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The economic regime of avoidance

Doctrine of a territorial predictive vigilance infrastructure under advanced chronicity

> A note for public decision-makers, hospital financial directors, regional health authorities, the compulsory health insurance fund (CNAM), and infrastructure-grade healthcare investors.

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Executive summary

The French healthcare system is no longer principally organized around the acute episode. It is organized around the chronic trajectory. This transition is not a marginal evolution: it constitutes the dominant budgetary transformation of contemporary medicine. Long-term conditions (ALD) now concentrate approximately 67% of compulsory health insurance expenditure for 17% of the population, and this proportion is progressing at constant behavior.

In this context, the cost of non-surveillance is no longer a diffuse externality. It becomes an identifiable economic envelope: between 510,000 and 742,000 potentially avoidable hospitalizations per year, approximately 4 million potentially avoidable emergency visits — that is, on hospitalizations alone, €2 to €3 billion annually, a conservative range, excluding medico-social downstream effects.

This note defends three linked propositions.

> **FIRST PROPOSITION**
>
> The principal lock on predictive prevention in France is no longer technological or clinical. It is institutional, accounting-related, and conventional. The system is technically capable of producing preventive value; it is structurally incapable of capturing, attributing, and financing it within the temporality of its effects.

> **SECOND PROPOSITION**
>
> A territorial predictive vigilance infrastructure should not be understood as an additional digital device. It constitutes an infrastructure of continuous medico-economic visibility production. Its primary function is not to predict; it is to render observable — and therefore financeable — what is today economically invisible: the value produced by longitudinal avoidance.

> **THIRD PROPOSITION**
>
> No systemic transformation is viable without an explicit operational vehicle. This note proposes a concrete mechanism articulating a ring-fenced ONDAM line, regional CPOM contractualization, an HAS-CEESP imputation doctrine adapted to longitudinality, a territorial return mechanism for captured savings, and a trajectory of progressive T2A reallocation across selected chronic disease lines.

The French problem is neither the absence of innovation, nor the absence of data, nor the absence of clinical doctrine. It is the absence of an observation regime that renders avoidance visible at the moment one must finance it.

1. The structural shift: from acute episode to chronic trajectory

Our healthcare system was designed for an event-based medicine. Its acts are discrete, its episodes short, its causalities localizable. Remuneration follows an occurrence logic: an act produced, an act paid. Activity-based pricing (T2A, *tarification à l'activité*) perfectly espoused the epidemiology that dominated its design.

This epidemiology is no longer ours.

Chronicity inverts, term by term, the economic properties of the acute episode. Its trajectories are longitudinal, not discrete; multifactorial, not causally localizable; partially irreversible, not spontaneously resolutive; punctuated by successive micro-decompensations rather than isolated events; economically cumulative, not additive. It is not the same medicine. It cannot be the same financing regime.

Yet the financing regime has not followed this transition.

The result is a structural misalignment: a medicine of trajectories financed as if it remained a medicine of events. The accounting consequence is massive. ALDs concentrate expenditure, but the system has no stable mechanism for financing what slows them down, delays them, or avoids them. It finances what manifests them: hospitalizations, emergency visits, corrective acts downstream of decompensations that could have been detected upstream.

> *The system does not refuse prevention. It systematically remunerates it at a loss.*

This dissymmetry is not a drift. It is the mechanical effect of a financing regime designed for another epidemiology. The cost is no longer the event — it is the absence of longitudinal visibility on what precedes it.

2. Operational definition: what a territorial predictive vigilance infrastructure is, and is not

The expression "territorial digital twin" has circulated through enough innovation notes to deserve a sober clarification. Without it, the concept oscillates between three defective readings: AI platform, regional data lake, generalized surveillance. None is accurate.

A territorial predictive vigilance infrastructure may be defined functionally, in the most stripped-down manner possible, as follows.

OPERATIONAL DEFINITION

> *An infrastructure of continuous comparison, at territorial scale, between observed health trajectories and simulated counterfactual trajectories, whose function is to produce simultaneously (i) a capacity for early clinical detection, (ii) a longitudinal medico-economic visibility, and (iii) a capacity for territorial budgetary arbitration.*

Three elements deserve to be underlined.

First, it is not a prediction infrastructure. It does not claim to announce what will happen; it compares what is happening to what could have happened under other intervention hypotheses. This posture difference is essential: it shifts the system's object from an oracular promise toward a measurement function.

Second, it is not an AI platform. AI is instrumental there, not constitutive. The infrastructure's value does not reside in the model — it resides in the longitudinal persistence of observation and in the comparison capacity it makes possible.

Third, it is not generalized surveillance. The infrastructure is territorial, not individual. Its purpose is population-level arbitration, not disciplinary follow-up. This distinction is not cosmetic: it conditions GDPR compliance, social acceptability, and the governance doctrine.

A compression formula sums up the posture.

> *A classical pipeline predicts then forgets. A vigilance infrastructure remembers and compares.*

What is at stake is therefore not the performance of a model, but the stability of an observation and comparison function. It is this stability, not algorithmic sophistication, that produces the new economic visibility.

3. The cost of non-surveillance: bounded orders of magnitude

Several converging sources allow us to establish, with a level of robustness sufficient for decision-making, the orders of magnitude that follow. None is novel; their interest is not in novelty but in convergence.

On potentially avoidable hospitalizations, estimates converge in a bracket between 510,000 and 742,000 annual stays depending on the definition adopted (DREES, IRDES, international work on Ambulatory Care Sensitive Conditions). On potentially avoidable emergency visits, the order of magnitude stands at around 4 million per year. On expenditure concentration, ALDs represent approximately 67% of compulsory health insurance expenditure for 17% of the population — a proportion in structural progression.

These figures do not demonstrate that a predictive infrastructure would mechanically suppress these volumes. They do not pretend to. They demonstrate something more modest, but more important for economic analysis: the existence of an envelope *structurally exposed* to longitudinal mitigation mechanisms.

The relevant question is therefore no longer whether a deposit exists. It is why the current system is incapable of durably capturing a significant fraction of it, and of financing the actors who produce that capture. It is this incapacity that constitutes the true object of this note.

4. The central pathology: dissociation between value creation and value capture

The French system structurally produces a dissociation between the actors who create preventive value and the actors who capture the associated savings.

This dissociation is the central pathology. It is not a side effect — it is the rational equilibrium produced by the current architecture of incentives.

Examined soberly, it states itself as follows. The operator who invests in surveillance, coordination, and longitudinal follow-up bears immediate costs — clinical time, organization, equipment, training, infrastructure — whose profitability does not return to them. The savings their practice produces appear on lines they do not control: hospital envelopes, downstream ALD expenditure, medical transport, rehospitalizations, sick leave, medico-social dependency. The economic beneficiary is not the economic producer.

In such an architecture, preventive under-investment is not a moral malfunction. It is an economically rational behavior.

> *An avoided trajectory is not financed. A trajectory that occurred is.*

It is this asymmetry, and it alone, that explains why decades of exhortation toward prevention have not produced a structural budgetary transformation. Prevention is not held back by lack of conviction among actors. It is held back by lack of a capture mechanism. As long as the value produced has no instrument of observation and redistribution, its production will remain an activity borne by the operators who assume its cost without perceiving its return.

The doctrinal consequence is sharp: no preventive reform will hold without first building the mechanism by which avoidance value becomes observable, attributable, and redistributable. Everything else — AI, platforms, dashboards, clinical doctrines — comes after.

5. Why current devices fail

Five structural locks articulate a coherent causal chain. None resolves itself independently of the others. Any proposal that attacks only one of them will fail to produce the targeted transformation.

5.1 Time misalignment between clinical and institutional horizons

Longitudinal preventive benefits appear over horizons of 5 to 15 years. ONDAM arbitrations are annual. Political mandates oscillate between 2 and 5 years. None of these temporalities covers the effect horizon of the device it is supposed to evaluate. Longitudinal prevention is therefore not penalized because it would be ineffective; it is penalized because its effect horizon exceeds the decisional horizon of the decision-makers in charge of financing it.

5.2 T2A as an intrinsically anti-preventive mechanism

Activity-based pricing remunerates the event. Effective prevention reduces the event. An establishment that performs well in prevention therefore reduces, all else equal, its own financing base. This is not an accidental flaw of the device: it is a structural property. As long as the dominant hospital remuneration mode rests on the production of occurrences, effective prevention there remains penalizing for the producer.

5.3 The trap of derogatory devices

The Article 51 experimentations and FIR (Regional Intervention Fund) financings have allowed local innovation. They do not allow systemic transformation. Why: limited temporality, absence of automatic transition into common law, weak multi-year visibility, incapacity to bear stable infrastructure at national scale, difficulty of long-term contractualization. Experimentation then paradoxically becomes a mechanism of confinement of transformation: it absorbs reformist energy without permitting its installation.

5.4 The circle of budgetary prudence

Authorities legitimately demand robust proof before perennial financing. But without stable financing, no scaled deployment. Without scaled deployment, no longitudinal cohort. Without longitudinal cohort, no proof conforming to evaluation standards. Without conforming proof, no stable financing. The system therefore demands proofs whose production it renders structurally difficult through its own architecture.

5.5 Fragmentation of arbitration authorities

The actors who could contractualize a territorial vigilance infrastructure — DGOS, DGS, CNAM, ARS, HAS-CEESP, local authorities — share no common doctrine of longitudinal economic arbitration. None is fully competent alone; none holds the multi-year imputation authority required. The decision is therefore not made. This is not an individual blockage — it is the absence of an institutional architecture of arbitration adapted to the object to be arbitrated.

6. International comparative reading

The diagnosis above may seem narrowly French. It is in fact structural: the healthcare systems that have better confronted advanced chronicity have done so by explicitly building a regime of observation and redistribution of avoidance value. Three instructive examples.

6.1 Medicare Advantage and risk-adjusted capitation (United States)

The Medicare Advantage program remunerates care organizations on a risk-adjusted capitation basis, which transforms the incentive architecture: revenue is no longer a function of occurrence, but a function of a population envelope whose avoidance of complications becomes a direct determinant of margin. The mechanism produces its own pathologies — over-coding of HCC scores, adverse selection, indicator gaming — but it has established, at large scale, an economic equivalence between prevention and profitability. It is this equivalence, and not clinical sophistication, that constitutes the transformative mechanism.

6.2 Accountable Care Organizations and shared savings (United States)

ACOs have explicitly introduced the shared-savings mechanism: an operator that reduces population expenditure below a benchmark captures a defined fraction of the savings produced. Here too the devices are imperfect — contested benchmark methodologies, uncertain causal attribution, regulatory instability — but they have materialized a principle: the economic return to the producer of prevention. This is the most directly transposable version, in principle, of the mechanism proposed in §7.

6.3 Integrated Care Systems and population health budgeting (United Kingdom, Netherlands)

The English Integrated Care Systems and several Dutch regions have shifted part of budgetary arbitrations toward a population logic: the envelope is allocated to a territory for a defined cohort, charging the integrated operator with arbitrating between curative care and preventive investment. The logic is less one of remuneration for avoidance than one of territorial accountability over the global envelope. It has

demonstrated, under certain governance conditions, a capacity to moderate the drift of chronic expenditure without degradation of health indicators.

These devices are not transposable as such. France is neither Medicare nor the NHS. But they establish an empirical point that is hard to circumvent.

> *The systems that have produced a substantial preventive transformation have done so by building an explicit mechanism of capture and redistribution, not by adding digital preventive tools.*

The French absence is not the absence of innovation. It is the absence of an economic vehicle for inscription.

7. Doctrine of the minimal operational vehicle

This section answers the principal objection that an institutional reader — a regional health agency CFO, a ministerial cabinet, a CNAM delegate — will necessarily formulate against a text that would describe only locks: describing the lock is not enough; one must still propose the landing mechanism. The proposal that follows is not the only one possible. It aims to show that a concrete mechanism exists, that it can be examined by the competent authorities, and that it does not require constitutional upheaval.

The minimal vehicle articulates five coherent elements.

7.1 A ring-fenced multi-year budgetary line

Inscription, in the ONDAM trajectory, of a line dedicated to the territorial predictive vigilance infrastructure, isolated from classical annual arbitrations over a 5- to 7-year window. Ring-fencing is not a fiscal exception; it is a condition of longitudinal observability. Without it, the infrastructure cannot produce the cohorts necessary for its own evaluation, and the critique of the budgetary prudence circle (§5.4) remains insoluble. The 5- to 7-year window is the minimum horizon at which longitudinal effects on chronic trajectories become statistically detectable.

7.2 Territorial contractualization through ARS and CPOM

The ARS contractualizes with a territorial operator — which may be a GHT (Hospital Territory Group), GCS (Healthcare Cooperation Group), GRADeS (Regional e-Health Support Group), a hospital-private practice consortium, or an ad hoc structure — over a duration aligned with the ring-fenced budgetary window. The contract sets the covered cohort, the perimeter of targeted chronic trajectories, the longitudinal indicators, the methodological protocol, and the economic return mechanism. The legal instrument exists: the CPOM (Multi-year Objectives and Means Contract), adapted to longitudinality requirements. No institutional creation is required — only conventional adaptation.

7.3 An HAS-CEESP imputation doctrine adapted to longitudinality

Current medico-economic evaluation, as practiced by CEESP, rests on standards designed for discrete health products — drugs, medical devices. It is poorly calibrated for longitudinal infrastructures, whose effects are distributed, multifactorial, and causally non-isolable in the sense of a randomized trial. An adapted evaluation doctrine must be examined — not to soften the proof requirement, but to calibrate it on the real object to be evaluated. This doctrine must in particular admit the informational value of comparisons between observed trajectories and simulated counterfactual trajectories (see §8) and inscribe the corresponding methodological requirements.

7.4 A territorial return mechanism for captured savings

A defined fraction of the demonstrated budgetary savings — on hospital envelopes, downstream ALD, medical transport, rehospitalizations — returns to the territorial operator in the form of conventional remuneration supplement. The precise ratio (for example 30 to 50%) is secondary; what matters is the closure of the economic loop between prevention producer and savings beneficiary. This mechanism is the functional analogue of ACO shared savings, adapted to French conventional grammar. Without this loop, §5.2 and §5.3 remain insoluble.

7.5 A trajectory of progressive T2A reallocation across selected chronic-disease lines

T2A has no vocation to be suppressed. It has the vocation to be progressively substituted, on the chronic trajectories where it produces its most counterproductive effects, by a mixed logic associating population-based remuneration and longitudinal quality-based remuneration. The trajectory may be slow — five to ten years — but it must be doctrinally explicit. Without this explicitness, prevention will remain structurally penalized, and any other measure will remain cosmetic.

> *Prevention is not reformed by adding tools. It is reformed by building the accounting regime that renders it visible.*

This minimal vehicle is not a utopia. It is the coherent composition of existing instruments: ONDAM line, CPOM, HAS-CEESP doctrine, hospital and private-practice conventions. It does not presuppose new political power: it presupposes a decision of articulation. That decision can be deferred. It cannot be simulated by an additional experimental device.

8. The methodological problem of causality

A predictive vigilance infrastructure rests, in order to produce its economic visibility, on the comparison between observed trajectories and simulated counterfactual trajectories. This mechanism has a known methodological vulnerability that must be addressed explicitly rather than dissimulated.

The objection states itself as follows: a simulated trajectory is never the real counterfactual. It is a model-dependent estimate of an unobserved state. It is subject to several identified biases: selection bias, population drift, causal confusion, behavioral endogeneity, model misspecification. A rigorous HAS evaluator or a demanding health economist will be right to formulate it.

The objection is valid. It does not disqualify the device. It circumscribes its legitimate domain of use. Three doctrinal clarifications are required.

8.1 The observed-simulated differential is not a causal proof

The differential between observed trajectory and simulated counterfactual trajectory does not constitute a causal measurement in the sense of a randomized controlled trial. It does not pretend to. A vigilance infrastructure is not a strict causal inference device; it is an instrument for reducing decisional uncertainty in an environment where classical trials are structurally ill-suited to the real dynamics of chronicity — multifactorial, longitudinal, subject to coordination effects that controlled trials struggle to isolate.

8.2 The differential's function is probabilistic and longitudinal

The differential produces a continuous signal that informs arbitration without replacing it. Its value is not in the certainty it provides; it is in the stability of the longitudinal observation it makes possible. A probabilistic signal continuously re-evaluated on a territorial cohort, under a stable methodological protocol, is a legitimate economic arbitration instrument. It does not substitute for causal proof where that proof is available and pertinent; it intervenes where that proof is not.

8.3 The methodology must be inscribed, not exempted

Self-immunization against bias does not occur through exhortation, but through protocol. This presupposes: pre-specification of cohorts, external validation on independent cohorts, third-party methodological audit, publication of gaps between model prediction and real observation, an arbitration doctrine in case of drift, and periodic revision of the reference model. These requirements must be inscribed in the adapted HAS-CEESP doctrine mentioned in §7.3 — not to relax the proof requirement, but to render it practicable on the considered object.

A vigilance infrastructure does not replace proof. It structures residual uncertainty so as to render it arbitrable.

It is this epistemic modesty that renders the proposition defensible. An infrastructure that claimed to provide causal certainty would be rightly disqualified. An infrastructure that produces continuous uncertainty reduction, under stable and audited protocol, is a legitimate economic instrument — and probably the only instrument compatible with the real dynamics of advanced chronicity.

9. The real political economy of the transformation

The proposition implies redistribution. This deserves to be said, rather than evaded.

Any infrastructure that renders avoidance visible renders, by construction, inefficiencies visible. Any redistribution that finances the producer of prevention modifies the flows currently financing the implicit beneficiaries of non-prevention. Any progressive transition from an occurrence logic to a population logic shifts budgetary power toward territorial operators and away from other actors. No reform of this nature is neutral. Let us examine soberly the actors concerned.

9.1 Hospital federations

A trajectory of progressive T2A reallocation across selected chronic-disease lines, however limited, modifies the revenue structure of certain establishments. Hospital federations — FHF, FHP, FEHAP, Unicancer — hold different positions according to their models, but none is neutral before a mechanism that reintroduces a population logic into financing. Conditionality of support will be real, and it will be negotiated. Anticipating that negotiation is a condition of viability, not a detail.

9.2 Medical unions and primary-care actors

Any territorial predictive vigilance infrastructure burdens, prima facie, primary-care actors with a new role of longitudinal coordination. This burden must be conventionally recognized, failing which the reform will be perceived — rightly — as an unremunerated transfer of complexity. Medical conventional negotiation must therefore be engaged in parallel, not downstream. An infrastructure whose primary-care clinical layer is not economically aligned is an infrastructure that does not deploy.

9.3 Curative-care industrial actors

Industrial actors whose economic model rests on the volume of acute events — certain medical devices, certain pharmaceutical lines downstream of ALD — have a structural interest in slowing a transition that would reduce their envelope. They will not oppose it frontally; they will argue methodologically, on the terrain of counterfactual causality (§8) and the robustness of savings measurements. That is their right. The response is not invective — it is the robustness of the evaluation protocol and the transparency of the imputation doctrine.

9.4 Regional Health Agencies and the National Health Insurance Fund

The ARS gains a territorial arbitration instrument it does not currently possess. The Health Insurance Fund gains longitudinal visibility on its own savings. But each will have to accept a partial dilution of its individual arbitration autonomy in favor of a common contractual vehicle. This dilution is structurally difficult in an administrative apparatus where autonomy is a political resource. The vehicle's governance must be designed to render this dilution acceptable — typically through explicit co-piloting, not through indistinct mutualization.

9.5 Territorial collectivities

Regions and certain metropolitan authorities have a direct interest in a territorial vigilance infrastructure, which falls within their competencies in territorial public health, autonomy, and cohesion. They may be, under certain configurations, the natural co-contractors of the vehicle described in §7. Their place in the device

must be made explicit, failing which the infrastructure will be perceived as a State deconcentration without territorial interest — which is, in practice, the most unfavorable scenario for its adoption.

The strategic consequence is sharp: the transformation described is not administratively neutral. It presupposes a real conventional negotiation, simultaneous on multiple fronts. To underestimate this is to reproduce the classical scenario of reforms intellectually excellent and practically unactionable. The French cemetery of brilliant unactioned notes is sufficiently populated to spare us, here, an additional cenotaph.

10. Private capturability: what a sustainable economic model looks like

This section addresses a question the previous version of the note did not treat explicitly, and which is central for healthcare infrastructure investors, candidate territorial operators, and long-term insurance actors: where does value capturability lie for a private actor?

The starting point must be frank. The value capturable by a private actor in this type of infrastructure is not principally technological. It is positional, contractual, and regulatory.

10.1 Value is not in the software

The software underlying a territorial vigilance infrastructure can, over the long term, be commoditized. The AI, simulation, and visualization bricks are not what makes the infrastructure defensible. A private actor who thinks they can sell software to ARS does not build a sustainable model; they build, at best, a precarious revenue line — and probably a compressible one as mature open source progresses on the constituent bricks.

10.2 Value is in the position of integrated operator

What is defensible is the position of territorial infrastructure operator holding: the longitudinal data, the stable methodological protocol, the multi-year contract with the ARS, and the recognized economic imputation doctrine. This position is costly to constitute; once constituted, it is costly to substitute. It is in this substitution cost, and not in technical performance, that the real economic moat resides.

10.3 The contract is the primary asset

The principal economic asset is not the platform. It is the long-duration contract with the public authority, backed by a recognized imputation doctrine. This contract constitutes a recurring revenue, indexed, with low churn risk, over windows of 5 to 10 years. For an infrastructure investor, this is precisely the nature of asset sought — close, in its profile, to regulated infrastructure concessions (water, energy, transport, territorial telecoms), and not to the SaaS software publisher whose risk profile is wholly different.

10.4 Conditions of model sustainability

Four cumulative conditions govern the economic sustainability of a private operator.

First condition: regulatory stability. The vehicle described in §7 is viable only if the multi-year ONDAM trajectory is held, and if the HAS-CEESP doctrine is adapted. Without these two conditions, private investment does not have the right risk profile.

Second condition: methodological portability. The operator must be able to transpose their protocol from one territory to another. Without this portability, the infrastructure remains a local project and never reaches the scale necessary to amortize its methodological fixed cost.

Third condition: a recognized imputation doctrine. The economic value produced by the infrastructure must be measurable according to a doctrine shared by the regulatory authority. Without this doctrine, the economic return mechanism (§7.4) remains discretionary — and therefore non-bankable.

Fourth condition: methodological barrier to entry. The operator must constitute a protocol, audit, and governance expertise sufficient that their position is not replicable by a new entrant at marginal cost. This barrier is one of institutional know-how, not solely technical.

The institutional sustainability of such an infrastructure also presupposes guarantees of reversibility, auditability, and jurisdictional control compatible with its status as critical public-health infrastructure.

10.5 The dominant risk

The dominant risk for an investor in this infrastructure class is not technological. It is politico-budgetary and conventional. Rupture of the ONDAM trajectory, revision of HAS doctrine, conventional renegotiation are the real risk factors. The appropriate risk analysis is not a technological risk analysis in the sense of classical venture capital; it is a regulated risk analysis in the sense of infrastructure concessions.

> *A territorial vigilance infrastructure is not a technological asset. It is a concession of economic observation, whose value is proportional to the stability of the conventional regime that renders it bankable.*

This characterization conditions the relevant investor profile. Regulated infrastructure funds, long-term insurance actors, public-private investment vehicles, and certain mission-driven mutualities are the natural counterparts. Classical venture capital, which seeks rapid scaling models with low regulatory dependency, is not — and confusing the two investor profiles is a frequent cause of strategic failure in this asset class.

11. Limits and conditions of validity of the proposition

A doctrinal note that claimed to have no limits would disqualify itself. The principal limits are as follows.

Limit 1 — Epidemiological domain of validity. The proposition is calibrated for advanced chronicity trajectories with strong avoidable components (metabolic syndrome, chronic heart failure, COPD, certain psychiatric pathologies, certain long oncological trajectories). It is not relevant for non-chronic acute medicine, nor for rare diseases with high unit cost. Any generalization outside this domain must be examined separately.

Limit 2 — Prerequisite technical conditions. The infrastructure presupposes a minimal degree of health-data interoperability, sufficient quality of longitudinal chaining (SNDS, DMP, registries), and territorialized computational capacity. None of these conditions is complete today. The proposition is viable only if a prerequisite infrastructural investment is consented, or explicitly programmed in the multi-year trajectory (§7.1).

Limit 3 — Risk of population drift. Any population-arbitration device carries a risk of adverse selection — operators incentivized to avoid patients with poor prognosis. The imputation doctrine must explicitly provide for risk adjustment, failing which the infrastructure will produce effects contrary to its objectives. The Medicare Advantage pathologies on this point are documented and must be anticipated upstream, not corrected downstream.

Limit 4 — Social acceptability and GDPR. The territorial — non-individual — nature of the device is a condition of acceptability. Any drift toward individualized disciplinary vigilance would be both illegal and strategically suicidal. Data governance must be inscribed in the contract from the outset, not deferred to a downstream ethics committee.

Limit 5 — Political temporality. The proposition presupposes a political will to support a 5- to 10-year trajectory, absent disruptive political events. This condition cannot be guaranteed by the proposition itself. It belongs to political choice, which the note can only document in its stakes.

Recognizing these limits does not weaken the doctrine — it renders it defensible. A proposition without limit is, by construction, a proposition without arbitration framework.

12. Conclusion

The cost of non-surveillance is not a future cost. It is a cost already paid — in avoidable hospitalizations, avoidable emergency visits, late decompensations, aggravated ALD trajectories, autonomy losses, longitudinal expenditures insufficiently amortized. This cost is merely accounted for elsewhere than where it could be avoided.

The French problem is no longer the absence of preventive innovation. It is the absence of an economic regime capable of observing this value, of attributing it, of redistributing it, and of financing it within a temporality compatible with its effects.

A territorial predictive vigilance infrastructure is not, primarily, a digital infrastructure. It is an infrastructure of economic visibility for chronicity. It is this visibility that is missing today — not for clinical actors, who experience it daily, but for the budgetary regime that should be able to seize it.

Building this regime presupposes neither constitutional rupture, nor new technology, nor unprecedented doctrine. It presupposes the coherent composition of existing instruments: ring-fenced ONDAM line, regional CPOM contractualization, adapted HAS-CEESP doctrine, territorial return mechanism, trajectory of progressive T2A reallocation. None of these instruments is new. It is their articulation that constitutes the suspended decision.

> *An economy that does not know how to measure its avoidances can only finance its occurrences.*

This phrase, by itself, states the contemporary lock of prevention under advanced chronicity. It will not be lifted by an additional device. It will be lifted — or maintained — by a decision of institutional architecture.

The real political question is no longer: *can effective prevention be done?* It is: *do we accept to finance what does not occur?*

As long as this question remains unanswered, chronicity will continue to erode the envelope of compulsory health insurance, and every excellently written report on this subject — this one included — will remain an intellectually satisfying note politically absorbed. This is the minimal lucidity to retain in delivering this text.

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