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Supporting Seniors at Home Through Integrated Health Care: Canada and France Compared

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Supporting Seniors at Home Through Integrated Health Care: Canada and France Compared

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Abstract

To meet the challenges of better care for the elderly at home, France and Canada encourage the development of integrated systems of care. We examine the role of regional health governance (meso level) to foster and regulate such innovations towards more integration. We study the comparative practices of regional agencies in Ontario (Champlain, Ottawa) and Provence-Alps-Cotes d'Azur (PACA) (Marseille and its surroundings). This comparison is of interest for several reasons: the different histories of these two regional bodies, their geographical area, and the organization of the various health stakeholders

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and public policies in each country or province. Finally, we observed differentiated practice in institutional contexts that are identical, that is, strengthening the public governance of the national/provincial systems at the regional level.

Analysis of regional governance practices allow us to expand the concept of integrated care, which turns out to be a complex interweaving between integration and coordination. This analysis also emphasizes the richness of the role of regional governments, especially on two points: the importance of legitimizing and duplicating innovations carried out by front-line workers, and the importance of enabling health regions to lead the changes.

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Introduction

Throughout the industrialized world, public policies are in place to promote better care for the elderly living at home. These policies encourage innovation to better integrate a wide range of professionals, and private and public organizations to improve quality of care. However, despite a growing number of countries developing integrated health care, many of the services available to seniors still exist in silos.

The vast majority of OECD countries have been reorganizing public health regional agencies (Williams and Sullivan, 2009). But while the literature is abundant on the concept and management of integrated systems of care, as well as governance systems in health, few studies have focused on integrated systems of care within regional settings.

In this paper we compare Ontario, Canada (Champlain / Ottawa) and PACA France (Provence-Alps-Cotes d'Azur/ Marseille) with respect to preferred practices in this regard. The goal is to better understand how two dissimilar regions, pursuing the same goals, develop practices determined to be beneficial for improving integration of care and services for the elderly at home.

To do this, first we examine the issues around governance, integration and innovation, as implemented in Ontario and France / PACA region. Then, we discuss the issues that underlay our study, and the methodology used. Based on some specific cases, we compare the practices that exist in both jurisdictions.

Background

The Concepts of Governance, Integration of Care and Innovation

For us, governance refers to new practices of *public policy planning and regulation* by public authorities and new *relationships* (between public authorities and stakeholders in health care), characterized by joint ventures and co-decision making in the development or implementation of collective goals (Enjolras, 2008). Governance then incorporates three elements that form what Enjolras (2008) calls a *system* of governance: stakeholders, regulations, and incentives as well as the interactions among the three.

The term governance is used to examine the methods of intervention of the State and its decentralized services, and relationships established with local authorities, the private sector, and public or para public organizations (Enjolras, 2008). *'The concept of governance [...] can then enable us to examine the process of collective problem solving, decision making and overall satisfaction of multiple stakeholders'* (Richez-Battesti and Gianfaldoni, 2005, p. 622). Public policy becomes polycentric and emphasizes multi-stakeholder collaboration that facilitates action at the regional level (Grenier and Philippe Guitton, 2010).

Combining these three aspects and their characteristics defines four types of governance systems (Enjolras, 2008):

- *Public governance,* where the State and its decentralized and outsourced services are responsible for the full implementation of public policies (production / resources construction, service delivery, etc.).
- *Corporatist-type governance,* where an 'umbrella organization representing organized interests' (Enjolras, 2008, p. 33) is entrusted by the public authority granting a monopoly on service delivery, which is controlled by non competitive regulatory mechanisms.
- *Competitive governance,* which enhances market mechanisms. Public authority allows providers and recipients of care to play the game of competition and freedom, while still guiding (to varying degrees) the processes of resource planning (identification, implementation, financing), pricing mechanisms or quality assurance.
- *Partnership governance,* resulting from a partnership between the public and an array of local stakeholders. Public authority no longer relies on coercive power, but on collaborative planning practices, regulation, incentives and coordination. The efficiency of this system is based on the emergence of new stakeholders (especially those representing population needs), their ability to intervene in the coproduction of public decisions, and their ability to build partnerships between them. The territory is very often associated with this governance regime, where multiple relationships are formed to best address population needs and to respond in a more collaborative fashion.

These governance systems suggest how regions implement their roles and mandates, and how integration of services delivered to patients and beneficiaries of public policies is related to better management of care. *Integrated care* then refers to the practices of cooperation between providers based on '*joint goals, shared or single management arrangements, joint commissioning, and joint arrangements for managing strategic and operational issues, and strategies for promoting integrated care*' (Williams and Sullivan, 2009, p.3). More specifically, the practices of coordination and integration, according to Grone and Garcia-Barbero (2002), encompass five areas: information flow, system vision, resource use, decision-making and nature of partnerships (Table 1).

Innovation refers to 'a new idea which can be either a recombination of old ideas, a schema that changes the existing order, a formula or a unique approach perceived as new by the individuals concerned '(Van de Ven, 1986). It aims to apply new knowledge, practices, devices or tools, and more generally forms of action. It is multidimensional in scope encompassing technology (knowledge, tools, devices), organization (collective modes of action), politics (mode of regulation and governance), and social issues (the concept of the individual within the society).

In health care, however, innovation is not just a product or service but rather a paradigm change, which significantly modifies the practices, values, and representations of all stakeholders. Chevalier (2005, p. 383) defines it as '*the development of new social practices, standing on the sidelines of*

representations and dominant behaviors, introducing elements of social evolution'. Innovation in health care challenges more or less profoundly the rules, frameworks or standards (Alter, 2000) in which the stakeholders normally function.

One issue regarding innovation is the ability of stakeholders (or the system) to develop themselves as agents of change, which leads to a discussion of health innovation with respect to public policies and institutions. This discussion is on the agenda of current governments, and we see more and more the emergence of a discourse and models for governance or partnership that is more collaborative and multi-levels based, while at the same time calling for a renewed relationship between the public sector and health care providers.

Regions of PACA (France) and Champlain/Ottawa (Ontario):
Different Regions, but Similar Issues Regarding Home Care for the Elderly

Canada (especially Ontario) and France (especially in the PACA region) are experiencing similar issues regarding the needs of their aging populations. Their elderly populations are growing, compounded by increasing retirement of the 'baby boomers' (soon to become 'pappy boomers') and increasing life expectancy at age 65. As well, the two regions are facing the same challenges with respect to the increasing proportion of the population with dementia (including Alzheimer's disease) (Table 2).

As for the care of older people, policies tend to focus on home care, reducing the number of patients waiting in acute and post-acute hospitals for alternate levels of care (ALC). When a patient is occupying a bed in a hospital and does not require the intensity of resources/services provided in this care setting (Acute, Complex Continuing Care, Mental Health or Rehabilitation), the patient must be designated Alternate Level of Care (ALC) at that time by the physician or her/his delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination (or when the patient's needs or condition changes and the designation of ALC no longer applies).

Another challenge is to provide multidisciplinary diagnoses and patient care paths, leading to the emergence of new stakeholders, called case managers or coordinators whose primary responsibility is to coordinate numerous and different professionals belonging to different institutions.

Research Questions and Methodology

Research Questions

The research sought to compare how two different regional governances cope with the variety of stakeholders (institutions, medical and social services, etc.) involved in the care of elderly at home, their overarching goal being to improve the integration of services.

Based on a qualitative, semi-inductive and comparative data collection and analysis approach, two research questions guided our research:

1. What are the roles of regional bodies that facilitate the integration of services for the care of the elderly at home?
2. What are the roles of regional bodies that foster innovative services for the care of the elderly at home?

Methodology

Data were collected from the stakeholders affiliated with a variety of institutions (Table 3). A select number of respondents were interviewed several times, especially to validate intermediate and final analyses of our data, with respect to changing patterns of regional governance in France during the period of our research (for example, URCAM and Agence Régionale de l'Hospitalisation [ARH]) were merged to form a single regional agency, the ARS). All interviews were recorded and transcribed.

These primary data were complemented by an extensive review of secondary data:

- In the PACA / Marseille region: the Loi Hôpital Patient Santé et Territoire (HPST legislation), the Schéma Régionale d'Organisation Sanitaire (SROS) I, II & III schemas for the PACA region (2006-2011), the departmental plans for the elderly by the General Council [CG] (2009-2013), charters and activity reports of the various gerontology networks and multi-purpose territories, as well asother administrative documents.
- In the Champlain / Ottawa region: annual reports of the LHINs, minutes of meetings of the Board of the LHIN, minutes of meetings of the GEM, various other reports as well as documents produced by different partners, such as the CCAC.

All of this material was coded to enable a comparison between the two regions and between the regions and the literature This analytical approach, based on the qualitative and semi-inductive research of Glaser and Strauss (1967), allowed us to develop a variety of codes around the three main domains of our theoretical framework (governance, integration and innovation).

Results and Discussion: Some Lessons from the Comparison of Regional Practices for Care of the Elderly at Home

The comparative analysis of our two sites shows how coordination and integration are intertwined. An understanding of what is observed and the movement desired by the regions led us to enrich the matrix developed by Grone and Garcia-Barbero (2002) (Table 4).

An initial enhancement shows that the policy areas of coordination and integration can intersect to form particular combinations of coordination / integration. Thus, according to the fields in question, the pilot programs/ projects are analyzed in a more integrative logic of coordination (see Table 4).

Integration practices are different in both regions studied, and consequently on how we can understand these differences, too. Historically, it

appears that *coordination* has prevailed in France, while *integration* has been emphasized in Ontario. Table 4 suggests that we should now qualify this historical observation. First we note that a move towards more integration begins very pragmatically, particularly by harmonizing data collection instruments for patient assessment. In all cases, protocols have been developed and the use of common tools (such as the Resident Assessment Instrument [RAI]) has been introduced.

Moreover, it is now over 15 years that greater coordination has been encouraged, supported and deployed in France, despite a compartmentalized and highly fragmented environment. Nonetheless, the stakeholders have adopted a certain capacity and ability to gather together and understand their respective interests and perspectives. This could help explain the fact that French projects have been able to develop more integration on a shared vision of the healthcare system (and improvements to it). In Ontario on the other hand, the providers themselves have addressed the response to fragmentation by grouping together to develop a horizontal or vertical internalization of various services (e.g., CCAC). There has been less emphasis on coordination practices. In France, however, fragmentation of the system has not, for example, allowed the four gerontology networks of Marseille to give greater strategic importance to the Steering Committee (whose presidency is rotating every six months), preparing the move towards integration (starting 2012).

In Ontario, while the emphasis is on shared responsibility with a goal of meeting the needs of a given population, the fact remains that the overarching objective is to coordinate resources within a more coherent view of the health system, even though the autonomy of service providers is maintained within this framework.

Regarding the use of resources we observe that in both regions, the decision-making process and the nature of partnerships are more based on coordination than on integration. And yet, within this environment, the MAIA project in France, which allows integration in the use of resources, is exemplary. Indeed, MAIA partners commit to provide human resources, to train them as members of a common team, and to use the same evaluation tools. Unique among projects conducted to date, the MAIA 13 was able to truly integrate the General Council in this framework.

A second observation is related to the goal of integration: patient assessment or services delivery following a care pathway. In Marseille (and France), the regional agencies encourage greater coordination both at assessment and delivery phases. But providers involved in the care phase remain independent and largely fragmented. Regional bodies can only try to encourage greater coordination among these providers by encouraging contracting and pooling. By contrast, in the Champlain region, the efforts of the regional body are mainly focused on integration / coordination of care providers, while there is more diversity of those involved in assessing needs of the elderly.

A third consideration is the level at which the movement towards greater integration and coordination takes place. In Ontario, the coordination practices were weak and those in place were not really well known to the LHIN. It is therefore more 'top down', i.e., its initiative to develop a comprehensive plan

(Aging at Home), and based on strategic and political levels of providers the regional authority has been given greater responsibility for integration. In France, by contrast, URCAM only had the ability to encourage local providers to set up coordination mechanisms. So instead, a 'bottom up' movement is observed, which relies primarily on the will of the stakeholders. This helps explain how the URCAM was able to identify 'only' eleven holders of gerontology networks (representing a very low coverage of the target population). Another consequence of this 'bottom up' movement is to note how, while common practices have been established through consultation, the four networks are struggling to formally assign a real political role to their Steering Committees.

A final observation relates to the identification of health providers who are concerned with the movements of coordination / integration. Both regional bodies have difficulty involving private medical practitioners. As well, due to their restricted level of responsibility related to integration, both regional authorities cannot effectively incorporate social services.

Regional Governance and Innovation Support Services for the Elderly at Home

If integration takes many faces, innovation does too. Innovation is increasingly encouraged and both regional bodies have been moving to legitimize their respective coordination / integration mechanisms.

Regional authorities have seen their discretionary power to support local innovations greatly reduced. If each has been allocated financial resources to carry out projects (e.g., Fonds d'Intervention pour la Qualité et la Coordination des Soins [FIQCS] in France or projects in Ontario), they can be either reduced or redirected to projects identified at the macro level. The recent contracting by Contrat Pluriannuel d'Objectifs et de Moyens (CPOM) that links the ARS to the Department of Health in France is an example of this evolution. Thus, the governance relationship that exists between the national and regional levels strongly influences the role of the LHIN and the ARS. We thus observe an emphasis on the public governance type of system. However, each tries to give room to manoeuvre to encourage innovation within existing plans or models at local levels, either at the margin or more profoundly.

Very recent information suggests that both the regional structure of the LHIN in Ontario and the ARS in France are developing a stronger interventionist role to achieve more rapid integration in the health system. in Ontario, the LHIN has gradually developed a 'way' to identify and promote good projects (based on three approaches):

- Selection, financing and evaluation of projects proposed by local stakeholders, when they are relevant and fall within the strategic guidelines set by the province.
- For health issues that the regional body has identified, it has encouraged stakeholders to come together voluntarily to identify innovative solutions.
- For health problems that the regional body considered as priorities, it would identify stakeholders with which it would work to develop innovative solutions. These health issues are either those identified by

the province (and for which it is accountable), or those it has itself identified as priorities (e.g., supervised housing for elderly).

In the PACA region, the ARS is now developing new tools to achieve more integration, which are different from the way the URCAM usually functioned. Because URCAM could only encourage (and not impose) this move toward integration, the result, locally, was a true ownership of the innovation and the development of new practices. However, it did result in some small duplication (which was observed in the willingness of other providers), as well as a lack of harmonization among these programs. This is indicative of the fact that innovative practices (even in health) still require a long period of maturation to develop ownership. There is some apprehension that encouraging innovation this way will not change in the current context, where the ARS acquires the stronger planning capacity of the ARH, and where in France there is an increasingly strong 'requirement to innovate' (Grenier and Philippe Guitton, 2010). Thus, for example, during the second wave of experimentation that the MAIA is currently putting in place, the ARS must adhere to a very tight schedule of implementation activities required by the Caisse Nationale de Solidarité pour l'Autonomie (CNSA).

Given the above observations, it seems important, then, that beyond processes of bottom-up or top-down, and incentives for innovation, regional governments must allow stakeholders the time and ability to really innovate and adapt. Analysis of the data indicated two roles that the regional agencies wish to play, namely legitimizing innovation and change leadership in the territory.

With respect to legitimizing innovation, in the Champlain region the LHIN was given the responsibility to select measures thought to be innovative. They were based on an accurate identification of partners to work with the logic of integration. However, even if stakeholders accept these measures as valid (resulting from the LHIN's process of negotiation), we note the difficulty to actually implement them at the clinical or operational level. In addition, if the GEM is equipped to assess seniors in the emergency room from a multidisciplinary perspective, this does not mean that they have the means to better target appropriate support services for these people. Hospitals do not have levers to co-opt general practitioners in private practice in the community, but they usually have on-site general practitioners. On the other hand, the CCAC seems well positioned to network with various paramedical resources (nursing, physiotherapy, occupational therapy, social workers, dietitians, psychologists, podiatrists, etc.), and community resources (housekeepers, transportation, meals-on-wheels, etc.), since it has the capacity from one location to access a range of multidisciplinary resources in order to weave together the necessary links. Again, however, it has no levers to involve community physicians (or specialists) in the assessment process or the treatment of patients.

In the PACA region (and France), when they were taken into account in the SROS III and with ARS developing an outpatient SROS IV, we note that different coordination mechanisms (which are institutional in nature) have developed over time Also, the measures that were studied gained acceptance by

the providers closest to the people supported. Nonetheless, in trying to strengthen that legitimacy, regional governance is facing a double challenge. First, the partners with whom they cooperate have no legal obligation to enter into an agreement with them, and it is especially difficult to attract General Practitioners (GPs) to participate in the multidisciplinary assessment of the elderly On the other hand, since the health care environment is being blurred by a wide variety of measures that vary in their mode of operation, with each claiming to have the legitimate task of coordination, implementation responds in a heterogeneous fashion. The ARS wants to encourage more pooling (or grouping) of the measures so they can have greater visibility and strengthen response capacity. The ARS is positioned to broaden its responsibilities over those of the URCAM.

With respect to regional change leadership, here also we observed different practices. The region is a major instrument of intervention in health. It can be a geographical, administrative, socio-economic, historical, or cultural form, in which public policies are explicitly implemented. Taken together, it is the ideal place to think about information, prevention, care and support of a population, using an approach known as the New Public Health (Kickbush, 2003). Change leadership *'increases the opportunities for innovation, encouraging participation, building capacity of local government and is responsible for the decision at the level where unexpected effects or are not controlled to a minimum'* (Duran and Thoenig, 1996, p. 596). This leadership function is clearly a responsibility of the LHIN and the ARS, but their method of putting it into practice seems difficult, especially since health care providers in Ontario have this function by legislation, while those in France have an obligation and a strong incentive to play this role.

Our data seem to suggest that leadership is based on content, the territorial level of exercise and the authority being exerted.

As for content, ensure that all providers know each other in the territory (which in fact is not the case), provide stakeholders with data on needs of the population in the territory to better plan resource allocation, and enable the emergence of new initiatives for more coordination / integration.

Regarding the other two dimensions, approaches differ mainly in view of the size of the region. The LHIN covers an area of approximately 1.2 million people, while and the ARS covers about 4.9 million. The LHIN is roughly equivalent to Marseille and its surroundings (which may include e.g., Allauch - Plan Cuques Townships). In this context, the LHIN seems fully invested in this leadership function, particularly through various structures and mechanisms, three of which are prescribed by law: a consultation for health professionals, Aboriginal communities, and planning for French-language services. Gradually the LHIN is seeking a more detailed knowledge of the population and its needs, and the actual activities of the providers to develop more fully its leadership function. In France, the law HPST of 2009 clearly states the direction of territorial development and regulation of the health care system (whereas the previous guidelines add value to the care pathways). The territory is no longer just a way to allocate resources (e.g., SROS rationale.). But the organization of this leadership function is not yet clearly determined: either the ARS delegates this responsibility to regional offices that comprise the territory and therefore is

modeled on those of the departments, or it delegates, by mandate, to providers such as local health systems and hospitals, which are natural stakeholders. However, in both cases, the regional authorities are developing tools to enable them to assume greater leadership and to favor emergence of 'entrepreneurs' who would enhance this process of integration more rapidly (but in line with the policy orientations of the regional authorities).

Conclusion

In the context of developing integrated systems of care for the elderly at home, we studied the role of regional governance in encouraging integration and innovation that to go beyond traditional health systems. We examined the practices of two regional governments, one in Ontario (Champlain) and the other in the PACA region (France), particularly in and around Marseille.

This comparison is interesting because of the different histories of these two regional bodies and the geographical areas in which they function. It is also of interest because of the organization of the various health providers and public policies in each country or province. Finally, we observed differentiated practices in institutional contexts of decentralizing public governance from the national to regional levels.

A major observation is that while health care systems are presented as a complex mix of autonomy, coordination and integration, our analysis shows that innovative measures used to provide care to the elderly at home is an intricate interweaving of integration and coordination. On the one hand, it seems that integration at the clinical and operational level is more difficult to achieve than decisions at the strategic and organizational level. Whatever the constraints that can influence the regional agencies in the way they regulate and plan, it seems essential that they be given 'time' to develop new methods and to implement them. This requires, in addition to specific evaluation mechanisms, being able to frame a comprehensive plan and to allocate resources to support stakeholders.

Finally, another important observation is the enhancement of the regional governance function. Usually characterized by its functions of planning, regulation, collective decision-making (and encouraging innovation), our analysis shows how it could be enhanced through stronger leadership in the regions. More specifically, it would be beneficial to identify needs more explicitly and where greater integration can be achieved. And we saw how the question of authority to exercise this leadership function depends largely on the geographic area covered by the regional agencies. In terms of size, the two regions studied are very different. Each has its advantages and limitations. But at a time when all countries are seeking to improve the functioning of health systems, and having embarked on similar movements towards greater governance partnerships and towards greater integration of services, it may be crystallization of regional governance that could be a new avenue of understanding and action.

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Table 1. *Concepts of Coordination and Integration According to Grone and Garcia-Barbero (2002)*

	Coordination	**Integration**
Information Flow	Actively circulating among groups of different partners	Directs partners to work to meet agreed-upon goals
System Vision	Based on a shared commitment to improve overall system performance	A common benchmark, allowing each partner to feel more socially responsible
Use of Resources	Often, to ensure complementary and mutually reinforcement	Used as a common framework for planning, organizing and evaluating
Decision-making	Consultative process in decision making	Partners delegate some authority to a single decision-making mode
Nature of partnership	Cooperation projects *(cooperative ventures)* are available for projects of limited duration	Mission statements and / or legislation support an institutionalized partnership.

Table 2. *Comparative Demographics*

Population	PACA region	Marseille	Ontario	Champlain
Total	4.9 million	808,700	13,210,700	1,200,000
65+	876,600 (11.1% of the population in 2010)	151,000 (18% of the population in 2010)	1,833,900 (13.9% of the population in 2010)	162,000 (13.5% of population)
With dementia	Approximately 72,000 over 75 years in 2005	Not available	Not available	16,000 elderly

Table 3. *Sources of Primary Data Collection*

PACA / Marseille		Ontario / Champlain	
URCAM (*)	. X: Project Manager for the provision of care, URCAM and now Project Manager at the Directorate of Strategy / Observatory and Department Studies, ARS *(4 interviews)* . Y: Project Manager for the provision of care, URCAM and now Special Assistant for Patient Management, Provision of care, autonomy, medical and social services *(4 interviews)*	*Champlain LHIN*	. X: Project Officer, Department of Planning, Integration and Community Engagement *(4 interviews)* . Y: Consultant, Department of Planning, Integration and Community Engagement *(2 interviews)* . Z: Senior Planner *(2 interviews)*
DRASS (*)	. X: Project Manager, Social Affairs *(1 interview)*		
Gerontology Network	. A: CGD East Health Network *(2 interviews)* . B, Centre Health Network *(1 interview)* . C and D: Medical Coordinators, Centre Health Network *(3 interviews)* . E and F: South Health Network *(2 interviews)*	*GEM (Geriatric Emergency Management)*	. X: Program Manager, Ottawa Hospital *(3 interviews)*
MAIA	. X: Coordinator *(1 interview)*	*Aging in Place (Champlain CCAC)*	. X: Director, Client Services *(2 interviews)*