

# Heart failure

policy and practice  
in Europe

# France



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**The Heart  
Failure Policy  
Network**



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## About the Heart Failure Policy Network

The Heart Failure Policy Network (HFPN) is an independent, multidisciplinary network of healthcare professionals, advocacy groups, policymakers and other stakeholders from across Europe. It was established in 2015 with the goal of raising awareness of unmet needs and seeking meaningful improvements in heart failure policy and care. Our aim is to help reduce the burden of heart failure – on people living with it, those supporting them, health systems and society at large. All members of the HFPN provide their time for free. All Network content is non-promotional and non-commercial. The Secretariat is provided by The Health Policy Partnership Ltd, an independent health policy consultancy based in London, UK.

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# **About** Heart failure policy and practice in Europe

Heart failure (HF) is a common and complex condition responsible for extensive avoidable morbidity, mortality and healthcare costs. There is a clear need to advance HF policy and practice across Europe, and this requires recognition of the real challenge in each country.

To this end, the Heart Failure Policy Network (HFPPN) has developed *Heart failure policy and practice in Europe* – a comprehensive analysis of key gaps and best practice both in HF policy and in clinical performance across 11 European countries. In this work, we investigate each country's progress in addressing the HF challenge, for example in terms of the existence and implementation of HF policies and the provision of multidisciplinary and integrated HF care. Findings are presented in an overarching report, which outlines the methodology for this work and includes a pan-European narrative, and in standalone country profiles with dedicated national-level analysis.

Urgent action is needed to address the growing burden of HF and ensure the sustainability of our healthcare systems. This country profile aims to assist HF advocates across France in engaging healthcare system leaders to demand constructive changes to HF policy and care provision, to reduce the impact of HF on people living with the syndrome, their families and carers, the healthcare system and society.

# Heart failure in France

## SUMMARY

Heart failure (HF) places a heavy burden on health services in France – it is one of the leading causes of hospitalisations and mortality.<sup>1,2</sup> HF management has been estimated to cost around €2.5 billion per year, of which hospital stay was by far the most expensive cost component, accounting for 30% of the overall spend.<sup>3</sup>

Government organisations have started to recognise the burden of chronic diseases such as HF and have begun reforming the healthcare system with a focus on community-based care.<sup>4</sup> The High Authority of Health has published a guide to the HF care pathway that has been successful in improving national HF care.<sup>5</sup>

However, experts report insufficient recognition of the value of integration of care, and HF management remains highly fragmented, with multidisciplinary care being far from standard practice.<sup>6,7</sup> While there has been increased investment and use of telemedicine services in HF,<sup>4</sup> mainstream implementation of these programmes is patchy at best, and there are significant inequalities in HF care across the country.

## HF is a common syndrome

HF is estimated to affect nearly one million people in France, which is approximately 2.3% of the entire population.<sup>1,2</sup>

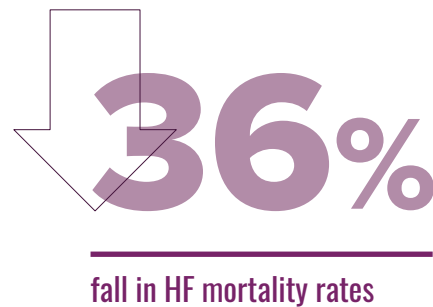
In people aged 70 and over and in socially deprived populations, prevalence rates can be as high as 10%.<sup>2,3</sup> Incidence has been reported at 120,000 new cases per year.<sup>1</sup>



## Outcomes for people with HF are often poor

Hospitalisation due to HF is frequent.<sup>2</sup> In 2014, 165,000 people were hospitalised with HF, and the average number of hospitalisations per person was 1.3.<sup>2</sup> Hospital readmission rates grew by more than 30% between 2002 and 2014,<sup>2</sup> and with the cessation of funding for HF disease management programmes, hospitalisations for HF have continued to increase since.<sup>8</sup>

HF is responsible for over 70,000 deaths per year, with around two thirds occurring in people aged 85 or over.<sup>2,9</sup> HF mortality rates have been improving significantly since 1990, with an overall 36% decrease noted between 2000 and 2013.<sup>2,10</sup> Despite this, HF remains one of the leading causes of death in France, with the five-year mortality rate for advanced HF at 50%.<sup>1</sup>



In 2015, around 6% of people hospitalised for HF died in the 30 days after discharge.<sup>11</sup>

## There is significant regional variation in the burden of HF

Regional disparities exist regarding the prevalence and outcomes of HF, mainly owing to the higher prevalence of risk factors for cardiovascular disease in certain regions, differences in HF care and unequal access to care.<sup>2,11</sup>

Regional variations in hospitalisations are high.<sup>11</sup> In 2014, the northern regions Hauts-de-France and Normandy had the highest hospitalisation rates, more than 10% higher than the national average. Meanwhile, the south-eastern regions and certain regions in the Caribbean had rates well below the national average: more than 10% lower in Occitanie, Provence-Alpes-Côte d'Azur, Guadeloupe and Martinique.<sup>2</sup>

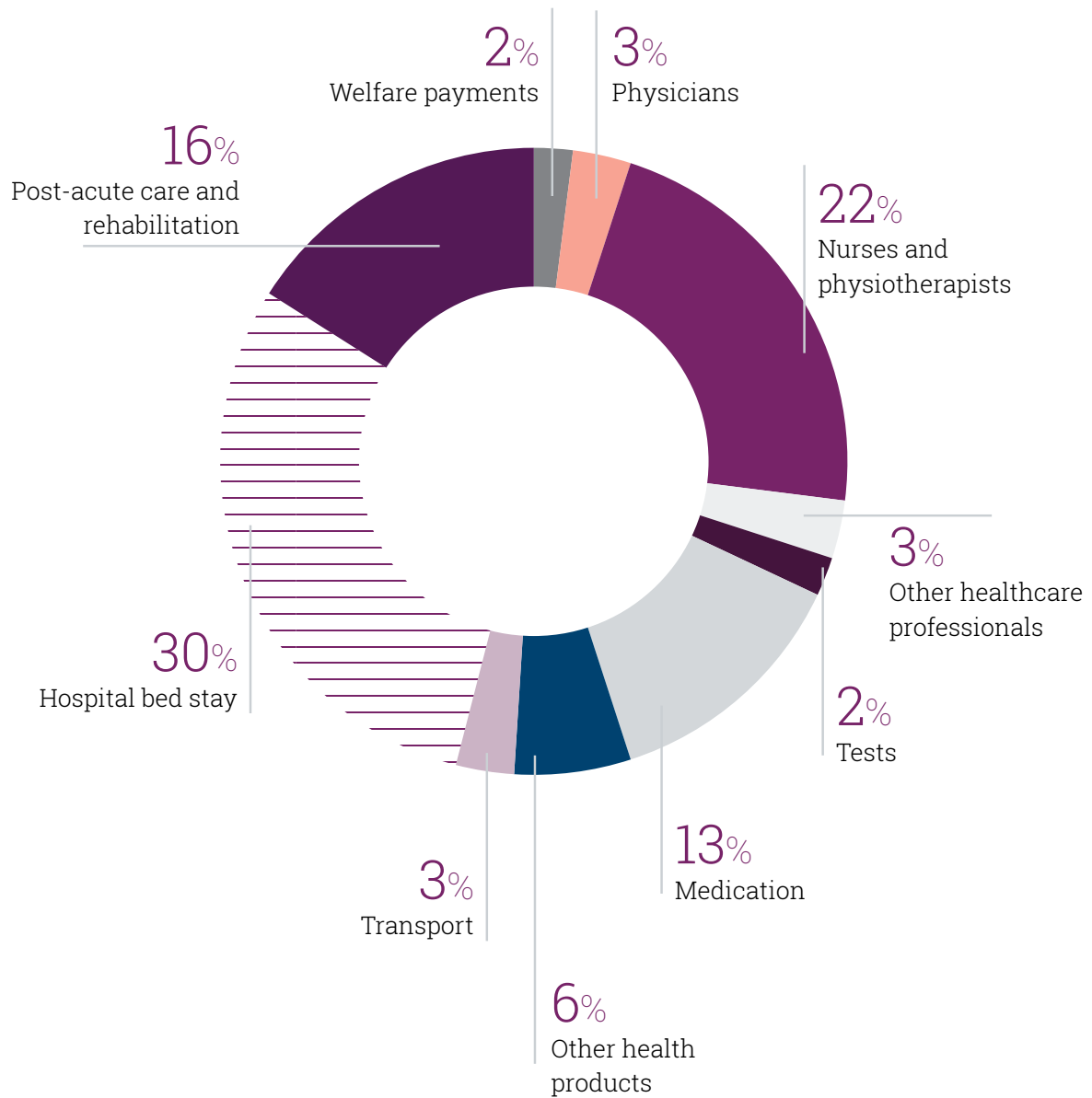
There are also considerable regional variations in mortality. In 2014, the highest death rates were reported in Hauts-de-France, Corsica and Grand-Est regions, at more than 10% above the national average. In the regions with the lowest mortality (the Paris region Île-de-France, Guadeloupe, Martinique and French Guiana) rates were at least 10% below the national average.<sup>2</sup>

## HF is associated with high expenditure

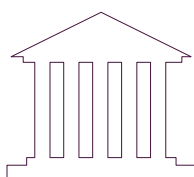
According to the national health insurance database, in 2013 alone, management of HF cost a total of €2.5 billion (see *Figure 1*).<sup>3</sup> Hospital bed stay was by far the most expensive cost component, accounting for 30% of the overall spend, followed by costs associated with outpatient care provided by nurses and physiotherapists.



FIGURE 1. Breakdown of heart failure costs in France in 2013 (€2.5 billion)<sup>3</sup>







# Heart failure policy in France

## Formal plans on HF

### France lacks a dedicated strategy for HF

The French government has yet to develop a formal plan on HF. In 2018, the Ministry of Health announced a healthcare transformation plan, Ma Santé 2022, which highlighted the need to strengthen and formalise the HF care pathway.<sup>12</sup> However, experts note that HF was discussed from a medical but not organisational point of view, missing an opportunity to progress HF as a policy issue, and indeed HF has not been mentioned in subsequent plans.<sup>6,13</sup> The COVID-19 pandemic has prompted a healthcare summit and consultation of high-level stakeholders to discuss a health system reform – Ségur de la Santé.<sup>14</sup> The main conclusions, however, do not consider HF specifically.

According to experts, short-term barriers to the development of HF policy may include the costs associated with the implementation of a comprehensive HF care pathway, particularly at a time when the healthcare system has been trying to manage the COVID-19 pandemic and may be focusing on cost containment.<sup>7</sup> Longer-term challenges in developing an HF-specific strategy cited by national experts include the bureaucratic and fragmented nature of decision-making within the healthcare system, both at the national and regional level, and lack of continuity and follow-up from existing strategies.<sup>6,7</sup>

## Investment in integrated HF models and facilitative tools

### HF diagnostic tests are consistently reimbursed but investment in HF care programmes is limited

Experts state that natriuretic peptide (NP) testing is reimbursed across care settings, including in primary care, while the gold-standard echocardiography<sup>15</sup> is consistently available for specialist physicians.<sup>16</sup>

Policymakers have recognised the need to improve chronic disease management and support a shift in care from acute to community settings, but efforts in HF have been inconsistent. Disease management programmes exist for several chronic diseases, such as diabetes and asthma,<sup>4</sup> but they have yet to be developed for HF.

Investment in regional HF programmes has been limited. For example, the ICALOR programme (Insuffisance CARDiaque en LORraine), which led to a reduction in hospitalisations and mortality from HF and saved almost €2 million in averted hospitalisations in 2010 alone,<sup>17</sup> was interrupted in 2014 when funding ceased.<sup>8</sup> In 2013, the French National Health Insurance Fund (Caisse nationale de l'Assurance Maladie) implemented PRADO Insuffisance Cardiaque, a programme to support transition from hospital to community care in HF.<sup>18,19</sup> However, experts state that PRADO works mostly as a facilitator of care, not a true disease management programme, making the effort insufficient to ensure proper post-discharge care to all people with HF.<sup>6,7</sup>

Evidence suggests that an HF disease management programme could achieve significant cost savings. A recent study showed that implementing ICALOR at the national level could cost around €60 million per year and contribute to savings of around €235 million per year, resulting in national net estimated savings of €175 million annually.<sup>8</sup>

### **Inadequate information technology infrastructure hinders integration of care**

Limited interoperability of information technology (IT) systems is widely recognised as a challenge to integrated working between healthcare professionals in France.<sup>13</sup> Systems differ among healthcare settings and medical information is often not accessible across settings. For example, experts highlight that patients are allowed to delete information from their electronic medical records, which may reduce the value of the record system (dossier medical partagé).<sup>6</sup> In addition, people with HF are often followed up by cardiologists in private practice, who use IT systems that do not normally communicate with that in public hospitals.<sup>6,7</sup>

## **Development of the HF healthcare workforce**

### **System-wide investments are building up the healthcare workforce, but HF-specific efforts are also needed**

There are significant regional disparities in the distribution of healthcare professionals. To address this, as well as concerns over a shortage of doctors, the Ministry of Health has implemented measures to increase the capacity of medical schools, the number of general practitioners (GPs) and retention of healthcare professionals in underserved areas.<sup>4,12</sup> It has created the role of a medical assistant to provide support to GPs in the coordination of care. The 2016 Health Reform Law,

among others, planned to promote multidisciplinary working in management of chronic diseases to support a shift from acute to community settings.<sup>4</sup> While commendable, these efforts are broad in scope and it will be important to develop HF-specific strategies to support an HF workforce.

### **HF specialist roles are not formally accredited, but there are opportunities for specialist training**

There is no system of national accreditation for HF specialist roles.<sup>7</sup> Nurses, however, may require some level of specialisation to provide certain aspects of care,<sup>13</sup> for example through the newly established advanced nursing role (infirmier en pratique avancée); one of the four specialist qualifications is chronic diseases, including cardiac diseases.<sup>20</sup> Since 2017, private nurses are required to undertake specialist training in order to bill for care provided to people with HF following hospitalisation.<sup>21</sup> Accreditation can be gained through seven hours of online training.

Recent policies may contribute to greater involvement of nurses in HF care. In December 2019, a protocol was passed by the Ministry of Social Affairs and Health enabling the involvement of nurses in the management of the HF.<sup>22</sup> These nurses are required to have relevant training (100 hours including theoretical and practical training) and at least three years of experience.<sup>23</sup>

There are some HF training opportunities for healthcare professionals. One notable example is a university diploma that requires around 100 hours of training and is available for doctors, nurses and physiotherapists, among others.<sup>24,25</sup>

## **Guidance and local care pathways for delivery of quality care**

### **Formal HF guidance is available, but existing care protocols are not widely implemented**

The French Society of Cardiology (Société Française de Cardiologie, SFC) has endorsed the 2016 guidelines on HF from the European Society of Cardiology.<sup>26</sup> It has also published recommendations for specific aspects of care, such as multidisciplinary patient education for people living with HF.<sup>27,28</sup> This followed the 2007 guidance by the High Authority of Health (Haute Autorité de Santé, HAS) and the National Institute for Prevention and Health Education (Institut National de Prévention et d'Éducation à la Santé) on therapeutic patient education.<sup>29</sup>

In 2014, the HAS published a care pathway for HF, which aimed to improve the management of HF, including better coordination of care and patient involvement through therapeutic education.<sup>5</sup> However, its implementation is inconsistent across the country and experts report it is common for healthcare professionals to base their practice directly on European guidelines.<sup>6</sup>

There have also been efforts to improve the HF care pathway at the regional level. For example, the Agence Régionale de Santé (ARS) of the Paris region Île-de-France organises regular multi-stakeholder meetings in partnership with the national health insurance fund. Their aim is to promote discussions on improving HF management in the region.<sup>30</sup> Two meetings take place every three years per hospital area. This initiative focuses on the use of care assessment and the implementation of digital tools to improve HF care and reduce hospitalisations and mortality, while enhancing quality of life.

## Public audits of performance and high-level assessment initiatives

### **There are some national efforts to monitor HF trends, but a more coordinated and consistent approach is needed**

There is no national ongoing registry specific to HF. The national healthcare database (Système National des Données de Santé) collects a wide range of healthcare data for the majority of the population, allowing for an assessment of performance in several disease areas, including HF.<sup>11,31</sup> However, its usefulness in HF may be limited. On the one hand, there are not sufficient data, because the database does not include all clinical information nor the entire population; on the other hand, there is a surplus of data, because it is not disease specific. Development of an HF registry could help overcome these challenges, but funding may be an issue, not only for infrastructure but also for staff to register and analyse the data. Without dedicated staff, the data collection and analysis may have to rely on the motivation of individual healthcare professionals.<sup>7</sup>

Since 2014, the SFC has been running The FRENch Survey on Heart failure (FRESH) – a multi-year longitudinal study aiming to describe the demographics, clinical characteristics and practice regarding diagnosis and treatment of HF (both acute and chronic).<sup>16,32</sup> The study is expected to be completed in 2025.<sup>33</sup> The SFC is also managing a registry focusing on acute HF – OFICA.<sup>16</sup> Participation in these registries is not mandatory, and therefore not all cases in the country are recorded. The initiative is, however, likely to be a promising resource with which to justify and guide central policy and investment.



# Heart failure practice in France

## Diagnosis

### **Diagnosis is hindered by limited awareness of HF and inconsistent use of key diagnostic tests**

HF diagnosis is often delayed in France. Several factors may contribute to this, including limited awareness of HF among the general public, which may delay contact with healthcare professionals.<sup>16</sup> In addition, HF signs and symptoms are often dismissed or misinterpreted in primary care, with people sometimes not being referred for diagnostic tests or to cardiologists.<sup>7</sup>

Research demonstrates the underuse of recommended diagnostic tests, which may further contribute to delayed diagnosis of HF. Data from a French health insurance database in 2014 revealed that, during the year leading up to the first hospitalisation for HF, only around 40% of people had at least one NP test and around 39% underwent at least one echocardiogram.<sup>34</sup> Historical data have shown limited use of key HF diagnostic tests and a need to improve knowledge of best practice in HF diagnosis in geriatric care (including acute, rehabilitation and nursing care settings).<sup>35</sup> This may be due to wider problems in securing specialist-led advice in these settings.

Communication of diagnosis may also be an issue. Experts report that if a healthcare professional thinks that the term 'heart failure' will worry a patient, they may refrain from using it.<sup>13</sup> Not using the correct terminology may lead to the person not understanding their condition and not realising its seriousness until much later.

## Hospital care and discharge

### **There is no standard guidance or accreditation for specialist HF units, resulting in inconsistent acute HF care**

Experts report that the lack of accreditation for dedicated HF units has contributed to significant variation in the provision of care to people with acute HF.<sup>16</sup> In hospital, patients may be admitted to different departments, for example cardiology, internal medicine, geriatrics or post-emergency, and many do not see a cardiologist before they are discharged.<sup>7</sup>

### **High-quality discharge planning and post-discharge care are not regular practice**

People with HF are often discharged without a care plan and the timeline for follow-up appointments does not typically align with guideline recommendations.<sup>36,37</sup> In some disease areas, such as heart attack, hospitals are evaluated on a yearly basis by the health authorities to ensure quality in discharge planning, but this does not happen in HF.

PRADO Insuffisance Cardiaque is a programme developed to support transition from hospital to community settings, but, as noted by experts, it is a facilitator of care rather than a disease management programme.<sup>7</sup> In addition, PRADO is not consistently used, which experts attribute partly to limited awareness of the programme among healthcare professionals and sickness funds alike.<sup>6,7</sup> Experts have stated that more comprehensive disease management programmes are crucial to support discharge planning,<sup>7</sup> and discharge checklists for HF may also be important in this process.<sup>36</sup>

## Key components of quality care in community settings

### **Lack of collaboration between specialists and primary care professionals may obstruct guideline-based care**

Studies show that HF is often not optimally managed in the community setting. A study of almost 13,000 people with HF spanning 2008–2012 pointed to concerning patterns of service use and medication uptake; while most of the people included in the study visited their GP relatively frequently, cardiologist visits were less frequent, and guideline-recommended treatments were not prescribed consistently.<sup>38</sup> Almost half of these patients were hospitalised within one year, with around one in four hospitalisations due to HF. Data from 2015 reinforced these findings, showing poor adherence to guidelines, both in terms of medical appointments and medication prescribed.<sup>11</sup> Marked regional disparities have been noted, particularly in the number

of consultations with a cardiologist, which may be due to the unequal distribution of healthcare professionals and/or variations in the integration of care between hospital and community settings.

Experts report significant variation in ongoing HF management and highlight that while GPs may be motivated to do what is right for people living with HF, they are often not sufficiently supported to follow best-practice recommendations.<sup>6</sup>

### **Cardiac rehabilitation is not consistently provided in the management of HF**

There is limited provision of cardiac rehabilitation in HF.<sup>13</sup> Available services typically take place in specialist centres, but capacity is limited and referrals are low.<sup>5</sup> It is estimated that only about 10% of people discharged from hospital following exacerbation of HF have access to cardiac rehabilitation programmes.<sup>34,39</sup> Barriers include poor accessibility outside of urban areas and a general lack of funding and resourcing for these centres to operate effectively, which limits their capacity.<sup>39</sup>

### **Self-care education is not standard practice in HF care**

Self-care education and patient empowerment are not consistently offered as an element of HF care. Low uptake of existing local services is also a challenge.<sup>13</sup> While some people with HF can access multidisciplinary therapeutic education programmes in specialist centres (see *Case study 1*) – which may include hospital units, cardiac rehabilitation centres and nursing homes<sup>5,23,40,41</sup> – many are not given access to this care component. The resulting low awareness of important self-care behaviours may contribute to the limited levels of physical activity noted in people living with HF.<sup>39</sup> Barriers to self-care education include lack of appropriate space, funding and staff, particularly nurses.<sup>7,23</sup>

A non-HF-specific programme for telemonitoring – Telemedicine Experiments for the Improvement of Care Pathways (Expérimentations de Télémédecine pour l'Amélioration des Parcours En Santé, ETAPES) – is being trialled to support management of chronic diseases, including HF.<sup>42</sup> In September 2019, 2,500 people living with HF were estimated to use ETAPES to receive care remotely.<sup>43</sup> The programme offers sessions over the course of six months, including some on patient education.<sup>7</sup> Outside of this programme, it is very difficult to receive reimbursement for patient education in the community.

**CASE STUDY 1.**Local initiatives to improve post-discharge and community care<sup>7</sup>

The University Hospital Centre (Centre Hospitalier Universitaire, CHU) in Nancy has developed a protocol to facilitate post-discharge care for people living with HF and prevent rehospitalisation. Within around 10 days of discharge, a person attends an outpatient service for a half-day functional evaluation. This includes an echocardiogram and a six-minute walk test, followed by patient education to promote self-care.

The hospital has also introduced protocols for annual revision of HF and treatment at the outset of HF exacerbation to prevent hospitalisation. There are plans to initiate a nurse-led HF care model.

**Lack of clarity on the appropriate initiation of palliative care may hinder its provision for people with HF**

National guidance on HF care recommends offering palliative care to people with severe HF, persistent symptoms and a poor prognosis.<sup>5</sup> It acknowledges that it may be difficult for HF specialists to decide when a person should be offered palliative care. Experts report that palliative care is not standard practice in HF, partly due to a lack of training for cardiologists.<sup>16</sup>

**Tools and methods to support multidisciplinary and integrated ongoing HF care****While integrated HF care is not standard practice, local and regional initiatives hold promise in improving HF care**

Multidisciplinary and integrated HF care is not a consistent reality across France.<sup>6</sup> However, there are promising tools that may help to drive change and improve HF care. For example, there is a national trend towards innovation in clinical practice (see *Case study 2*),<sup>144</sup> and a pilot model of multidisciplinary and integrated HF care has recently been initiated by the French Hospitals Federation (see *Case study 3*).

New platforms are also under development. One is the Doctor–Patient Health Interactive Platform (Plateforme Interactive Médecins Patients Santé, PIMPS), which is currently being trialled in 300 people with HF for home monitoring.<sup>45 46</sup> It provides training to healthcare professionals in HF management, patient education and telemonitoring of symptoms. What is unique to PIMPS is that it enables self-monitoring of NP levels through blood tests that can be administered at home.<sup>44</sup>



## CASE STUDY 2.

### Publicly funded telemedicine programmes offering innovation in HF care

**E-care** is a multidisciplinary telemedicine system to optimise management of advanced HF and avoid hospitalisation.<sup>47</sup> The platform relies on non-invasive sensors to measure a number of clinical parameters (including blood pressure, heart rate, oxygen level and weight), a tablet for communication and a web portal accessible by both the person with HF and the care team.<sup>1</sup> The system sends automated alerts to the care team when the person with HF is at risk of exacerbation, prompting immediate action and helping to avoid hospitalisations. The programme also includes an educational component.<sup>47</sup> E-care is being rolled out to Strasbourg University Hospitals.

**System Poitiers** was developed at the Poitiers University Hospital to support care following hospital discharge.<sup>16</sup> Participants have access to medical equipment at home and a smartphone app to record and transmit a range of parameters: weight, blood pressure and cardiac frequency, along with a personal assessment of their level of swelling, breathlessness and tiredness. Some people report signs and symptoms every day, while others do so twice a week.<sup>16</sup> Alerts sent to the platform are managed by a coordinating nurse, who notifies the physician if needed. People with HF are typically in the programme for six months, but this can be extended if necessary.<sup>13</sup> There are plans to further develop the system to include educational messages.<sup>16</sup>

## CASE STUDY 3.

### Implementing a multidisciplinary and integrated HF care model

The French Hospitals Federation (Fédération Hospitalière de France, FHF) has initiated a pilot project of a model of multidisciplinary and integrated HF care in five territorial hospital groups to improve HF care and promote more efficient use of resources.<sup>48</sup> The programme relies on both population responsibility – meaning shared accountability of each HF case – and population data.<sup>6</sup> This allows for a comprehensive understanding of the challenge that HF poses, including prevalence and risk stratification, and guides the development of treatment protocols per HF population group.

The FHF has engaged with a number of experts for this project, including professional societies and patient representatives.<sup>6</sup> Together, they are developing

supportive clinical tools and methods, as well as practical tools that can assist in the implementation of the programme in other territories. The project recognises the need for a robust IT platform, and the FHF is engaging with high-level stakeholders, including ARSs, to help improve the system currently available.

Expansion of the HF care model will require the support of national, regional or local decision-makers, which the FHF is currently seeking.<sup>6</sup>

# The way forward

HF poses a challenge to the sustainability of healthcare systems in countries across Europe, including France. It is a manageable – and often preventable – syndrome, yet it continues to affect a great number of people and its burden on the national health system and society is significant.

There is an urgent need for concerted efforts to address the challenge that HF poses in France, which has been further highlighted by the recent impact of COVID-19 on the healthcare system. The healthcare transformation strategy Ma Santé 2022 was an important step in this area, but will prove insufficient if it does not translate to more specific central plans and commitments in HF. Policymakers and healthcare professionals need clear direction and coordination to develop truly multidisciplinary and integrated HF care.

## **SEVERAL ACTIONS ARE ESSENTIAL TO ADDRESS THIS CHALLENGE.**

### **Increase** awareness of HF among the public, healthcare professionals and decision-makers

Understanding of HF must be improved at all levels of society. Targeted messaging for decision-makers is important to raise awareness of the challenge that HF poses and drive the development of a coherent and robust national strategy. A focus on raising awareness among the public has been initiated in the creation of the acronym EPOF, which stands for key signs and symptoms of HF: breathlessness, weight gain, oedema and fatigue (essoufflement, prise de poids, œdème et fatigue). It is important to maintain the efforts to make EPOF universally known and encourage people to see a healthcare professional as soon as they start experiencing signs and symptoms of HF. It is also crucial to increase professional expertise in HF. Professional societies can support healthcare workers to expand their knowledge of the correct identification of the signs and symptoms of HF, and the accurate use and interpretation of diagnostic tests, via training opportunities.

### **Develop** a formal strategy for HF with adequate funding

The inclusion of HF in the healthcare transformation plan Ma Santé 2022 was an important step in addressing the HF challenge. This must now be followed by a dedicated strategy with adequate funding for improvement of HF services. It is important to financially recognise HF care services provided in hospital and to fund specialist roles, such as nurses, to coordinate HF care. These can be the first steps in the creation of HF units with standardised protocols for acute

care and discharge, which will likely translate to better outcomes and overall reduced HF expenditure. Professional societies may have a role in the creation of HF-specific settings through the development of comprehensive guidance and quality indicators for accreditation.

### **Promote** multidisciplinary and integrated HF care though the development of an HF network and a comprehensive model of funding

The importance of integration of care in the management of HF is well documented; there is now a need for protocols that support collaboration. HF is often managed across care settings – in public hospitals and outpatient services and in private healthcare – but the value of collaboration may not have been fully understood yet. There is a need for incentives to promote communication between healthcare professionals and a clear pathway clarifying how this contact should take place. This can be achieved, for example, via the development of referral pathways or an HF network. Healthcare in France relies heavily on regional implementation, so it is crucial that national and regional decision-makers are involved in the development of these care structures. This will help ensure an appropriate response to the HF challenge, supporting equality in care across the country.

### **Invest** in tools to support communication across care settings, including an appropriate IT system

There is a clear need for a system that fosters greater communication and collaboration between healthcare professionals. An advanced IT system that links different care settings would promote fully informed decision-making, helping to improve outcomes and reduce the burden of HF. This could become the foundation for a national ongoing HF registry, which would help to characterise the HF challenge, assess the benefits of clinical practice and incentivise adherence to guideline recommendations.

### **Promote** collaboration with patient associations to ensure provision of self-care education and ongoing support

Self-care can undeniably improve HF outcomes and it should be consistently included in HF care. Clinicians have a heavy workload and often lack the time to focus on empowering patients and their families or carers to self-care. While the development of an HF specialist nursing workforce may help to fill this gap, close collaboration with patient organisations can also be an efficient model, as it allows clinicians to focus on clinical duties while leaving the general aspects of self-care education to patient organisations.

Focusing on these priority areas will likely offer a cost-effective opportunity to improve life for people with HF, reduce hospitalisations and mitigate future pressures.

This is an investment in a more resilient and prepared health system, not just for HF but for chronic diseases more generally.

The creation and maintenance of national strategies and plans in HF is likely to be vital to long-term success. There are many strengths and existing resources within the healthcare system on which to build. Lasting success will require effective central oversight of inequalities and unacceptable variations, as well as long-term collaboration and commitment from decision-makers, patient representatives, healthcare professionals and the private sector. Failure to pursue the actions recommended in this report will allow HF to continue to challenge the sustainability of the healthcare system in France.

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## The Heart Failure Policy Network

To find out more about the Heart Failure Policy Network and this work, go to **[www.hfpolicynetwork.org](http://www.hfpolicynetwork.org)**

If you have any comments or questions, please get in touch with the authors at **[info@hfpolicynetwork.org](mailto:info@hfpolicynetwork.org)**

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