European Journal of Preventive Cardiology (2026) **33**, 812–814
https://doi.org/10.1093/eurjpc/zwaf756

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Revolutionizing cardiac rehabilitation: France’s new paths beyond the centre

Frédéric Schnell [1,2], Xuejiao Wu [3], and Linqi Xu [4]*

[1]University of Rennes, 263 avenue Général Leclerc, 35042 Rennes Cedex, France; [2]CHU de Rennes, 2 rue Henri Le Guilloux 35033 Rennes Cedex 9, France; [3]Jilin University, Changchun, Jilin Province, China; and [4]Hasselt University, Agoralaan gebouw D, 3590 Diepenbeek, Belgium

Received 12 October 2025; accepted 23 November 2025

Breaking the walls of cardiac rehab

Cardiac rehabilitation (CR) is recognized worldwide as one of the most effective post-cardiac event interventions: it helps patients recover strength, reduce the risk of recurrence, and improve overall quality of life. Despite robust guidelines and clear benefits, CR under-utilization remains a major issue across both high- and middle-income countries. For example, in the United States only about one-third of eligible patients after myocardial infarction,[1] percutaneous coronary intervention, or coronary artery bypass surgery are referred to CR, and participation rates decline sharply among women and older adults. In the United Kingdom, participation hovers around 50%,[2] while in Canada and Australia, referral and enrolment rates vary widely, often below 30–40%.[3,4] In many low- and middle-income countries, rates are even lower, in some cases under 20%.[5]

Barriers to participation are similarly global: long travel distances to rehab facilities, competing work or family responsibilities, lack of transportation, limited programme capacity, and socio-economic disparities. These challenges create a gap between what guidelines recommend and what patients actually receive.

To address this challenge, the Group Exercise Rehabilitation Sports–Prevention of the French Society of Cardiology recently published a consensus document proposing innovative solutions.[6] Their aim is to make CR more flexible, more accessible, and better adapted to the realities of patients’ lives. The document outlines four experimental care models that go beyond traditional hospital-based rehabilitation.

New models, new hope: the innovative approaches to cardiac rehab

1. Light private rehabilitation structures (LPRS)

Community-based teams mirror traditional centres but with greater flexibility. Extended opening hours help patients balance rehab with work and family life. Early trials involving thousands of patients suggest strong adherence and higher participation among women.

2. Home-based telerehabilitation (Walk Hop)

After an initial in-centre assessment, patients continue at home with a cycle ergometer, heart-rate monitor, and digital platform. Data are transmitted daily, with remote supervision and weekly video calls. Results: improved fitness (+15%), adherence near 90%, and high patient satisfaction.

3. Hybrid telerehabilitation (Read’hy)

Combines supervised centre sessions with home-based training, supported by telemedicine. Tested across various patient groups, it showed gains of +22% in exercise capacity and improved quality of life, with adherence above 80%.

4. Coupled care with multi-professional group practices (EVA CORSE)

Patients begin in a specialist centre and continue locally in multi-professional group practices (MGPs), coordinated remotely by the central team. This reduces travel barriers and supports vulnerable patients, while maintaining safety and quality.

‘We Are Still Experimenting’—Dr. Schnell on France’s pilot programmes

To gain insight into how these models work in practice, we interviewed Dr. Frédéric Schnell, one of the consensus document’s authors. He emphasized that these initiatives are not academic trials in the traditional sense, but rather real-world experiments launched under France’s Article 51 innovation framework.

‘It’s more like experimentation than academic research’, Dr. Schnell explained. ‘The goal is to test new organizational models, to see whether they are safe, effective, and acceptable. If they prove successful, the government may eventually reimburse them and integrate them into standard care’.

* Corresponding author. Email: linqi.xu@uhasselt.be

Why France needs new models?

According to Dr. Schnell, the need for innovation is clear. Traditional inpatient CR requires substantial resources and is not scalable to the entire patient population. 'We cannot provide enough inpatient rehab for everyone', he said. 'We need simpler, lighter solutions so that more patients can benefit'.

In some regions of France, the shortage of rehabilitation centres is particularly stark. Patients may face journeys of over an hour each way to attend sessions, a barrier that makes participation unrealistic. This geographical factor also explains why France still relies more heavily on inpatient rehabilitation compared with neighbouring Belgium, where distances are shorter and outpatient rehab is more feasible.

Who gets what kind of rehab?

One of the key challenges is deciding which patients should go to inpatient, outpatient, or home-based rehabilitation. Dr. Schnell described the process as a step-by-step evaluation: patients who have undergone major surgery or transplantation, or who remain medically unstable, clearly require inpatient care. Stable patients living close to a centre may be directed to outpatient programmes. Meanwhile, patients at lower risk who live further away can be referred to LPRS facilities or to telerehabilitation.

'We think we need a bit of everything to cover a broad range of patients', Dr. Schnell said. 'It would be dangerous to impose a single model. Flexibility is essential'.

Telerehabilitation: promise and hesitation

The pilots have demonstrated that telerehabilitation can be safe, effective, and popular with patients. But financial and policy barriers remain. 'The government is cautious', Dr. Schnell noted. 'They fear that if telerehabilitation is reimbursed for everyone, costs could escalate quickly. For now, these models are still experimental. But early results suggest that they are cost-effective in the long run, because preventing complications and hospital readmissions saves money overall'.

In this respect, the French debate mirrors international discussions about how best to integrate digital health into mainstream care. The challenge is not only technical but also political: how to balance innovation, safety, and financial sustainability.

Geography shapes care

Geography is a central theme in the French experience. 'Sometimes it's just too far', Dr. Schnell said. 'In Brittany, for example, patients may live more than an hour from the nearest rehabilitation centre. That explains why we still rely more on inpatient rehabilitation'.

In contrast, in small countries like Belgium distances are shorter, which has allowed outpatient rehabilitation to dominate. These differences highlight the importance of tailoring health policy to the realities of each healthcare system and its geography.

The road ahead

The consensus document represents an important milestone in the evolution of CR in France. By formalizing the lessons of ongoing experiments, it provides a framework for scaling up alternative models of care. Whether these models will be widely adopted depends on the results of ongoing evaluations and on future policy decisions.

For Schnell, one principle remains non-negotiable: safety. 'Safety was the first requirement', he said. 'The patient must understand when they should not be in a remote pathway. But if we do this right, we can finally reach many more patients who need rehabilitation'.

In the end, France's experiments in CR may hold lessons not just for its own health system, but for other countries grappling with similar challenges of access, cost, and patient engagement.

At a glance: France's four new models of cardiac rehabilitation

Model	Where it Happens	For Whom	Key Features	Results so far
1. LPRS	Local, private multi-disciplinary centres	Patients unable to access hospital-based CR	Flexible hours; coordinated by cardiologists; formal hospital links	>3000 patients; higher female participation
2. Walk Hop (Home-Based Telerehab)	Initial 3–5 days in centre, then at home	Stable, digitally autonomous patients	Heart-rate monitor + ergometer; daily supervision; weekly calls	+15% exercise capacity; 89% adherence; 91% satisfaction
3. Read'hy (Hybrid Telerehab)	Alternating between centre and home	Coronary disease, heart failure, diabetes	Telemedicine platform; centre + home sessions	+22% exercise power; improved quality of life
4. EVA CORSE (Coupled CRC-MGP)	Start at CRC, then local MGPs	Vulnerable, rural or remote patients	Local GPs/nurses trained by CRC; telemedicine support	+20% exercise capacity; improved access

Author contributions

Frédéric Schnell (Conceptualization [lead], Project administration [equal], Resources [lead], Supervision [equal], Writing—original draft [equal], Writing—review & editing [lead]), Xuejiao Wu (Project administration [supporting], Supervision [supporting], Writing—original draft [equal], Writing—review & editing [lead]), and Linqi Xu (Conceptualization [lead], Methodology [lead], Project administration [lead], Supervision [lead], Writing—original draft [lead], Writing—review & editing [equal])

Conflict of interest: The authors declare no conflict of interest.

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