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Quality and cost-effectiveness in long-term care and dependency prevention

IN-DEPTH STUDY: FRANCE

French national integration pathways and local integration dynamics

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November 2019

European Commission

1 Introduction

1.1 Integration policies in France

In France, the necessity to develop coordination at various levels in the elderly care field has been a longstanding preoccupation of the state (Amyot, 2006; Henrard and Vedel, 2003; Bloch and Hénaut, 2014) and a response to the highly fragmented organization and funding of health, social and what are referred to as 'medico-social' interventions. Since the 1980s, various public policies regarding the elderly care sector have been introduced that can be seen as coordination and integration initiatives. These have targeted different levels and dimensions of integration and, to follow the classification identified by Valentijn et al. (2013), include institutional integration at the macro system level, organizational and professional integration at the meso level, and clinical integration at the micro (user) level. Among the most significant, we can point to the gerontological coordinators, the home nursing providers (SSIAD) and the gerontological health networks in the 1980s; or the multidisciplinary care teams (EMS), the local information and coordination centres (CLIC), the health networks, the mobile geriatric teams (EMG), the hospital at home programmes (HAD) or the intra-hospitals geriatric care services (*filières de soins gériatriques*) in the 1990s and the 2000s. They all concerned the meso-organizational and micro-users' levels and were related to either social or health care sectors; only occasionally did they link both sectors.[1]

In the 2000s, two laws reshaped the LTC sector institutional settings and governance at both national and regional levels by creating two new agencies: the national solidarity fund for autonomy (CNSA)[2] in charge of funding benefits for elderly *and disabled* people, of guaranteeing territorial equality and of providing information and expertise on both sectors; and the regional health agencies (ARS)[3] representative of central government and implementing national health policies at the local level. The regional health agencies' responsibilities were also extended to the social (medico-social) care sector though without removing traditional leading role of the *départements* (local administrative divisions) in financing and organizing both cash benefits and social care provision on their territories. The need for coordination between the different institutional and territorial levels dealing with different aspects of health and social care for elderly people was thus accentuated (Le Bihan and Sopadzhiyan, 2017a).

1.2 Recent developments: presentation of the measures included in the in-depth study

Attempts to better coordinate health and social care for the elderly have intensified since the beginning of the 2010s with the development of three different and independent schemes: the MAIA, the PAERPA and the PTA schemes:[4]

The MAIA scheme: method of action for the integration of health and social services in the field of autonomy.[5]

Created by the third national plan on Alzheimer's disease (2008–2012) and transcribed to common law through various pieces of legislation. It concerns professionals intervening with elderly people aged 60+ with complex health and social care situations. It has three main components or integration mechanisms: a consultation process at two interdependent – institutional and organizational – levels (*table stratégique and table tactique*); an integrated entry point (*guichet intégré*); and intensive case management for complex cases (*gestionnaire de cas*). Its functioning is insured by a MAIA pilot

[1] This is the case for the multidisciplinary care teams in the départements which were introduced as a part of a national reform creating a specific allowance for older people in a bid to offer them financial support in setting up an adapted care arrangement (Le Bihan and Martin, 2007).

[2] Law on solidarity and loss of autonomy of 2004.

[3] 'Hospital, Patients, Health Territories' Law of 2009.

[4] For a detailed description of the policies, see Appendix and the French national report and templates (Le Bihan and Sopadzhiyan, 2017b).

[5] *Méthode d'action pour l'intégration des services d'aide et de soins dans le champ de l'autonomie*.

recruited to foster integration dynamics across the scheme's territory, alongside between two and five case managers in charge of up to 40 complex cases each.

■ The PAERPA scheme: elderly people at risk of loss of autonomy.[6]

Created by the social security financing law of 2013, the PAERPA is a specific programme combining a range of tools in a prevention perspective targeting elderly people aged 75+. It has five interdependent objectives – preventing elderly people's loss of autonomy, better coordination of health and social care, secure hospital discharges, avoiding unplanned hospitalizations and better use of medicines. Locally, it is composed of a decision-making and evaluation body at the strategic or institutional level and a tactical or organizational body defining regional monitoring indicators and local needs. At the operational level, the scheme leans on coordination between front-line professionals (close clinical coordination, *coordination clinique de proximité, CCP*), and offers support to front-line professionals' coordination functions through a dedicated territorial platform (dedicated territorial coordination, *coordination territoriale d'appui, CTA*). It can be accessed by both professionals and elderly people. An earlier version of the programme was contained in article 70 of the social security financing law of 2012.

■ The PTA scheme: territorial support platforms for coordination[7].

Created by the health law on modernizing the health system of 2016 (Art. 74). This provides support to health, social and medico-social professionals for the coordination of *complex* health pathways in order to prevent avoidable hospitalizations and discontinuities in care. The aim is three-fold: mobilize available resources in a territory and support frontline professionals (GPs); identify existing solutions during admissions and discharges from hospital and prevent avoidable hospitalizations and discontinuities of care. The PTAs are not population-based and can intervene with all patients in complex situations, whatever their age. They represent the transcription into common law of PAERPA's dedicated territorial platforms (CTA).

All three schemes have been created at the national level and are designed to be implemented locally. On the one hand, they have **common objectives**: enhancing coordination between the regional health agencies and the local départements in charge of social care at institutional 'strategic' level; and between health and social care organizations and professionals at 'tactical' operational level. For these purposes, they create specific bodies, functions or professionals to support the social, medico-social and health professionals in their coordination tasks. On the other hand, they also **clearly differ** in terms of each scheme's target population, focus (whether on prevention, care or cure), or the degree to which they encompass the three intervention sectors concerned – i.e. health, social and medico-social sectors.

1.3 Why is it relevant?

The existing evaluation reports which analyse the different schemes separately – CNSA (2017) for MAIA and ANAP (2016) and DREES (Gand et al., 2017) for PAERPA – put the emphasis on their first positive impact in terms of continuity of health and social care interventions on the territories, as well as on their complementarity with other pre-existing and recently created schemes. They also underline the necessity not to superpose their interventions. A better understanding of the simultaneous implementation of all three schemes is needed, for several reasons.

First, when analysed together, the coordination schemes examined here may appear as clearly overlapping. Several more comprehensive national reports – Cour des comptes (2016), IGAS (2014) and also DREES (Gand et al., 2017) – stress the lack of coherence in terms of decision-making, institutional responsibilities, financing and implementation which

[6] *Personnes âgées en risque de perte d'autonomie*.

[7] *Plateformes territoriales d'appui*.

characterizes the schemes' functioning in silos. Locally, there is a lack of clarity on the way the schemes interact and function. The situation generates tensions – between national, regional and local administrations concerned as well as the health and social care organizations under their responsibility, and also between professionals involved – and is proving very costly. The overall cost of a range of schemes with common coordination objectives[8] was estimated at €898 million per year (IGAS, 2014). The actual amount is likely to be higher as there is a lack of centralized information and evaluation on the schemes' financing and as the PTA's cost was not included in the estimation.

Second, the necessity to go further in coordinating health and social care, including institutional and financial integration at the national level, is high on the political agenda. It was inscribed in both the national health strategy (2018-2022) and the strategy for transforming the health care system (2018). A national working group including representatives from all ministries and financing institutions has also been appointed. The search for **more coherence and convergence** of existing dedicated coordination and integration schemes at both national and local levels has therefore become prominent in the fight against the fragmentation of the health and social care systems and a main objective of national integration policies.

Finally, comparative research underlines that integration is more likely to happen when national policies exist (Leichsenring, 2004; Mur-Veeman, van Raak and Paulus, 2008), but also indicates that top-down national policies may represent both opportunities and constraints to the development of local integration dynamics, and can even be a considerable source of tension (Goodwin et al., 2014; Williams and Sullivan, 2009). The scope of integration policies is thus determined by the aptitude of local actors to cope with the changing landscape. From a public policy analysis perspective, the integration policies mentioned illustrate a specificity of the French configuration, where new integration schemes are often created without removing the existing ones (Le Bihan and Sopadzhiyan, 2017a). A concrete implication of this is that different generations of schemes coexist at the local level, thus creating institutional and organizational complexity which runs counter to the policies' aim of simplification. Building on international evidence and the state of the art, we make the assumption that concrete integration dynamics take place at the local level where the institutional, financial, organizational and professional fragmentations are made visible by frontline professionals' and users' experience. **The aim of the French in-depth study is to take a close look at the local implementation of all three above-mentioned schemes and to analyse the factors facilitating and impeding local integration processes. Similarly, the conditions required to break away from the overlapping of schemes and to enhance convergence and coherence at the local level will investigated**. We hypothesize that the coherence between the different integration schemes in a territory is shaped first and foremost by local actors.

1.4 Data and methods

This French in-depth study is based on review of available evidence including national and local official reports and research articles, as well as on qualitative semi-directive interviews performed in research programmes[9] conducted by the authors between 2015 and 2016 (n=30). Additional qualitative research on local integration dynamics was carried out in 2018 by a group of EHESP students as part of their academic curricula and directed by the authors (n= 12).

[8] Health networks, CLICs, MAIAs, PAERPA, the coordination mission of the health centres, or the different coordination payments to the health professionals or groups of professionals.

[9] The POLIA INLOVE project, funded by the Excellence Initiative Project for Investment in the Future (IDEX) of the University of Sorbonne Paris Cité (USPC) in 2013 and the DYANA Project funded by the Foundation for scientific cooperation (FCS) in 2015.

2 Local context

This in-depth study explores the local integration dynamics in a territory where all three schemes were implemented following different dynamics and timescales. While the territory chosen for the case study is not representative of the way these three schemes have been implemented locally, the study nevertheless shows how implementation of integration processes takes place in France.

2.1 Characteristics of the territory covered

The territory covered by the in-depth study is a part of a départements in the north-west of France and includes the capital city of both the département and the region. It corresponds to the territory covered by the PAERPA pilot and encompasses territories covered by the two other schemes. It is composed of three sub-territories – A, B and C – each presenting different characteristic (see details in Table 1). Territory A accounts for 80% of the population living in the pilot territory, whereas territories B and C have much lower density of population compared to the regional and national averages. The proportion of elderly people in local population in the territory is also lower than the regional and national averages and there are large disparities in their distribution within each of the sub-territories. The proportion is expected to grow over the coming years.

Health care coverage in the territory is uneven: primary care services are well distributed in territory A, whereas territories B and C are under covered (especially regarding GPs) and inversely, there is higher density of nurses in territories B and C and lower density in territory A compared to that of the département. In territories B and C, 32% to 38% of the area is more than 30 minutes drive from emergency care services, whereas territory A is well covered by specialized hospital care as the university hospital (and the corresponding

Table 1: Territory covered by the study – main characteristics

	Territory	Sub-Territories					
	PAERPA	A	B	C	Department	Region	France
Inhabitants	646 266	508 761	67 757	69 748	1 019 923	3 258 707	65 564 756
Area (km²)	3 141	1 385	840	916	6 775	27 208	643 801
Elderly people as proportion of total population (%)							
65–74 years	6.7	6.7	6.8	6.4	7.6	9.3	8.6
75–84 years	4.9	4.8	5.6	5.1	5.9	7.2	6.3
85+ years	2.2	2.1	2.6	2.1	2.6	3.2	2.8
Elderly people's (aged 75+) place of living (%)							
Home	51	52	49	48	50	49	52
Home (isolated)	36	36	35	38	37	39	39
Institution	12	12	16	14	12	12	10

intra-hospitals[10] geriatric care services) is situated in it. Social care service coverage is high across the whole territory compared to departmental and regional rates, especially residential nursing care as well as home nursing care equipment rates. However, 86% of home care services are concentrated on territory A, where there are also two providers offering both care and nursing care services (SPASAD).

2.2 Dedicated coordination/integration schemes

Since the 2000s, all three sub-territories studied have been progressively covered by coordination and information centres (CLICs). Locally, the CLICs work with the département's multidisciplinary care teams. Introduced in the mid-1990s, these representing the first level of case management for the assessment and follow-up of elderly people's care needs and situation.

The coverage of recent coordination schemes presents a rather different picture (see Table 2). In **territory A**, a MAIA scheme (referred to below as MAIA A) was created in 2012 by the four local information and coordination centres (CLICs) in the territory. **Territory B** is characterized by the diversity of available dedicated coordination schemes: one CLIC covers the entire territory and a small part of the territory is also covered by an implementation of article 70 of the Social security financial law from 2012 (hereafter article 70 as the scheme has no specific name).[11] In 2016, a MAIA was also created (hereafter MAIA B), but its governance and functioning is quite different from MAIA A. Unlike MAIA A, MAIA B was initiated by the département and it targets not only elderly people aged 60+ in complex health and social care situations, but also disabled people. Finally, there is only one CLIC in **territory C** which is also the most rural one. However, some coordination dynamics of behalf of outpatient professionals do exist in sub-territory C.

[10] Hospitals with geriatric services that are linked into a single geriatric care pathway covering the territory.

[11] It puts the emphasis on hospital discharges and readmissions and prefigured in a way the experimentation of the PAERPA scheme, created by the Social security law from the next year.

Table 2: Dedicated coordination schemes in the study territory

		Territory	Sub-Territories		
Chronology	Coordination scheme	PAERPA	A	B	C
Introduced at the national level in the 1990s–2000s	Department's multidisciplinary care teams	15	11	1	3
	CLIC	7 (5 entirely within scheme territory)	4	1	2
	Gerontological health networks	0	0	0	0
Introduced at the national level since 2010	Pilot Art. 70	1	0	1	0
	MAIA	2	1	1	0
	PAERPA	1	–	–	–
	PTA	–	1	1	–

After the PAERPA scheme was extended nation-wide in 2016 with the objective of implementing at least one scheme in each region[12], a decision to create a PAERPA scheme in all three territories A, B and C was taken. The territory delimitated for the local experimentation of the PAERPA scheme is thus also covered by the various coordination schemes described above.

Finally, the creation of the PTA scheme by the 2016 Health law and its implementation decree[13] also led to the introduction of two PTA schemes in territories A and B: the first initiated by a local health network on diabetes and the second by the team which had been leading the implementation of article 70 since 2013. In territory C, there is a project to create a territorial community of health professionals (CPTS) – another form of coordination initiative enhanced by the 2016 Health law and focusing on community-based collaborations between primary care frontline professionals.

3 Results: building coherence at the local level

The results of our in-depth study are summarised below: section A presents results from secondary analysis of literature, including local reports and internal documents and section B presents the main results from our empirical survey.

3.1 Institutional will to prevent organizational complexity

The territory studied here is located in a département with a strong intervention tradition in the elderly care sector. The necessity to bring together the various forms of coordination in the territory has been voiced since the late 1990s and resulted in a specific cooperation between the CLIC and the APA schemes. Unlike most 'level 3' CLICs, the CLICs within this département do not offer home visits as these are carried out by the APA multidisciplinary teams so as not to overlap their interventions. The same département was a pilot for both the CLIC and APA schemes before their wider roll-out in the 2000s.

With the creation of the regional health agencies in 2010, the local institutional context changed: the competences of these agencies included the medico-social sector traditionally governed by the département. A direct consequence is that the regional health agencies are involved in the implementation of national social policies at the local level, which implies an articulation with policy measures implemented by the département.

Further political and financial issues induced by the new local institutional picture (see Le Bihan and Sopadzhiyan, 2017b on that specific point), the département and the regional health agency seem to have reached an agreement to take into account local pre-existing coordination policies when implementing new dedicated coordination schemes. This is particularly visible in the way the implementation of the local PAERPA pilot was decided.

The involvement of the département in the governance of the PAERPA scheme

The national specifications for the PAERPA scheme specify that its governance is overseen by the regional health agencies which negotiate its implementation plan with different local actors – of which the département is one. Given its historical investment in local coordination policies in the elderly care field, the département was actively involved in the creation of the new PAERPA scheme. A letter of engagement was signed in 2016 between the regional health agency, the département, and the representatives of the main retirement funds and regional organizations of frontline professionals. The PAERPA pilot steering committee – which corresponds to the 'strategic' decision-making and evaluation component of the PAERPA scheme (see Appendix) – was installed in March 2017. The latter is chaired by the regional health agency and

[12] See national report (Le Bihan and Sopadzhiyan, 2017b).

[13] Décret n° 2016-919 du 4 juillet 2016 relatif aux fonctions d'appui aux professionnels pour la coordination des parcours de santé complexes.

co-chaired by the département, which goes beyond the requirements described in the national specifications. Finally, the published version of the local PAERPA project specifies the main institutional actors' will to implement it in coherence with all the pre-existing, recent or future dedicated coordination schemes in order to avoid their overlapping (ARS anonymised, 2017)[14]. This local institutional will is visible in the way the PAERPA pilot's territory was defined and in the way its specific components are articulated.

Defining the PAERPA pilot's territory

A major specific feature of the local PAERPA pilot studied here is its territory being composed of three sub-territories, each having different characteristics and dynamics.

The delimitation of the pilot's territory was subject to prior negotiations: the pilot's site was pre-selected by the national administration because of the ongoing implementation of article 70 within territory B, in a bid to extend the pilot to all its territory. Territory B on its own was too small for the purposes of the PAERPA pilot, so it was combined with territory A, which includes the administrative centre for both the département and the region. Finally, territory C was included in order to extend local integration dynamics to this rural area where there were previously few coordination schemes. Another rationale in play was to make the PAERPA pilot's territory correspond to the territory covered by the local intra-hospitals geriatric care services.

Articulating pre-existing and new dedicated coordination schemes

Taking into consideration the pre-existing coordination dynamics within each sub-territory has direct implications on the way the local operational – or 'tactical' (see Appendix) – components of the PAERPA pilot are intended to articulate with other pre-existing dedicated coordination components. For this purpose, three distinct operating committees were created within each sub-territory. The PAERPA operating committees A and B were articulated with MAIA's A and B 'tactical' operational meetings to avoid duplicating meetings with similar subjects. These do not have exactly the same functions as a direct consequence of MAIAs A and B having different initiators and target populations and mobilizing different health and social care providers. As far as territory C is concerned, a decision was taken to create a MAIA scheme in order to make the functioning of PAERPA operating committee C more similar to territories A and B.

Common local priorities

Finally, common local priorities for the PAERPA scheme encompassing all three territories were agreed on:

- Detection of risk factors for loss of autonomy and signs of fragility at home;
- Organization of hospital discharges to elderly people's living place (home or institution) / preventing re-hospitalizations,
- Social care and links between health and social care

All these elements bring us to underline the visible signs of the existence of joint work at the institutional level – in line with local coordination traditions in the elderly care field and national priorities to build coherence and convergence in order to prevent overlapping of schemes and policies. The next section explores the perceptions and concrete experience of local stakeholders – both institutions and organizations – of local integration processes brought about by the implementation of all three schemes.

3.2 The slow manufacturing of local integration dynamics

When asked about their concrete experience from the implementation of the three schemes studied here, both institutional and professional actors from the territory agree in saying that it has enhanced some integration dynamics (a). Those achievements

[14] The exact author name and title of the report are not revealed in order to preserve anonymity in the presentation of our results.

need to be put against the persistent difficulties accompanying the local integration process (b).

(a) Achievements: local reorganization

Previous research on the implementation of MAIA A in territory A (Le Bihan and Sopadzhiyan, 2017b) led us to acknowledge that local integration processes are shaped by opportunities and constraints represented by the implementation of both national (top-down) policies and pre-existing local integration initiatives. In this perspective, initial institutional, organizational or professional resistance to the import of the new policies and schemes and the concerns about their overlapping with pre-existing ones constituted a starting point to their local acceptance. Three factors appeared to be central to this process:

- **regular meetings between both institutional and professional actors** which helped to clarify their positions;[15]
- **flexibility** – and to a certain extent the ambiguity – of the way national schemes were meant to be implemented locally; and
- **time** necessary for local negotiations and restructuring to take place.

These previous results appear to be validated by evidence from the analysis of the implementation of three different coordination schemes on a larger territory. The empirical results from this study further point to several achievements due to the successive implementation of various coordination schemes: the regular meetings between local health and social care professionals which favoured local actors' better knowledge of one another and facilitated their involvement in further local integration dynamics.

[15] The département's positioning vis-à-vis the regional health agency regarding the national rollout of the MAIA scheme and the traditional professionals' positioning regarding new coordination professionals introduced by the MAIA scheme.

■ Better mutual knowledge

The first effect of the implementation of recent dedicated coordination schemes is local actors' better mutual knowledge. This is due to the fact that all three coordination schemes specifically created dedicated spaces for both institutional and organizational actors to meet. Two different levels co-exist: the strategic institutional and decision-making level with the MAIA's strategic meetings and PAERPA's strategic committee; and the organizational level, with the MAIA's tactical meetings and PAERPA's operating committees.

Stakeholders from both levels underline the benefits from these regular meetings:

Regional health agency: *'[Talking about PAERPA] Indicators are not enough to appreciate all the work done in all those meetings. We've been working hard, we created a base, it was long and unfortunately not very valued because there are no indicators for this… But it has to be taken into account because it's probably PAERPA's biggest achievement: to have managed to gather all the actors in the pilot territories, to make them cooperate. Every time, there are 30 people who get to know each other and build a relationship. Local integration is about this: we managed to get to know actors from all three fields on a circumscribed territory, including actors from the medico-social sector with the département. Without PAERPA they would probably never have met'.*

Département: *'It is early to talk about the impact. The good thing about it is that with all these schemes and meetings, people meet again and again, we know each other which, it is true, could make it easier to work together.'*

Regional palliative care organization: *'MAIA organizes meetings where different professionals go and explain their functioning. And then you know, OK, they work like this… it is important to get familiar with one another's functioning. Over the past five years, we've been doing a great job with all the other palliative care structures to develop palliative culture outside of the institutions. So, we invite ourselves to these meetings regularly. We knew about the prevention project for elderly people 75+ and PAERPA thanks to the MAIA. Each time I go to a PAERPA meeting, the MAIA and the PTA are also there. Everyone participates and everyone gets to know all these new schemes and to find their place in them.'*

PTA: *'The last time I went to the working group, there were also two social workers. This is a great contribution! The notion of pathway [central to both PAERPA and PTA schemes] is new and it is important as it contributes to create new links between the patients and the professionals'*

Facilitating future integration dynamics

Proactive integration policies at the national level and their implementation brings frequently change to the local context. This brings local stakeholders involved in coordination to position themselves in order to capitalize on their experience. Evidence from territory B is particularly significant in this sense:

Pathway coordinator, territory B: *'We are already used to working together. Our aim, our vision is to expand our action, the article 70, to all territory B and reach frontline professionals who are not involved in this dynamic. As the experimentation of the article 70 stops in December 2018, we thought that we could use PAERPA as a way to develop the culture of tracing care plans. So we negotiated to have it included in the PAERPA pilot. And after that, we will become a PTA. This was quite logical for us. With the difference that PTA will be a permanent scheme and not a pilot. Let's hope that all this will come together in 2019. Being within a PERPA pilot territory is a chance for us to have extra means to extend the dynamics from the article 70 to the entire territory B. This is our logic, it seems very logical.'*

This is also consistent with evidence from territory A and the reasons why the MAIA A was created in 2012 by the four local actors from the social care sector: the four local information and coordination centres (CLICs):

'We were aware that we were working in the same direction. And when we saw the national definition of the MAIAs, we thought that we were legitimate to initiate the scheme. The coordination part was already included in our work as CLICs, and the MAIA scheme was a way to take it further'.

This shows both the significance of pre-existing local dynamics for the implementation of new integration schemes and the fact that the financial support they offer can constitute an opportunity to develop pre-existing coordination activities by extending or formalizing them. At the institutional level, the regional health agency also underlines the existence of an integration dynamic within the territory, facilitated by the implementation of recent coordination schemes:

'Having worked on all these projects makes the territory more fertile to receive other coordination projects. […] Now that there is a PAERPA scheme in territory C, they also want to create a MAIA before this summer. I think that PAERPA facilitated this, as all the actors concerned already met.'

Improvement of mutual knowledge facilitating local integration processes is underlined in national qualitative evaluations and separately for each of the dedicated integration schemes investigated here. It could be seen as one of the major

achievements of the French strategies for enhancing integration at the local level.

Others: revealing new local needs and better coordination between services

One of the coordination stakeholders involved with the pilot of article 70 on territory B identifies another effect on their territory:

> *'It was difficult for us in the beginning. We did a lot on tracking of cases that were not known by home care services, elderly people who were living in their homes with cognitive impairments. As a result, the first year, we generated a lot of APA demands and the response was: we have much more work! This is a risk, it's true, but these people existed and no one had heard about them!'*

This is consistent with international evidence showing that different forms of integrated care may lead to an increase of the use of care settings (see Robertson, 2011 and CEQUA Thematic Report 5). Here, the dedicated coordination scheme enabled the identification of new home care needs which led to an increase in the APA demands. Early evidence from PAERPA's health impact also suggests that the formalization of a personalized health plan (PPS) allows the most frail elderly people with unmet health and social care needs in the territory to be identified (Or et al., 2018).

(b) Challenges: a convergence process paved with difficulties

Empirical evidence highlights the existence of institutional efforts to avoid overlapping when implementing the recent dedicated integration schemes, as well as some achievements visible on both institutional and operational levels. Nevertheless, interviews with local stakeholders also reveal **persistent resistance** and **unequal adherence** to those schemes.

All local actors are convinced by the idea that better coordination and integration between health and social care is needed, but not all of them are actively involved in dedicated coordination schemes. On the contrary, some actors are critical about the latter. Both categories of actors identify difficulties that challenge local integration processes, one of the most significant ones being the simultaneous implementation of various dedicated coordination schemes on the same territory.

> **Département:** *'Let me sum up. There have been plenty of coordination schemes – first the CLICs and the networks, then the MAIAs, the PAERPA, then the PTA … They first fall within the hands of the regional agencies, and then in ours … They are imposed on both of us and then we are asked to make them converge and not to multiply the meetings. But they all have the same components… We have to make them converge.'*

> **Regional palliative care organization:** *'All this is not very … visible. We have the impression of having superposed a number of schemes in the past four to five years. Every year, there is a new one! And the articulation between them remains … difficult'.*

> **MAIA B:** *'Four schemes in a year [in territory B] … Normally, they should be complementary. In theory, they are complementary. But I saw them yesterday at the meeting. Actors are all the same. And they all want to keep their positions…'*

> **Regional nurses' organization:** *'It is easy to get lost with all these schemes … And in the end, the question is: aren't they all the same? […] It is complicated for the GPs and specialists to have 50 different correspondents. To make it clear, the medical doctors do not know all these schemes!'*

A spontaneous response on behalf of local actors to the critics of the overlapping of schemes is to argue for their complementarity. Nevertheless, when

questioned about the objective of making their functioning more coherent in line with national priorities, two interdependent visions emerge out of their discourse. On the one hand is the idea of **complementarity** between local coordination schemes and health and social services which underpins the idea of better mutual knowledge:

Regional health agency: *'It is not the same target group and not the same work. MAIA applies to 5% of the elderly population and PAERPA 15-20%. Yes, there have been a lot of these schemes lately, but the components of PAERPA [CTA] are being created together with the PTA on Territory A. And the PTA will be larger than PAERPA's target group.'*

Département: *'It is much more than convergence. It is about working in complementarity and articulating our actions. Working in complementarity means being confident, it is much more than convergence. This is why it is important to know what the others do and what are their limits.'*

Care coordinator, territory B*: 'Convergence means everyone goes in the same direction. I think it is much more important to be complementary, to know exactly what the others do and what their missions are.'*

The related vision, on the other hand, is the concept of **rationalization**, which underpins the need to remove structures and schemes that do similar work:

ANAP: *'Convergence means simply identifying who makes what in a territory… It's not implying mergers between CLICs, networks, MAIAs….'*

MAIA A: *'The will to make the schemes converge puts much more pressure on us – MAIA pilots – to work even more with the other stakeholders in the territory and to try to make things work better … There are plenty of MAIAs that merge with the PTAs, that's it…'*

Given that mixed picture and the issues that arise from new policies on convergence, the following sub-sections identify **factors contributing to the persistent resistance and unequal adherence to all three dedicated coordination schemes**.

New differentiation processes

Analysis of our interviews shows that local actors do subscribe to the idea of integration but they also defend it from their own position. When questioning the reasons for this unequal support which seems more exclusive than inclusive, two elements of response emerge.

The first level of response refers to differentiation processes that occur locally when joining a new scheme. Given the plurality of schemes, local actors may be led to make strategic choices to invest in one scheme or another according to opportunities (and constraints) it represents for the actors themselves:

Regional nurses' organization: *'We want to be involved in all PTA projects in the region. Because PTA's aim is to support frontline professionals. We are involved in their construction, we represent the nurses and we make sure that the PTA objectives correspond to the territory's local needs. As far as MAIAs are concerned … after a consultation we made the choice not to invest the MAIAs. We can't be everywhere. We can't ask frontline professionals to be everywhere. The PTA is the priority because it makes the link with the medical doctors. MAIA remains very … nebulous …'*

These differentiation processes cannot be performed without having identified the aims and missions of each dedicated coordination scheme. In that sense, they contribute to the construction of local coherence and mutual knowledge.

MAIA B: *'PAERPA is for elderly people to stay healthy, MAIA – for elderly people with complex situations, the CLICs – information, advice, orientation…'*

These results underpin the conceptualization of integration as a boundary reshaping process (Gobet and Emilsson, 2013, p. 15) in which 'boundary work' performed by actors causes local actors to reposition themselves and to clarify their position. The process is closely linked to new economic and political stakes associated with the objective of rationalization of local resources. This constitutes a second level of understanding of the unequal adherence and persistent resistance to the successive implementation of dedicated coordination schemes:

Regional health agency: *'What you need to keep in mind is that all these schemes employ human resources. This is why it is difficult. The difficulty is how to make all these people live in the same house without dismissing people. When people say overlapping of schemes, they forget that behind this, these people are completely devoted to their work, they love what they do and they do it well. Convergence also has consequences. In a way, these people are afraid to lose their jobs when they see all these new schemes arrive'.*

Département: *'In the beginning, the coordination was the CLIC's affair. And they also did coordination at the individual level. This is why it is important to know exactly what everyone is doing. When the MAIAs arrived, the CLICs had to renounce to some of their competences … This is why we gave them other new competences.'*

The differentiation processes and boundary work thus engaged are a way for local actors to anticipate the potential effects of competition between them induced by rationalization and to reaffirm their legitimacy to cope with coordination issues in the elderly care field. This is all the more the case as these dedicated coordination schemes create and employ new professionals: typically the MAIA's pilots (Bertillot, 2018) and case managers (Campéon et al., 2017). As demonstrated in previous research, professional resistance encountered by new professionals on behalf of pre-existing ones was related to their shared professional interest in complex situations (Le Bihan and Sopadzhiyan, 2017a and 2017b). The arrival of new case managers specialized in complex cases called into question traditional professionals' legitimacy to cope with such cases, which are often also the most interesting and stimulating ones. This is also what stands behind the discourse of this care coordinator, involved in the pilot of article 70:

'We know each other well with the CLICs. But we will have to adjust things with them as they absolutely want to do coordination. Coordination of what? They don't have the competences of a health professional. I militate for coordination to be done only by health professionals'.

The notion of boundary is particularly useful for the analysis of professions where 'boundary work' designates demarcation and/or professionalization processes performed by social actors to delimitate their activities (Gieryn 1983, p. 791; Abbott, 1988, 1995, 2005). The same boundary work and the same stakes can be identified at the institutional level. With the creation of the regional health agencies, the départements were no longer the sole institutional actor competent in local elderly care and coordination policies. In this shifting local institutional context, maintaining a role in regional implementation of national coordination policies is an issue in itself:

Département: *'For us, there was one condition for all this to work: we had to really be part of it. And the regional health agency took it into account and understood that it had to be done in our way. Well, that we had to work together'.*

This département, which had traditionally strong and proactive elderly care and coordination policies, therefore took a strategic decision to go further in the differentiation processes by extending the MAIA method to the area of disabled care. This can be interpreted as a way to reaffirm its legitimacy as a key local institutional actor in the elderly care and coordination fields (Le Bihan and Sopadzhiyan, 2017b).

Dissonance between institutional actors and frontline professionals

The implementation of the new convergence objective in its double acceptance – complementarity and rationalization – and associated differentiation processes at both institutional and professional levels have as a direct consequence the re-politicizing of local institutional decision-making processes. The timescale of institutional decision making becomes distended, as complex negotiations on different aspects of the implementation process require time. As a result, the timescale needed for local institutional negotiations no longer corresponds to the timescale of local professional actors and their expectations for rapid solutions.

Département: *'Professionals want concrete solutions. And it's long.'*

PTA A: *'[talking about PAERPA] the regional health agency started working on it on April 2017 and there is still nothing concrete'.*

Care coordinator B: *'There are institutional obstacles. There is not a political will to say, OK, all professionals from the département will have a secured messaging system. I think this issue should be of the competence of the region. But they spend their time so as to please everyone … And this is something very concrete we need.'*

MAIA A: *It is complicated because depending on what you want to put in place you need institutional validations. The stakeholders on the territory want things to go quickly and it is not always possible … Do what I say and not what I do. They want us to change our ways of doing things and to work together, but sometimes the integration between the département and the regional health agency, it is really complicated. When you ask them to better coordinate their schemes, it is much more complicated!'*

Meanwhile, local actors are also very critical of the time allotted to the experimentations, perceived as too short. Whereas all actors underline the importance of the long run for transforming a system and for establishing its legitimacy, various local stakeholders highlight the difficulty they have to support experimentations which are limited in time and have an uncertain future.

Care coordinator B: *'So we find ourselves with a PAERPA pilot on territories A, B and C. They started thinking about it in May 2017 after having elaborated a roadmap which begins to be more or less clear now and with the experimentation ending in December 2018. How do you want to motivate local actors on something like this? You need to think, to change your practice, and it stops in six months and they needed a year just to define the roadmap! And we don't even know if it is going to be made permanent or not.'*

PTA A: *'You need 10 years for a system to be recognized, to develop. In 10 years' time, we are known and recognized. But now, there is a succession of schemes which only have the time to be experimental and then they are replaced by new schemes, how can you make them converge in that case?'*

This perception of implementation processes as at the same time too long-drawn out but also too brief has also been identified as an obstacle in PAERPA's first wave evaluation reports (Gand et al., 2017; Ministry of Solidarities and Health, 2018). Our study builds on this evidence by pointing to the dissonance of both priorities and temporality between institutional actors and frontline professionals. Nevertheless, delay in implementation has also been found to be a factor facilitating local actors' mobilization and the scheme's adaptation to local specificities and needs (Ministry of Solidarities and Health, 2018).

Remaining complexity and the risks it involves

Finally, the last element explaining unequal support and persistent resistance is the feeling expressed by local stakeholders that the system remains as complex as it was:

Regional nurses' organization: *When we went to the meeting for the PAERPA presentation, they [the regional health agency] were unable to tell us how the PAERPA and the MAIA and PAERPA and PTA were meant to articulated.*

Département: *[talking about PAERPA] This is something additional, which brings many positive elements, but it was implemented in a territory where there were already many other things. There are too many things implemented at the same time.*

MAIA B: *In territory B, everything was done at the same time. This implies a lot of professionals who dit not even have the time to understand what the MAIA was about and since then there have been three other schemes!*

In the face of these persistent difficulties, the disengagement of local actors (both medical doctors and residential care stakeholders) due to lack of time and interest was identified as a major risk in our interviews. In local dynamics strongly dependent on the engagement of local actors, the process of making sense of the integration project remains a major factor determining local integration outputs. All factors contributing to hindering this process carry the risk of local actors' disengagement and further challenge the effective integration of health and social care for the elderly.

4 Discussion

4.1 French pathways for producing health and social care integration in the elderly sector

The aim of the French in-depth study was to take a close look at the implementation of French integration policies by putting the emphasis on the local level.

Analysis shows that local integration processes do take place as a consequence of both pre-existent dynamics and implementing national policies. A major achievement in the territory studied here is the established cooperation between regional and local institutional actors, as well as other financing stakeholders, when implementing different coordination schemes. This cooperation was not obvious due to the traditional legitimacy of the département and its responsibility for local social care policies, and to the regional agencies' relatively recent creation and their responsibilities within the social (medico-social) sector. Nor is this cooperation perfect, as the two institutional actors intervene at different levels of governance, represent different

authorities and have different funding and interests. Nevertheless, evidence clearly shows their joint efforts avoid contributing to local complexity by implementing all three coordination schemes independently from one another.

However, results also point to the fact the French pathways of integrating health and social care in the elderly care sector are neither the shortest nor the simplest. Local institutional and professional stakeholders remain attached to the idea of complementarity in a bid to ameliorate their practices and prevent discontinuities in elderly people and their families' experience through the system. But they are also critical of the second inherent objective of rationalization supported by current convergence policies. The latter brings them to better define the scope of their actions in order to avoid duplication, which favours integration. But it also creates conditions for competition for capturing the rare available resources. This jeopardizes previous collaboration dynamics and the adherence to the idea of complementarity central to the objective of better mutual knowledge as a precondition for integration.

Finally, this in-depth study also shows the limits of transferring responsibility for making the system more coherent at the local level. Despite local actors' willingness to contribute to elderly people's more seamless experience from the system, their resistance and disengagement remains closely linked to the complexity inherent in implementing a number of different but very similar coordination schemes at the same time. The feeling of local stakeholders that they have to achieve objectives that are not met by national institutional actors is a recurrent motive for criticism. More coherent national policies are more than expected by local stakeholders. The evolution from the experimentation of article 70 to that of PAERPA and finally the transcription into law of the PTA as a permanent version of the CTA is in itself a way of building coherence at the national level. Nevertheless, this process of integration of health and social care remains quite nebulous for local stakeholders, who need clearer directives and concrete solutions.

Supporting the integration objective does not appear to be a problem in itself. Supporting a variety of coordination schemes at a time remains much more problematic. A long-term view on processes over time is necessary to confirm or modify these results.

4.2 Evaluation, health impact and cost-effectiveness

Policies based on the development of dedicated coordination schemes cost money, but their overall cost is difficult to estimate due to lack of centralized information and cost evaluation tradition. The cost of a range of schemes with common coordination objectives[16] was estimated in 2014 at a total of €898 million per year (IGAS, 2014).

The implementation of the PAERPA scheme could be a game changer in this regard. Under the supervision of the DREES and the Social Security Department, the implementation of PAERPA includes a three-fold continuous **evaluation** process:

- Process indicators monitoring: i.e. the number of trained professionals, of personalized health plans or of secured message systems deployed within the scheme's territory.
- Qualitative evaluation aiming at identifying the facilitating factors and difficulties affecting the implementation process at both national and territorial levels (Gand et al., 2017).
- Cost-effectiveness evaluation performed by IRDES, including health consumption indicators related to drug consumption and hospital admissions, and health impact indicators.

The evaluation's main hypothesis is that the redefinition of roles, tasks and practices of the different actors and organizations involved in the elderly person's health pathway would results in

[16] Health networks, CLICs, MAIAs, PAERPA, the coordination mission of the health centers, and the different coordination payments to the health professionals or groups of professionals.

improvements in the quality of life of both elderly people and their families, and better use of hospital resources and drugs. The **cost-effectiveness** of the scheme – both in terms of better quality and resource savings – is a main criterion for its generalization. In order to evaluate it, a control group for each territory was constituted. The main indicators used for the medico-economic evaluation are: cumulative duration of hospital stays, rehospitalizations at 30 days, unplanned hospitalizations, avoidable hospital stays, emergency department visits, continuous polymedication, and (at least one) inappropriate medical prescription.

To date, data from the cost-effectiveness evaluation performed by the IRDES puts the annual cost of the programme to €9 million in 2016, half of which (48%) is specifically dedicated to coordination actions (CTA, PPS, SI).[17] A medico-economic evaluation (Or et al. 2018) aims to establish effects on any of the outcome indicators when all the pilots are evaluated together: here analysis was performed over a short period (2014-2016) and the territory's characteristics and starting point situation (2013-2014) were not controlled. Nevertheless, it shows some tendencies at both overall and territorial levels.

At the overall level, the observations were of a decrease in continuous polymedication, inappropriate medical prescriptions and cumulative length of stay, and an increase in rehospitalizations over a period of 30 days, unplanned hospitalizations, avoidable hospitalizations and emergency department visits which were not followed by a hospitalization were observed. At territorial level, some significant effects related to the outcomes most sensitive to the primary care organization were registered within each of the territories studied and independently from one another: a significant decrease in polymedication in two territories (Aquitaine and Nord pas de Calais), significant effect on inappropriate medical prescriptions (Nord pas de Calais), favourable results regarding emergency department visits not followed by hospitalization (in Lorraine), significant reduction in non-programmed hospitalizations (Midi-Pyrénées and Bourgogne), significant effect on avoidable hospitalizations (Bourgogne) and no significant effect concerning cumulative length of stay and rehospitalizations in 30 days' time in any of the experimental territories.

Results on the impact of the use of personalized health plans (PPS) on hospital care use and the number of medicines taken by the elderly person suggest that the PPS is often formalized after a period of intensive use of the care system (both outpatient and inpatient care) by the elderly person. As such, the formalization of a PPS serves to identify the most fragile elderly people in the territory, whose care needs were not met, as the risk of hospitalization in the year following the formalization of the PPS is particularly high. Also, it results in an up to 6% reduction in the proportion of elderly people with polyprescriptions. These early results should be interpreted with caution as there may be a persistent bias effect between the experimental and control groups.[18] Data will continue to be collected as the period the current results are built on remains too short to be conclusive on organizational and system impact. Finally, no indicators are available for key dimensions such as quality of life for both elderly people and their relatives or access to health and social care.

The evaluation report concludes that the lack of impact of pilots on hospital utilization, in all territories, suggests that it would be legitimate to explore other levers of action for improving hospital

[17] The overall cost of the programme since its initiation (2014-2017) is estimated at €49 million, financed by the regional investment fund, and at €53 million when including territories from the second wave. To this amount should be added funding from other sources such as the CNSA for training in the home care sector, from the départements for prevention actions and funding from other central administration departments financing other coordination schemes on which PAERPA relies.

[18] Due to lack of information on the level of vulnerability (dependence) and social context in the medico-administrative database.

practices and coordination between hospital and primary care providers, and to evolve PAERPA (Or et al. 2018).

A list of publications known to the authors which present results from the cost-effectiveness evaluation performed by the IRDES can be found in Box 1.

Box 1: Main evaluation reports and publications on PAERPA's cost-effectiveness evaluation performed by the IRDES

Or Z, Bricard D, Le Guen N, Penneau A (IRDES), 2018. *Évaluation d'impact de l'expérimentation Parcours santé des aînés (Paerpa). Premiers résultats.* Les rapports de l'IRDES, 567, juin 2018.

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Appendix: details of the policies

	MAIA – Method of action for the integration of health and social services in the field of autonomy	PAERPA – Elderly people at risk of loss of autonomy	PTA
CHARACTERISTICS			
Target group	60+ Elderly people in complex health and social care situations	75+ Elderly people at risk of loss of autonomy	All ages Complex health and social care situations
Aims	Support the organization of health and social care: – harmonizing information and orientation practices of professionals involved ('integrated entry point') – structuring of shared bodies in order to enhance shared responsibilities at institutional and organizational levels – complex case management: intensive coordination and follow up of professional interventions	– Prevent loss of autonomy by identifying at an early stage risk factors leading to hospitalizations and/or early institutionalizations – Coordination of health, social and medico-social interventions: support to frontline professionals in their coordination functions, providing information, orientation to the adequate service – Secure hospital discharges and limiting unplanned (avoidable) hospitalizations or unnecessary emergency visits: improving coordination between hospital and primary care – Better use of medicines: reduce polymedication and drug-related iatrogenia	– Mobilize available resources in a territory and support frontline professionals (GPs) – Identify the existing solution during admissions and discharges from hospitals – Prevent avoidable hospitalizations and avoid discontinuities in care provided
Fields covered	Social, medico-social and health care sectors	Relies on professionals from the social medico-social and health care sectors	Relies on professionals from the social medico-social and health care sectors (emphasis on hospital and outpatient/primary care)
National governance	CNSA and department of social cohesion	Department of social security	Department of care provision
Regional/local governance:			
– project validation and supervising	ARS	ARS	ARS
– project initiator	Health and social care actors (both institutional actors and professionals) from the territory	Health and social care providers from the territory	Health actors from the territory (previous health networks)
Funding authority	CNSAFIR	ONDAMFIR	ONDAMFIR
Cost	Per year / per scheme: – €100,000: recruitment of the pilot and operating costs; – €60,000 per intensive case manager	€150,000 to €300,000 per year / CTA plus funding of the schemes on which PAERPA relies	FIR for project actionsplus funding of the schemes on which PTA relies

	MAIA - Method of action for the integration of health and social services in the field of autonomy	PAERPA – Elderly people at risk of loss of autonomy	PTA
DETAILS			
Who can enter the scheme?	– Health and social care professionals	– Users – Health and social care professionals (priority to frontline professionals and MG)	– Health and social care professionals (priority to frontline professionals and MG)
Components	– Consultation bodies at two interdependent levels: institutional strategic meetings and tactical organizational meeting (table tactique) – Integrated entry point (guichet intégré) – Intensive case management for complex cases (gestionnaire de cas)	Two local governance bodies: – 'strategic' decision-making and evaluation body institutional and funding stakeholders – 'tactical' body including all health, social and medico-social services in the territory and organized by the promoter of the local dedicated territorial coordination (coordination territoriale d'appui, CTA): Two operational components: – CTA: information for both professionals and elderly people and their relatives: orientation to appropriate health or social care facility – 'close clinical coordination' between front-line professionals (coordination clinique de proximité, CCP)	– Depending on resources available in the territory
Professionals involved	MAIA team composed of: – 1 MAIA pilot; and – several (2–3 to 5) complex case managers	– Multidisciplinary team	– Multidisciplinary team – Care pathway coordinators (coordinateur de parcours)
Types of services:			
– to users	– Complex case management	– Call service (in collaboration with the CLICs) – Information on available services	
– to professionals		– Dedicated phone number	– Dedicated phone number – Information on resources available in a territory – Support for health care professionals (especially GPs) for the organization of complex health pathways – Logistical and operational support for professional initiatives and practices improving coordination and care continuity

	MAIA - Method of action for the integration of health and social services in the field of autonomy	PAERPA – Elderly people at risk of loss of autonomy	PTA
Tools:			
– information/ orientation	Depending on each scheme: resource directory, professionals' intervention directory, benchmark for analysis, coordination and orientation forms, intensive case management inclusion criteria, IS	– Resources directory – Unique telephone number-Information platform – IS	– Dedicated phone number – Resources directory – IS
– information sharing	– Secure messaging system – Shared medical file (DMP)	– Secure messaging system – Shared medical file (DMP)	– Standardized information sheets – Secure messaging system – Shared medical file (DMP)
– elderly person's evaluation	– Multidimensional evaluation tool: InterRAI Home Care; with existing official common standard	– Local tools: personalized health plan	– Local tools – Coordination IS
– follow-up	– Individualized service plan	– Personalized health care plan jointly elaborated under the scrutiny of the GP	– Personalized health care plan – Individualized service plan
– scheme's evaluation tools	– MAIA's specific follow up tools	– ANAP: national trimestrial and annual indicators platform – IRDES/DREES: health economics evaluation	– PTA follow-up tools
IMPLEMENTATION			
Territorial coverage	Designed to cover all the territory. In December 2016 – 352 MAIAs covering 98% of national territory	At least one for each ARS regional territory 17 territories	Designed to cover all the territory by transforming the pre-existing health networks to PTA

Source: Authors' adaptation from French country report and templates and national administrations' documents