://www.anesm.sante.gouv.fr/IMG/pdf/ANESM-RBPP-Accompagnement_sante-Juillet_2013.pdf.



time a dialogue with the persons concerned about their lifestyle could take place. Relatives could express how they perceive the disabled person's needs and their expectations in matters of health.

The National Health Authority has also made some recommendations. Several of them could immediately be feasible.⁸³ Discussion groups, already mentioned, should focus on the routine care alongside the specific disability care such as hygiene, prevention and screening.

3.3.2 Campaigns (eg by DPOs) or Calls (eg in academic publications) for Accessible Generic Health-Related Information

In 2005, INPES created the Prevention Days to promote health education and health promotion to enrich the knowledge, experience and practice of professionals. In addition, INPES implemented a database⁸⁴ of academic degrees in health promotion, health education and patient education, taught in France: 41 academic degrees have been listed. This list is updated every year.

In 2010, INPES also created the Chair in "health promotion" within the EHESP.⁸⁵ This Chair works to improve health promotion strategies to reduce health inequalities by promoting innovations and improving high-level training.⁸⁶

The CNSA has also made a call for projects to improve accessibility for people with intellectual disabilities in matters of public information.⁸⁷ Projects must aim to reduce the inequalities with adapted and appropriate information.

3.4 Additional Information about the Accessibility of Generic Health-Related Information

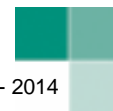
⁸³ Zucman, E. (2009). L'accès aux soins courants pour les personnes en situation de handicap, In Les Cahiers de l'Actif 402-403, pp. 199-208. http://www.actif-online.com/fichiers/articles/art_zucman_402_403.pdf.

⁸⁴ <http://www.inpes.sante.fr/FormationsEpS/index.asp>.

⁸⁵ <http://www.ehesp.fr/recherche/les-chaire/chaire-inpes-promotion-de-la-sante-a-ehesp/>.

⁸⁶ <http://www.ehesp.fr/recherche/les-chaire/chaire-inpes-promotion-de-la-sante-a-ehesp/>.

⁸⁷ http://www.cnsa.fr/IMG/pdf/Appel_a_projets_CNSA_Accessibilite_de_l_information_publicque_aux_personnes_handicapees_mentales.pdf.



4 Medical Equipment

4.1 Obligations and Standards

4.1.1 Mandatory/Binding Accessibility Requirements applicable to Medical Equipment

In matters of obligations, the access of medical equipments is firstly seen through the accessibility of buildings. For medical equipment, there are also preferential rates and an increased compensation payment.

Article 278-0 bis, of the General Tax Code allows VAT to be reduced by 5.5% for special equipment designed exclusively for disabled persons. Repairs are also subject to this specific VAT charge. This reduced VAT is for all electronic deafness correctors⁸⁸ and all hearing aids.⁸⁹ As regards medical devices, they can be supported and reimbursed.⁹⁰ The maximum refund is 3960 euros.⁹¹

The Compensatory disability benefit (PCH) and personal autonomy allowance (APA) also provide funding for technical assistance on top of the health insurance programme.

Besides this, the decree of May 27, 2014 specifies the healthcare list of medical equipment which can be reimbursed by health insurance outside of France. This decree is based on Regulation No 883/2004 of the European Parliament and the European Council of April 29, 2004 on the coordination of social security systems.⁹²

Article R. 332-4, of the Social Security Code, states that care can be reimbursed when it is given abroad especially when the care requires major medical equipment,⁹³ medical imaging, endovascular and cardiology interventions, ophthalmology surgeries, chronic renal or cancer treatments and genetic characteristics examinations.

⁸⁸ Article L. 165-1 of the Social Security Code.

<http://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006073189&idArticle=LEG IARTI000006740893&dateTexte&categorieLien=cid>.

⁸⁹ Annex IV of General Tax Code.

<http://www.legifrance.gouv.fr/affichCode.do?cidTexte=LEGITEXT000006069576>.

⁹⁰ <http://informations.handicap.fr/pdf-decrets/arrete-2008-07-18.pdf>.

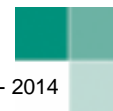
⁹¹ Fricotté, L. (2014) Guide Néret : Droit des personnes handicapées 2014. Wolters Kluwer France : Paris.

⁹²

http://europa.eu/legislation_summaries/employment_and_social_policy/social_protection/sp0002_en.htm.

⁹³ Article R. 6122-26 of the Public Health Code.

<http://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006072665&idArticle=LEG IARTI000006916685&dateTexte=&categorieLien=cid>.



In France, access to medical equipments is firstly seen in terms of access to buildings open to the public. Thus, Article L111-7, of the Construction and Housing Code specifies that "the architectural arrangements, indoor and outdoor facilities [...] have to be accessible for all, including disabled persons." This legal obligation includes medical equipments. However, the risks of penalties concern the buildings and not medical equipment.

In the case of non compliance, the guilty person is liable to legal sanctions: closure of the institution, repayment of the grant, a 45,000 euro fine, prohibition to exercise and 6 months' imprisonment in case of recurrence.⁹⁴ However, there are exceptions to this principle: in cases of technical impossibility, architectural heritage and manifest disproportion between the improvements and their consequences.

As of January 1, 2015, all medical offices have to make necessary work changes. This objective will not be achieved. The French government created the scheduled accessibility agenda (Ad'AP or Agenda d'accessibilité programmée) to allow health professionals to make the necessary arrangements within an additional period. Commitment letters must be submitted before December 31, 2014. Practitioners will have one year to make the necessary arrangements.

4.1.2 Technical Accessibility Standards or Guidance relating to Medical Equipment

It seems there there are no national guidelines for medical equipment. However, there are some for access to buildings.⁹⁵

4.1.3 Litigation or Other Publicly Documented Complaints about Inaccessible Medical Equipment

As already mentioned, the obligations relating to the accessibility of buildings will not be complied with in 2015. With Ad'Ap, the government will to help all institutions respect this obligation during the next year.

The Ad'AP project will be approved by the Prefect and Departmental Advisory on Safety and Accessibility Committee. The absence of formal approval decision means acceptance, except where there is an exemption request. Failure to deposit within one year after the publication of the ordinance is liable to a fine ranging from 1,500 to 5,000 euros.

As for medical equipment, some people have acknowledged that the medical equipment may not be accessible. Examination tables or dental chairs are not

⁹⁴ Articles 41 and 43 of the Disabled persons' rights law.

<http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000809647>.

⁹⁵ <http://www.argos-services.com/boite-a-outils/fiches-pratiques/fiche-no5-accessibilite-des-cabinets-medicaux/>.



adapted for a person with multiple disabilities. X-ray machines do not allow to perform a test on a patient in a wheelchair.⁹⁶

4.2 Accessibility of Medical Equipment in Practice

4.2.1 Extent of Accessibility

To measure access to screening, we can take into account regional actions. For example, in a region of the south of France, five associations are leading the screening programme.⁹⁷ For disabled persons living at home, the invitations to take part in screening are directly sent to the individuals. For people living in medical-social institutes, their home is the host institute. Even if sometimes the invitations are not sent, 27 out of the 28 institutes studied in a recent report received invitations.⁹⁸

Furthermore, screening for breast cancer has become standard practice: mammography is practically systematic, sometimes without invitation. gynecological care exists in over 90% of institutes studied.⁹⁹ For colon cancer, screening is recent and does not imply the same involvement from professionals, because the screening is complex.¹⁰⁰

In another study, persons asked did not seem to know about cancer. Thus, persons with a severe disability have more testicular cancers (9.9 times more than the general population), gallbladder cancers (10.3) and brain tumors (3,5).¹⁰¹

In the case of physical disability, inaccessibility to medical equipment seems to be a real problem: "Achieving the mammography of a patient in a wheelchair is not easy. Some people are unable to have an appropriate position."¹⁰²

In a study meant to identify the institutes' practices in matters of cancer screening, the authors show that the low medicalisation of the institutes is a real barrier to implementing the screening.¹⁰³

⁹⁶ Assurer la continuité du parcours de santé des personnes handicapées mentales. Géront Expo-Handicap Expo - 17-19 mai 2011 - Paris, Porte de Versailles. LAGIER Pierre.

⁹⁷ http://www.creai-pacacorse.com/depot_creai/documentation/85/85_17_doc.pdf.

⁹⁸ http://www.creai-pacacorse.com/depot_creai/documentation/85/85_17_doc.pdf.

⁹⁹ http://www.creai-pacacorse.com/depot_creai/documentation/85/85_17_doc.pdf.

¹⁰⁰ http://www.creai-pacacorse.com/depot_creai/documentation/85/85_17_doc.pdf.

¹⁰¹ http://www3.ligue-cancer.net/article/11389_cancer-et-handicap-pour-des-soins-accessibles-a-tous.

¹⁰² National Health Authority. (2009). Audition publique. L'accès aux soins des personnes en situation de handicap. http://www.has-sante.fr/portail/upload/docs/application/pdf/2009-01/audition_publicue_acces_soins_personnes_handicap_22_23102008.pdf.

¹⁰³ Couëpel L et al., « Dépistage du cancer chez les personnes handicapées : pratiques et difficultés spécifiques en établissement médico-social », Pratiques et Organisation des Soins 4/ 2011 (Vol. 42), p. 245-253. www.cairn.info/revue-pratiques-et-organisation-des-soins-2011-4-page-245.htm.



4.2.2 Good Practice Examples

Examples of good practices often refer to moving medical equipment to the patient's home. For example, healthcare home beds are medical-social services which were implemented in 2009. They allow people suffering from chronic diseases to receive medical and paramedical care, and social support, when they live at home or in special institutes.¹⁰⁴ This experiment refers to a recent commitment by the State to develop home hospitalisation.

4.3 Ongoing Developments

4.3.1 Commitments to Improvement

Home hospitalisation "HAD"¹⁰⁵ is a form of full-time hospitalisation at home. Care is provided at the person's home. These past few years, home hospitalisation¹⁰⁶ has been developed over the entire national territory. Care that is eligible for home hospitalisation is cancer treatment, perinatal care and ongoing care. Recently, an area was developed within medical-social services, readaptation institutes and pediatric services.

For the Ministry of Health,¹⁰⁷ home hospitalisation is useful when care is not possible in medical offices, because it is too complex, intense or technical. This service is available for persons who need ongoing care or a multidisciplinary medicalised team. It also facilitates the accessibility of healthcare for disabled persons who cannot move, or whose disability requires a familiar environment. In 2011, 305 medical-social structures provided home hospitalisation services for 100,000 patients.

To benefit from home hospitalisation, several conditions must be met: living in a geographical area covered by an authorised service, and living in an appropriate home enabling home hospitalisation.

The Health Insurance Programme covers 80% of fees, as for any hospitalisation, except in cases of long-standing disease. In this case, the health insurance covers all the fees. The patient may also benefit from the exemption of fees payment for: practitioner fees, drug costs, biological analysis, ambulance, medical hospital day, medical equipment or specific furniture.¹⁰⁸

¹⁰⁴ Conférence nationale de lutte contre la pauvreté et pour l'inclusion sociale. Travaux préparatoires (2012).

Groupe de travail « Santé et accès aux soins ». Pour un accès plus égal et facilité à la santé et aux soins.

http://www.social-sante.gouv.fr/IMG/pdf/sante_couv.pdf.

¹⁰⁵ <http://www.sante.gouv.fr/l-hospitalisation-a-domicile-had,12379.html>.

¹⁰⁶ <http://www.sante.gouv.fr/les-schemas-regionaux-d-organisation-des-soins-sros.html>.

¹⁰⁷ <http://www.sante.gouv.fr/l-hospitalisation-a-domicile-had,12379.html>.

¹⁰⁸ <http://www.ameli.fr/assures/soins-et-remboursements/combien-serez-vous-rembourser/hospitalisation/l-8217-hospitalisation-a-domicile.php>.

The fees take into account the nature of the care, the complexity of the clinical situation, the state of dependence, the duration of care and the evolution of the patient's health. They can range from 86 euros up to 500 euros per day. In 2011, the average price amounted to 198 euros.¹⁰⁹

4.3.2 Campaigns (eg by DPOs) or Calls (eg in academic publications) for Medical Equipment to be made Accessible

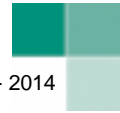
For Lagier, "we have to strengthen the professional teams to ensure ongoing monitoring and care."¹¹⁰

4.4 Additional Information about the Accessibility of Medical Equipment

No additional information.

¹⁰⁹ <http://www.sante.gouv.fr/l-hospitalisation-a-domicile-had,12379.html>.

¹¹⁰ Lagier, P. (2011). *Assurer le parcours de santé des personnes handicapées mentales*. Symposium « Geront Expo – Handicap Expo », pp. 12-16.



5 Telemedicine Services

5.1 Obligations and Standards

5.1.1 Mandatory/Binding Accessibility Requirements applicable to Telemedicine Services

Currently, there are no penalties in instances where the telemedicine service is not accessible. In the Disabled persons law, there is no indication about telemedicine services. This practice has been recognised in Article 78 of the "Hospital, patients, health and territories" Law (HPST law) in 2009.¹¹¹

Telemedicine services are not a substitute for current medical practice. For the Ministry of Health, they are a solution to fight the medical wastelands (see Report on Law and Policy in regard to Health Care, question 1).¹¹² Telemedicine services also aim to cope with the rise in chronic diseases and poly-pathologies. In case of disability, the law covers costs such as subscription to a telemedicine service.¹¹³

Article L.6316-1, of the Public Health Code defines telemedicine as a medical practice permitting the connecting of practitioners and patients or professionals. Theoretically, a telemedicine service allows establishment of an official diagnosis, ensures a preventive or therapeutic monitoring, requires expert advice to prepare a therapeutic decision or prescribes products.

The Ministry of Health tries to promote these kinds of devices in medical offices and medical-social institutes. Currently, implementation is in its experimental phase, which will be discussed in 5.1.2.

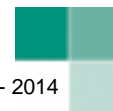
In 2013, there were 331 telemedicine devices and 19% were for disabled persons.¹¹⁴

¹¹¹ <http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000020879475>.

¹¹² <http://www.sante.gouv.fr/deploiement-de-la-telemedecine-tout-se-joue-maintenant.html>.

¹¹³ Fricotté, L. (2014) Guide Néret : Droit des personnes handicapées 2014. Wolters Kluwer France : Paris.

¹¹⁴ <http://www.sante.gouv.fr/deploiement-de-la-telemedecine-en-ville-et-dans-le-secteur-medico-social-9-regions-selectionnees-afin-d-experimenter-des-tarifs-prefigureurs.html>; Direction Générale de l'Offre de Soins (2012) Télémédecine Plaquette de Communication. http://www.sante.gouv.fr/IMG/pdf/Telemedecine_Plaquette_Communication_DGOS.pdf.



The main obligations are similar to the traditional dimensions of medicine. Firstly, as regards informed consent, the practitioner must inform the patient about the medical procedure¹¹⁵ and the telemedicine process.¹¹⁶ He has to explain the differences between telemedicine services and the medical conventional consultation to the patient, as well as guarantees of confidentiality.

In addition, the first consultation has to be made face-to-face, to deliver the information and obtain the informed consent of the patient. In the case of denial of the patient, the practitioner has to respect this decision and inform the patient about the consequences.¹¹⁷ Finally, the establishment of a telemedicine treatment must be authorised by the CNIL because it involves sharing e-health records.¹¹⁸

5.1.2 Technical Accessibility Standards or Guidance relating to Telemedicine Services

From a general point of view, five conditions are necessary to make up a telemedicine service: professional and patient identification, access to health records for professionals, training of the patient to use the device if needed, and updated health medical records. The healthcare service which organises a telemedicine activity must also ensure that professionals have the required training and technical abilities.¹¹⁹

Technical guidance has to make health accessible for the general population and to ensure compliance with certain regulations. Thus, experiments are subject to specific authorizations.

Health professional organizations which manage telemedicine activities have to intergrate the national telemedicine programme or sign a contract with the Health Regional Agency, which authorises the projects. The Regional Health Agencies take into account the needs of the population and of the territory.¹²⁰ Professionals have several technical guidelines to make their own services. For example, the National

¹¹⁵ Article L.1111-2 of Health Public Code.

<http://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006072665&idArticle=LEGJARTI000006685758&dateTexte=&categorieLien=cid>.

¹¹⁶ Article. R.6316- 2 of Health Public Code.

http://www.legifrance.gouv.fr/affichCode.do;jsessionid=66F02A35A058F6C5C4DD94989D0F94E5.tpdj_o13v_1?idSectionTA=LEGISCTA000022934373&cidTexte=LEGITEXT000006072665&dateTexte=20141205.

¹¹⁷ Article R. 4127-36 of Health Public Code.

http://www.legifrance.gouv.fr/affichCode.do;jsessionid=66F02A35A058F6C5C4DD94989D0F94E5.tpdj_o13v_1?idSectionTA=LEGISCTA000006196409&cidTexte=LEGITEXT000006072665&dateTexte=20141205.

¹¹⁸ <http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000000886460>.

¹¹⁹ REF.

¹²⁰ Article R6316-6 of Public Health Code.

http://www.legifrance.gouv.fr/affichCode.do;jsessionid=66F02A35A058F6C5C4DD94989D0F94E5.tpdj_o13v_1?idSectionTA=LEGISCTA000022934362&cidTexte=LEGITEXT000006072665&dateTexte=20141205.

Health Authority has released a guidebook.¹²¹ It is an educational tool designed to support deployment. The purpose is to assure patients that telemedicine activity is safe.

The National Health Performance Agency (ANAP) has also released a telemedicine services handbook.¹²² For the health professionals and Regional Health Agencies, this handbook aims to help them consolidate existing telemedicine services and to create new projects, through the feedback and capitalization of 25 already implemented projects. The projects include ongoing care in medical images, stroke treatment, management of chronic diseases such as heart failure, renal failure and monitoring of diabetes.

The French National Medical Order has also produced a telemedicine handbook.¹²³ This guidebook focuses on the practical applications of the regulatory framework, to provide an ethical basis.

5.1.3 Litigation or Other Publicly Documented Complaints about Inaccessible Telemedicine Services

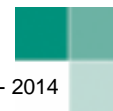
There do not seem to be any litigations on this issue. However, the different national strategies point out the debates held. Thus, there were many questions about confidentiality and deontology. Indeed, telemedicine services multiply some risks, especially because they may involve other kinds of professionals, like technicians.¹²⁴ Similarly, there is the problem of technology efficiency, like breakdowns or poor quality of data collection.

¹²¹ Haute Autorité de Santé (2013) Grille de pilotage et de sécurité d'un projet de télémédecine. http://www.has-sante.fr/portail/upload/docs/application/pdf/2013-07/guide_grille_de_pilotage_et_de_securite_d_un_projet_de_telemedecine_2013-07-18_13-34-47_545.pdf.

¹²² ANAP (2012). La télémédecine en action : 25 projets passés à la loupe. Un éclairage pour le déploiement national. Tome 2 : monographies http://www.anap.fr/uploads/tx_sabasedocu/ANAP_Telemedecine_en_action_tome2.pdf.

¹²³ Conseil National de l'Ordre des Médecins (2014). Vade-mecum : télémédecine. http://www.antel.fr/site/2014/vade-mecum_telemedecine.pdf.

¹²⁴ Haute Autorité de Santé (2013). Grille de pilotage et de sécurité d'un projet en télémédecine. http://www.has-sante.fr/portail/upload/docs/application/pdf/2013-07/guide_grille_de_pilotage_et_de_securite_d_un_projet_de_telemedecine_2013-07-18_13-34-47_545.pdf.



5.2 Accessibility of Telemedicine Services in Practice

5.2.1 Extent of Accessibility

It does not currently seem possible to measure the accessibility of telemedicine services, because they are in an experimental phase. Other things are being tested, such as the viability and relevance of tools or ethical issues.¹²⁵

However, radiology telemedicine devices have particularly been developed for ongoing care and the stroke monitoring.¹²⁶ We may also mention the expertise of nephrology telemedicine between nephrologist and general practitioner in monitoring chronic renal failure. Cardiology telemedicine expertise or the monitoring of chronic diseases for diabetes are other examples currently being tried out.

5.2.2 Good Practice Examples

As examples of good practice, we will take some recent initiatives. Thus, the practice of telemedicine in the South-East of France has become common since the creation of the European Centre for Telemedicine.¹²⁷ In this case, dermatologists have early access to the center and are developing teledermatology. The dermatology department is involved in different activities: participation in the Regional Network to ask for a specialist's advice and presenting their patients in real time, organisation of telemedicine sessions to discuss specific records, inter-regional meetings and training sessions for private dermatologists.

The TELENEURO regional project¹²⁸ is designed to meet the specific needs in the treatment of strokes, to facilitate the consultation of specialists by a telemedicine service.

Odys is the regional medical teleconsultation service, applied to a variety of medical topics, and allowing tele-expertise and tele-diagnosis.¹²⁹

The BB EEG platform project aims to develop an Internet portal providing telemedicine and e-learning services in the field of the electroencephalographic signals of the newborn.¹³⁰

¹²⁵ Conseil National de l'Ordre des Médecins (2014). Vade-mecum télé-médecine. http://www.antel.fr/site/2014/vade-mecum_telemedecine.pdf.

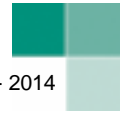
¹²⁶ Agence Régionale de Santé (2012). Programme Régional de Santé Alsace. http://www.ars.alsace.sante.fr/fileadmin/ALSACE/ars_alsace/Projet_regional_de_sante/consultation/RT_PRS_Alsace_2012-2016.pdf.

¹²⁷ Binet J.-L., Ardaillou R. (2006). Bulletin de l'Académie de Médecine. <http://www.academie-medicine.fr/wp-content/uploads/2013/03/2006.2.pdf>.

¹²⁸ Agence Régionale de Santé (2012). Programme Régional de Télé-médecine. <http://prs.sante-iledefrance.fr/wp-content/uploads/2012/09/ars-idf-prs-programme-telemedecine.pdf>.

¹²⁹ <https://www.sante-lorraine.fr/portail/les-services/odys,428,257.html>.

¹³⁰ [http://www.agence-nationale-recherche.fr/en/anr-funded-project/?tx_lwmsuivibilan_pi2\[CODE\]=ANR-10-TECS-0009](http://www.agence-nationale-recherche.fr/en/anr-funded-project/?tx_lwmsuivibilan_pi2[CODE]=ANR-10-TECS-0009).



5.3 Ongoing Developments

5.3.1 Commitments to Improvement

The main themes of the Digital Hospital Programme are the telemonitoring of chronic diseases, telemedicine activities which reduce inequalities in access to healthcare, ongoing healthcare with medical images and deployment in medico-social services.¹³¹

At the inter-regional level, a call for projects was launched to reduce medical wastelands.¹³² The projects must include the following elements: a medical project using telemedicine services as a factor to improve access of healthcare in the area, an organisational model for the area concerned to implement the medical plan, and an economic model identifying the necessary investments, the operational costs and compensation to the professionals.

5.3.2 Campaigns (eg by DPOs) or Calls (eg in academic publications) for Accessible Telemedicine Services

The High Speed Plan (Plan France Haut Débit) is the most recent national plan, for the Digital Hospital Programme.¹³³ Launched in 2013, the Programme aims to cover the entire national territory by 2022. To achieve this objective, the Programme is based on the shared network deployment of fibre optics, and mobilises an investment of 20 billion euros in ten years.¹³⁴

5.4 Additional Information about the Accessibility of Telemedicine Services

No additional information.

¹³¹ <http://prs.sante-iledefrance.fr/wp-content/uploads/2012/09/ars-idf-prs-programme-telemedecine.pdf>.

¹³² <http://massif-central.eu/sites/default/files/AMI%20T%C3%A9l%C3%A9m%C3%A9decine.pdf>.

¹³³ Direction Générale de l'Offre de Soins, ANAP, ASIP Santé (2013). Guide d'accompagnement pour l'expression des besoins en infrastructures à haut et très haut débit pour le déploiement des projets de télémédecine. http://www.datar.gouv.fr/sites/default/files/guide_datar_telemedecine_2013.pdf.

¹³⁴ <http://www.francethd.fr/comprendre-le-plan-france-tres-haut-debit/>.