Health systems and long-term care for older people in Europe
Modelling the interfaces and links between
prevention, rehabilitation, quality of services and informal care

Quality Assurance and Quality Development in LTC

National Report France

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1 Introduction and background

This report focuses on quality management of long-term care (LTC) in France. We therefore report on how quality policy is organised, monitored, utilised and regulated and try to give results about its impact on service delivery.

The way quality is managed in the LTC system depends not only on specific concepts and methods regarding quality but also on the very content of care and its link with cure which constitutes the major dimension of the structure of LTC and how it connects with the health system and society at large.

This is why we begin this report by giving a short description of how the French LTC system is organised; how services are funded and delivered, focusing on the characteristics most relevant for quality assessment. In this regard, it is important to acknowledge that, despite recent efforts, the provision of LTC services has remained fragmented with structural barriers between the heath and social sectors still strong despite measures aiming at reducing related gaps. This separation raises also the issue of the pertinence of quality criteria applied to care services with health and social components.

Quality regulation is, slowly moving from an approach based on minimum quality standards set at the national level (quality assurance) to a more outcome-based assessment emphasizing quality management with more responsibility given to local levels.

We present below the current “state of the art” in the field of quality measurement and regulation while trying to give some insight about the potential future. However, we would like to note that some elements may be missing or the evolution may be anticipated wrongly as some of the existing quality measures are being changed or abandoned while others are still in an experimental stage.

A first version of this report was provided in September 2009 as an input to the INTERLINKS European Overview Paper on quality assurance and quality management (Nies et al, 2010). This version was updated in Spring 2011 to include latest developments in France.

1.1 Historical background

In France, LTC policies are characterize by three historical legacies.

First, even if they are in constant interplay when dealing with the issues of curing and caring older and/or disabled people, LTC (called “*médico social*“) and the health system have been separately regulated and funded. So it is important to sketch first how the health care system is organised and regulated. For a long time, the French health care system has been mainly structured around acute public hospitals with a relatively strong system of central state planning and command regulation. However the last 15 years have shown a constant trend to shift responsibilities in planning, organising and regulating to different levels of local authorities (regions, departments, municipalities). A new step was undertaken in April 2010 with the HPST law that replaced the regional hospital agency (ARH) by regional health agencies (LOI HPST, 2010) with responsibilities encompassing both sectors (see below). Another important divide in the health sector stems from the fact that the primary care sector is regulated separately from the hospital sector, mainly by the National Health Insurance Agency (NHIA). Even if, over the past ten years, the central state has tended to exert a growing control, coordination between primary care, secondary and tertiary hospital sectors still remains weak despite efforts to increase networking (Igas).

The second specific characteristic of LTC in France is the age barrier dividing the population with disabilities into two groups: the first consisting of persons with disabilities below the age of 60 (called "handicapped") and the second consisting of older people with care needs over 60 (and called "dependant"), with specific policies for each group. For a long time, policy actions targeting the 'dependent' older population (over 60) remained rudimentary. In fact, these people used to be easily placed either in acute hospitals, more frequently in poorly staffed LTC institutions, owing to a chronic lack of specific funding but also due to the dominant medical approach to disability linking it to the existence of chronic conditions. Therefore, although measures aiming at keeping older people in their usual home environment has been on the social policy agendas for more than 50 years (Rapport Laroque, 1962), a chronic lack of specific funding implied that care at home was and is mainly provided by informal carers. Until the beginning of the past decade there was no specific policy for targeting LTC globally or specifically home care. The only exceptions were the development of the "housekeeping helper" in 1981 and the set up in 1983 of "geriatric coordination" which were networks set up at departmental level in order to connect the primary and the secondary health care sectors.

Only in 2002 (after a five year experiment) a dramatic change occurred with the legislation (JORF, 2001) of the attendance allowance scheme (APA) and its ensuing implementation. This move was followed by a series of laws, passed in a five year period, and marking a renewed interest in policies specifically aiming at the LTC system as a whole, with a strong focus on home care, while at the same time reinforcing the level of staffing and management of care homes, and enhancing the professionalisation of social carers. The 2 January 2002 law (JORF, 2002) reshaped the way all LTC providers of services were to be authorized, managed and staffed specifically regarding quality assurance. The 13 August 2004 law for "local liberty" (JORF, 2004: 1) gave major responsibilities to the "general councils", (executive body of the local political level named "départements") to plan, organise and regulate policies related to residential and home care in relationship with the state division of social affairs either at regional (DRASS) or at departmental (DDASS) levels. This "process of devolution" has led to a blurred separation between the different political levels involved and their executive bodies as well as a complex mix of funding mechanisms. For even if the general council is supposed to take the leadership in planning and regulating the LTC system through the "departmental gerontology plan", its real capacity is frequently challenged, as other plans also exist at regional (PRIAC, CROSMS) and national state administration levels (DGAS, DGOS) concerning health care agencies, hospital at home and specific residential homes.

The 30 June 2004 (JORF, 2004: 2) law called for a national day of solidarity: All social contributions from employed work and from some other types of revenues generated that day were to be collected to fund extra measures for disabled or handicapped persons. The same law called for the creation of a specific independent agency called CNSA (National Fund for Autonomy and Solidarity)[1] that would act as the "coordinating body" of all policies targeting the disabled population at national level. In this regard the law for 'the equality of rights and opportunities, participation and citizenship of disabled persons', voted on 11 February 2005 (JORF, 2005), marked a turning point since it stressed the necessity to reconcile separate policies on disability issues (with the expectation that the more favourable legislation for the handicapped would trigger advantages for older people with care needs. A specific LTC insurance

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[1] http://www.cnsa.fr/

scheme (called “fifth risk”) which would cover all disabled person and would not depend on age was set as a political priority. The Gissereau report (Gissereau, 2007) gave some financial projection relating to this new “social risk. Following this law, the CNSA was put in place in 2005 and, two years later, an independent agency called ANESM (National Agency for Assessing LTC Organisations)[2] was launched in order to boost good practice recommendations for LTC professionals and for all types of care providers.

These laws were completed by two LTC plans. The first one (called ‘plan for ageing and solidarity with the elderly’) was drafted in November 2003 shortly after the “heat wave scandal” of August 2003. It was followed by a second one (Plan solidarité grand âge 2006) based on a report entitled “Building the free choice scenario for older disabled people” (CAS, 2006). Regarding informal care we shall also mention, the “Family conference” of June 2006 that aimed at facilitating intergenerational solidarity. It stressed the crucial role of families and (to a lesser extent) the support measures they needed, especially the ones caring for Alzheimer’s patients which were formally accounted through the third Alzheimer plan.[3] All these laws tackled the problem of LTC globally called also for a better quality of services mainly through a reinforcement of quality Assurance methods and the reinforcement of the professionalization of all LTC providers. Rhetorically at least, they stressed the crucial role of the families and (to a lesser extent) the support they needed and more collective funding was supposed to follow.

But this evolution should also be placed in the broader context of French employment policies which, from the Seguin law of 1987 until the first “Borloo law” of July 2005 (JORF, 2005: 2), aimed at developing the “services sector” with a focus on services of all types of personal services delivered at home. The creation of a specific governmental agency (ANSP)[4] stressed this orientation with of the older population at large being conceived as a specific target group.

However, LTC regulation also relied increasingly on market mechanisms to improve the efficiency of services through competition between, on one side, the traditional public and private non-profit agencies and, on the other side, commercial newcomers since 1996. In this regard, fiscal incentives to buy domestic care services were developed for and directed to not only provider organisations but also to older people considered as potential individual employers. As these fiscal incentives were not specifically targeting the frail older people and their needs – they could also be used also for leisure services – one can say that, as a third historical characteristic, ageing and LTC policies in France have always been embedded in global employment policies.

1.2 Funding and reimbursing for health and social care

Funding **for health care** comes mainly from social contributions resulting from “employed work” but also from a portion of general social contributions (CSG) that are more “revenue based” and can thus be considered as similar to a tax.

Services delivered by acute and intermediate care hospitals are reimbursed by the national health insurance agency as are nursing care delivered home either by home nursing care agencies (SSIAD) and/or self employed nurses and “Hospital at home” targeting complex chronically ill and/or disabled

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[2] http://www.anesm.sante.gouv.fr/

[3] http://www.plan-alzheimer.gouv.fr/

[4] http://www.servicesalapersonne.gouv.fr/ANSP.cml

older people. The public average reimbursement rate amounts to 74.5% of total costs (HCAM, 2009).[5] There is also a competing market of private for-profit and non-profit health insurers that are contracted voluntarily or mandatory through employers and complement reimbursements coming from the public health agency. Patients with an income below a defined threshold (650€/month) get access to health care through a specific publicly funded two stage scheme (called CMU and CMU-C) with the latter being a free coverage of complementary health costs. Overall this system leads to an average out-of-pocket spending of 9% (2009). Considering the users' viewpoint, health care is free at the point of delivery although a rising share (6%) of the population is not eligible to free access to surgery and ambulatory specialist care, and thus incurs a high level of out-of-pocket expenses that amounted to €2.6 billion in 2010 (HCAM, 2011)

For "social care services" public funding is mixed, involving contributions coming from central government (5% through fiscal exemptions) and from a portion of the CNSA budget (15%), with the main contributors being the National Health Insurance Agency (CNAM: 62%) and the general council (22%) through local taxes. All sources are gathered by the CNSA in order to be redistributed to the executive local level (General Council). In 2010, CNSA's overall budget (CNSA, 2010) amounted €19 billion covering some health and all social related services, while the overall LTC budget (with all other health services) was estimated at €24 million (1.3% of GDP compared to 10.5% for the health care budget).[6]

Access to services

The attendance allowance scheme for older people over 60 called APA can be claimed by any person who meets the age threshold and the criteria of the needs assessment measured by a national assessment tool called "the AGGIR grid". Claimants are classified according to their level of care needs into 6 different groups (GIR groups) with only persons belonging to group 1 to 4 (higher levels) to benefit from APA. A special commission of the general council fixes its amount according to the assessment with a maximum amount for each group. APA does not only fund care services but also some technical devices as well as a small portion of housing adaptation.

A co-payment applies to all beneficiaries unless their revenue is below the minimum pension level – it reaches from 10% to 90% of the granted amount. The care plan is designed according to the assessment but services are granted based on the older person's environment which encompasses housing conditions and the availability of potential informal carers. I many cases (28% in average) the care plan does therefore not cover all real needs, but social welfare allowances at national or local levels can partially compensate for persons with low revenue (means tested).

People with disabilities may, even when they reach the age of 60, keep their more generous specific attendance allowance scheme (called PCH) until they are 75, if they were entitled to it before 60. The PCH is based on a different assessment tool called GEVA and results, for a comparable level of disability, in a higher financial amount than APA (Debout, 2008). A convergence between these two systems based on PCH criteria would thus entail supplementary funding.

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[5] http:// www.sante.gouv.fr/dossiers/hcaam/rapport 2009.pdf

[6] May 2011: see http://www.dependance.gouv.fr/Consulter-les-documents-des-quatre.html

For older persons with a lower level of disability public funding may come from other institutions such as the National Fund for Pensioners (CNAV) or (for specific cases), from the National Health Insurance Agency.

There is a complex private market of individual and collective private disability insurance with about 5.5 million people insured (2010). The average annual premium amounts to €450. However, this system lacks in transparency: users are not well informed regarding how they are insured and for what. Also the percentage of the covered population entitled to benefits is scarce (less 0.1% estimate) as contracts are activated only in case of a very high disability level or in case of end-of-life care.

Existing tension from the service user's perspective relates to gaps between collective funding and service accessibility with respect to the level of services publicly covered by APA and revenues:

- In many cases the APA amount does not meet all needs – on average, the APA benefit covers less than 72% of services defined in the care plan (Espagnol, 2008; Debout, 2009).
- Personal health care services can be met more easily due to higher availability and with lower out-of-pocket expenses as they are better reimbursed by the National Health Insurance Agency (100% for chronically ill patients)
- The same care or other types of needs (home help), if available, may frequently incur higher out-of-pocket expenses as fiscal incentives tend to reward wealthier people (Accounting court, 2007; IGAS, 2009).

1.3 Provider organisations

There are more than 30,000 provider organisations in the LTC sectors, covering home care and residential care for older people and regulated either through the health and/or social legislation.

For disabled and chronically ill older person needing medical care, home nursing care (technical, personal and home help) is delivered by 1,300 Nursing Agencies (SSIAD) covering an estimate of 100,000 clients (2008). Their staff consist of employed "assistant nurses (AS)" delivering most of the personal nursing care, but also of private practice nurses working under contract with the agency. They can also deliver technical nursing services prescribed by physicians.

Hospital at home (HAH) is used for complex needs of chronically ill people with disabilities. In 2008, there existed 164 providers delivering care to 4,500 clients with an average length of stay of 20 days (Chaleil, 2009; Afrite, 2009; see also good practice example.

Regarding the social care sector, at the end of 2007 (Prevot, 2009: 1,2) 10,300 residential settings hosted 657,000 residents above 60. Among them 6,750 called EPHAD (residential care for disabled older people) were entitled to public money if their staff (managers, nurses and social workers) fulfil legal requirements. They are run by public (40%), private non-profit (40%) and for-profit (20%) organisations. They deliver care to 480,000 clients among which more than 50% are highly disabled (GIR levels 1 and 2). There exist large regional variations in their level of accessibility.

Home help services as well as personal care (ADL and IADL) are delivered by home help agencies (SAD). They are numerous (around 20,000) and heterogeneous in size. The majority are managed by private non-profit (40%) and public (40%) organisations with a long.standing record in this field. Private for-profit organisations entered this field as newcomers in 1996. They are supposed to boost the sector and bring more quality through competition. For the latter, specific umbrella organisations (called Enseignes) have been set up in particular by insurers or banks as the “Borloo law” called for their development in order to regulate services provided by their affiliates.

1.4 Choice of social care providers

An older person qualifying for public funding for care services according to the AGGIR assessment can either opt for in-kind services with their care managed (whether in a residential care facility or at home) by professionals working on behalf of accredited agencies (“organisations prestataires”); or to opt for the cash benefit: i.e. to use the APA amount to hire and pay a carer who could be a directly employed home carer or a carer employed through an intermediate agency (called *Mandataire*). In the two latter cases the beneficiary will benefit from a system of vouchers with financial incentives (see paragraph 2.4). These vouchers are linked to an exemption from social security contributions (for employers) and tax reduction (for tax payers) so that the average hourly cost of a directly employed home care worker is lower (€10/hours) than if s/he would be hired through an intermediate agency (€12), and much lower than if services were provided by an employed worker of an accredited agency that, on average, has to calculate with about €20 of staff costs per hour (Devetter, 2008). While in the latter case, local authorities can check if services are delivered in line with the individual care plan and try to measure their quality, in the two other cases there is generally a much less stringent control (experts).

All types of providers work under their specific umbrella organisations which are subject to different legislations with respect to labour regulation and social protection of their employees (even if some convergence is sought for). As a result, home care workers’ payment levels, social rights, training, education, supervision and working conditions depend on whether they are salaried by an agency or employed (directly or via an intermediary agency) by an older person – with important differences, respectively (Cerc, 2008). Surveys have shown that, when home care workers are employed, their activity is not constant throughout the year with fragmented work schedules due to multiple clients. Moreover, when they have to care for more than two clients (which is a frequent case) their overall working hours do not equal those of a full-time job. Notwithstanding their difficult working conditions they earn low salaries with at best 120% of the legal minimum salary for a full time licensed home care worker (Bony, 2008).

This entails a first “retention issue” for accredited agencies with the most qualified home workers choosing to be directly employed. It has been estimated that, in 2008, 85% of new home care helpers choose to be directly employed, thus with a low use of intermediate agencies (Jany Catrice, 2009). Being able to care only for one or two clients allow them to dedicate more time for each because their individual employer can pay them more and less fragmented hours (as they are cheaper). Furthermore, they can also benefit of ‘grey’ money if his/her employer can pay for the needs not covered by APA, thus resulting in higher income. A second “retention issue” arises as fully trained and licensed home care workers leave home agencies in order to work in care homes (EPHAD) where they can benefit from better working conditions with supervision and more favourable access to social rights (Experts).

2 How is quality assessed, measured and managed?

2.1 Preliminary

From the LTC system description above it appears that quality regulation should be examined at two political levels: national and local (general council) but also according to the fact that different quality regulation systems apply to the health and the social care sectors. In fact, quality management systems have developed earlier in the hospital sector (see appendix 1). Therefore, the methods and concepts for measuring and assessing quality in LTC have been strongly influenced by these experiences. This can create difficulties to move toward innovative methods and indicators more adapted to the social sector and to the real content of care as opposed to cure. Also the client's perspective (older person and/or his/her informal carer) in assessing quality appears to be a key component in LTC quality assessment, but there remain major difficulties in measuring satisfaction and the quality of life related to social care. Nevertheless the above factors have contributed to a gradual rethinking both among service providers and national institutions regarding how to measure and regulate LTC services quality.

2.2 Quality control of organisations

2.2.1 General overview

In this report, we will focus specifically on providers of home care and care homes while, in a short annex, quality regulation in "hospital at home" services and home nursing agencies (SSIAD) will be described.

A first step in quality management was to define accreditation procedures for residential and home care providers at national level, but to be implemented by local authorities. They were designed to entitle providers to operate in the area of LTC for older people by guaranteeing minimum quality standards, mostly structure and process oriented and considered as "preconditions" for quality. This first move was followed, especially in the past ten years, at national level and through the work of different national agencies (ANESM, ANSP, CNSA) by the development of protocols and best practice guides, staff certification and accreditation mechanisms for nursing homes and home care agencies which began to be more outcome oriented. At the provider level came the introduction of quality management mechanisms pushing for "service charters" and/or quality management systems. The modernisation of management of LTC providers and the professionalization of their workforce was another strong trend. But even at decentralised levels, due to the tradition of "strong state control and command" system, traditional methods of relying on legislation and decrees is still strong, and there exist a lack of clarity in the specific responsibilities devoted to the various institutional bodies in charge of the quality sector. (IGAS 2010) What are the concerned institutions and at which level?

At national level, main bodies directly or indirectly concerned by LTC quality are:

- The Ministry of Health and Social Affairs general through its central direction for social affairs (DGCS) and the direction for hospital organisation (DHOS) is responsible for setting national legislation and regulation to acknowledge all organisations providing services in the "medico-social" sector. The role of ANESM is to set criteria for best professional practice; staff's recertification; accreditation (residential and home care providers); while the CNSA pushes for innovative organisation of services by funding pilot projects and research in the overall disability sector.

- The Ministry of Labour is in charge of employees' quality policy in the service sector and acts through two agencies (ANSP and ANACT/National Agency for Working Conditions). All three agencies (CNSA, ANSP and ANACT) work together regarding the issue of professionalisation (skills and expertise), the first on behalf of the Ministry of Social Affairs, the two others in coordination with the Ministry of Labour.
- The Ministry of Education is concerned through accrediting educational programmes as is the Ministry of Finance for regulating user rights regarding commercial services through a specific agency called DGCRF.
- *At local level,* the executive body (General Council) of the "departments" are responsible for putting in place policies regarding all LTC organisations in accordance with respective legislation and to monitor the quality of services delivered by accredited organisations in coordination with the decentralised directions of the Health and Social Affairs Administration (DASS which is now included in the ARS) and the local agency of the Ministry of Labour (DDTPE).
- *At provider level,* all organizations providing social care are supposed to be engaged in "quality management policies" applying to nursing homes (EPHAD) and to home care agencies (SAD).

2.2.2 Monitoring quality through national legislation: Accreditation procedures

Accredited providers have to comply with legislative requirements considered as "quality preconditions". They are the only social and health care organisations entitled by law to deliver care services to frail and/or disabled old persons and also to receive funding and fiscal advantages from public authorities. Regulations differ between residential and home care providers and, regarding the latter, there exist two different types of procedures.

Nursing homes (EPHAD)

Since April 1999, in order to operate in the LTC sector, all nursing homes (EPHAD) must sign a "three-party contract" which is set between the General Council and (since 2011) with the new Regional Health Agency (ARS) which includes the former division of the Ministry for Health and Social Affairs (DASS). This contract stipulates all specifications the institution must comply with in order to provide quality services to all residents and to cover all aspects of life in the institution: comfort of environment, quality of welcome, entertainment and catering; resident's rights and social contact with the outside world; the approach to end-of-life care and specific criteria relating to preventive care and treatment. All these specifications are included in a quality chart called "Angélique" (Dubuisson, 2001)

The care process of the resident must be organised in the framework of an "institutional project" set out in a "life project" and a "treatment project" under the supervision of the employed "co-ordinating practitioner" attached to the nursing home.

Specific criteria related to all domains of care are defined in a document which can be considered as a "self-assessment tool" measuring the institution's goals in terms of quality. Nursing homes are accredited for a 5 year period during which they must respect the agreed upon quality criteria, with "Angelique" supposed to be used to yearly monitor their quality level and measure their improvement.

At national level no data exist to assess how this scheme works and how it influences care quality. Besides, neither the institution's review protocol (type of information collected to monitor services, modalities to reassess patients and their treatment and life project) nor the annual report are publicly disclosed. Moreover, the way this report is used by local regulating bodies is not documented. In any case (according to experts), if an institution fails to get a renewed authorization (very rare) this situation is more often linked to heavy financial problems and/or understaffing and/or important faults (ill treatment) rather than to quality issues at large.

Home care agencies

The two types of regulation concerning home care agencies rely on different legislative bodies and respective criteria that are mostly oriented to structural quality.

- Authorization is conceded for a 15 year period by the president of the general council, after approval by the Regional Committee of Health, Social and Medical-Social Organization (CROSSMS). It is mandatory to ensure that the services delivered will be billed according to the official tariffs. This concerns only public and non-profit providers that employ social workers. This authorization entitles any public or private non-profit provider to be automatically accredited (see below) as long as they deliver home care only, i.e. the organisation must not run residential homes contemporaneously.
- The procedure called accreditation (“Quality agreement”) is delivered for a 5 years period by the state representative (préfet) following a proposal made by the regulating body of the labour sector (DDTEP). It is mandatory for agencies providing services at home and specifically for commercial agencies to access the market of LTC services for older people. It also entitles them to specific benefits (the same than with the former “authorisation”) and a lower rate on social charges (Cour des Comptes, 2005).

Even if the criteria for both procedures look very similar, their logic is not the same: The first procedure is based on requirements coming from the Ministry of Health and Social Affairs and its main target is to guarantee older people’s safety at home. The second aims at regulating the volume of employers in the service sector without compromising quality. This difference is clear when looking at the price setting procedure: in the first case, they are administratively fixed by the General Council. In the second, organisations are free to set their prices at a level that allows them to compete with other organisations without compromising their financial balance.

There is also a procedure called “simple accreditation” for private for-profit providers only, if they deliver services to people with a lower disability level or those who are completely autonomous and thus cannot benefit from APA.

Furthermore, there are two other national authorization/accreditation procedures**:** one is delivered on behalf of the National Health Insurance Agency and enables home care agencies to provide their services to people benefiting from social assistance; the second one is delivered by the Pension Insurance Fund (CNAV) and entitles home care agencies to deliver services to pensioners with a lower care level (GIR5/6) funded by subsidies from CNAV.

2.3 Accreditation of home care agencies and nursing homes

2.3.1 State accreditation of providers

The National Agency for Health and Social Care Facilities and Services (ANESM) created in 2007 is in charge of providing practice guideline but also to put in place a new accreditation procedure for all provider organisations working in the LTC field. According to criteria set up by ANESM any commercial firm (consultancy firms, certification agencies) having objective track records with general audits and certification as well as expertise in the LTC sector can subscribe to become a member of the task force in charge of auditing home care services and care homes. It is the ANESM staff's responsibility to monitor the auditing process, namely that the methodology used by each enlisted firm is in line with the defined criteria and able to promote a quality improvement in home care agencies and care homes (EHPAD). This process began in 2010. By June 2011, about 50% of all providers had been audited by 755 firms belonging to the task force (only 10 auditing firms were unlisted due to non-compliance).

The link between this new auditing procedure and the former authorization and accreditation procedures is still under debate. Also, the position of CNSA (which is a member of the ANESM executive board) and the way in which ANESM's practice guidelines are to be integrated in the accreditation procedures remain to be clarified.

2.3.2 Other types of certification and quality labels

Other types of certification procedures exist on the free market of certifications, sometimes also called quality labels. Despite being voluntary, they are more and more sought after as they are considered as giving a "positive signal" in a competitive market. Two main certification procedures exist, each of them relying on recognised bodies, whether international (ISO) or national (SGS). Criteria relating to AFNOR (ISO) quality certification for personal services (AFNOR NF X50-056 standard) is increasingly being considered by both for and non-profit providers, but the overall use of this certification procedure is very low. Another French certification is coined "Qualicert". They are quite similar and in line with criteria included in the accreditation procedure. However, compared to the latter they are more demanding and more precise, especially regarding user satisfaction and "complaint procedures". Both try to monitor quality improvement and are considered as facilitating the national accreditation procedure.

Quality labels have been set up either on behalf of General Councils (for public and non-profit organisations) or by umbrella organisations of all types of home care agencies. They are less demanding than the previous certification procedure, but considered as a first step towards it. In the first case, General Councils can allow better tariffs to organisations with a "quality label". In the second case the label is used as a tool to ensure similar quality levels by all organisations adhering to the umbrella organization and supposed to act as a market signal. This is also why all these procedures are looking for an "official" recognition by national agencies.

2.4 Monitoring quality through local legislation

The regulation of rules set at national level should apply to all accredited providers. However, controls are different according to the type of procedure. Under the authorisation procedure (only for public and non-profit providers) it is up to each General Council to use its own inspection methodology and criteria to monitor the quality of services delivered. This leads to differences in monitoring processes and requirements that, however, share the following similarities: agencies are asked to provide evidence for their workforce's skills and expertise; they have to set up a quality management system with a subsystem on safety (Patte, 2004); pain control procedures have to be documented (Alberola, 2007) as well as access to palliative care and the existence of complaint management procedures. Up to 2010, it was the members of the DASS who would carry out this control with some support by General Council inspection teams. The focus is more on safety issues than on the comprehensive quality of services or a focus on patient satisfaction. In general, inspection is mainly based on checking documents, rather than on systematic visits in the agencies or nursing homes.

The quality assessment of intermediary organisations (Mandataires) is not done in the same way and not by the same teams. Inspections are carried out on behalf of the local office of the Ministry of Labour and focus more on the respect of consumer's rights than on the way care is provided.

2.5 Managing quality: the provider level

Home care agencies are formally responsible for monitoring their employees' work. They can freely establish their own quality control procedures based on internal and proprietary (not public) criteria. Generally, the monitoring process consists in a monthly review of the home care worker by the coordinator, who is the beneficiary's contact person. The process can also involve home visits (at least once a year for reassessment purposes). Even though a close monitoring is considered mandatory for all types of accredited organisations, with the exception of agencies voluntarily certified based on the AFNOR scheme, this has not really been put in place and is not necessarily mentioned in the annual report supplied to the General Council. So as potential changes resulting from this internal monitoring are not known, the impact of the overall process cannot be assessed at local level.

2.6 Guaranteeing quality: Professionalisation of care work

Quality of LTC services should benefit from the increasing efforts in the professionalisation of social workers (CAS/DARES, 2008). For the last five years, there has been a growing and continuous trend to build a comprehensive, yet modular, training and education programme for Social Carers. In the area of LTC national and regional plans have been launched in 2007, with the CNSA as main coordinating body. Home care workers in the LTC sector can now acquire qualification through five main diplomas (Grenat, 2009).

A specific training procedure based on vocational experience for non-qualified workers has also been put in place (Marquet, 2008).

Furthermore, training courses for managers of home care agencies in "Quality Management in Health Care" and "Care Management" are available through several Universities, the National High School of Public Health (EHESP), or private non-profit social training agencies.

Up to now, training programmes for social care workers have not been as successful as expected. This is not only due to a lack of funding but also to the low gain in revenue that qualified workers get compared to the effort they have to make (as the training program is considered rather demanding and not really adapted to the learning capacities of the target public)). The salary of a home help workers with the highest diploma (AVS) is, at best, only 20% above the minimum wage due to the low level of LTC funding.

2.7 Research, innovation and good practice

2.7.1 Innovation: the role of national agencies

Different national agencies play a prominent role.

CNSA

The CNSA acts not only as a distributor of funds and as a lever for enhancing professionalisation. It is also a leader for developing innovative practice and organisations, and it acts as a consultant in quality assessment methods.

In 2008, from its the €19 billion budget, €290 million (1.7%) were directed toward "innovative actions" (investments and modernisation of providers organisations, training, and professionalisation of staff; €10 million were dedicated to research). CNSA also receives funds relating to specific programs (such as Alzheimer plans) and coordinates all processes regarding innovation (Gallouj, 2008).

At national level, CNSA staff directly supports and monitors various types of innovative experiences that are either initiated through tenders directed to action research or by local initiatives. One example is experiencing new ways for discharge planning by using various forms of case management designed for complex cases (see practice example COPA[7] and annex 2 in this report)

CNSA assumes its monitoring and expertise functions by:

- Enhancing information, exchange between promoters about the design and the methodology of the various experiments and their assessment;
- Monitoring the whole experimental period while counselling and supporting promoters.
- Synthesizing results and updating good practices
- Transferring innovation and turn them into legislation.
- Helping monitor the diffusion of innovation on a routine basis.

In the context of the Alzheimer plan the following quality programmes are supported:

- Testing the efficiency of different types of service points for people with Alzheimer diseases and their informal carers (see practice example MAIA)[8] with case management designed for complex cases.
- Finding innovative form of respite care including various types of supportive actions dedicated jointly to the elderly and their families (see related good practice example on the web).
- New tools for education/support and training of families.

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[7] http://interlinks.euro.centre.org/model/example/CoordinatingCareForOlderPeopleCOPA.

[8] http://interlinks.euro.centre.org/model/example/NationalPilotProjectMAIA.

ANESM

Building practice guidelines for professionals and implementing them in real life is one of the main responsibilities of ANESM. This new agency (2007) is still in a development phase, with a limited programme and reduced staff. About ten professional practices guidelines (PPG) have yet been issued according to the ANESM's own methodology focusing on "good practice" as opposed to "ill treatment". Still little is known about the implementation process of these guidelines, its monitoring and relationship with the new accreditation programme. Even though ANESM is supposed to work in close relationship with CNSA, local authorities, umbrella organisations of providers and professional bodies, the frame of their respective responsibilities is not yet clear. Also no professional certification process is yet in place.

2.7.2 Research

The CNSA operates mostly trough research tenders with other research bodies, the most important being the ANR (National agency for research). Also and jointly with the health Ministry research department (MIRE), the CNSA recently launched 3 research bids devoted to quality measurement methods in France and in foreign countries. Some of them focused on informal carer's new supportive forms of action or toward new methodology for measuring service's quality.

3 Quality indicators and incentives/sanctions to measure, ensure and/or improve quality in everyday practice

Even though quality has always been part of professional ethics in health and social care, it is far from being common practice in the area of LTC to systematically assess and measure quality of care through structural, process and outcome indicators. Only recently, a "tool oriented" approach has started to develop. Again, this development can be examined at four levels: national, local; providers and beneficiaries.

3.1 National level

As quoted before, public authorities are trying to move from purely administrative approaches (authorization, accreditation, quality assurance) towards self-assessment (Angelique) and third party certification (audits) using the new agencies (CNSA, ANESM) as main drivers of this cultural transformation. The aim is to create more professional dynamics in relation to quality issues. However, the development of regulation based on quality management is clearly linked with the introduction of more competition and market-oriented mechanisms for governing health and social care. The underpinning rationale that LTC providers which have to face competition to attract clients would be forced to increase their transparency and the quality of their services mainly targeted on traditional non-profit providers that now have to compete with newly emerging commercial providers which were given the opportunity to enter the previously 'closed market' of care services in 1996 (Dubonneuil, 2008). Already well-positioned in the area of care homes (20%), private providers were supposed (at least rhetorically) to use their “quality certification expertise” as a way to increase trust of purchasers of home care services and potential residents and thus boost the quality level of their opponents.

No data show that this expectation was fulfilled. On the contrary, there exist numerous examples showing that competition may even be detrimental to quality. As described above, most of the new agencies act as intermediates between the older person with care needs who wishes to hire a home care worker and the domestic care workers. However, the introduction of the cash benefit mechanism carries the risk of poor service quality linked to an inappropriate choice of the home worker. In order to avoid this risk the legislator introduced financial incentives to commercial firms (insurers, bankers, large firms in the service industry) to create umbrella organizations, called “Enseignes”. These would select and supervise intermediary for-profit organisations (called “Associations Mandataires”) as a link between the demand and the supply side by guaranteeing the level of expertise and skills of the hired domestic care worker and monitoring the quality of her/his work while releasing the older person from the paper work linked to his/her status as employer.

In this regard two issues can be raised linked to the fact that the resulting competition between new and old agencies is more driven by a search for economies than for quality (Brun, 2007; IGAS, 2009):

- First the umbrella organisations of for-profit agencies claim their ability to guarantee the quality of their members based on their previous expertise in quality and certification in what is their core business in service delivery such in the banking or the insurance sector. But this does not entail this will be automatically the case for the very specific LTC services. Furthermore, as very little is known about how for-profit agencies are controlled by their umbrella organisations and as it is known that they are poorly monitored by local authorities when they act as intermediary, no guarantee exist regarding their efficiency in fulfilling their supervision function.
- The second reason for introducing these for-profit intermediate agencies was that the costs of the services they provide were expected to be lower than those of private non-profit or public home care providers which happened to be the case. Still, this does not necessary correlate with a better efficiency, but rather to the specific fiscal incentives they benefit from (Accounting Court, 2005; Cerc, 2007) and perhaps also from the above-mentioned lack of supervision. This fiscal bias may force a non-profit provider to lower its cost either by hiring a non-qualified worker or to also act as an intermediate agency for some of its part-time staff, resulting in both cases in a risk of providing lower quality (experts). This explains why even if some General Council uses the new comers as a tool to lower services prices of authorized providers, others GCs are less prone to let for profit agencies enter the market.

Finally, and regarding financial incentives, for-profit intermediate agencies may bring inequity in the way older people may access care: at a similar disability level (GIR2) an older person with a monthly revenue of €5,000 will get through APA (€1,000 in this case) minus co-payment plus fiscal exemption a monthly public support of €2,600 compared to the APA amount only (€1,000) for a beneficiary with a monthly income of €670 (minimum pension) who is exempted from co-payments.

3.2 Local level

A growing number of local authorities are looking for more and more explicit requirements in defining the quality of services delivered by provider organisations. This concerns not only the existence of decently trained staff (whether at the management or at the delivery level) but also the introduction of quality management mechanisms such as self-assessment and monitoring procedures (Bocquet, 2009) or the inclusion of specific criteria linked to quality labels in their annual reports. These initiatives can be used as levers by granting better tariffs to these agencies. But even if there exists a clear will to move towards this approach, many local authorities have yet not enough resources to implement it, giving the scarcity of their budget and a great lack in routine data in their information system (experts).

On the opposite, the question of sanctions according to quality results is far from being clear: If a home agency is facing growing difficulties to find qualified staff or if a nursing home can not comply with the relatively low minimum standards concerning safety and hygiene, will sanctions follow and providers be shut down? Experiences show that, apart from "catastrophic events", real enforcement rarely happens mostly due to a shortage of providers. A closure would thus entail the risk of aggravating the situation at short term.

So it remains to be seen if and how quality requirements will be fulfilled by providers and/or whether they need to be complemented by financial incentives as, for instance, a pay for performance system.

3.3 Provider level

Up to now, except meeting national minimum standards linked to legal requirement, care homes and home care agencies are not explicitly asked to use any specific quality indicators to monitor the services they deliver. They are only required to use the common assessment tool AGGIR to assess the disability level of the older person in need of care, to set up their care plan and then monitor the care process. However, AGGIR, notwithstanding its proven partial validity and reliability and contrary to RAI, is not able to produce any quality indicator nor any tool to help monitor and assess the quality of the care. As shown by Fermond (2004) each provider uses its genuine quality framework according to its means and "quality culture", but with no public knowledge about their respective impact.

3.4 Beneficiaries

On the demand side, quality management is at stake with the new opportunity to directly purchase services and/or hire a home care worker. Potential users and their family, even if weakly organised in a collective way, are thus expressing more and more interest in getting information about the contents and outputs/results of what they could purchase and/or consume. However, as mentioned before, either at individual or at collective level (Ennuyer, 2009) the grey power is not considered as a major stakeholder. Up to now, there is no national information system based on sound data which could help users to choose effectively between different types of providers (experts). Some media are beginning, as it has been the case for more than 10 years for acute hospitals, to display various form of rankings and satisfaction surveys, in particular concerning nursing homes. These surveys are mostly poorly designed, their criteria are disputable and their impact is not known. A recent survey by the research division of the Ministry for Health and Social Affairs (DREES) gives some insight on users' and their families' opinions regarding their life conditions in care homes (Solidarité Santé, 2011).

Quality indicators to monitor patient pathways across services involving both health and social providers (such as hospital discharge) are poorly developed at national level. This situation might improve in the following years when the consolidated results of the first certification process led by ANESM will be available – similar to what happened for acute hospital 10 years after the introduction of an accreditation process led by HAS. Based also on this experience, one can anticipate that these indicators will be in the first phase more process than outcome oriented.

4 Quality-policies for informal carers and volunteers

4.1 Is the quality of the care provided by informal carers measured and monitored?

The answer is clearly negative: issues related to the risk that family members (or volunteers) may not be able to provide the quality of care a person in need of LTC necessitates has not been given a high priority. There are no scientific surveys trying specifically to assess the quality of care delivered by informal carers. The only exception consists in a survey looking at the determinants of abuse which have led ANESM to issue specific recommendations (Anesm, 2011).

4.2 Is there a global policy to insure that carers are given good caring conditions?

Also the answer to this question is negative as evidenced by Naiditch (2011) who showed that only fragmented measures exist. These aim at helping informal carers in performing their caring tasks (direct measures) such as counseling or training and that could potentially ensure the quality of services they deliver. Another type of existing measures aims at improving the "caring environment" of carers (indirect measures).

4.2.1 Direct measures

- *Information:* Surveys have shown consistently that there is still a big need in terms of information about access and choice of providers. There are various organisations providing information (such as CLIC, MDPH, CCAS). General councils are trying to reconcile all these various settings in order to create unique information points and to assess needs and monitor the care process, but no global assessment of their efficiency exists.
- *Education/training/support:* Apart from some organisations working for Alzheimer's families, it is not known how many providers of community care services have set up training courses during which family carers are given basic hints and technical support for caring at home. The only national policy in this regard is yet experimental and consists in the third national Alzheimer plan with the hope that innovation in this domain will transfer to the general population of informal carers. But will the resources to do so be available?

4.2.2 Indirect measures

- *APA:* Given the fact that almost 2/3 of home care was provided by family and other informal carers and that they cannot alone cover all care needs, APA was introduced as a financial contribution to care-related to additional costs for people with long-term care needs. This scheme gave the entitled person the opportunity to rely on skilled professionals for delivering uncovered service and thus to indirectly to downsize the caring burden of their informal carers and thus indirectly adding a better quality to their caring work. Surveys have show (Petite, 2006; Rivaud, 2006; Campeon, 2006) that APA did not result in less caring hours but changed, for 17% of the informal carers the type of care they delivered.

- *Fiscal incentives:* The APA scheme also allows the beneficiary and/or his/her family to use this allowance to directly employ a home care worker with important fiscal incentives. In this case the choice but also the supervision of the hired home care worker becomes the full responsibility of the person and of his family. As no other supervision system exists in this case, the quality of the delivered services appears as a blind spot.
- *Care leave:* Some informal carers (15%) are facing difficult arbitrage between their professional, social and caring role. In case the health status of the older person is worsening, one member of the family may benefit of a work leave, for a limited period of time during which he will not be paid but will not lose his rights to a retirement pension. This leave cannot be renewed more than three times a year with at least 6 weeks between each leave period (JORF, 2007). Also during the end of life period and in order to permit one member of the family to participate in palliative care, the parliament voted a law allowing for a three week period of work exemption with each day of leave being paid with €47. However, this law has not yet been implemented. More generally, as ageing is considered as linked to “productivity loss”, firms are not very prone to adopt such arrangements, in particular for senior workers.
- *Respite care:* Informal carers may also benefit from the existence of day care centres and/or a temporary stay though such places are not easily available: among the total 684,000 beds of all types of residential homes, only 6,000 are dedicated to day care and 500 to night stay. Also, only 1% of the 657,000 residents are temporary residents and only 100 residential homes are offering setting temporary stay (Debout, 2009). CNAV also fund temporary day custody. One paradox is that financial data show that funding planned for a 4 year period in order to enhance the number of day care (+ 12,125 places/year) and temporary places (+ 1,124 places/year) has not been consumed. The main reason for this shortfall is manly that, even if the need exists, the demand is not effective as family carers feel guilty to leave their family member in need of care in these places. For temporary stay, one reason is that, as it may prove difficult to manage temporary stays in an organisation where routine full stay is the rule, managers are hesitant to ask for these funds (Experts).
- *Technical support:* APA pays only partially for supports such as technical equipment or housing adaptation as other funding bodies may intervene (National health agency, General Council; CNAV). No systematic monitoring process exists to ensure that the equipment is used in a correct way and thus brings more quality by meeting the expectations of both users and informal carers. In order to check that funds have been used in a purposeful way, i.e. as intended in the care plan, only few inspections are carried out.

5 How financially sustainable are the approaches being adopted?

Managing quality bears the cost of its introduction (training staff), of its maintenance (working-time of staff involved, costs for third-party audits and certification) and finally the cost of the improvement measures which are derived from assessment. In France quality issues started to be really publicly debated and organised only ten years ago. In a period when funding for LTC is facing hard competition the question on sustainability turns into new ones: Are the global costs of these measures worth the outcomes they are supposed to deliver? And will usual cost containment strategies by budget policy trigger or further hamper investments in quality and quality management?

The answers are far from being evident:

- On the one side, some may consider these opportunity costs as being relatively marginal when compared to those resulting from doubtful structural expenditures occurring in nursing homes or considering the costs of their unanticipated closure due to quality defect. In addition, costs for quality improvement include a potential for reducing costs in a mid- and long-term perspective.
- On the other hand, while quality management methods may potentially enhance quality and/or save money for the regulating bodies, they will clearly increase the workload for the regulators and thus call for more resources. Furthermore, quality management measures already create a constant complaint among health professionals for the incurred paperwork that is felt as a waste of time for it could better be used to provide hands-on care. One can anticipate that this will also happen in the social sector at least in a mid-term perspective, if there is no proof of a positive impact of quality measurement – which may be difficult to achieve. In this regard competition was supposed to bring more efficiency and as the best lever for developing quality. For reasons yet described it is not straightforward that this has or is about to happen. If not, this may lead to QM implementations being patchy, with those having more resources to spend on the development of a more quality oriented culture being better able to provide a higher quality of services, thus leading to inequity in the distribution of quality. So the role of regulating bodies will remain important in this regard.

6 Is cultural diversity a subject in quality management?

To answer the question whether quality management methodologies are conceived and can be adapted to the cultural diversity of informal carers it is necessary to be able to measure this diversity which entails at least the existence of information related to the origin of the immigrant population. In France this is not the case for, if issues regarding the working status immigrants have gained momentum, they take place in a specific political environment:

- First, France has a long tradition of being an immigration country as shown by the percentage of immigrants who are estimated roughly to represent 10% of the French population that was 63.5 million in 2008. The stock of immigrants is thus “old”: a survey (Health survey, 2003) showed that, in the “French born population” those above the age of 70 represent 14%, compared to 18.6% for the naturalized immigrants (old immigration), but only 6.6 for the not naturalized citizens, the latter corresponding roughly to the most recently arrived.

- Secondly, France attracted mainly people from “black” Africa in the last decades, while the previous generation of migrants mainly came from the Maghreb region.
- Thirdly, France has also a long tradition to avoid “ethnic statistics” linked to a universal conception of citizenship and thus opposed to “community based policies” and reinforced by the tragic precedent of the “Jews file” during the Second World War. In the national statistics, information about the country of origin is thus not routinely reported and information related to the “community of origin” of a worker is either not accessible or presented in a way that no “ethnic recognition” of an individual is possible. This is the case in particular in the LTC field.

Most studies (some with representative samples) are therefore mainly focusing on the demand side: how is the immigrant population ageing in France (Attias-Donfut, 2006) and in particular if and how are they using LTC services? It has been shown on the “demand side” (Jusot, 2008; Dourgnon, 2009) that the objective and subjectively declared health status of this population are both significantly lower than the corresponding one for the French born population; that most of their disabled members could rely on a broad network of family members and used health and community services at a much lower rate than the latter (Wolff, 2007).

No studies have been oriented at looking at migrants as a work force supplying services. It is further impossible to isolate from most studies specific data for the “black community” (as they represent a small sub sample of 7%). Although there is a consensus between experts to estimate that a vast majority (50/70%) of the IADL services are delivered by foreign Africans, in the absence of data it is impossible to know from the most recent publications directed to direct employ (Marquet 2010) data specific to the “black community” and thus to know their country of origin, if they are naturalized or not, if they have a legal or illegal status (especially for those directly employed). It is also difficult to estimate how many of them work on behalf of the different types of home care agencies and under what status they are employed (salaried or directly or indirectly employed by beneficiaries).

It is thus difficult to conduct studies aiming at analyzing if methods used to monitor the quality of services are adapted to the cultural context of the home workers.

7 A critical overview

Long-term care should be a harmonious cooperation of health and social care to maintain people at home, or to help them move other facilities or care homes if needed. In reality, provider organisations still operate within two independent systems. As a result there is a lack of practical guidance on how care providers should link and cooperate in order to maximize quality of care for older people.

France is currently undergoing important changes in the measurement and management of quality with new legislation being issued at national level and shifting the responsibilities to the local levels (General

Councils) while having established specific agencies devoted to quality measurement in the LTC field (Recoat, 2008) with a balance of responsibilities far from being clarified.

Another main trait of this new LTC agenda is to push providers for innovation and professionalisation of workers (Gallouj, 2008) with the use of competition considered as a potential driver for improving quality.

What is the state of the art?

Although some minimum standards for providers of health and social care have been defined by legislation, quality indicators specific to long term care are rarely existing. Providers are asked to provide bare minimum standards, and evidence of the care they are delivering through documents, checks and paperwork. Existing standards tend to focus mainly on processes and structures rather than on the desired outcome for the person. If some important efforts (such as social staff professionalization of issuing working protocols) have been made over the past few years, they should merely be considered as preconditions to further improve quality in LTC through more effective measures and more specific tools for managing quality.

An inflation of "external" quality procedures can be observed (authorisation, quality agreement, accreditation, labels, certification), all of them sharing more or less the same attributes and leading to an incoherent set of weak, though redundant, and thus not efficient control mechanims, coming from different ministries (health and social affairs, labour, finance) and put in place by their respective institutional bodies acting at different levels and based on different logics. The whole process is considered to be bureaucratic and poorly linked to quality enhancement according to a recent report of the General Inspectorate of the Ministry of Health and Social Affairs (IGAS, 2009).

The creation of regional health agencies in April 2010 (Loi HPST, 2009) could be a critical momentum in this process as they are supposed to take responsibilities in both the health and the social sector. It is yet too soon to anticipate whether this "institutional innovation" will fulfil the task of bridging health and social systems more functionally. The way the public debate and the following legislative process were organised clearly demonstrates that health care reformers still do not consider the LTC sector as a dominant one, and their stakeholders as strong partners in the definition of new policies regarding quality in LTC. If it is too early to assess the potential impact of all these institutional changes, there exist at least some caveats that are worth being taken into account in order for the ongoing initiatives to be really fruitful. At the provision level, there is a trend (even if weak) to allow health and social care organisations to develop local standards according to local needs and monitor their care on a regular basis. This is a good direction in term of professional dynamics. But there exist two potential drawbacks:

- The first is that this may lead to a great variability of methods, criteria and indicators and thus to a lack of comparability at the central level with the inability to monitor potential inequities in the delivery of services.
- The second relates to the public disclosure of results of audits or accreditation reports which could harm some providers without fairness (as it happened for acute hospitals after their first release). This may lead providers to write their report in a more favourable way in order to avoid "public humiliation". So if public benchmarking is considered as a means to enhance quality and help consumer make better choices (a claim poorly evidence based) all stakeholders should closely discuss this point and envisage the best way to link self-assessments with public reporting before taking any

decision. The new accreditation scheme by ANESM could be a step towards more outcome based quality indicators though no evidence exists about such an achievement. The choice of creating a different agency from HAS, dedicated to LTC quality issues, may be explained by the will to allow this new institution to develop its own (and possibly) innovative methods specific to the LTC field in quality measurement. But the counterpart is the obligation of linking the production of both institutions in their interface areas in order to fill all remaining gaps, a problem that will persist as long as the two institutions will not work in a more close relationship.

Social care is moving towards personalisation with direct payments of services through individual budgets. Under these schemes, service users in order to buy high quality services should be given all guarantees they need. This is the case (but not always) when services are delivered through non-profit organisations (in this regard, one article of the 2001 law stipulates that regulators should favour this solution for highly disabled older people, but it was not effectively enforced). However, attendance allowance schemes such as APA entitle users to directly employ home care workers (including family members) who do not fall under the remit of any regulatory bodies. It was shown that fiscal incentives favour direct employment (because of cheaper hourly costs). So as highly disabled person need more hours and as directly hired home workers are weakly (not to say not) regulated and poorly supervised by their employer, these facts combined with their difficult working conditions (Cerc, 2007; Jany Catrice, 2009; Devetter, 2008) raise strong concerns about the quality of the services they deliver – and casts doubt on the capacity of the LTC system to enhance its average quality level dramatically (IGAS, 2009) without more structural reforms.

There is also a risk that competition between providers may not provide expected benefits**.** This may happen for different reasons. If there is a lack of providers (most frequent), the local authority will have almost no lever to act: closing a provider with a proven poor quality level may be difficult as it may reflect badly on the local authority's previous work; but it may also create difficulties for access in an already limited market. At the same time, doing nothing still entails to provide access to services with known quality problems. In case of extra supply, in theory only the best services should be authorized, but as services compete with each other for clients, they may be induced by local authorities to do so on different grounds than quality. For example, by being forced to be more productive (more turn over) or to sell services at lower prices by employing less qualified staff. Authorised services may thus be cheaper while not delivering better care. This may sometimes even happen without knowledge by the regulator, due to his lack of resources and/or capacity to control provider's behaviour. So competition may not bring a better quality.

Finally, no quality system can exist without appropriate funding. If quality may (sometime) bring economies, not giving appropriate funding to the LTC system may proof detrimental not only in terms of technical and human quality of the delivered services (as stated above), but also in term of access (which is a major component of quality) and equity – with only the best-off being able to bridge the gap between real and publicly covered needs, by benefiting from the existing system of fiscal incentives. The high level of out-of-pocket contributions (the public system covers only 70% of the needs) has changed the way in which future reforms of LTC funding, linked to the next elections (May 2012), are being discussed. This discussion differs from recommendations of the Rosso Debord report (2010) that were very market oriented and based on the introduction of a system of private LTC insurance, thus raising strong concerns regarding equity and access (Elbaum, 2008; Henrard, 2008; Ennuyer 2009). Still, even if new debates may focus on equity, it must be acknowledged that quality per se has not been an important and specific issue during the on-going, mainly budget-oriented debate.

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9 Annexe 1: Quality regulations of health organisations

Authorisation: Hospital at Home (HAH) and nursing agencies (SSIAD)

- HAH (hospital at home) as well as Nursing agencies are authorised by the Regional Health and Social Affairs department (DRAS) This decentralised division of the state acts as the regulative body fixing the number of places according to a complex planning process and related to the needs of the covered population
- To be authorized both types of organisations have to comply mostly to structural criteria poorly linked to quality.

Accreditation: The process is entirely different for HAH and Nursing agencies.

- **HAH:** Because they are (since 2006) considered as a "hospital-like organisation", HAH are "quality regulated" the same way as acute and mid-term care (rehabilitation) hospitals. They are thus subject to a strong accreditation procedure on behalf of the high authority in health (HAS). Intermediate and final outcome indicators were introduced in the second version and there are supposed to be more than 40 in the next one (2010). Security issues such as preventing nosocomial infections at home are specially focused (Patte, 2005). HAH also participates to the Compach program which aims at developing outcome indicators targeted at long term care conditions (Diabetes, Cardiac deficiency, COPD…) but also at pain control and palliative care.
- **Nursing agencies:** As neither HAS nor ANESM have been given responsibilities for them, there exists no such accreditation procedure for nursing agencies.

Hospital Certification

More and more hospitals are seeking for the Afnor certification procedure (ISO 9001).

Professional certification

Regarding the reappraisal of their professional knowledge and expertise during their professional life, all medical professionals, whether they work in or out a hospital have to follow every five years a weak procedure of practice recertification called "professional practice evaluation" not involving outcome indicators but rather process based. No such procedure exists for nurses working in nursing agencies. But the National Health Insurance fund has established some practice recommendations (ACBUS) regarding specific practice's areas. But they relate to the nursing profession as a whole and are not specific to provision of services involving technical nursing care and they are weakly monitored. Also there exist no specific measures aiming at controlling the quality of care delivered by nursing assistants (ADL) working in these structures.

10 Annexe 2: An innovative experiment: COPA

Promoters: Geriatric Department of an LTC department of a university hospital located in a borough of Paris and its related health and social professional community network.

Rational: Despite strong evidence of the efficacy of LTC integrated systems, securing the participation of health professionals, particularly primary care physicians (PCPs), has proven to be very difficult in the French context. COPA model try to solve this dilemma through an original design process in which health professionals, including PCPs, and managers were actively involved in the model designing process through a serie of focus groups. The goal was to obtain (through a better participation of PCPs), a better fit between the services provided and the needs of the elderly by reducing excess healthcare use (shown by a pre evaluation study) such as unnecessary emergency room (ER) visits and hospitalizations; but also to prevent inappropriate long-term nursing home placements.

Focus group revealed that fragmentation was perceived by all stakeholders as the main challenges in caring for older persons: it existed not only inside the primary care sector as professionals used to work independently but also between primary and specialized care due to a lack of communication and collaboration. Moreover the study brought to light three features of the new model to construct and deemed essential by all participants for its success: first as home and thus primary care would remain the best healthcare setting for older patients. PCP should remain the main pivotal medical actor and play a key role in the continuity and coordination of care. But case managers for the more complex cases should also be introduced and work in close collaboration with PCPs. Third, participants expected that an improved form of access to geriatric expertise would ease direct hospital admission.

Activities: COPA is a form of “transmural network” targeting very frail community-dwelling elders in order to maintain them in their homes securely while limiting the number of admission through ER. All voluntary health and social professionals of the Burroughs have been integrated into a multidisciplinary primary care team. Elders are recruited by their Primary Care Physicians according to agreed criteria. The team includes 2 case managers who collaborate closely with the PCPs while implementing care management programs and organizing direct hospitalizations. The network integrates “specialized care” through hospital geriatricians who are easily available for counselling but can also see patients in their homes and perform geriatric assessment using RAI. But PCPs remain in all cases responsible for all medical decisions as they actively participate in patient recruitment, in setting priorities, and in developing care plans by deciding which evidence-based protocols will be used. They are kept informed as the care plan is implemented and can make referrals to medical specialists and in particular, to geriatricians. They can recommend the planned hospitalization of a patient (avoiding the emergency department) and participate also to all significant decisions made during the hospital stay. Two care management programs are available through COPA, depending on the patient recruitment process and the duration of case management.

Under the long-term care management programme, the PCP and the case manager review the PCP’s charts to pro-actively recruit all eligible patients of selected PCPs having a large number of elderly patients in their practice (over 50% are >= 65). This programme is provided until the patient is placed in a nursing home or until death.

Under the temporary care management program, recruitment is passive through referrals from other PCPs, caregivers, or family members who feel overwhelmed caring for an elderly patient in a critical situation. For these patients, the program is provided only until the end of the crisis. Only one case manager is assigned to each PCP and each case manager works with only a few PCPs.

Once these assessment are made, the case managers meet with or contact the larger multidisciplinary team by telephone in order to develop a care plan that: (1) is consistent with the patient's expectations and available resources and (2) meets patients' needs effectively and efficiently. Case managers then meet the PCPs at their office to improve the care plan, set priorities and decide which evidence-based protocols will be used as PCP has to approve the care plan before its implementation. PCPs receive compensation for the time spent in this meeting. The case managers then implement the care plan and coordinate health and social services across the different settings and among the numerous care providers. They organize inpatient visits and hospital discharge in collaboration with the hospital team. They follow up on and reassess patients' needs every three months or more frequently if needed. They are in regular contact with the PCP by telephone to consult in case of complicated decisions. Case managers can be reached by professionals, patients and family members if a problem arises.

COPA community-based geriatricians work in the community and collaborate closely with PCPs as consultant following a request from a PCP. They provide in-home geriatric expertise and advise PCPs but do not write prescriptions as PCPs remain responsible for medical decision-making. In addition, since COPA geriatricians are also affiliated with the participating hospitals, they facilitate the relationships between hospital physicians and PCPs. They can organize a hospital admission at the request of a PCP, avoiding a pre-hospitalization visit to the ER. The staff physician communicates with PCP when the patient is admitted and asks the PCP for his input whenever important decisions need to be made.

Scope: In October 2007, 249 patients aged 65 years and more had been referred to COPA. Of this group, 110 (44.2%) met the inclusion criteria and 106 (96.4%) consented to receive care under COPA.

Among the latter, 76 (69%) were enrolled in the long-term care management program through pro-active recruitment from the PCPs' databases, while the rest (3O patients) were enrolled in the temporary care management program through passive recruitment. Patients had an average age of 86 (S.D. 6.7) and represented a group of very frail elderly with a mix of ADL and IADL impairments, cognitive impairment, isolation and medical conditions.

Support and evaluation

The model is still in an assessing process through a quasi-experimental study design: the COPA group will be compared with two control groups from neighbouring boroughs with similar inclusion criteria; participants > 65 years able to give informed consent (or the proxy gives consent) and with a CA+ score ≥6. Main outcome of the study is service utilization defined through various indicators such as the number of hospital admissions, length of stay, emergency room visits and institutionalization. More specifically the ratio of planned over unplanned hospitalizations will serve as the main outcome measure. Secondary outcomes measures include mortality, functional status, quality of life and caregiver burden. Moreover a qualitative study will analyse the participation and satisfaction of professionals in the COPA model and the satisfaction of patients

A preliminary assessment during the implementation period has show that the number of PCPs participating in COPA steadily increased from October 2006 to October 2007 to reach a total of 79 out of the 200 PCPs practicing in the borough. In term of process indicator, 27.4% of participant PCPs had a face-to-face meeting with the case manager to discuss the care plan. This (low) number does not reflect actual collaboration since it records only meetings at the PCPs' office for complex cases whereas case managers more frequently contacted PCPs by telephone. Also 42.5% of the patients were seen homes by COPA geriatricians at the request of their PCPs.

In term of outcomes, the service utilization rate appears to be lower than the national rate for the same age group (29.2% to compare with 62%) even though COPA targeted very frail persons in this group. In addition, the rate of Emergency room use (9.4%) stood well below the national rate (40%). Finally, the rate of home deaths (50%) appeared to be higher for COPA patients than the national rate reported for the same age group (26%) indicating a more prevalent use of the home as place of death.

So even without the results of the quasi experimental assessment, it can be hypothesize that the COPA experiment provides interesting directions for the development and implementation of an efficient models of integrated care in the French LTC sector. But it remains to see if and how it can be generalized.