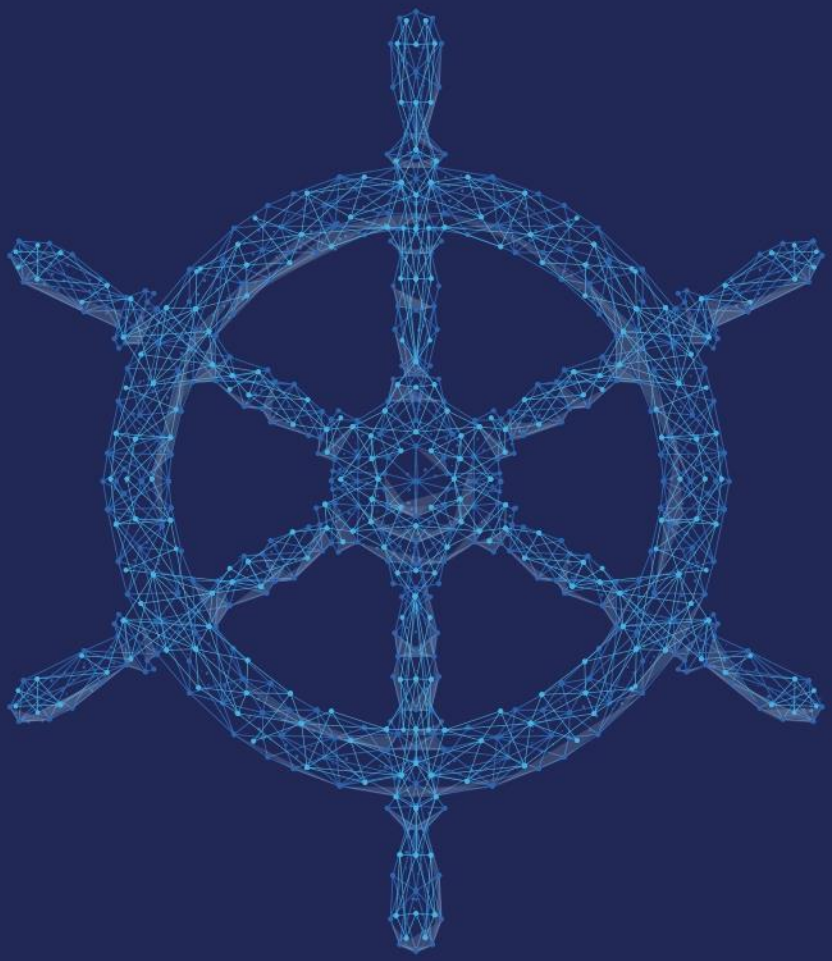
CHAM

Inventing the future of health systems
Convention on **H**ealth **A**nalysis and **M**anagement

HEALTH SYSTEMS
WHAT GOVERNANCE?



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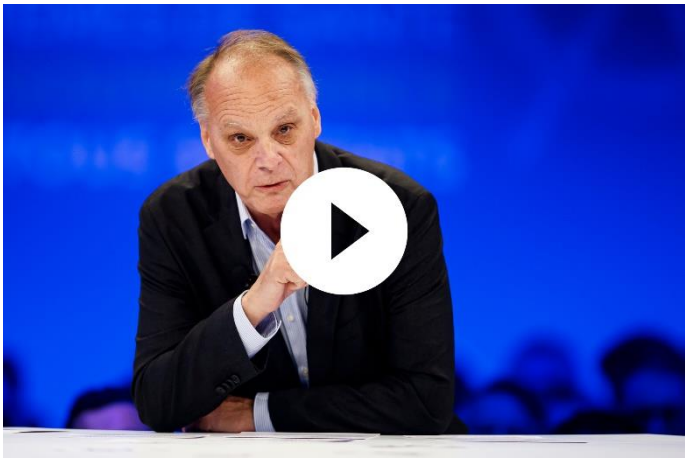
Speaker: Guy VALLANCIEN, President of CHAM | France



"A man had only bones and skin, as Artificial Intelligence was so much in control.

This man meets a robot as powerful as it is beautiful, strong, polite, which had accidentally gotten lost through misadventure.

To attack it, to confine it, the man would have done it willingly, but it was necessary to do battle and the Evil One was able to fearlessly defend itself.

So the man approaches it humbly, starts a conversation, and compliments it on its processors, which he admires. "It will be up to you, handsome sire, to be as strong as I am," said the robot... "You would be better off leaving the woods, there your fellow men are miserable, they are laggards, hated ones and poor devils whose condition is to starve. Why? Nothing is assured, no loose stitch, all on the head of a needle. Follow me; you will have a much better future"

The man answered "What will I have to do?"

"Almost nothing" says the robot: "giving chase to people carrying sticks, and to beggars; fawn on the people of the house, please its master; whereupon your algorithms will be strong reflections in every way: many bytes, all in Python, without talking about the main business"

The man is already imagining a happiness that makes him cry with tenderness.

On the way he saw the scratched collar of the robot:

- What is that? he asks.
- Nothing.
- What? Nothing?
- Just a trifle.
- But what?
- The collar which is attached to what you can see is perhaps the cause?
- Attached? says the man "you cannot go where you want?"
- Not always, but what does it matter?
- It matters so much that I do not want any of your meals, and I would not even want a treasure at such a price.

Having said this, the man fled, and is still running.

This digital version of the fable "The Wolf and the Dog" by Jean de la Fontaine reflects the difficulty of our societies to rethink their organizations between freedom to act and the constraint of standards, between invariance and dynamics.

Far be it for me to think that freedom is about doing what I want when and where I like, but we will not transform our old world without taking risk, freedom that relies first on trust, demonstration before any other consideration of respect for others. The laws come after.

The political quarrels in the media fanned by social networks with an ever increasing nuisance pollute the space of expression scrambling the discussion and the exchanges based on listening and reason. These battles by malevolent transmitters inevitably generate the exact opposite of a world of values which recognizes the differences while the growing influence of planetary enterprises challenge our Governments.

Yes to a strategic Government, designating the goal to achieve, but especially to a Government that gives a free hand to the teams that control a posteriori the deviances, without freezing goodwill in a sterilizing preventive standardization.

Yes, regulation is essential, and Governments must be the guarantor, but please let it give the players the means to invent, to test, even enabling them to make mistakes without there being a legislative and regulatory deluge that freezes initiatives which bloom everywhere in France and in Europe .

Local regional public-private collaborations exist that succeed, but who are aware of the exemplary partnership between hospitals and clinics, gathered under the same roof to share their expertise? These tried-and-tested experiences disturb the established bodies. So they keep them quiet or consider them as non-repeatable.

How to harmonize without standardizing? How to organize without suffocating? Is it necessary that healthcare is exactly the same from Brest to Strasburg, from Lille to Marseille!!! Or from Berlin to Rome, from Copenhagen to Madrid, Stockholm, Paris or Brussels?

We can only build a new healthcare system suitable to current times by allowing those involved to innovate, not hampered by reducing decrees, leaving a deadly precautionary principle which annihilates the dynamism of transformation.

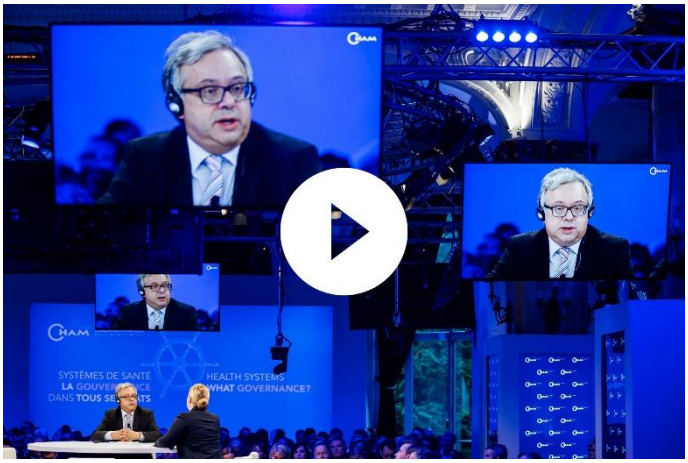
Instead of only looking at their own terrain, ready to protect their private fiefdom, everyone will have to question themselves, from the supervising authorities to the unions, from the public institutions to the private companies, in order to engage in a joint adventure which surpasses them.

Sons of the Lights, if we have excellent researchers, the best engineers and health professionals, social protection systems that others envy us, how is it that no world-wide digital enterprise has so far emerged in our territory? The suspicion which reigns amongst our public and private players, the absence of the permanent cross-exchange these two worlds who spy on each other and who too often engage in wars, hampers the development of distributed intelligence industries, the key to the future.

Finally, what should we do? The most difficult thing! This means leaving behind our old petty reflexes in order to build a true Europe of healthcare together, including the diversity of its component!

Speaker: Martin SEYCHELL, Deputy Director-General for Health at the European Commission | European Union

Interviewed by **Viktoria KLEISOVA**, Senior Consultant, GovHe | France



— An encouraging overview of European health governance

According to the European Commission's report Health at a Glance: Europe 2018, healthcare policies in Europe are still struggling on issues such as mental health, the fight against obesity, and the relevance of spending; but are also accumulating significant successes.

These successes - for example in life expectancy, cancer survival or tobacco control - are achieved both by the Member States and by the European Union's healthcare governance. The latter complements national actions by coordinating the transfer and deployment of knowledge, tools, financial instruments and programs to support improvement. Where certain problems, global in nature, could not be dealt with effectively by a single Member State, European governance makes it possible to respond with common standards and tools to cross-border problems: antimicrobial resistance, large-scale epidemic risks, interoperability of digital transformation, and coordination of pharmaceutical and medical innovation. It has already made it possible to deploy:

- A European reference network for the treatment of rare diseases (knowledge transfer rather than patients, waiting time decrease, improved prospect of pooling clinical trials);
- Common guidelines on different cancer screening and care programs to ensure homogenous quality (including colorectal, cervical and breast cancer).

— Shared challenges to levy innovation as a means to accessible healthcare

Although the health asymmetry of resources and information is still prevalent in the European Union, Member States have gathered to face common challenges in order to:

- Build interoperability standards and trusted governance that enable digital innovation (services, data, AI) to be used for healthcare, in a context where providers, mainly from the traditional digital sector, must integrate ethical issues in health-specific data management. The European Commission is also working to create a European Health Area, which would make pathological databases on a European scale accessible to all doctors.
- Address common pathological challenges by conciliating both innovation (research and new treatments) and access (stocks and prices), and by balancing standards

and incentives for the pharmaceutical industry, which can only be effectively addressed at the level of European governance. The need for targeted incentives for innovation remains (antimicrobial resistance, vaccines, etc.), but it must now be considered along with incentives for access to healthcare in each country at a reasonable price. The two types of incentives could thus be conditioned on each other.

— **European priorities for the coming years: prevention, assistance and coordination of Member States' actions, and information to citizens**

The Commission plans to intensify its pro-active response to these challenges in order to propose to the European Parliament targeted actions to assist Member States. The priorities are therefore to provide equal information on health technologies through a European evaluation, to redesign incentives for innovation in line with those for access to care (to be created), to concentrate academic and industry cross-disciplinary research, and to prevent communicable diseases. Lastly, efforts must be made to curb involvement and knowledge gaps, as a CHAM-IPSOS survey of 5 major European countries shows that 48% of citizens are currently unaware of the European Commission's role in healthcare governance.

DRAW ME A HEALTH TERRITORY: FROM MY MUNICIPALITY TO BRUSSELS

Speakers: Catherine CERISEY, co-Founder of Patients and Web | France, **Paul GARASSUS,** President of the European Union of Private Hospitals, UEHP | Belgium, **Gisèle GRAVIER,** Coordinator of the CPTS Sud Lochois | France, **Françoise GROSSETÊTE,** Former Member of the European Parliament | European Union, **Olivier OBRECHT,** Deputy General Manager of the ARS Bourgogne-Franche-Comté | France

Debate led by **Vincent OLIVIER**, President of RectoVerso | France

— Restoring coherence to healthcare districts

Access to healthcare was an important topic in the major debate in France. Several healthcare policies, such as the shift to ambulatory care, have not been sufficiently in connection with the territories. The lack of consideration of distances still generates territorial inequalities in the management of emergencies. The involvement and coordination of local actors, Agences Régionales de Santé (ARS - Regional Healthcare Agencies), health insurance, private doctors, hospitals, local elected officials, is essential to remedy this situation. In this respect, Territorial Professional Health Communities (CPTS) can contribute to the structuring of coherent healthcare regions. LRAs must be positioned as integrators of all health structures: organising access to care in the field and coordinating routes between hospitals and primary care, within primary care itself and with long term care structures.

— European regions are a relevant pattern to design healthcare districts

In Germany, the care offer is organized at Landers level and structured around health and community care centres. In comparison, France lacks a level between the isolated practitioner and the health care institution. Flexibility at the national legal framework must also be provided so that regions retain entrepreneurial freedom. In Burgundy-Franche-Comté, the division of the region into 33 healthcare districts resulting from consultation between local elected officials, Regional Healthcare Agencies, departmental councils, health insurance and health professionals has resulted in concrete projects that go beyond what was provided by the legal framework. Skill sharing between the territorial levels is essential to provide both a healthcare offering of equivalent quality throughout the country, driven at the national level, and adapted to local needs.

A number of topics - pandemic control, harmonization of vaccination policies, etc. - should be addressed at the European level. This requires rethinking the governance of our national health policies and valuing foreign examples.

— Digital coverage is a key issue for healthcare access

e-Health will not standardize territories but will reduce inequalities in access to care - especially urgent and specialized care - an obvious prerequisite to which being the existence of digital coverage of sufficient quality. It has to be considered at a European scale: e-prescription tools should therefore be transversal to countries in order to connect healthcare systems. Finally, Regional Healthcare Agencies should be connected to their European counterparts.

— An experiment must be assessed before generalization

The development of new models of care must be iterative and co-constructed by the different territorial levels, professionals and patient associations. The implementation of experiments (as per the article 51 of the Social Security Financing Act (LFSS) for 2018) must also be followed by indicators and criteria to assess the desirability of their generalization. The challenge is complex: the temporality of the experimentation is different from the needs of the field to move quickly, and yet necessary in order not to generalize these innovations without proper assessment and adjustment. There are many areas for improvement: coordination and decompartmentalization of healthcare professions to refocus the value of medical time on expertise, professionalization of "patient experts". Broadly speaking, the aim is to reconcile a French healthcare system built around the hospital, specialty medicine and individual practice with the new paradigm of a medicine focused on first-line care, coordinated and ambulatory care.

Speakers: Daniel CAILLE, President of Vivalto | France, **Didier DELETTE,** General Practitioner, Care Home of Fruges | France, **Anne JASTRUP,** CEO of the Bispebjerg and Frederiksberg Hospitals | Denmark, **Marc PENAUD,** General Manager of the CHU Toulouse | France, **Aurélien ROUSSEAU,** General Manager of the ARS Île-de-France | France

Debate led by **Antoine FLAHAULT,** General Manager of the Global Health Institute of the University of Geneva | Switzerland

— Rethinking hospitals as an entrepreneur: the current situation

If hospitals are regulated by public policies, a degree of freedom and entrepreneurial spirit at the local level is also necessary. As such, an organizational change is now required to overcome the stiffness of habits and identities of each profession. If hospitals are quintessentially risk averse regarding patient safety, this essential requirement should not be deemed a fundamental opposition to innovation. Global contracts between regulators and healthcare providers are possible, as in Ile-de-France with the "0 stretcher" contract; and allow for new clinical approaches. Lastly, if hospitals do have strong hierarchical cultures, they must be irrigated with a managerial culture, the very essence of which is to encourage innovation proposals from each employee. The experimentation of Article 51 seeks to instil this culture of innovation, where healthcare financing policies do not hinder the potential care pathways offered to patients. Accepting failure and trial and error is a necessary condition in order to make this transition, which is necessary both in hospitals and in primary care.

The conflicting imperatives, the need for innovation and the strict rules of the public hospital service - national solidarity, neutrality, equity and the precautionary principle - should not hinder freedom of initiative. It is then a matter of dealing with this complex framework to build ambitious projects around external, internal, private and public stakeholders, as illustrated by the consortium project in Toulouse on ageing. To be successful, these projects must aim to create both scientific and medical value as well as economic value. Recent laws, such as the PACTE law, favour this valuation.

Lastly, healthcare professionals are too ill prepared to face the many administrative procedures necessary to create new forms of organizations. Doctors' schedules and daily stakes are, more often than not, ignored by regulators, which is particularly true when it comes to scheduling meetings, thus straining potential implication. Simplifying the system is now a must.

— Patients are at the core of the change to be undertaken

Hospitals spend human and capital resources to serve a medical project. This project itself is aimed at the patient – often targeting the latter's implication and knowledge. Patients are now back in the spotlight with the advent of personalized medicine. Disease is no longer the focus, the patient is. To this end, new bottom-up methods are being used to integrate, in France or Denmark, the expectations of patients and their families when designing organizations. Caught between their wish to be at their patient's side and

the heavy burden of standards that weigh on them, doctors can be confused as to the priority of their mission.

Other realizations are now happening, disrupting traditional patterns: care pathways are no longer limited to the hospital, just as practitioners are no longer alone in taking care of patients; but parts of very large teams. Therefore, in order to build a collaborative, digital and innovative hospital, each healthcare professional must question themselves and commit themselves, in line with the project itself and not with the framework of which they are a part.

Speaker: Maxime GROUT, Nurse on the Molène island | France

— An organization of care tailored to local constraints

The island of Molène is an island of fishermen. Access to care and particularly the ability to respond quickly to emergency situations had to be strongly adapted accordingly. A nursing presence is ensured on a continuous basis (based on 8 days presence alternated between the professionals) and enables the delivery of care (peak activity in the morning with the return from fishing). In these situations, the nurse works with the fire brigade to install venous lines and distribute medicines, in coordination with the Emergency Service of the Brest University Hospital, which can be reached by helicopter in 7 minutes. When weather conditions do not permit it, the Société Nationale de Sauvetage en Mer (SNSM – French lifeboat service) is called upon.

The system is completed by the presence of a doctor one day a week on the island. Together with the nurse, he visits patients with reduced mobility at home in the morning and the afternoon is devoted to consultations at the medical and social centre. The introduction of remote medical consultations has also made it possible to refer patients to a specialist, or to a general practitioner outside of on-site presence.

The nurse is also responsible for the pharmacy available on the island.

— Ongoing training to accelerate the ability to meet the needs

The nurses will receive training to perform stitches and thereby solve some of the problems related to the seasonal difficulties of access to the island for the SAMU (French Emergency Medical Service) - impossibility to use the helicopter during the winter.

The doctor on duty is also being trained in the handling and analysis of ultrasound scans, with the aim of accelerating the diagnosis and initiation of treatment. A mobile ultrasound scanner would facilitate this work. This project foreshadows the national ambition to set up mobile nurses with the equipment to provide first-aid care on site without the necessity of travelling to the emergency services.

CAREGIVERS: NEW POSITION, NEW RESPONSIBILITIES?

Speakers: Tatiana HENRIOT, President of the National Union of nurse practitioner – UNIPA | France, **Christine LALIBERTÉ,** Nurse practitioner and President of the Aipsq | Canada, **Anna VALENTE,** Surgical Care Practitioner at Western Sussex Hospitals NHS Trust | United Kingdom

Debate led by **Jean-David Zeitoun,** Physician and Entrepreneur of Inato | France

— The new roles of nurses: Canada, United Kingdom, France

According to a CHAM-IPSOS survey conducted in 5 major European countries, a large majority of citizens would be willing to delegate more medical tasks to nurses - from 50% for small surgical procedures to 70% for test prescriptions. This trend is even more pronounced in France.

These delegations are calling for the creation of nursing statuses with extended responsibilities. In Canada, this refers to the nurse practitioner (created in 2005), who can work in both general practices and hospitals, is authorized to prescribe drugs and tests and can conduct consultations without an appointment. In most of Canada, the nurse is also qualified to diagnose in certain conditions and can systematically monitor chronic conditions. The United Kingdom is even more advanced (the first nurse practitioner originated from 1993!): in addition to nurse practitioners oriented towards medicine (in town and in hospitals), surgical care practitioners also exist. They play the role of first assistant for their surgeon and can even perform a variety of simple surgical procedures on their own (joint injections, wound debridement, etc.). They ensure the continuity of the patient's follow-up, from the pre-surgical consultation to the post-operative phase.

In France, the newly graduated Advanced Practice Nurse (APN) requires 3 years of professional experience and two years of specific training, with four possible mentions (Stabilized Chronic Diseases, Renal Diseases and Transplants, Oncology-Haematology, Mental Health). They are trained for the patient's screening, referral, follow-up, and quality of life, and are authorized to prescribe tests and medications in their chosen specialty. Although there are currently only 60 accredited advanced practice nurses, this number is expected to exceed 400 by 2020 and increase rapidly afterwards due to the high popularity of the program in the universities.

— The advanced practice nurse, an economic model still unclear

The economic model for the liberal exercise of the APNs in France is under negotiation, but with very little solicitation of the APNs themselves; the packages currently under discussion (€160 per year for the follow-up of a chronic patient, for example) present a risk of financial insecurity for the professionals, believes Tatiana Henriot. In comparison, a surgical nurse practitioner in the United Kingdom starts his or her career at €42,000 a year and potentially goes beyond €70,000, which is a very significant improvement over the status of a "regular" nurse. Moreover, the hospital is the one financing his/her studies. In Quebec too, the nurse practitioner will progress from € 40,000 to 70,000 annually and will benefit from a grant to finance his/her training.

— Responsibilities and interactions with physicians

In each of the three countries, there are no real problems of cohabitation between doctors and nurses: in a context of medical shortage, complementarity functions well overall and without overlaps. An educational effort remains necessary for physicians who hadn't had the opportunity to work with APNs yet, but the ability to work in pairs is not a significant barrier to deployment. Legally, the doctor is not responsible for the APNs, which can be prosecuted by the patient like any other health professional: there is a major challenge to properly document every action taken, and of course to strictly respect the protocols, both national and specific to a healthcare facility.

Speakers: Philippe EMERY, General Manager Division Abbott Diabetes Care, Abbott France | France, **Stanislas NIOX-CHÂTEAU,** President of Doctolib | France, **Dominique PON,** Ministerial Delegate for Digital Transformation in Health at Ministry of Solidarities and Health | France

Debate led by **Olivier LE PENNETIER,** MD at the AP-HP and at the SAMU de Paris | France

— Facing the pressure from major digital companies, France is lagging behind in its infrastructures for managing and sharing medical and medico-economic data

Far from the American model where GAFAMI (Google, Amazon, Facebook, Apple, Microsoft, IBM) are increasingly present in the health sector, France and Europe remain very conservative about their medical and medico-economic data. This represents a barrier for the development of private actors in the field, start-ups or manufacturers. In particular, the lack of a secure messaging service, a system for collecting and exploiting health data, and a real lack of software interoperability are all delays compared to countries such as Sweden, where data are much more efficiently centralized.

— Artificial intelligence, a tool to assist in diagnosis but also in organization

Artificial Intelligence (AI) is a tool that must be studied and developed, putting aside the mistrust it can generate. Indeed, the goal is not to replace health practitioners, but rather to help them in their work in order to free up time for medical activity. This can be done in two ways: by helping with diagnosis, which is therefore a help with medical activity itself; or by helping with upstream organization.

In both cases, it is important to include health professionals while developing these tools, if the solution is to be sustainable. Indeed, users are the ones who will naturally select the applications that are useful to them and those that will be condemned to disappear. It is also the key factor of success of the Shared Medical Record: it has been operational since 2008 but is not used by most of the health professionals due to its lack of user-friendliness and functionalities.

— A consensus is emerging about the governance of health data by the State, and the provision, under conditions, of these data to innovative private companies

Indeed, all stakeholders agree that it is the State that must centralize, consolidate and secure health data as well as medico-economic data. It is on this ground that private companies, both manufacturers and start-up, could be involved thanks to authorizations granted by the State on a case-by-case basis.

However, if sharing these data with private actors to improve the overall environment is to become possible, these accesses must be granted sparingly, particularly for GAFAMI whose business model is based on the valuation and resale of the data. This type of collaboration is currently irrelevant, because unlike the United States, in France it is the Caisse Nationale d'Assurance Maladie that has data governance, and it is up to it and not to private actors to value them.

Therefore, it is essential to invest in digital technologies, mainly in order to provide institutions with modern and efficient tools, able to better communicate with each other and improve the organization of centres and between centres, ultimately freeing up time for practitioners. This must be undertaken on the basis of data collected and distributed by the State, then used by private partners to meet the needs of patients and health professionals.

CYBERSECURITY: HEALTH AS A TARGET

Speaker: Vincent TRELY, President of APSISS | France

Interviewed by **Fabien GUEZ,** Journalist at BFM Life | France

— An area increasingly under attacks

The health sector is in constant digital expansion: data are increasingly digitized, biomedical devices are systematically operated by connected digital systems, information flows are opening up outside the hospital, etc.

It raises new vulnerability issues to cyberattacks, which can be of two kinds:

- Theft of medical data, resold online on the black market to power business intelligence algorithms (e.g. Atlanta Hospital data are available for the price of 300 bitcoins, or about 2 million euros)
- Crypto virus, or ransomwares, encrypting access to data and/or control software for ransom (e.g. 600 workstations at the Montpellier University Hospital blocked for a week at the beginning of 2019)

— To counter these attacks, human and technological responses are being implemented

Thus, many positions are created for Information Systems Security Manager (ISSM), in charge of hardware security, and Data Protection Officers in charge of data protection and software security.

In addition, data flow security protocols are implemented, including the introduction of an electronic signature, the encryption of remote medical consultations or the storage of data on secure servers. The use of blockchain technology to secure data flows throughout their journey in and out of healthcare facilities is also being investigated. Finally, new processes are using Artificial Intelligence (AI) to carry out security assessments at the facility level.

— An arms race is taking place between increasingly sophisticated cyberattacks and information system security protocols

Indeed, the health sector is particularly vulnerable to cyberattacks from all over the world, against which it is very difficult to respond effectively. The means of protecting against it therefore progresses by successive improvements after each new attack, while the attacks in question are becoming increasingly more complex over time.

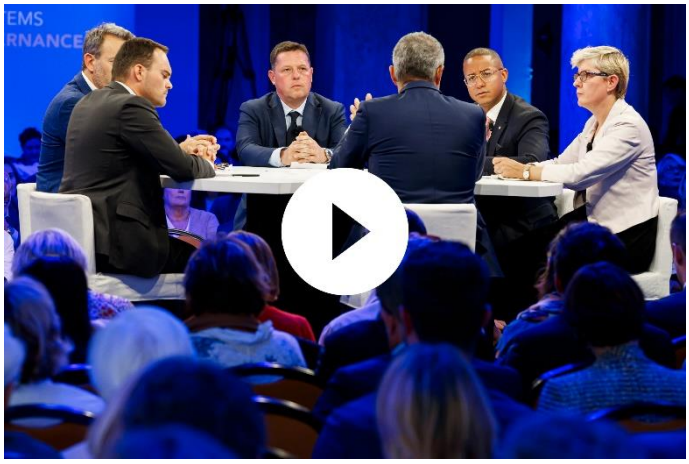
As a form of defence, "ethical hackers" uncover computer vulnerabilities in industry and health facilities in return for a reward. For instance, an Australian hacker was able to reveal a fault allowing a pacemaker to generate a 830V voltage at a distance of 50m. In another case, a team of Israeli researchers was able to modify imaging results to add or remove nodules, thereby altering the doctor's diagnosis.

However, beyond technological vulnerabilities, about 9 out of 10 attacks still occur due to human failures, such as downloading infected emails.

DECENTRALIZATION AND EMPOWERMENT

Speakers: Cédric ARCOS, Deputy General Manager of the Île-de-France region | France, **Thierry CHICHE,** President of Elsan | France, **James Loïc GEORGES,** Head of International Business and Advisor to the President of Gruppo San Donato | Italy, **Katia JULIENNE,** Director of the DGOS at the Ministry of Solidarities and Health | France, **Frédéric MASQUELIER,** Mayor of the city of Saint-Raphaël | France

Debate led by **Norbert NABET,** General Manager Media, Consulting, Events and Training of *nehs* | France



The way in which policy definition and its application to health territories is organized is a fundamental question for a health system. The demand formulated by citizens is very clear in France: equal access to healthcare and participation in the organization of said healthcare system.

In this respect, the participants noted that the system is quite illegible and does not encourage innovation and taking responsibility. In addition, there is a compartmentalization that hinders the development of new solutions

The problem arises in different terms depending on whether you are the elected official of a local community, the director of healthcare in a region, or the head of a group of private clinics. Expectations, on the other hand, are relatively convergent:

- To have a clear and stable playing field by avoiding the overlaps that are too often observed today between the national and local levels, between Agences Régionales de Santé (ARS - Regional Healthcare Agencies) and institutions...
- To reintroduce trust by empowering and contracting.

In a French system that includes 3 levels of territories (the region, the department and the community of communes), there is a maieutic to be built: explain what we are doing and discuss what we are going to do. It's a question of method. The new organizations of Territorial Hospital Groups and Territorial Professional Health Communities constitute a favorable ground for a new approach in health policies. The success of these new measures is in fact determined at the territory level with significant areas for initiatives. National policies must be designed by observing what the territories do. It then becomes possible to leave spaces for discussion to build solutions adapted to the health needs of populations in each territory. The steps taken with Incitations Financières pour l'Amélioration de la Qualité (IFAQ – Financial Incentives for Quality Improvement) and new financing methods are in line with this approach.

To combat the feeling of mistrust that is developing in the face of changes in the health system, it is essential to create spaces for dialogue and exchange in healthcare practices in order to reconcile the imperatives of efficiency with the expectations of the populations and those who represent them.

The example of the San Donato group in Italy is interesting in this respect: by entrusting a private actor with care, teaching and research missions that are carried out in a public mode but according to private modalities.

It is becoming important to reintroduce politics so that health issues may bring people together rather than divide them.

Speaker: Thomas LEMKE, CEO of Sana Kliniken AG | Germany

— The response to medical desertification in rural areas

Areas experiencing a shortage of doctors have increased in the past in Germany due to the retirement of many rural practitioners without having been able to identify a successor. The lack of healthcare supply has accelerated the redesign of solutions for access to care services in rural areas, mixing public incentives from the government and local authorities (financial incentives for implementation, reimbursement of consumables and medical services, or partial financing of medical studies conditional on implementation in sub-dense areas) and private initiatives, such as those of implemented by Sana hospital group (knowledge-sharing agreements between rural practitioners and clinics, organization of medical activities in local hospitals by co-management involving a head of department of a larger territorial hospital, financial incentives to work in more isolated structures, and an obligation to have worked in a local hospital in order to run a department in a large hospital). Part of the Sana Group's efforts also includes the use of a common IS, which allows, via telemedicine, to make the expertise of large hospitals available to rural stakeholders.

— A response to the saturation of emergency departments in need of further improvement

Germany also faces problems of Emergency Department (ED) saturation by non-urgent requests that are closer to unscheduled care demand. This phenomenon is accentuated by the context of budgetary constraints weighing on consultations, forcing many liberal practitioners to restrict their patients to those with private health insurance, with the fall back of requests on hospitals as a result. The hospital is also an easy solution for the patient, reassured by the idea of finding a technical platform and a complete range of specialties. The matter of regulating the use of emergency services is therefore becoming urgent, with an ongoing political debate on the proposed bill. Thomas Lemke remains skeptical, however, about the chances of success of regulations that would not be based on a system of patient behavior financial incentives. The explosion in flows to emergency departments was partly linked to the 2012 abolition of the increased financial contribution system (a supplement of 10 euros for any emergency consultation assessed as non-urgent, and an additional 10 euros per quarter for any person who requested at least one consultation).

— The experience of public-private university hospital management

The Sana private hospital group is responsible for ten or so establishments, including private clinics, but also university hospitals under a public-private management mandate. This model, which is based on a different relationship to private investment in public health services than in France, is applied in German university hospitals according to different degrees of private investment. There are 2 fully privatized university hospitals, several hybrid institutions where only some medical departments are privatized, and

a significant proportion of traditional public university hospitals. As soon as a service is managed by a private group, the latter is fully responsible for the activity and the associated rewards and economic risks. Professors are appointed with the Faculty of Medicine but employed by the private administrator group, with research and teaching then conducted in collaboration with the university on a shared site. The private sector provides private economic management capable of carrying out rapid decision-making processes when required by universities. Hospitals remain under the authority of the Länder, and the federal government promulgates common legislative standards, including financial ones. Historically, the German model has promoted decentralization through the self-administration committee which brings together hospitals and insurers to approve procedures and standards, but it is now faced with the multiplication of federal legislation, even though the time would be right to rethink and adapt our models to digital and societal change.

Speakers: Véronique ANATOLE-TOUZET, Vice-President of the Conference of the General Manager of the CHUs | France, **Dominique LE GULUDEC,** President of the French National Authority for Health – HAS | France, **Zeynep OR,** Research Director and Economist of the Institute for Research and Information in Health Economics - IRDES | France, **Ignacio RIESGO,** Health Advisor | Spain

Debate led by **Didier BAZZOCCHI**, General Manager of MMA, Covéa group | France

— Build relevant indicators to assess the quality of care

Quality of care has five dimensions: effectiveness, accessibility, safety, patient experience, and efficiency. The challenge is to define relevant indicators that make sense for health professionals and users alike in order to assess quality according to these criteria. The indicators collected in France, for example as part of the Haute Autorité de Santé (HAS – French National Authority for Health), certification, are mainly process indicators; from now on, it is time to identify result indicators.

The patient experience is a quality criterion that has long been neglected. A European CHAM-IPSOS survey reveals that for 49% of people, the most important criterion for assessing the quality of doctors' work is the relationship with the doctor or quality of life. The E-SATIS survey collects patient satisfaction data by facility, but it remains very generic. Overall, quality assessment in France is still mainly based on administrative databases, which should be supplemented by large-scale, more qualified patient surveys (by clinical indication, by population, etc.).

In addition, quality assessment is still mainly carried out at the level of health institutions, sometimes at the level of services, but often neglects the variety of clinical cases, which hinders the possibility of comparison. The new quality indicators will be journey indicators: the HAS is currently working on guides for 13 major care journeys. In parallel, the "tracer patient" approach is being applied to study care journeys at the scale of the territory, and no longer only within an establishment.

Finally, the collection of quality indicators is nowadays dependent on the potential of information systems. To allow for analysis all along the way, and to guarantee data quality, major investments in digital technology are necessary.

— Financial incentives, a necessary tool but not the only lever

Current funding methods do not encourage quality; on the contrary, they reward the volume of care rather than its relevance. Financial incentives for quality are necessary because economic constraints guide practices. The first step is to identify good practices for the quality of care and then to define a funding system to support them.

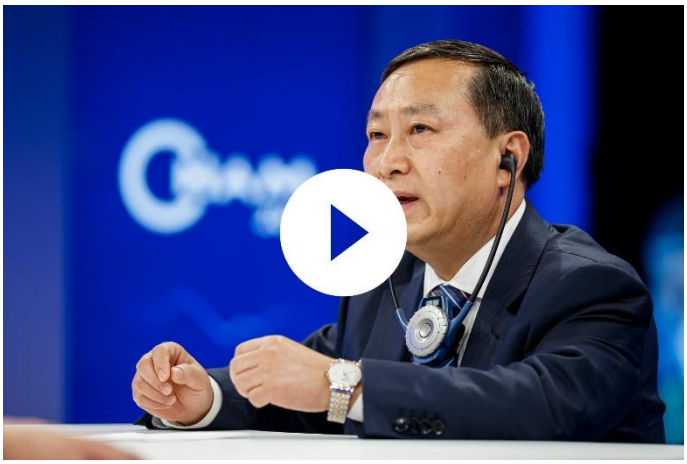
While financial incentives are essential, they are not the only lever: professional ethics, transparency and reputation, as well as training, are incentives to improve quality.

— Finding a balance between national approach and local initiatives

The quality improvement approach concerns in the first place health professionals and patients, who experience first-hand the problems in the field and are best able to identify priorities. Therefore, the HAS involves professionals and users in a co-construction approach to define quality indicators. While a national quality approach is necessary to provide the impetus for reforms, build standards and financing methods, ownership of the approach is in the end at the local level. Regional Healthcare Agencies (ARS), Territorial Professional Health Communities (CPTS), and health facilities therefore have a key role in both designing and implementing improvements in the quality of care production.

CHINESE EXPERIENCE: AI SERVING HOSPITAL GOVERNANCE

Speaker: Fu ZHU, President of the Shanghai Xuhui Cloud Hospital | China
Interviewed by **Guy Vallancien,** President of CHAM | France



— Shanghai, a world-city with a growing need for efficiency in medical care

With a large metropolitan area of about 80 million inhabitants, 365 hospitals and hundreds of local centers, Shanghai faces health challenges comparable to most European countries. To meet these needs, one of the first experiments of a hospital assisted by Artificial Intelligence was set up. One year and over 92,000 consultations later, here are the first results.

— A patient journey assisted by Artificial Intelligence

From initial information gathering to obtaining a prescription, the hospital's Artificial Intelligence plays a role at every stage:

First, the patient makes an appointment on the Internet, on a smartphone or on WeChat (Chinese equivalent of WhatsApp) by completing a questionnaire that should allow the AI to propose an appointment with the appropriate service in the shortest possible time. The AI also schedules appointments to take additional exams if necessary.

At the end of these examinations, the AI is able to propose an appropriate treatment and prescription. This prescription is systematically reviewed, modified and validated by a doctor, who is legally responsible for it. Finally, feedback is provided by the physician for the continuous improvement of AI.

— Benefits in terms of efficiency and sharing of medical data

This system is presented as having many advantages. First of all, efficiency, with doctors' working time focused on proofreading and confirmation of consultations, which makes it possible to establish a 24-hour medical permanence. Indeed, the AI is largely autonomous to make appointments at any time, partly thanks to man-machine interface technologies such as Natural Language Recognition.

In addition, assistance by an AI allows teleconsultations to be planned in remote and hard-to-reach areas such as Tibet. Indeed, doctors on site can request assistance from the AI remotely from a connection center to assist them during consultations.

Finally, the medical files generated within the hospital are shared throughout the municipality in a secure manner, which should allow for greater fluidity in the patient's journey and avoid redundant questions and examinations.

— **Limitations in ergonomics towards some of the users, as well as concerns about IT security**

However, the transition towards this new operating mode has not been without its difficulties. First, the patient interface seems to pose some issues, especially for older patients. Nurses are on site to help those patients complete the questionnaires and interact with the hospital's applications.

Secondly, doctors and caregivers in the broad sense had to be trained in the use of the new tools, some of which radically changed the organization and working habits.

Finally, data and software protection is obviously at the heart of the concerns, which has led to drastic protocols for access control and information monitoring.

Speakers: Frédéric COLLET, President of Novartis France | France, **Evelyne POUPET,** General Manager of the Hospital and Hospital groups of territory of Châteauroux | France, **Eric SALAT,** Patient Expert and co-Director of university diploma "Democracy in health" at Sorbonne Universities | France

Debate led by **Olivier MARIOTTE,** President of nile | France

— It is now time to move the patient's place from a consultative and representative role to an active part in the governance of health structures

Since 2002, health democracy has been developing in France and the place of the patient is now widely recognized in the health system, accepted by all authorities of the system, which increasingly require the participation of the patient. On the other hand, the patient's empowerment remains limited, particularly in discussions with Regional Healthcare Agencies (ARS) or regarding participation possibilities in the health products committee. The patient is currently present in governance, but we cannot say that he or she is legitimate yet.

However, patients demand greater patient involvement, as shown by the CHAM-IPSOS survey: 63% of patients would agree to participate on the board of directors of a healthcare institution, 58% and 50% in drug and medical device companies.

Although desired, this evolution for more legitimacy poses difficulties for patients. Participation in governance can now represent more than 35 hours per week of volunteer work. We must think about the training of these patients involved in the proceedings of institutions.

The scope of user participation must be extended beyond what was intended in framework texts, including upstream in health professionals initial training, by integrating patient participation in the governance bodies of nursing and healthcare assistants training institutes.

We must not work for the patient but with the patient and we must not do so out of naïve principles, but rather to meet a need. For drug companies, the patient must be integrated into the drug's life cycle: from the development of the drug until it becomes a generic or biosimilar. Already today, patients are included at an extremely early stage in the drafting of protocols and consents. According to some, patients must be more involved in governance, but in a context where a need is well identified, and therefore, the board of directors is not necessarily the best platform.

— A dialogue remaining to be built within Territorial Professional Health Communities (CPTS) and Territorial Hospital Groups (GHT)

The patient will have to play an essential role because with these new structures the patient's journey becomes the heart of the matter. Patients are best positioned to report dysfunctions and disruptions in the care journey and can therefore become mediators between the different professionals and structures involved in said care journey.

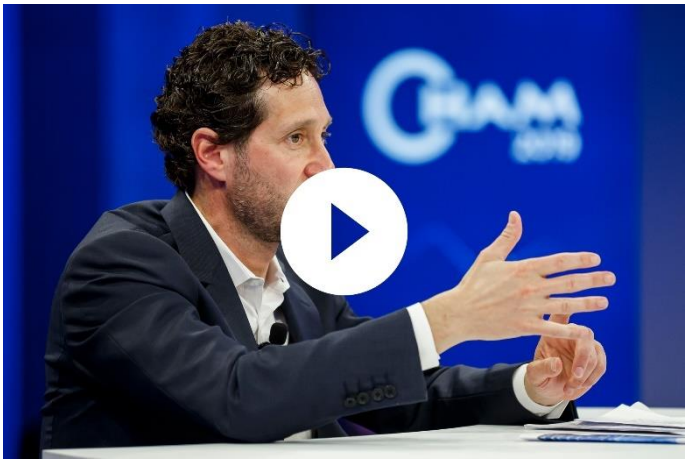
These patient care pathways must be co-constructed with patients, as is already the case with oral cancer therapies, where patients become fully responsible for taking the drug and must be involved in the design of the pathways.

— Health system quality assessment

Patients are already included in regular assessment groups such as experience reports (Comités de Retour d'Expérience – CREX) and morbidity reviews in some hospitals. On the other hand, user committees can play an active role, for example by encouraging flu vaccination for health workers and through the production of reports for the Haute Autorité de Santé (HAS – French National Authority for Health). Regarding health products' quality, patients already participate in bodies such as the HAS and the Economic Committee on Health Products.

AMERICAN EXPERIENCE: AN INTEGRATED HEALTH SYSTEM

Speaker: Paul KRAKOVITZ, Vice-President and Chief Medical Officer of Intermountain Healthcare | USA
Interviewed by **Thomas LONDON,** Partner, McKinsey & Company | France



— Intermountain Healthcare: a golden nugget in the American healthcare system

Intermountain Healthcare is a non-profit healthcare system that encompasses 24 hospitals, including a virtual one, and primary care units in Utah, covering half of the medical care delivered in the state. It stands out for its exceptional results both in terms of quality and cost control. Said costs amount to only half of the average costs observed in the rest of the country.

The medical care provided by Intermountain is organized into two axis: *community base care*, which is focused on first recourse, and *specialty care* which is focused on second recourse medical care.

— A double action to reduce the costs of the entire system

In order to reduce hospital care costs, Intermountain relies heavily on widespread strategies such as developing ambulatory surgery centres, including for specialties such as cardiovascular (ambulatory coronary angiography), and imaging centres in cities.

Nevertheless, the main objective is to limit the number of patients coming to the hospital, through the use of two levers:

- reducing the use of emergency rooms, which is promoted by redirecting people to unscheduled, open access health centres in cities;
- developing primary care through an innovative model where a multi-professional team is responsible for a panel of about 1,000 patients. This team reviews their patient group every morning, looking at their data to see if some patients are at risk or have been to the emergency room, and allocating tasks to be able to proactively address the needs of these patients.

— A bridge between city and hospital facilitated by clinical programs

Pathways based on standardized care process models for cardiovascular, oncology, musculoskeletal and behavioural care have been developed to identify how to act to avoid patients requiring hospital care. In cases where hospital care is required, these models are also used to limit the duration of stay. These pathways have made it possible to reduce costs while maintaining quality.

— Telemedicine to improve access to care in rural areas and to reduce the number of visits to emergency rooms

Hospitals with a very small number of doctors can be found in isolated areas. In order to maintain a good level of quality of care, they can rely on nurse practitioners and telemedicine. Practitioners from the major centres guide local actors on the actions to be taken in more complex clinical cases.

Telemedicine is also used to avoid patients coming to the emergency room via a mobile application that allows the patient to indicate their symptoms and, depending on the case, receive a prescription, be referred to a specialist or, if necessary, to the emergency room.

— To improve performance, Intermountain concentrates on the fundamentals

Quality, safety, patient experience, caregiver experience, cost reduction and growth are the fundamentals that guide the actions of Intermountain. They rely on continuous improvement and the use of *lean management*, which are regularly measured by key performance indicators to determine whether objectives are being met.

Speakers: Xavier BERTRAND, President of the region of the Hauts-de-France | France, **Nekane MURGA EIZAGAECHEVARRIA,** Health Minister of the Basque Country | Spain, **Hans WINBERG,** Secretary General of the Leading Health Care Foundation | Sweden

Debate led by **Benoît PERICARD,** Partner and National Director of Health and Public Sector, KPMG | France

— What place for local healthcare governance?

The survey conducted by IPSOS for CHAM reveals that the majority of European citizens would entrust the management of hospitals, nursing homes and retirement homes to local public institutions: region or municipality.

In Sweden and Spain, this is indeed the case: the regions are in charge of the vast majority of the budget dedicated to healthcare. This decision is paying off, particularly in the Basque Country where the healthcare budget is in balance. The government of the region sets every four years a health plan defining the priority actions for its healthcare system, with results targets. In Sweden, the local government (at regional level for the health field and at municipal level for medico-social) also makes it possible to respond to the challenges of geographically and demographically very diverse regions. The federal state has little power over healthcare policies.

The French system, on the other hand, is highly centralized. The regions have limited budgets dedicated to health (10 million euros for the Hauts-de-France region, for instance) which do not allow sufficient resources to be mobilized to respond to local needs. Budgets could do a better job of taking regional specificities into account, for example by using equalization to distribute resources equitably among the regions most in need, or by transforming the national health expenditure target into regional objectives that can be adjusted. The establishment of Regional Healthcare Agencies (ARS) does not meet these challenges: these agencies have missions that are too broad, over too large a territory.

— Local governance for policies adapted to the needs

Local governance has the advantage of fostering the emergence of innovations to address particular needs. In Sweden, for instance, access to healthcare is a major challenge in widely dispersed and sparsely populated regions. To address this, telemedicine has been broadly deployed over the past five years.

Moreover, working on a small scale allows a more integrated approach: in the Basque Country, health is a transversal issue, which is taken into account in the other fields of responsibility of the autonomous government. Initiatives in the social, food and housing sectors, for instance, are also evaluated according to their impact on health. On the contrary, in France, the regions are not part of the ARS, and the two institutions are therefore not coordinated.

— Rethinking governance to meet new challenges

The world of healthcare has experienced two revolutions in the last thirty years: a medical revolution and a digital one. However, the system of governance has not yet evolved to take into account these new practices. In addition, there is a shortage of resources allocated to healthcare in France: human resources with a shortage of doctors, and financial resources with strong budgetary restrictions. Regions can and wish to become involved in healthcare policies to meet these challenges, for example by supporting private medical practice through administrative management platforms or the introduction of medical assistants.

Neither an entirely centralized nor a decentralized system are optimal, but a balance must be found. Health is a multidimensional subject, it is important to observe and recognize the local healthcare culture before defining a proper governance to support it. For this reason, one solution would be to leave room for experimentation, in order to bring about a better system of governance.

WHICH GOVERNANCE TO PROMOTE INNOVATION AND THE PROVISION OF HEALTH PRODUCTS?

Speakers: Jean-Noël ALBERTINI, Professor of Cardiovascular Surgery at the CHU Saint-Etienne and President of PrediSurge | France, **Jean-Luc BÉLINGARD,** Vice-President of the Institut Mérieux and President of the CSIS | France, **Catherine ESTRAMPES,** President and CEO of GE Healthcare Europe | France, **Nicolas REVEL,** Director of the CNAM | France

Debate led by **Jean-François LEMOINE,** MD and Journalist at Fréquence M | France

— The innovations identified for the next 10 years

In an evolving European health system, a CHAM-IPSOS survey, questioning the objects of health innovation for the next 10 years, reveals that citizens perceive possible innovations first for drugs and medical devices, then on the role offered to patients in the system, through the Dossier Médical Partagé (DMP – Shared Medical Record), the massive development of prevention and online appointments, and finally innovations related to the progress of technology, the Internet and Artificial Intelligence.

The objective of the sharing of information is an essential lever for organizational innovation and improved care, and is currently supported by the DMP, which aims to cover the entire population by 2021 and constitute the basic building block for digital innovation.

— A two-tier pace of innovation and availability of health products in France

Today, France has a conflicting relationship with innovation and the availability of healthcare products: the system is both advantageous because of the amount of financial support provided by government agencies and at the same time counterproductive because of the complex and lengthy procedures for authorizing new drugs and medical devices.

Thus, while financial support and government programs, such as Article 51, enable manufacturers to develop innovations and promote this particular market by supporting innovative start-ups, the complex procedures and deadlines for the release of products are an incentive for manufacturers to favour neighbouring countries, such as Germany, where this average period is of 8 months, against 18 months in France.

In a context of globalization, this complexity undermines the French reputation in public healthcare.

— A solution: integrated governance combining medical and industrial actors along with the government

An approach has been initiated by manufacturers with the government to simplify this process and reduce delays, mainly influenced by evaluations that are not well suited to innovation, and by lengthy financial negotiations. While agreeing to simplify, government agencies however point out that a certain amount of time is essential to select products that are truly innovative and provide real added value in terms of actual care.

The creation of the Comité Stratégique des Industries de Santé (CSIS – Strategic Committee for Health Industries) and the dialogue between manufacturers and the government on simplification confirm the initiation of a common governance as well as the objective of developing innovation in France, but also herald long-term work to reconcile different healthcare cultures and find changes that satisfy all of the actors.

Speakers: Isabelle CADET, Lecturer in Management Sciences at IAE Paris Sorbonne Business School | France, **François GRACIA,** CE Chief Engineer, Head of Quality Waste Management Certification of CHU Montpellier | France, **Marc GUYOT,** Head of ESG of LBO France | France, **Guillaume LEROY,** President of Sanofi France | France, **Claude TENDIL,** Vice-President and President of the reform commission of social protection of the MEDEF | France

Debate led by **Thierry GUERRIER,** Journalist | France

— CSR, an old concept, at the heart of today's crisis response

CSR (Corporate Social Responsibility) is a phenomenon that has become widely established in the life of companies and organizations. Whether it is a question of progress in waste management, better consideration of the quality of life at work, the issue of a meaningful work environment, the choice of more "virtuous" business partners and more responsible investments, the impacts that organizations can have on society are increasingly being taken into account.

In a context of "public health emergencies shock", climate emergencies, social emergencies, etc., the problematic appears to be central. However, despite this relevance of the concept, one observation remains: the general public is unaware of CSR, and it is difficult to distinguish between the advertising effects, the reported figures and the tangible implementations. Thus, according to a CHAM-IPSOS survey conducted in 5 major European countries, 21% of respondents think that the CSR actions implemented by companies for the wellbeing of their employees are effective, 20% think that these measures are ineffective and 59% say they do not have sufficient information on this matter. The heart of the debate thus revolves around the perception of the actions undertaken, in a context where the very definition of CSR has evolved considerably to move towards more and more vague boundaries.

— A multifaceted concept with unclear boundaries but a great potential?

Indeed, a limitation of this concept is the plastic nature of its definition, which nowadays refers to very diverse situations, making it difficult to determine its implications.

CSR was thus born from the formalization of American managerial reflections on the benefits for a company to consider its responsibility over the wellbeing of its employees. The development of environmental, but also social and economic concerns has contributed to the broadening of this dynamic. With the intensification of these challenges, a form of institutionalization has been adopted and governments, particularly in Europe, have supervised and extended the measures taken, by initiating a monitoring of sustainable development performance and by identifying national objectives. This trend is helping to gradually move CSR out of its internal focus and into a new perspective, with a stronger focus on its stakeholders. In turn, this evolution forces us to reassess expectations regarding the social role of the company: both as an actor and as a contributor to the social community, through the significance

that work offers and the way it is carried out. CSR is thus extending to the point of becoming one of the elements that motivates the company's action, for some of its employees. In this respect, CSR must involve all organizations, including hospitals, such as the Montpellier University Hospital, which has already made it into an important part of their activities. This evolution "by expansion" contributes in a sense to the blurred vision of the concept, but above all it extends its possibilities and achievements.

It thus appears that if CSR is a trend, this trend has gradually taken on an increasingly high priority and is finally asserting its legitimacy through what it accomplishes. It is then up to its actors to work on communication and to promote its successes.

Speaker: Agnès PANNIER-RUNACHER, Minister of State, attached to the Minister of Economy and Finance | France

Interviewed by **Karim TADJEDDINE,** Partner, McKinsey & Company | France et **Guy VALLANCIEN,** President of CHAM | France

— Signs of renewal for the French industry

After declining for two decades, the first signals of the renewal of the French industry are finally being observed. They mark the end of the idea of a post-industrial society based solely on services. While the attempts at redeploying a French industry began in 2010, they really took off in 2017, through measures for competitiveness such as reforming of labor laws, taxing capitals to encourage riskier investments towards building companies, and reducing corporate taxes, an international marker for investment.

These efforts have borne fruit and France now ranks as the leading destination in Europe for foreign investment for industry and research as well as development centers.

— The challenges of evolving this dynamic

There are four challenges to this dynamic. The first is the transition from a quasi-Taylorian production mode to a production mode integrating additive manufacturing machines, numerical controls, robots and cobots. This transition will ensure greater flexibility and leverage the French strength in terms of engineers. The high added value of these production methods will offset the high production costs in France. The second challenge is to support the development of skills, which is reflected in a €15 billion plan. The third is to simplify the administrative complexity, so that it does not hinder installation in France. Finally, the attractiveness of industrial sectors is the fourth challenge. While the biotech and pharmaceutical sectors offer as many intellectual and social transformation challenges as the GAFAs, industry in general can suffer from an image of deteriorated working conditions.

— Giving priority to the healthcare industries

However, while there have been improvements in the French industry, few are felt in the pharmaceutical industry. Indeed, less than 10% of industrial projects concern this sector. That is why the government has made the healthcare industries a priority. A main lever is the preservation of the research tax credit, a major element of the French competitiveness that benefits the pharmaceutical sector with nearly 600 million euros. The PACTE law is another tool to simplify the transition from basic to applied research and to protect intellectual property. In addition, the last part of the action plan of the strategic committee of health companies finances innovation, both to impact the patient and production capacities. The staff of the HAS and Comité Économique des Produits de Santé (CEPS – Economic Committee for Medicinal Products) will also be increased, and the spectrum of their missions will be extended to evaluating the industrial framework for the production of health products.

— The development of a European industrial strategy

At the national level, France has many assets and deploys one of the most powerful databases in the world with the recent Health Data Hub. Still, it is also necessary to think about a strategy at the European level. Europe has chosen to invest massively in the Artificial Intelligence sectors, linked to the health industries, to lead to investments from European countries and develop European innovation. This is to ensure European competitiveness and sovereignty.

EXPECTATIONS OF CITIZENS AND MANAGEMENT REQUIREMENTS: AN IMPOSSIBLE EQUATION?

Speakers: Agnès BUZYN, Minister of Solidarities and Health | France, **Nora KRONIG ROMERO,** Ambassador, Vice-Director, Federal Office of Public Health – FOPH | Switzerland, **Per OKKELS,** Permanent Secretary, Danish Ministry of Health and Senior Citizens | Denmark

Débat animé par **Philippe JUVIN,** former Member of the European Parliament and Professor of Emergency Medicine of the HEGP | France et **Guy VALLANCIEN,** President of CHAM | France

— Switzerland, Denmark, France: fundamentally different health systems facing similar challenges

The Swiss and Danish health systems are much more decentralized than the French system. Their organization is based on intermediate levels, 26 cantons in Switzerland and 5 regions in Denmark, responsible for allocating resources to institutions and ensuring the quality of care production. Even though *Ma Santé 2022* aims to territorialize decision-making, the French regions still won't be in charge of spending and revenue to avoid excessive competition between regions.

The balance between public and private actors is also a significant difference. Public actors have a predominant place in Denmark - the State is the sole payer of health expenditure financed by taxes and only 2 to 4% of care is produced by private actors - and in France - 78% of health insurance is of public origin. While Switzerland also finances health expenditure through an insurance system, 75% of the funding comes from private sources: the health expenditure of Swiss citizens is therefore 2 and 3 times higher than in Denmark and France respectively. The Swiss system still has the specificity of being based on direct democracy: citizens participate in decision-making.

Yet the challenges and priorities at the national level are similar. The 3 States must meet the same demographic, epidemiological (growing but ageing population, chronic disease management) and organizational (emergency crisis, interprofessional medical professional) challenges and have the same final objectives: controlling avoidable costs, guaranteeing a system with sustainable financing, and providing a quality service.

— Is Denmark, an example for France?

While France is starting reforms with the *Ma Santé 2022* project, Denmark has already become an efficiency benchmark by reducing the national MSD to 3.2 days. The reform, financed by of 40 billion euros over 6 years, was based on the use of city medicine and the delegation of powers. In 3 years, emergency room visits have decreased by 25% due to a screening process for patients in acute care. Certain doctors are available 24 hours a day to take care of the less serious patients in outsourced units close to the hospital, while small specialized units take care of acute care. The objective is now to treat 20% of chronic diseases outside the hospital, while Danish emergency doctors believe that 75% of diabetes cases treated in hospitals could be outsourced. The delegation of tasks to better trained nursing staff speeds up patient care: nurses are twice as numerous in Denmark as in the EU average and are trained over 4 years.

— Focusing on *Ma Santé 2022*

The strategy for transforming the French health system is based on:

- Trust and recognition in the field: the State must guarantee equal access to care, but the organization of care is transmitted to health professionals through Territorial Professional Health Communities (CPTS) and multi-professional health centers. The skills of the health professions must be upgraded, through the Master's degree of nurses and the creation of the post of medical assistants, in order to expand the roles of medical and nursing staff;
- Serving patients: the reorientation of GHT management towards medical projects (and no longer only administrative or financial) and the creation of community hospitals are examples of this.

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