CHAM 2017

WORKFORCE AND FACILITIES

5 years to change

Synthesis of discussions and recommendations

SUMMARY OF DISCUSSIONS

The new technologies are challenging us. Are we going to sit on the sidelines of this revolution, or will we tackle the challenge and act for the good of humanity? The challenges facing us are immense; all the more reason to tackle them in a fully informed way.

Is the money that we are spending on our health being put to good use? Are our skills and structures appropriate and adequate for these challenges? There is no single answer. Let us therefore work together to build a system that leaves no one by the wayside, and at an acceptable price.

None of us should escape scrutiny of how we do things. The old world is collapsing. The technologies that we are developing are opening up exhilarating and dangerous prospects.

Will we reach beyond corporatism to innovate and meet the demands of those who are suffering in body and mind?

In the CHAM 2017 debates we articulated these questions through four main themes – Evaluation**, Change, Leadership and (re)Invention** – to establish recommendations for the guidelines to adopt for the next five years.

Contents

EVALUATION

Evaluation by patients of medical outcomes: how to evaluate? what to evaluate?

Should patients evaluate medical outcomes? The answer is obviously "yes". There is no question of it. In reality, it is about how patients should evaluate medical results. This evaluation should not be done when they are discharged, under pressure – even though well-meaning – by health professionals. Patients have to be able to express themselves freely, spontaneously, in order to concretely measure the effect of the medical treatment on the quality of their daily life. Evaluation must be done over time. It should not be limited to accommodation services or administrative care during their hospital stay. In other words, evaluation should no longer consist of measuring a potential shortfall against a standard, but should be based on the patient's view of his day-to-day practical experience once admitted to hospital.

The use of questionnaires emailed to patients which should then be systematically collated into their notes (unless the patient refuses) would permit regular monitoring of their post-treatment health and in particular their quality of life at personal, family, social, and professional level.

The collected data would be used to populate databases from which outcome statistics could be derived.

No entity or body is currently able to report the average level of outcomes from a given treatment, so everyone is financing the system on a blind basis.

Evaluation of drugs and medical devices: what effect on patient health and economic health?

It is with the evaluation of patients' long-term health in mind, that drug prices should be set. Drug prices should no longer be set by adding a margin to research and production costs. The degree of innovation and, ultimately, the patient's interest should be used to determine the price. Health is a market unlike any other – the benefit of drugs to society and the economy should be measured by their therapeutic efficacy and their impact on the economic efficiency of the healthcare system. Faster time-to-market **with real-time feedback of information from the most important patient segments via the**

internet, would detect weak signals that would alert authorities and manufacturers early to the harmful effects of health products.

The same applies to the use of medical devices, which could be leased to patients on a long-term basis to allow them to benefit from the most innovative technologies.

CHANGE

Our jobs are now about to disappear tomorrow! However, the nature of work is changing. People's roles in work will be changing. Work will be digitising, automating, but will not disappear. This change should not be feared, nor obscured.

It should be embraced without fear to benefit the end-user of the healthcare system: the patient.

Change in core skills

Digitisation, automation and the development of artificial intelligence will change the jobs of healthcare professionals. Physicians will instead focus on complex consultations, support and prevention; cardiologists will no longer do electrocardiograms; and radiologists, biologists and anatomical pathologists will focus on disputed cases. Surgeons will focus on complex, urgent or non-programmable operations, and pharmacists will take on the role of "service providers" to abandon automatable tasks. These considerations must be taken into account today, to avoid an influx, in ten years' time, of new doctors who will have become unneeded.

Numerical limits should be maintained or reduced depending on the speciality being impacted by technological innovations, knowing also that many tasks will be delegated to other professionals thanks to new empowering tools.

(re)Defining our roles

Technology will not replace people. After all, technology has always existed. Innovations have shaped the history of healthcare as it has the history of industry. Every generation invents new tools and adjusts to them. Every generation has to reinvent its role, question its place.

Complementing artificial intelligence, people will have to become the ones to handle unexpected and complex situations. They will do things that a robot will never be able to reproduce. Automation will give physicians time to listen and to take charge of the patient's overall care.

The specialty that can benefit the most from this is General Practice, so it should be rolled out as much as possible in the field.

And structures?

One of the most remarkable effects of digitisation are the changes at regional level. A Regional Hospital Group (*Groupe Hospitalier de Territoire / GHT*) is largely defined by its unique Information System (IS) which it must build and maintain. Thanks to this unique IS, a patient's care can be region-wide ("regionalised"). Patient care becomes a consistent care pathway. The GHT regional concept could ultimately expand to include Regional Health Authorities, as digitisation develops tools, as well as care and structures to place patients and their pathways at the heart of the health system while driving ongoing prevention initiatives.

We therefore need to develop effective Hospital Care Groups, with all public and private stakeholders, cutting across political and regulatory lines, with no exclusions.

The "repopulation of deserts": industrialisation of production for better access to care

Medical deserts will not be repopulated. It would be misguided to encourage young doctors to go for this. It is the development of the digitisation and optimisation of care delivery that will enhance access to care. Young urban doctors are more inclined than their elders to **combine together in nursing homes, primary clinics and local hubs.** From these hubs, professionals would offer their particular services, alternating weekly to two segments: to underserviced villages and suburbs, and to specialist public and private establishments, by accelerating the number and scope of connections. **Mobile and remote data transmission resources will be expanded to ensure those services.**

The rationalisation of organisational structures primarily by delegating administrative and technical tasks, will allow doctors to find the time to devote to consultations. Emerging artificial intelligence will be able to handle simple consultations so that doctors can devote themselves to complex cases, provided they are paid accordingly.

In sum, the reorganisation and rationalisation of production will be conducive to the primary goal, which is better access to care, especially in "medical deserts" which will be transformed into **Multiprofessional Oases of Health**.

LEADERSHIP

Governmental and public agencies: parallel vertical systems

There are too many institutions, administrations, agencies and entities making up the public health system, producing too many mutually contradictory laws and regulations that create too many *a priori* controls. In such a system of vertical silos, no one is responsible for overall policy.

Unproductive opposition to the private sector

Although the institutions, administrations, agencies and entities that make up the public health system seem disjointed, what they often have in common is unproductively competing with the private sector. This mistrust of the private sector adds a layer of complexity. The public and private sectors, rather than working against each other, should get together to combine the best of each other to achieve the primary goal of the overall healthcare system, which is the health of patients.

Government strategy to support innovation

The verticality of the public health system is hampering the development of a multidisciplinary vision, the emergence of shared responsibility and the implementation of strategy to tackle the challenges, including the challenge to innovate. Although the public sector is only partly responsible for innovation, the other part – private sector innovation – is being held back by how the public sector is organised. **Government strategy must encourage grassroots innovation. It should limit State interference, give initiatives free rein, and establish controls that apply *a posteriori* rather than legislate *a priori*.**

Public agencies: a clear policy to drive innovation?

On this model, public agencies should not hold back innovation, but should assess the work done and above all give innovators the context and wherewithal to support their development. **Agencies should act as focus hubs for innovators and not continue to hold back local initiatives.** This approach is

thoroughly pragmatic, by acknowledging public sector aspirations and facilitating private sector development vectors, all in the interest of patients.

(RE)INVENTION

A hospital that no longer hospitalises

Hospitalisation is no longer the sole purpose of a hospital. By promoting outpatient care, hospitals are reinventing themselves. They need fewer and fewer beds and are increasingly becoming support facilities for patient care pathways. A growing number of facilities are setting up to provide fringe care as nursing homes, to deliver medical services that do not involve surgery or full hospitalisation. The switch to outpatient care is irreversible, all the more so when patients are asked for their assessment. Patients are now more informed than ever and are aware of care possibilities other than classic hospitalisation. Contrary to what hospitals often think, **patients do not necessarily expect their hospitalisation to include bed care. Private medical/surgical/obstetrics clinics should also embrace a vision that breaks the boundaries of healthcare actions.**

No longer doing for, but with patients

Patients are proactively informing themselves about the care they will receive, their physicians, and the facilities where they will be treated. They are comparing, formulating what are sometimes technical proposals, and giving their opinions to their doctor. Doctors can no longer treat their patients condescendingly. Doctors must talk with their patients, which can only increase patients' understanding, particularly in cases of chronic illness, and they have to rethink how they talk to their patients.

Human reinvention

It is said that digitisation, automation and artificial intelligence will drive people to question their jobs and roles in the workplace, and to reinvent themselves. People are not endangered by automation, precisely because they are able to reinvent themselves. A common perception is that robots will take over simple tasks and kill low-value-added jobs. This shows a gross misunderstanding of automation and what constitutes complexity for a robot. A robot is not an automated human being, it is not a humanoid. Robots do not kill people's jobs. In the industrial sphere, countries like Japan and Germany, having automated

their factories more so than France, have created productivity gains winning new contracts, growing jobs, and resiting their production facilities.

In healthcare, what freedom will artificial intelligence leave to doctors?

The doctor's role is increasingly less that of the sole diagnostician and therapist. Doctors are becoming the person in charge of overall care. They can draw on artificial intelligence to analyse the increasingly large amount of data. AI allows them to quickly make an informed decision based on numerous parameters. Artificial intelligence also ultimately gives doctors more freedom. It gives doctors access to the entire range of knowledge when deciding a care option. Artificial intelligence does not arise spontaneously, but is the result of programming in which medical professionals can participate in close partnership with other healthcare players. With this in mind, we should abolish the term "paramedics" in favour of **"medical personnel" with varying responsibilities** for any care professional.

RECOMMENDATIONS FROM CHAM 2017

Before the guidelines for the next 5-year term are set, it would be appropriate to make some recommendations about how to healthcare system and the innovation process:

- **Ensure that breakthrough innovations are rewarded financially, to encourage others to innovate without fear of getting nothing back**

- **Speed up time-to-market of innovative therapies by streamlining assessment procedures**

- **Finance innovative businesses through funds specialising in medical technology (Bpifrance), so they are fully able to disrupt markets**

- **Broaden digital transformation to anchor it in the practices and culture of the industry players**

- **Question the timeline of the proposed social welfare funding programme (PLFSS) to achieve the transformation and digitisation requirements**

- **Question the closed nature of PLFSS funding**

- **Simplify the governance and structure of committees, to limit the number of decision-makers**

- **Abolish the territorial wars between public and private hospitals, practice managers and doctors, administrators and institutions, traditional and home hospitalisation, to actually think about patients.**

FIVE DEVELOPMENT GUIDELINES AND HOW TO GET THERE

Switch from care to prevention, from isolated actions to a care pathway for quality of life

Prevention can only be achieved if doctors are remunerated for it. Doctors have to switch from their role as prescribers to a role as preventers. This change must be reflected in university syllabuses. At the same time, the State must commit to de-siloing the healthcare system. This means dismantling the disjointed processes that prevent coordinated lifetime healthcare pathways. **Senior nursing professionals ("health consultants") would be deployed at companies, local authorities, schools and universities** to provide local support to sufferers, to reduce stress, obesity, addiction, and occupational injury.

Exemptions and funding to favour efficient entities in "medical deserts" that would be pointless to repopulate.

Rather than encouraging doctors to move there, the State strategy should incentivise the doctors who are already there to combine with other care professionals to set up a more efficient structure. Once they have done so, doctors could then delegate simple cases and focus on complex pathologies. They have to be incentivised, particularly by financial payment for complex cases.

From crisis management to managing the unexpected

Crisis management policies are too often determined by the lessons learned from previous crises. But no crisis is the same. This means managing the unexpected. Healthcare systems are increasingly having to cope with the unexpected, rather than just a repetition of the previous crisis. **A National Health Emergency Response Group available 24/7** should be created to help legislators make decisions when facing a health crisis.

Creation of an intermediate stage between clinical research and care

Government strategy should include support for innovation. Its purpose should be to support the people who innovate and help them to do so. That said, it is the Government's strategic responsibility to exercise vigilance and ensure safety. It has to have an overall vision that takes into account the benefits of innovations to patients, more than just promoting grassroots innovation.

Drive digital transformation to improve healthcare pathways

The healthcare system must acknowledge the changes introduced by digitisation. Digitisation is key to developing a pathway for lifetime healthcare, focused on prevention where the players involved have only one objective: **the patient**.

Ultimately, it is only due to people's TRUST in the players and the technology used that the system can develop for everyone's benefit. Government strategy must set the targets and a timeline. It must ensure effective and equal access to the system for everyone while allowing the actors including patients to invent grassroots solutions on a case by case basis that may vary region by region.