HOSPITAL FREED?

Speakers: Rodolphe BOURRET, General Manager of the CH Valenciennes | France, **Marie-Sophie DESAULLE,** President of the FEHAP | France, **Tobias GRAF,** Head of ICU at the University hospital Schleswig-Holstein | Germany, **Laurence JULLIEN-FLAGEUL,** Director of Nursing at the CHU Brest | France, **Marie-Thérèse LECCIA,** Professor of Dermatology and President of the CME at the CHU Grenoble | France

Debate led by **Frédéric THOMAS**, Partner at KPMG | France

The concept of a liberated company extended to hospitals

For some years now, public support for "liberating structures", companies and institutions, also applicable to hospitals. A liberated company must meet the following 7 criteria:

- Combine well-being and productivity
- Leadership of the charismatic leader
- Sharing principle driven actions
- Shared decision making
- Self-determination of workers
- Principle of subsidiarity and disengagement
- Inverted pyramid

Contractualization, a tool to free hospitals while making them responsible for their organization

The magnetic hospital model adopts a new collective and participatory management system. The governance in place is based on a strong principle of delegation at the cluster level, steered by an administrative, medical and nursing trinomial. This trinomial is autonomous in the decision-making process oriented towards improving the quality of care.

In Germany, the concept of a magnetic hospital is commonplace at the state level. One of the criteria for obtaining reimbursement for services is a contract between the institutions and the state.

The experience of the Valenciennes University Hospital, which has set up a magnetic hospital governance system, is conclusive. The hospital has been in surplus for 10 years and has been able to reduce its administrative structure.

Integrating the logic of contracts between the hospital and its employees is an excellent way to manage an establishment while remaining close to the principles of a liberated company. This logic guides the governance of nonprofit structures. The two parties involved in the contract, the manager, and the board of directors, are bound both by the precise and measurable objectives, but also by the obligation to put in place the means to achieve them. This logic offers a capacity for reactivity and adaptation to changing needs and, above all, establishes a dynamic of evaluation of managers, which is not yet sufficiently applied in France. In the logic of a contract within a public institution, the director and the head doctor must work for the same project and the same objectives. Contracts are concluded within the medical teams and clusters themselves.

Discussions between the management and the medical teams are therefore carried out in a streamlined fashion. The freedom of healthcare professionals is translated into a stronger capacity to act and to carry out new projects, which in turn induces responsibilities.

The health crisis has been a catalyst for the hospital liberation process

The health crisis and governmental policies have removed the increasing deadlock that had developed between the government and health institutions. Governing bodies do not grant trust as a principle, as embodied by their overall wait-and-see position. This hinders team innovation as well as local action.

Institutional distrust remains the single largest hindrance to institutional freedom. National authorities have now demonstrated their ability to delegate and this is to be encouraged, not only in times of crisis, but also and above all as the norm.

The health crisis has also brought to light the importance of the dynamics of companionship and the training of health students. By mobilizing the students, the hospital system has enabled them to be integrated very early on and to immerse themselves in the environment of an institution.

Freeing oneself by extending the territory hospital groups principle to all actors in the territories

Article 51 had raised hopes for the freedom and ability of actors to coordinate themselves. Attempts to innovate were eventually guided and locked into numerous regulations, which greatly hindered potential innovations and disappointed the medical and nursing communities.

To enable the principles of subsidiarity and disengagement to be applied to hospitals, it is necessary to rethink the territorial logic now in place at the level of public institutions. The concept of local hospital networks does not represent all the actors necessary for a local patient pathway. In a logic of continuity of care, extending to the medico-social path, it is necessary to go beyond the simple federation of public structures and share common challenges between all care providers in a single area, in terms of quality indicators, care network and connection.