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The Health Area, a Planning Tool for the Organisation of Care Supply and Health Policy?

Evolutions from 2003 to 2011

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In 2003, during the preparation of the third generation Regional Strategic Health Plan (SROS 3), the Health Area was established as the regulatory framework for the organisation of healthcare, replacing the Health Map created in 1970. The health area is conceived as the key component in the organisational structure of healthcare framed by quantified care supply objectives, an area medical project, and Regional Health Conferences created to provide a consultative space promoting cooperation between different health sector players.

In this new context, regions are incited to rethink the geographical zoning of health areas. Initially centred on hospital facilities with the creation of the Regional Hospital Agency (ARH), the health area concept was then extended to include other public health and medico- social services within the framework of the 2009 Hospital, Patients, Health and Territories Act, and the creation of Regional Health Agencies (ARS). In what way have regions developed this care supply network? A panoramic view of the regionalisation of health services from 2003 to 2011.

The recent law on hospital reform focusing on patients, health and territories known as the HPST Law (2009), instituted the 'territory' at the core of its health programme. The regionalisation of health services is not a new concept; it is the outcome of a lengthy process (insert page 2) with the creation of the Medical Map in 1970 as its point of departure. Its aim was to regulate hospital care supply by setting need indicators (bed-to-population ratios) per region and health sector. This initial planning tool was completed twenty years later with the Law of July 31st 1991. It gave weight to the region as territorial authority in the organisation of healthcare, and marked a turning point in health planning with the creation of the Regional Strategic Health Plan (SROS), a new planning tool initially centred on hospital planning. Its task was to set qualitative objectives aimed at improving the quality, accessibility and efficiency of hospital care supply, as opposed to the quantitative objectives fixed by the Health Map.

The growing trend towards the regionalisation of public health policy, in other words elaborated on the basis of spatial realities, has progressively gained prominence due to several factors: the geocoding of health data with the introduction of the Medical Information Systems Programme (PMSI)[1] in 1984, findings on health disparities based on studies carried out by the Regional Health Observatories (RHO), the involvement of health geographers in the analyses etc. These different factors have progressively resulted in a paradigm shift, moving from a disease and treat-

[1] The Medical Information Systems Programme (MISP), in existence since 1997, provides hospitalisation data for both public and private hospitals. This programme, part of the French Health System reforms, aims to reduce inequalities in the distribution of hospital resources by providing standardized, quantified data on hospital activities.

ment-centred approach to a more global 'people-centred' public health approach integrating environmental factors that have an influence on population health (Amat-Roze, 2011). It should be reminded that this global, territorial approach to health had already been implemented in the mental health domain with the sectorisation of psychiatric services in the 1960's.

The most significant change occurred in 2003 with the elaboration of the third generation Regional Strategic Health Plans (SROS 3) and the abolition of the Medical Map. It was at this point that the 'health area' replaced the Medical Map (considered too inflexible and technocratic) as the regulatory framework for the organisation of care. The health area took responsibility for the organisation of care within a framework of quantified care supply objectives elaborated by each hospital in the form of multiannual contracts setting activity targets and medical equipment resources to achieve them. Through the creation of the Regional Health Conference, the Health Area is also conceived as a consultative space promoting cooperation between different health sector players. It was to act as a leverage point for the implementation of regional medical plans[2] organising patient care (from first-contact care to specialised referrals) and, *in fine*, defining the role of each health sector player. This semantic change marked a significant evolution in the health planning territory: from simple container, the territory becomes an active element in restructuring the organization of healthcare.

[2] Each health area is governed by a medical plan, an upgradeable living document that is not legally binding, elaborated by the health conferences with three aims: to contribute to the elaboration of the SROS, participate in its implementation and evaluation and facilitate contract agreements and cooperation (www.ars.centre.sante.fr).

Historical reminder of French health planning

The beginnings of health planning

The beginnings of health planning in France can be attributed to the Law of 21st December 1941 that put an end to the hospital-hospice as a health and social care establishment. It called for a census of existing public and private facilities. Fifteen years later, with its growing weight in the economy, health became one of the objectives of the IInd Plan (1954-1957) with the constitution of a Commission for health and social amenities, mandated to establish an inventory of resources, determine priorities and establish a planning schedule. The rulings of December 1958 introducing a hierarchical classification of public hospitals asserted the principles of health planning.

The idea of sectorisation was introduced from 1960 in relation to psychiatric services, but in practice, only became widespread from the 1970's. Health planning in its current sense of the term really came into being with the Hospital Law of 31st December 1970 creating the public service hospital and instituting the Medical Map (Nogues, Azema, 1996). The idea of health planning suggests anticipated action, organisation, the rational allocation of resources or means (Jourdain, de Turenne, 1997) rarely broached in previous laws.

The Medical Map instituted by the 1970 Hospital Law aimed at regulating and redistributing hospital resources that had developed somewhat anarchically since the 1960s. The Law created the conditions for the proactive planning of space (Vigneron, Brau, 1996) by subordinating the creation or addition of hospitals beds or heavy equipment to population needs as defined by the Medical Map. It thus fixed 'need' indicators, equipment ratios defined at national level, per health sector and region leading to the creation of 21 health regions and 256 sectors in 1974. The data and tools required to establish these geographical divisions were virtually non-existent and hospital sectors were initially delimited around urban catchment areas. These divisions were then refined on the basis of surveys carried out in hospital catchment areas, resulting in 223 health sectors in 1984.

This first planning tool proved to be extremely quantitative and rigid. Its primary aims were to achieve equality and equity. Based on the existing hospital care supply, the Medical Map did not permit the real restructuring of hospital care supply, nor reduce the surplus (Basset, Lopez, 1997).

The regionalisation of health planning

Twenty years later, with the Law of 31st July 1991, the regional management and organisation of the health system was introduced and marked a turning point in French health planning. The Decrees of April 1996 instituted the Regional Hospital Agencies (ARH) responsible for hospital planning, both private and public.

The health sector is still considered as an extremely important factor in health planning but a second planning tool will be added to complete and improve the initial Medical Map: the creation of the SROS. These Regional Strategic Health Plans are defined regionally from the 'measure of population needs and their evolution, taking into account demographic data and advances in medical technology drawn from a quantitative and qualitative analysis of existing care supply.' The Medical Map and Health Plan were to be revised at least every five years in order to take demographic changes and medical progress into account. This tool was far more flexible than the first one; the Hospital Law of 1991 no longer fixed standard national objectives applicable to each region, but took into account the specific context of each region.

Three generations of health plans will then follow: the SROS 1 from 1994 to 1999, the SROS 2 from 1999 to 2004 and the SROS 3 enacted in 2006 for the period 2006-2011. During the first generation SROS, the analysis of existing care supply led to a redefinition of health sectors in the majority of regions, especially as the implementing provisions fix a minimum threshold of 200,000 inhabitants per health sector, except for French departments counting less than 200,000 inhabitants which then constitute a single sector. Sector delimitations were often the result of a compromise between human geography and administrative and political constraints (Lucas, Tonnellier, 1996). This period was the opportunity for certain regions to associate health geographers to their planning process. Some regions used the concept of town and village catchment areas as defined by the INSEE, or employment zones. Others used hospital catchment areas measured by means of surveys, since data such as provided by the Medical Information Systems Programme (PMSI) was not yet available. France thus counted 152 health sectors in 1994.

Few regions reviewed their health sector zoning within the framework of the second generation SROS. Some regions occasionally refined their methodologies as new data and tools became available, but no real changes to existing sector zoning were observed. It was more a case of reinforcing the organisation of care elaborated within the framework of the first SROS. On the other hand, complementary infra-sectorial divisions were sometimes added to the health sector in some regions when size was problematic for the observation of certain activities (surgery or maternity areas) or even to create areas of cooperation between health establishments (cooperation focal points).

The third generation SROS however, instituted major changes in regional health planning. It should be replaced in the context following the Ordinance of September 4th 2003 simplifying hospital planning legislation with a move towards a more global approach based on the evaluation of healthcare needs. The Ordinance abolished the Medical Map making the SROS the only planning tool, providing for evolutions in preventive, palliative and curative care and answering physical and mental health needs and fixing in the appendix, quantified care supply objectives per health area.

The Hospital, Patients, Health and Territories (HPST) Law of 2009 instituted Regional Health Agencies (ARS) whose role was to regionalise public health policy. To implement the new organization of care supply, these agencies were charged with defining new health areas (with broader goals than the former health sectors controlled by the very hospital-centred ARH): relevant to public health activities, hospital care and facilities, medical-social care and assistance and access to first-contact care': (Art. L. 1434-16 of the Public Health Code).

In this new context, French regions were incited to define and delimit their health areas, notably via the ARH. Newly regionalised, the medical plans were to promote dialogue and cooperation between all health sector actors: hospitals and office-based care providers but also the medical-social sector, elected representatives and healthcare users. It was not until the HPST Law of 2009 was enacted that these regulatory tools of such a complementary nature became truly effective. The new regional health agencies (ARS) were given a broader scope of intervention with the inclusion of office-based care and the medico-social sector in addition to hospitals. With the HPST Law, the health area becomes the legal territorial framework for health planning. The definition of the new health areas is placed under the responsibility of the Regional Health Agencies, replacing the former ARH.

The progressively predominant role of the region in the organisation of healthcare since 2003 gives rise to a number of questions: which health areas are being referred to? How have the different regions delimited and developed these new planning areas? What were the concepts and methods implemented? What were the geographical zones defined and how did the HPST Law modify them? In this study, we aim to draw up a panoramic overview of health planning as a territorial network of care supply from 2003 to 2011 drawing from the work carried out by the regions. The 'tool boxes' used to define these health areas are extremely variable from one region to the next. In this respect, it will involve analysing regional interpretations of national directives, first of all within the framework of SROS 3, then SROS-RHP (Regional Health Project) with the creation of ARS (Sources and Methods insert). If the health area remains a planning instrument within the framework of the HPST Law, the ARS mission and available means of action were considerably modified and led to the redefinition of health areas that will be analysed here.

Sources and method

Data

The results presented in this study were drawn from a reading of the different regional SROS 3 and SROS-RHP (Regional Health Project) and some preparatory SROS documents. The regional documents vary considerably in terms of content and presentation. They correspond to what the different regions wished to emphasize in their conception of health areas.
Some SROS 3 documents are more precisely argued than others, and the methods used more or less detailed. Our work summarises the factors put forward in the planning documents, that is to say what the regions wanted 'to reveal' of their territorial reflections. Interviews with the actors involved would have been necessary to have a clearer view of the way health area definition was broached in the SROS. It is also possible that certain factors were not described in some regional plans whereas they were part of the thought process and choice of health area divisions, notably certain political constraints.

Method

1. Failing a standardised planning model, we elaborated an analysis grid from which we were able to extract essential information. The grid covers the instructions given in the Ordinance and circulars relative to the elaboration of SROS 3. For each region, we collected information on:
– health area characteristics: number and size, population and surface area;
– methods used to elaborate them;
– the characteristics of new health area divisions compared with second generation SROS : unchanged or partially modified areas, reasons for maintaining former divisions, maintaining administrative boundaries;
– the graduated organisation of care supply (number of levels and content);
– territorial divisions in the fields of psychiatry and mental health: attempts to coordinate it with the field of Medicine, Surgery and Obstetrics (MSO);
– SROS thematic areas: number themes in addition to obligatory themes;
– other planning instruments : quantified care supply objectives (OQOS) and their specific application to access in terms of opening hours, calculation methods, SROS evaluation;
– critical reading factors: well-argued strategy, clearly explained, a real efforts to rethink the territory, office-based care taken into account.
2. The analysis of SROS-RHP was carried out on the basis of regional legislation defining SROS-RHP zoning.

With the implementation of SROS 3 in 2003 the definition of health area is approached differently according to region

The health area designated as the core component in health planning

The health area was designated as the core component in health planning by the Directive of September 4th 2003 and corresponding circulars implementing the SROS 3, notably the circular of March 5th 2004. The Minister of Health requested that the regions 'implement an innovative method in their delimitation of health areas', taking into account local conditions and transcending the traditional administrative boundaries. The circular also invited regions to take into account areas' physical and human geographies and population behaviours with regard to existing care supply. A better understanding of spatial factors influencing population behaviour was required, often totally unrelated to administrative divisions and their nomenclature (regions, departments, cantons, communes…), and their integration into the new health area divisions. The INSEE[3] had already created the 'employment zone' in 1983, a geographical area within which the majority of the working population live and work, based on travel flows between place of residence and place of work and, twenty years later, the 'living area' constituting the smallest territory within which inhabitants have access to principal services and employment.

The circular also specified that regions could define their health areas according to medical activity: medicine, surgery, psychiatry, follow-up care and rehabilitation. At the same time, it advocated coherent area divisions coordinating the different activities concerned, notably with referral hospitals and mental health service facilities. In addition, and quite logically, the organisation of healthcare provision had to be graduated and permit the easy identification of different referral levels. Five levels of care graded

[3] French National Institute for Statistics and Economic Studies.

in ascending order of complexity were proposed (local, intermediate, referral, regional and interregional) [Definition insert], each level integrates preceding level(s), the local level being mandatory. In spatial terms, graduated health areas correspond to each different level of care, from local first-contact areas to the larger inter-regional health areas. The Directives on the elaboration of SROS gave no specific indications as to way health areas should be delimited, but certain regions chose to associate a specific health area to each level of care. Allowing the regions freedom and flexibility in the way they defined their health areas had the effect of adding the concept of 'geographical' reality with its variable contents and functions. Certain regions differentiated areas for medicine or surgery whilst others used different care levels to fix their quantified objectives for the provision of care (Oqos). Only the health area as planning space for the organisation of care supply required a precise geographical boundary for which the Oqos and multi-annual contracts setting objectives and means (CPOM) were fixed by the area medical plan. The health area generally corresponds to the level of care (Definitions insert).

If certain regions chose to maintain their former divisions…

Despite the directive to implement an 'innovative method' in redrawing health area boundaries, suggesting that in many cases former sectors were not adapted to population needs, a third of regions preferred to consolidate SROS 2 divisions either by maintaining former health sector divisions, grouping former sectors together or implementing marginal modifications. Some regions had in fact given the question considerable thought in the elaboration of previous SROS, notably through the major restructuring of the hospital sector.

After 2003, three regions chose to maintain their former health sector divisions as they were: the Central region, Limousin and Brittany. Within the SROS 2 framework, Brittany had already given a great deal of thought to its health sector boundaries defined on the results of a cross analysis of hospital activities and socioeconomic realities taking into account the employment zones defined by the INSEE. The efforts made in 2004 to bring health sectors in line with the 'Pays[4]', project areas characterised by their geographic, economic, cultural or social cohesion, reinforced their decision to maintain former health sectors whilst at the same time promoting greater cooperation between the different players. In the Central and Limousin regions, the departmental boundaries delimiting former health sectors were maintained as health areas. In both these rural regions, the department had been the major structural framework in the organisation of care supply and an analysis of populations' spatial behaviours in terms of healthcare use confirmed this choice.

Finally, certain regions such as Picardie and Lorraine simply grouped former sectors together whereas the Ile-de-France and Midi-Pyrenees regions only partially maintained former health sector divisions (Coldefy, Lucas-Gabrielli, 2010).

… the majority of ARH 'invented' new health areas for the SROS 3

The remaining two thirds of the regions, however, chose to completely reinvent their SROS 3 health areas using methods based on the study of population flows to healthcare facilities or other types of services. According to region, the SROS 3 health areas were either built around hospital patient flows (correlated or not to living areas), hospital and ambulatory patient flows, or exclusively based on living areas.

For example, six regions defined their health areas on the basis of actual hospital patient flows: Basse-Normandie, Pays de la Loire, Champagne-Ardenne, Bourgogne, Franche-Comté and Rhône-Alpes. These methods are based on an analysis of majority in-patient flows determined from PMSI data providing a geographic code (close to the post-code) for each patient's place of residence. Furthermore, certain regions defined a single health area for all healthcare activities to ensure territorial coherence, whereas others privileged medical coherence taking into account the heterogeneity of healthcare use by segmenting patient flows according to medical specialty, pathology or care level (Rhône-Alpes, Pays de la Loire, Basse-Normandie) [Coldefy, Lucas-Gabrielli, 2010]. Coordinating the two objectives of territorial and medical coherence constitutes one of the ambitions of the health area.[4]

Five regions (Haute-Normandie, Auvergne, Languedoc-Roussillon, Provence-Alpes-Côte d'Azur and Corse) used methods correlating observed hospital patient flows with living areas or employment zones based on population movement behaviours concerning the most commonly used public or private services.

Finally, only three regions (Alsace, Poitou-Charentes and Aquitaine), took ambulatory care into account in delimiting their health areas. These regions measured both hospital patient flows using PMSI data, and patient flows for office-based care from Health Insurance data. Although this approach attempts to achieve an integrated approach to healthcare, the notion of care path within the health system is little developed and the studies carried out are more often limited to identifying transversal flows than developing a coordinated, integrated approach to hospital and ambulatory care.

[4] The 'Pays' as areas of inter-communal cooperation were created by the Spatial Planning and Sustainable Development Act of June 25th 1999 aiming at greater participatory democracy, also known as the Voynet Law. The 'pays' is a French administrative planning division designating a spatial area characterised by the 'geographic, economic, cultural or social cohesion of its living areas or employment zone' permitting the study and implementation of development projects expressing 'the inter-communal economic, cultural and social interests of its population'.

DÉFINITIONS

Care level definitions

Local level: first-contact care level, or continuity of care level involving general practitioner, nurses and pharmacists.

Intermediate level: structured around polyvalent medicine, first hospitalisation or technical platform level.

Referral level: delivering specialised care, corresponding to hospital catchment area, pivotal point in healthcare use.

Regional level: includes specialised services not provided by preceding levels.

Inter-regional level: reserved for certain highly specialized activities such as major burns units or brain surgery.

Considerable differences in size and specialization among SROS3 health areas

These different approaches produce extremely varied health areas, notably in terms of size and specialisation. The number of health areas per region varies from 2 to 22. In 2007, the average size of a health area was 374,000 inhabitants against 418,000 in former plans. Considerable differences in population size are observed with a ratio of 1 to 14 between the ten smallest territories and the ten largest. Similar variations are observed in terms of surface area and thus travel distances to access care. Surface areas vary from between 25 km² (in Île-de-France) to over 11,000 km² in Lorraine. The smaller areas are often very densely populated and geographical size a compromise between density and surface area.

The considerable differences in population size calls into question the concept of area medical plans. In the case of small-sized areas, the risk of not taking into account the main referral hospital situated outside the area is significant, as is the difficulty of organising care supply. According to the French Hospital Federation, a minimum threshold of 150,000 inhabitants is currently necessary to permit both a hospital and a clinic to operate in the same health area, in technical and medico-economic terms. This raises the question of 'viability' regarding these small territories, especially when it concerns preserving a fragile zone, a local economy or keeping a hospital open. Moreover, the demographic evolution of medical professions and greater demands in terms of quality and safety of care, tend to favour the creation of vaster territories with the risk of having to cover the healthcare needs of an extremely heterogeneous population and making it more difficult to adapt care supply to needs. If these larger health areas provide greater flexibility in terms of health planning, they also present the risk of creating a vast agglomeration of hospitals and services serving very different populations. The idea of graduated care supply, with the possibility of determining local care levels and intermediary referral levels situated outside the planning territory and coordinating areas and care levels between them could be an answer to this considerable heterogeneity between health areas.

Despite increased cooperation, SROS3 area planning for the ARS finally remains focused on the hospital

A reading of the SROS 3 documents elaborated by the different regions, shows that certain ideas such as the permitted flexibility between type of activity and level of care had been well assimilated in the definition of health areas (Coldefy, Lucas-Gabrielli, 2010). The varying nature of designated health areas depended on the region and served to differentiate between areas for planning, consultation and cooperation, studies and projects. Many regions insisted on the importance of cooperation in determining their health areas. Involving healthcare users, elected representatives and healthcare professionals in the zoning process contributed to the creation of coordinated territories. Certain factors however, were not incorporated in regional planning efforts as successfully. This was the case for office-based care, social services and the medico-social sector that were rarely integrated in regional planning processes. Compartmentalisation remained significant and health planning remained centred on hospital care supply rather than global care supply. The attempt to create coherent territories was more often a case of fixing health area boundaries around hospital technical facilities or MSO and leaving it to the other disciplines, such as psychiatry, to adapt.

The HPST Law of 2009 and the creation of Regional Health Agencies (ARS) heralded the reconfiguration of health areas

The HPST Law of July 21st 2009 on hospital reform focusing on patients, health and territories, created the Regional Health Agencies (ARS) whose role was to regionalise public health policy. These agencies were charged with defining and implementing regional health policies and elaborating strategies within the framework of a regional health plan (RHP). Within this new framework, the SROS included two major changes: it became the operational tool for RHP implementation and saw its field of application extended to ambulatory care supply. In addition, the elaboration of the SROS-RHP demanded a coordinated approach integrating two additional regional plans, the Regional Prevention Plan (RPP) and the Regional Medico-social Plan (RMSP). The HPST Law prescribed that 'Regional Health Agencies define appropriate health areas for public health activities, treatment, hospital equipment, medico-social care and assistance and access to primary care.' (Art. L.1434-16 of the CSP).

With this new Law, health areas were given a new dimension associating all healthcare domains, whether hospitals, ambulatory care, medico-social care and prevention, thus favouring decompartmentalisation. In the definition of these new areas, several criteria needed to be taken into consideration among which, the integration of the health services supply chain as a whole so as to converge towards global health, the spatial practices of the population in the designated health area (habits, behaviours, observed use of health services), accessibility (time and distance to access services), or even its coherence with other public policies (urban policy, social cohesion, education…).

The majority of ARS chose to redefine SROS3 health area divisions

Within this new framework and its short implementation deadline, the majority of ARS chose to modify SROS3 health area divisions, despite the considerable thought and effort previously deployed by certain regions in defining them. Only one metropolitan region and two overseas departments maintained their former departmental divisions[5], whereas many others decided to reduce the number of health areas. The Île-de-France region, for

Context

This project falls within the framework of research on health areas carried out by IRDES. An analysis of third generation Strategic Regional Health Plan health areas (SROS 3) was published in 2010 (Coldefy, Lucas-Gabrielli, 2010). This study continues the research theme with the implementation of SROS-RHP (Regional Health Plan) following the Hospital, Patients, Health and Territories Law (HPST) and the regional zoning of new health areas.

example, reduced its health areas from 22 to 8 and the Languedoc-Roussillon region from 8 to 5! The end result was an overall decrease in the number of health areas by about a third, from 159 SROS 3 areas to 108 in the SROS-RHP (metropolitan France and Dom). The average population size for these new areas thus increased from 374,000 inhabitants in SROS 3, to 605,000 in SROS-RHP, thereby reducing the gap between the least populated areas and the most populated areas. The average area, counting 605,000 inhabitants does not, however, reflect the extreme ends of the scale as health area sizes in fact vary from 77,000 to over 2 million inhabitants, with 50 % of areas counting less than 450,000 inhabitants. The larger size of these new health areas can be explained by the fact that it provides the planner with greater margins for manoeuver.

[5] Each overseas department corresponded to a SROS 2 health sector except for Reunion Island, the most densely populated overseas department that had been divided into two health sectors since 1991. For RSHP3 and RSHP-RHP, Guyana and Martinique maintained their departmental divisions whereas Guadeloupe opted for infra-departmental divisions. The Reunion island marginally modified its health sector zoning between SROS3 and SROS-PRS. Furthermore, the Reunion includes an additional territory with the department of Mayotte.

For half the regions, health areas are based on departmental boundaries

Many regions chose to reconfigure their health areas in accordance with departmental boundaries (map and table) since twelve out of twenty six regions chose this administrative division as the planning level for care supply management, and four others chose to group departments together or the region as a whole (Champagne-Ardenne, Franche-Comté, Limousin, Corse).

The cross disciplinary relationship between the health and medico-social sectors is often used by regions to justify the choice of departmental division. The ARS for the Île-de-France region, for example, argued that 'correlating health areas with departmental boundaries permits aligning ARS policy with local government policy and that of the majority of actors involved in its different domains of competence'[6]. For these regions, it was thus easier to establish Regional Strategic Medico-social Plans (RSMP) in accordance with departmental plans for disabled or dependent persons legislated by regional County Councils. The latter are effectively involved on several levels: in the medico-social sphere with legal competencies for maternal and infant protection, gerontology and disability, public health (vaccinations, fight against tuberculosis, health education and health promotion),

[6] http://www.ars.iledefrance.sante.fr/fileadmin/ILE-DE-FRANCE/ARS/1_Votre_ARS/4_Contexte_Regional/Territoire_Sante/CP_territoires_17.11.10.pdf

T

Evolution of health area divisions in French regions between SROS 3 and SROS-RHP

	Territotial divisions used in health areas	
	Under SROS 3	Under SROS-RHP (Regional Health Plan)
Former divisions maintained		
Nord-Pas-de-Calais	Employment zones	Employment zones
Bretagne	Coordination of 'Pays' and hospital patient flows	Coordination between 'Pays' hospital patient flows
Alsace	Hospital and ambulatory patient flows	Hospital and ambulatory patient flows
Lorraine	Departments	Departments
Centre	Departments	Departments
Martinique	Departments	Departments
Guyana	Departments	Departments
Modification of divisionss		
Picardie	Groups of cantons	Establishments of Inter-Communal Cooperation (EPCI)
Haute-Normandie	Coordination between hospital flows and living areas	Establishments of Inter-Communal Cooperation (EPCI)
Guadeloupe	Departments	Infra-departmental divisions
The Reunion	Living areas or employment zones	Living areas or employment zones
Poitou-Charentes	Living areas	Inter-communal divisions and departments
Aquitaine	Hospital and ambulatory flows (integrated health approach)	Urban districts and departments
Rhône-Alpes	Hospital flows	Departments and groups of SROS3 health areas
Île-de-France	Hospital flows	Departments
Basse-Normandie	Hospital flows	Departments
Bourgogne	Hospital flows	Departments
Pays de la Loire	Hospital flows	Departments
Midi-Pyrénées	Hospital flows and population behaviours	Departments
Auvergne	Living areas	Departments
Languedoc-Roussillon	Coordination between hospital flows and living areas	Departments
Provence-Alpes-Côte d'Azur	Coordination between hospital flows and living areas	Departments
Champagne-Ardenne	Hospital flows	Groups of departments
Franche-Comté	Hospital flows	Groups of departments
Limousin	Départements	Groups of departments
Corse	Coordination between hospital flows and living areas	Groups of departments

but also in the fight against exclusion (RSA…). Regarding the argument put forward regarding the transversal nature of health domains, one can assume that relations between the different health sector players and power stakes between County Councils and ARS contributed to the choice of department as health planning area.

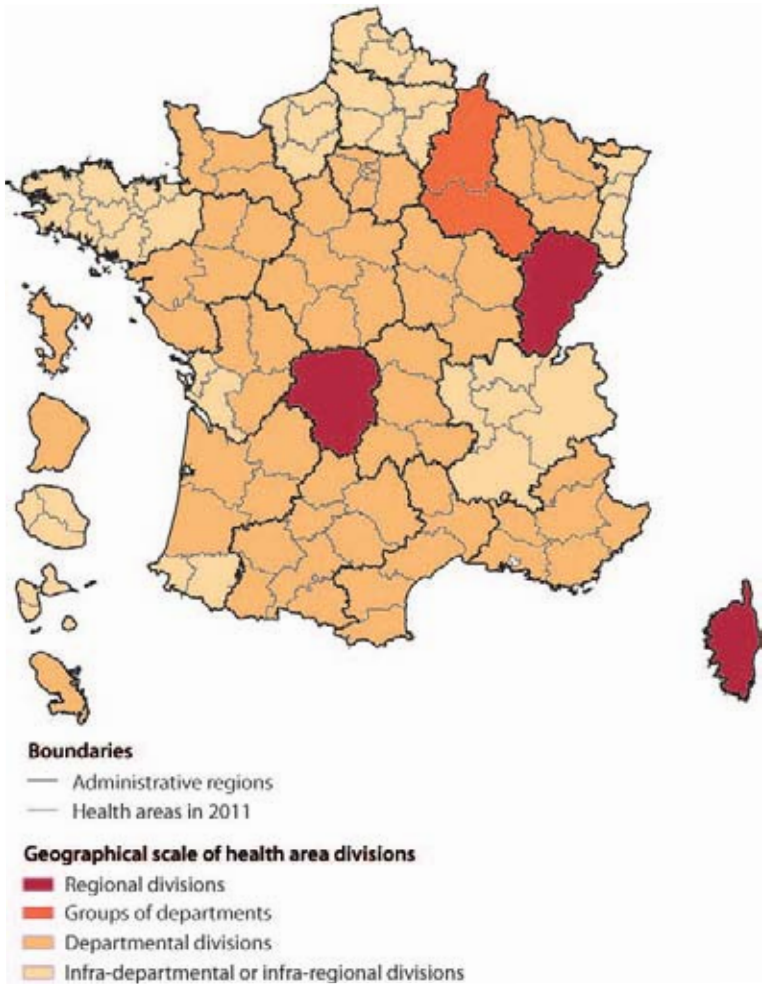
Only eight metropolitan regions and the Reunion island chose other divisions than departmental boundaries or their aggregation to define health areas. Two regions partially used departmental boundaries: in the Poitou-Charentes and Aquitaine regions, the majority of health areas correspond to a single department except one. The Charente-Maritime department (Poitou-Charentes) and the Pyrénées-Atlantiques (Aquitaine) are each divided into two health areas. These areas correspond to inter-communal groupings in Charente-Maritime and urban district groupings in the Pyrénées-Atlantiques. This choice answered the search for globally coherent public interventions by taking into account 'areas developed by other government players within their respective spheres of responsibility and, in particular, those promoted by the local authorities', (Decree of 26th October 2010 defining health areas in Poitou-Charentes). In Charente-Maritime, the ARS justified its choice of health area divisions on the basis of high population density, 'its geographical, social and cultural specificities' and more especially the historical structure of care supply in this department's health areas (*Ibid*). The division of Aquitaine into two distinct health areas corresponded to strong cultural and geographical identities in both the Bearn and Basque countries. These divisions nevertheless differ from former SROS 3 areas.

A few regions opted for continuity

Finally, a few regions made slight modifications to the health areas formerly defined in SROS 3. This was the case in Bretagne where the eight former health areas were globally maintained with slight adjustments to take subsequent hospital restructuration into account. 'This choice expresses the will to reinforce local policies taking into account area specificities whilst favouring coordination between actors within the health system,' (ARS Bretagne).

C

SROS-RHP health areas in 2011



Source : Irdes.

The Alsace region also opted for continuity judging that the previously defined health areas 'had proved their ability to structure hospital care supply and public health.' As in Bretagne, health area 'boundaries' were redefined taking into account changes in patient flow, healthcare consumption and demographic data. At the same time, they were brought closer in line with partner institutions' areas of intervention in the health and medico-social domains. The Nord-Pas-de-Calais region also opted for continuity and maintained their former divisions. Their choice was to group together local areas on the basis of urban planning criteria, population balance and the rate of use of hospital technical facilities. The local areas were redefined taking into account urban district boundaries (core network for State intervention), County Council action areas and Public Establishments of Inter-Communal Cooperation (EPCI), grouping together communes having decided to develop a certain number of services together (notably public transport and urban planning).

The EPCI also form the basis of health area divisions chosen by the Picardie region, an ascendant approach taking into account population behaviours and characteristics and a high level of coordination with other health, social and political areas. The Picardie approach drew on a diagnostic of health areas in terms of attractiveness, care supply, prevention, healthcare consumption and expenditures, population and living conditions and demographic evolution. The approach chosen by the Haute-Normandie region was similar in that it was also based on EPCI project areas whilst maintaining continuity with

previous policies. First-contact health areas were defined first, followed by local health areas and finally health areas. The form of organisation retained was centred on urban units and the graduation of existing care supply, a highly structuring factor in this region. Finally, the Rhône-Alpes region reduced its number of health areas from 13 to 5, aggregating hospital catchment areas previously defined in previous SROS.

* * *

Since 2003, the place and conception of space in health planning has considerably evolved. The methods and concepts used have been perfected as can be observed by comparing the number and size of health areas that have fluctuated constantly throughout the years 2000. These territorial divisions and their evolution illustrate the different phases in the regionalisation of health over the years at a given period. One thing is certain; the territory is now at the core of health system organisation.

Until now, and despite incentives and national directives, health planning has remained focused on the hospital. One of the major challenges of the 2009 HPST Law was to define health areas covering public health activities, hospital care, medico-social care and assistance and access to first-contact care. Numerous ARS thus redefined their health areas on the basis of departmental divisions or EPCI groupings so as to better manage the transversal nature of patient care. One also witnesses the development of diverse types of territory: project areas based on a different approach as health areas are no longer systematically top-down networks but use an ascendant approach based on local initiatives, development areas or contractualisation, with local health contracts permitting better coordination between Regional Health Plans and existing local initiatives.

With the growing needs for local care supply, graduated levels of hospital care and also coordination between local care supply and more specialised care, notably due to the growing percentage of elderly persons and patients suffering from multiple chronic diseases, the health area emerges as an essential tool in the global structuring of care between the different players in the health, social and medico-social spheres and in which the individual, or healthcare user, is the focal point. This study nevertheless shows that the health area can achieve nothing on its own. In order to gain substance, it must be accompanied by legal obligations and financial levers, such as integrated financing for example. ♦

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