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Supporting the Renewing of Public Policy on Healthcare at a Regional Level: Learning How to Break the Framework through National Pilot Programs under *Article 51*

Isabelle Bourgeois[1,2], Noémie Morize[1,3], Cécile Fournier[1]

Statement 51 of the 2018 French Social Security Funding Act (*Article 51, Loi de Financement de la Sécurité Sociale*, LFSS) introduced a scheme that allows for pilot experiments that derogate from standard funding and organisational rules for health care delivery organisations. They make it possible to decompartmentalise care, which is traditionally based on funding that remunerates services performed by self-employed healthcare professionals. Three pilot programs aimed at finding alternatives to fee-for-service payments were thus initiated at the national level (Morize et al., 2021): a risk-adjusted capitation payment accorded to the characteristics of the patients concerned for ambulatory healthcare professionals practising in Primary Care Teams (*Paiement en équipe de professionnels de santé en ville*, PEPS), a five-year pilot programme with additional financial incentives combining advances payment and shared savings aiming to improve coordination between hospital and Primary Care Teams (*Incitation à une prise en charge partagée*, IPEP), and an episode-based bundled payment system (*Paiement à l'épisode de soins*, EDS). Since the first two pilot programs focus, in particular, on the remuneration of primary healthcare professionals, they were examined in this study.

The circular of 13 April 2018 informed the French Regional Health Agencies (*Agences Régionales de Santé*, ARS) about the procedure for monitoring experimental projects. In the various regions, the initiation of the implementation of the PEPS and IPEP pilot programs took place from the first half of 2018 to the beginning of 2020. How did the regional actors, in particular the ARS, implement the new schemes, some of which were intended to be national schemes?

The qualitative sociological study, based on around twenty interviews conducted between November 2019 and February 2020 in four regions that had participated in the joint definition phase of the specifications for the PEPS and IPEP national pilot programs, analysed the steps taken by the regional referents in the ARS and the French National Health Insurance system's network, as well as the challenges encountered in the initial phase. This case study questioned more broadly the role played by the various regional players in the development and implementation of the renewing of public policy on healthcare.

The Regional Health Agencies (*Agences regionales de santé*, ARS), created by the 2009 Hospital, Patients, Health and Territories Act (*Loi Hôpital, Patients, Santé et Territoires*, HPST), are responsible for simultaneously implementing national policies at a local level, regulating healthcare provision, and funding and assessing projects adapted to the specificities of their region, based on guidelines set out in a Regional Health Plan (Plan Régional de Santé, PRS). By replacing the Regional Hospital Agencies (*Agences régionales de l'hospitalisation*), the ARS have broadened the scope of their activities to include, amongst others, the regulation of primary healthcare. In this context, *Article 51* of the 2018 French Social Security Funding Act (LFSS) introduced a scheme that allows for pilot experiments that derogate from standard funding and organisational rules for health care delivery organisations. There are several possible avenues for experimentation: experiments that are "on the initiative of the actors" (projects coordinated

[1] Institute for Research and Information in Health Economics (IRDES), Paris, France.

[2] Icone Médiation santé, Rennes, France.

[3] Centre for the Sociology of Organisations, a research unit of Sciences Po, Paris, France.

at a regional level), and experiments conceived in response to an interregional or national call for projects. This study focuses on the latter avenue for experimentation, through the calls for expressions of interest (AMI, *Appels à manifestations d'intérêt*) for two pilot programs named PEPS (*Paiement en équipe de professionnels de santé en ville)* –a fixed-rate payment for primary care teams for GPs and nurses-, and IPEP (*Incitation à une prise en charge partagée*)– additional incentive payments to improve coordination between hospital and primary care (*see* inset Definitions).

The implementation of the PEPS and IPEP pilot programs is thus based on centralised coordination accomplished by the executive teams of the programs in the Ministry of Health and the French National Health Insurance Fund (*Caisse nationale de l'Assurance maladie*, CNAM) [Morize *et al.*, 2021]. In the various regions, the ARS coordinate all the modalities of the *Article 51* scheme with the French National Health Insurance system's network. The State support teams thus interact with the 17 ARS through regional referents, a regional approach identified as appropriate for the implementation of healthcare policies (Pierru, 2012). Hence, the question arises as to how did the regional actors, and in particular the ARS, implement the new schemes, some of which were conceived and defined at the national level through calls for expressions of interest (AMI).

The apprehension and adoption of all the modalities of the *Article 51* scheme in the various regions occurred between the first half of 2018 and February 2019. During this period, the *Article 51* referents in the ARS and in the Regional Risk Management Coordination Centres *(Directions de la Coordination de la Gestion du Risque*, DCGDR) –regional hubs of the French health insurance system's network– faced various challenges: organisational challenges relating to new working methods; institutional challenges relating to the adoption of collaborative working practices, challenging the traditional institutional cultures; regional issues that questioned the roles and levels of decision-making, of the monitoring of the progress on projects, and the proximity to the project leaders; and, lastly, cognitive issues concerning ways of thinking, the use of certain tools and working methods, as well as the understanding of the projects' underlying economic models.

A comparative study of these issues and challenges and the national issues and challenges (Morize et al., 2021) contributes to reflection on the regional levels of action and the renewing of public policy on healthcare within the experimental framework of *Article 51*.

Three phases in the apprehension and adoption of the national framework of the PEPS and IPEP pilot programs in the various regions

In the various regions, the 17 ARS coordinate the *Article 51* scheme with the French National Health Insurance system's regional network, in conjunction with the State project teams via the regional referents. The four surveyed regions were involved with the commencement of the PEPS and IPEP pilot programs, because they responded to the national call for applications, which aimed to include several ARS, as observers, in the joint definition of the specifications (Morize et al., 2021).

This period comprised three phases: the phase in the first half of 2018, the phase in the summer of 2018, and the phase that occurred between the second half of 2018 and February 2019.

From the adoption of the Act to the wait for instructions in the various regions (January to July 2018): a vague period, which provided the players with an opportunity to apprehend a new framework

In the first half of 2018, the regional organisations –Regional Risk Management Coordination Centres (DCGDR) and ARS– were informed about the existence of a new experimental scheme. While the ARS coordinate the scheme in the regions, it was clearly stated that the French National Health insurance system's teams had to be involved at the start of the scheme: "The involvement of the National Health Insurance system is an essential precondition for the scheme's success. You are therefore invited to involve the risk management directors/coordinators and their teams in the implementation of the scheme and to devise with them ways of organising the healthcare system[1]".

In the four regions, the waiting period marked the beginning of the collaboration between Regional Risk Management Coordination Centres (DCGDR) and ARS on *Article 51* and the study of the texts to apprehend the scheme, which, at this stage, was perceived as very theoretical by the regional actors. The latter had not yet distinguished the "regional" *Article 51* projects from the forthcoming national pilot programs:

> "With (my colleague) M, I remember that we examined the texts on the Internet in great detail and that (...) we put everything on Post-its: all the actors on these schemes, all the stages, because the stages in *Article 51* were pretty long ... between having a project leader who's got an idea, who writes a letter of intent, and who then draws up specifications with us, which are also overseen by the Ministry and come back to us. There were quite a lot of stages in the work. (...) We had someone (...) with whom we were in contact from the outset, and, in fact, *Article 51* was primarily coordinated by the ARS at the beginning, in conjunction with the National Health Insurance system."
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> **ARS, Region C**

> "*Article 51* followed the Social Security Funding Act. We found out about the Article and, as a result, had to set up an organisation without initially understanding the whys and wherefores of the Article. From what we knew at the beginning, it was about innovation, and that had to come from the field. That's all we knew. We had several meetings with the ARS because we said: "Well, we'll have to organise ourselves to study the dossiers that are eligible for *Article 51*". (...) To find out if we had the same definition. And, internally, we invested a lot of time. It took us several months to understand exactly what an *Article 51* project was."
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> **Regional Risk Management Coordination Centre (DCGDR), Region A**

DEFINITIONS

In the *Article 51* scheme, two major avenues for experimentation are provided for: experiments that are 'on the initiative of the actors', suggested by healthcare professionals in healthcare delivery organisations and which are conducted at regional, interregional, or national level, which have not been studied in this paper; and experiments devised nationally by a central directorate in the Ministry of Health and the National Health Insurance Fund (CNAM), such as the PEPS (*Paiement en équipe de professionnels de santé en ville*) and IPEP (*Incitation à une prise en charge partagée*) pilot programs.

The IPEP pilot program is an additional to individual fee-for-services payment that combines advanced payment and shared savings, if any. It aims to improve coordination between hospital and primary care, via additional financial incentives depending on savings regarding patients health care expenditure. This **Accountable Care Organisation (ACO)** like contract is based on quality indicators, and an assessment of the development of a partnership in terms of efficiency.

The PEPS pilot program is an alternative to individual fee-for-service payment that includes a practice level prospective risk-adjusted capitation payment according to the characteristics of the patients concerned (all patients, diabetic patients, or over 65 years old patients), only for GPs indeed nurses and for a subset of care and services, practicing in Primary Care Teams. It includes also a retrospective performance-related payment based on the achievement of a set of quality indicators.

1 Circular No. SG/2018/106 of 13 April 2018.

The examination of the first project proposals from July to August 2018: regional institutions had little influence on the framework that was being developed

For the ARS referents in the four regions, the participation in the joint development of the AMIs in the PEPS and IPEP pilot programs was the actual beginning of their involvement in the *Article 51* scheme, or a way to help structure the work that had already been initiated in the regions. The latter case applied in particular to the regions in which there was a very large number of *Article 51* project proposals on the initiative of the actors from the outset. In other regions, the ARS did not immediately invite actors to submit projects on their initiative, in order to first familiarise themselves with the philosophy of the *Article 51* scheme through their participation in the joint development of the AMIs in the PEPS and IPEP pilot programs.

In the process used to select the participants, who began applying in 2018, the procedure for examining project proposals in the regions was based on regional referents' judgement of the actors' ability to contribute their expertise to the development of the specifications. Hence, the PEPS and IPEP project leaders, who were already known or involved in similar initiatives (for example, in the case of one IPEP application, the applicant was involved in a project to coordinate care between ambulatory healthcare facilities and hospitals), were viewed more favourably at the start of the process. In contrast, regional referents applied high standards when judging project leaders' ability to 'succeed' or the viability of a proposed project. And the projects that were based on an idea deemed interesting, but whose implementation had not yet been achieved or was not visible, were seldom viewed favourably. In retrospect, regional referents have found that certain projects, whose leaders had a national profile, had benefitted from backing at the national level. When they were heavily involved in the selection process, the disconnect between the solicitation of their knowledge of the field and selecting projects on the basis of criteria established externally caused amazement and disbelief, particularly when their unfavourable opinion was not echoed at the national level.

Participation in the joint development of the specifications from September 2018 to February 2019: ARS participated as observers to gain a better understanding of the scheme

The participation in the various working groups was –as some referents have maintained– the point at which the PEPS and IPEP pilot programs became more concrete. Although the regional referents in the ARS and the Regional Risk Management Coordination Centres (DCGDR) had participated in national meetings during the first half of 2018, they had nevertheless remained in a state of uncertainty. For some, the participation in the joint development of the specifications enabled them to assimilate *Article 51*, and contributed to establishing what the actors call a "regulatory framework" for the regional projects, via an initial involvement that could then be used in the regions

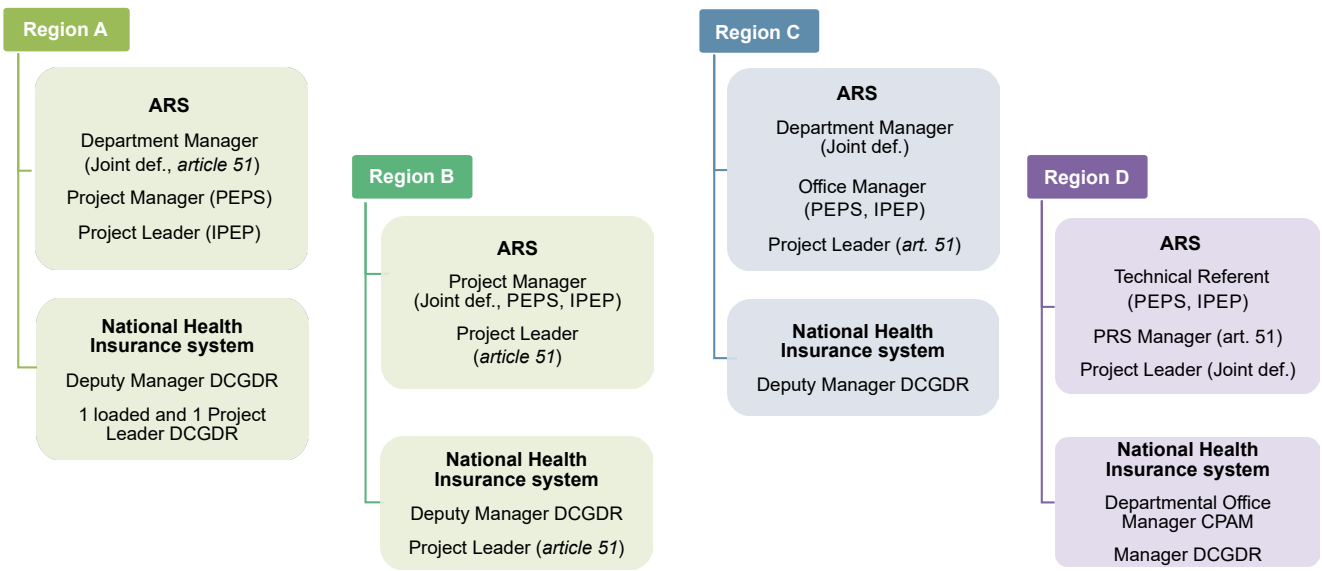
SOURCES AND METHODES

19 sociological interviews were conducted between November 2019 and February 2020 in the four regions that participated in the joint definition of the specifications for the PEPS and IPEP pilot programs (see Figure below). The retrospective interviews focused on what occurred at the beginning of this experimental scheme from the perspective of the regional actors, from the first half of 2018 to the beginning of 2020.

Some of those interviewed –referents designated to conduct the PEPS and IPEP pilot programs (referred to as "PEPS" or "IPEP" in the brackets in the Figure below)– were the regional interlocutors of the executive teams that coordinated the experiments. The other people interviewed in the ARS all played –or still play– a role in the *Article 51* scheme, either because they participated in the joint definition of the PEPS and IPEP pilot programs (referred to as "Joint def."), or because they were *Article 51* referents for the regional projects on the initiative of the local actors (*Article 51*), who sometimes had joint responsibility for the Regional Health Programme (*Programme Régional de Santé*, PRS) [two out of the four regions].

In order to preserve the anonymity of the actors interviewed, the interviews were made anonymous, as were the regions in which the survey was conducted. The institutional affiliations shown in the extracts from interviews quoted in this synthesis are broad to ensure that the actors concerned cannot be recognised. The regions are referred to with letters (A, B, C, and D).

Titles and missions of the regional referents in the Regional Health Agencies (ARS) and the Regional Risk Management Coordination Centres (DCGDR) who were interviewed



for projects that were not the subject of AMIs. The working method was also appreciated and was one of the advantages of the participation in the working groups. The idea of involving several ARS in the joint development phase was, in fact, conceived by the executive teams to familiarise them with the scheme.

> "We were learning. It served as feedback... a regulatory framework, almost. Yes, we'll have to tackle the issue of a coordinator. Isn't there one? We weren't actors, but we learned a lot.'
> **ARS, Region A**

> "When *Article 51* was introduced, I had to deal with that, and I was monitoring another project at the regional level, implemented by a health centre. And, in fact, I used what I had seen in the PEPS working group to advance the project in the region."
> **ARS, Region D**

> "The aim was to assimilate them, to make them people who had a good understanding of the whys and wherefores of the models that were being tested."
> **State project team**

Participation also provided the ARS referents with a vantage point from which they grasped the fact that not all the project leaders had the same level of commitment –some participated more than others–, and also that the various authorities of the Ministry of Health and those of other national institutions were not always in agreement. The experience remained very positive for the participants, who appreciated an initiative that deemed unique, effective, and productive. For some referents the initiative fostered closer relations with the project leaders in their region who had responded to the AMIs in the PEPS and IPEP pilot programs, and facilitated the creation of an inter-regional network of referents, making it possible to disseminate tools. Hence, the referents who participated in these meetings viewed them as beneficial on the whole, and some even considered them essential.

> "What I think is that for a region that hadn't participated in the joint definition phase, which fell within the scope of one of the three AMIs, it wasn't easy."
> **ARS, Region A**

Indeed, in the regions surveyed, the implementation of the PEPS and IPEP pilot programs primarily responded to organisational needs.

The organisational issues related to the implementation of the PEPS and IPEP pilot programs in the various regions: initiating the transversal coordination of a unique scheme

The implementation of the *Article 51* scheme in the regional institutions required project management to be structured locally. This required considerable work, due to the transversal nature of these schemes, which was new for the regional authorities and, particularly, the ARS.

The working methods were developed and evolved over time

The development of the work in the regions obliged the regional referents to make a significant investment in time. There was some confusion at the start of the process–a breaking-in period during which three subjects were dealt with: The examination of the proposed projects, the internal information circuits, and the working arrangements between the ARS and the French National Health Insurance system. This initial period involved the *Article 51* projects on the initiative of the actors and the AMIs. The referents in the regional institutions did not always distinguish between the two processes, which, as will be seen, fed one another. Then the working arrangements became more firmly established. The referents developed project monitoring tools, set up dashboards, formalised procedures, and disseminated information. Each region structured "its" *Article 51* scheme:

> "Everyone did what they could. So we established procedures and developed processes."
> **ARS, Region A**

There was another challenging issue in some of the regions: managing the flow of projects. In two regions, a very formalised system was set up to reach out to people who had expertise in a métier:

> "We had to effectively create an organisation so that, for each project we received, we could call on the required expertise internally."
> **ARS, Region A**

All the structuring in the form of procedures, dashboards, and the processing of proposed projects was part of a more general management mechanism that enabled the regional actors to make decisions. In addition to the internal structuring within each organisation –the ARS and the Regional Risk Management Coordination Centres (DCGDR)–, the development of joint working between the organisations occurred early on in the four regions. Joint working began in 2018 and the division of tasks seemed to be quite clear for the referents, centred around specific expertise. The ARS acted as coordinators and the DCGDR provided data and produced statistics. The regional collaboration between the two institutions was facilitated by the fact that it was driven at the national level, notably through joint meetings in Paris between the French National Health Insurance system and the Ministry of Health. However, this coordination was not easy. When they worked extensively together, coordination between the two organisations was fruitful. More generally, the *Article 51* scheme, at least at the start, relied heavily on the commitment and work of individuals who implemented it in the regional institutions.

A scheme based on the commitment of the regional referents, who worked outside traditional administrative frameworks

The success of the implementation of the pilot programs in the regions depended, in part, on individuals' ability to invent new forms of structuring (internal management in the ARS and modalities of collaboration between ARS and the French health insurance system) and put them into practice. This multifaceted ability involved, in particular, an investment in relations between the referents in the various institutions. For those in the first wave who apprehended the scheme together, and sometimes had to work hard together at the beginning to understand the texts, this sometimes brought people together.

CONTEXT

This study is anchored in the first sociological and qualitative part of the programme of assessment of the pilot programs aimed at finding alternatives to fee-for-service payments in the context of *Article 51* (Era2[1]), funded by the French National Health Insurance system. The conception and implementation of the *Article 51* scheme at the national level were analysed in a previous Issues in Health Economics (*Questions d'Économie de la Santé*[2]) which provided a general description of the scheme and the specifics of two calls for expressions of interest (AMI) for two pilot programs, a fixed-rate payment for primary care teams for GPs and nurses (PEPS, *Paiement en équipe de professionnels de santé en ville*), and incentive payments to improve coordination between hospital and primary care, (IPEP, *Incitation à une prise en charge partagée*) [Morize et al., 2021]. This study will be followed by a survey carried out in healthcare professionals' organisations that are conducting PEPS and IPEP pilot programs.

[1] https://www.irdes.fr/recherche/enquetes/era2-evaluation-d-experimentations-article-51-de-remuneration-alternative-a-l-acte/actualites.html

[2] https://www.irdes.fr/recherche/2021/qes-261-renouveler-l-action-publique-en-sante-un-article-51-pour-experimenter-avec-les-organisations-de-sante.html

In the end, the health insurance system's referents welcomed the experiment because it enabled them to work outside a framework that they perceived as an administrative straightjacket.

> "I guess that that's why I like *Article 51*... it released us from the health insurance system's regulatory straightjacket. I guess that's what I find interesting, because, ultimately, we said: "Well yes, in fact, we've got an idea. And, finally, it's possible to put it into action". I think that's good."
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> **Regional Risk Management Coordination Centre (DCGDR), Region B**

Other incentives to become involved stemmed from the fact that the experiment made it possible to create or strengthen links with healthcare professionals. In the opinion of these referents, it was a significant change of approach. Hence, some referents expressed their satisfaction at being able to help the actors to develop their projects rather than imposing a strict regulatory framework or specifications. The approach they adopted with regard to healthcare professionals – listening to the actor's needs and providing support– seemed more conducive to the emergence of projects.

> "I was won over by the method, the value and importance. And that motivated me every day. Listening to the actors' needs, trying to meet them, and the change of approach, even though it's complex. And I'm not a beginner in my métier, as has been seen. I've already got years of experience, so even though it's difficult not to make mistakes, I strongly believe in this approach. I want to work in that way."
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> **ARS, Region A**

Lastly, the enthusiasm also stemmed from the fact that this transversal and constructive approach enabled the referents to extend their network, even within their institution. The downside of the initial enthusiasm was the considerable investment in time that this required. In general, they felt that the workload had been underestimated. This is not a new phenomenon in the ARS and was addressed when the local health contracts (*Contrats locaux de santé*, CLS) were concluded. The difficulty of managing the flow of projects increased the officials' workload (Juhle *et al.*, 2021). In this case, the increased workload resulted from a dual shift: a shift towards the local actors as the approach was a localised one and was appreciated by the referents, and a shift towards the national level, which was a learning ground for the regional referents.

Some teams grew in size, others did not. The regional teams adapted and when they lost human resources, they became less committed. In general, the process was undermined by the movement of team members –parental leave and the end of fixed-term contracts (*Contrat à durée déterminée*, CDD)–, which was relatively frequent. In three of the four regions, there were movements of team members in the ARS and the DCGDR.

> "After the departure [of the *Article 51* referent], I found myself on the front line. (...) I participated in the last videoconference, at the end of December. But it's true that I thought that I wasn't going to be able to become involved in the same way [as her]. I've got a lot of other things to see to. So I don't know at the moment, I don't know. Recruiting internally is difficult. So, I'm not sure that people will be recruited. (...) When (the *Article 51* referent) said she was leaving, we panicked a little."
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> **DCGDR, Region B**

> "I came back a year ago after taking maternity leave and so I missed out (...) I was away for seven months (...) And when I returned, on 2 January, last year, I was asked to be a referent for Management."
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> **ARS, Region C**

Familiarity with the scheme, which operates outside the traditional administrative framework, lessened with the movement of team members. All the procedures that have been established aim to maintain the organisational modalities (the processing of proposed projects, comitology, etc.). The implementation of the *Article 51* experimental scheme and the issuing of AMIs is not, however, just an organisational process –it is also, as will be seen, a cognitive process. The accumulated knowledge cannot always be formalised, as is the case with the change of approach that occurs– from checking projects for compliance to providing support for projects. The organisational culture of the scheme has been assimilated and disseminated, but it is difficult to transpose it procedurally.

A transversal project implemented by many actors with specific expertise in compartmentalised settings

The transversal nature of the experiment meant that it was hampered by organisations based on distributed expertise. The referents had to deal with the fact that they did not always have sufficient knowledge of a project's specific issues, for example, and that they had to call on the required expertise. This could also be disruptive. They admitted that they had to "seek out information". The expertise was found in an institution's other departments. For example, the DCGDR could have risk prevention experts. The ARS are organised into specialist departments, stemming from funding approaches that were developed at the national level (Rolland, Pierru, 2013), and which correspond to various kinds of expertise.

> "We're going to see the right people at the right time. (...) Inviting the right person who knows how to use performance accelerators. (...) I can't be an expert in everything. So, sometimes, the accelerators are quite frustrating. Because you come out of the meeting and you think: *But I didn't know anything*."
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> **ARS, Region A**

> "[My role in the IPEP pilot programs] (...) it was more of an "information seeking" role... But effectively, that's what it was, trying to obtain information–that was the first thing I needed to do, and if I did obtain the information, sending it to the health insurance offices concerned, and also informing the National Health Insurance Fund (CNAM), and, lastly, the *Article 51* executive team in conjunction with the ARS because, often, we tried to inform both sides to ensure that it was fully taken into account."
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> **DCGDR, Region A**

Medical expertise was also sought from the health service's regional directorates (*Direction Régionale du Service Médical*, DRSM), decentralised departments of the French Local Health Insurance Fund (*Caisse primaire d'Assurance maladie*, CPAM). But some ARS also sought external expertise, for example expertise on the medical and social aspects from a departmental council (*Conseil Départemental*), or expertise in a university when there were partnerships.

> "The ARS has an agreement with the university (... on) everything relating to innovations in healthcare in general, but not necessarily in the framework of *Article 51*. There's a partnership with the university, but not solely in terms of knowledge of health economics–often it's in terms of statistics or public health in general. So, there's an agreement with the university that can involve expertise. During the steering committee, there were things like that... on the evaluation questions...'"
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> **ARS, Region B**

When the need to mobilise widely distributed expertise in various institutions had been ascertained, the mobilisation of expertise had to nevertheless be accomplished. Indeed, the specialist departments in the ARS were often called upon by the *Article 51* referents, above all those involved in the first step. To mobilise them, several modalities were put in place in the ARS. The information was disseminated continuously and through various channels. For example, some referents issued a newsletter, while others reached out to their interlocuters and gave an "*Article 51* briefing" at departmental meetings. The continuous nature of the information campaign caused the referents 'to become part of the landscape'. A more traditional modality was the creation of an ad hoc committee which made it possible to bring together all the actors, and the information flowed both ways: the referents informed the teams about the national developments of the *Article 51* scheme, and the members of the teams informed the *Article 51*

referents about the progress of certain projects that they were able to monitor. The disadvantage of these very institutional procedures is their complexity in terms of logistics (clash of agendas, drafting reports, room reservations, etc.), which led some ARS to abandon them. Another modality observed in the ARS was the ad hoc organisation of seminars in which the approaches adopted –closely modelled on those assimilated at the national level–, were attractive and aimed to motivate the participants.

Institutions' traditional roles have been redefined: shifting from checking projects for compliance to supporting emerging projects

In accordance with the circular of 13 April 2018, the ARS –institutions that have been established recently in the healthcare field and are gradually establishing themselves in their areas– were given the task of implementing the *Article 51* scheme, while the DCGDR and the French Local Health Insurance Fund (CPAM), whose relations with healthcare professionals have been strengthened by the interprofessional conventional agreement (ACI) in 2015, are involved in the scheme relating to multidisciplinary healthcare organisations. The Regional Health Agencies' scope of action is sometimes a cause for concern amongst their counterparts in the National Health Insurance system. Indeed, the relations between ARS and the DCGDR are not always easy:

> "There has, effectively, always been rivalry between the ARS and the National Health Insurance system. We sensed it when talking to former colleagues, in meetings in which we weren't informed about everything, and then in the middle of meetings you'd hear: "*And what's the view of the National Health Insurance system...?*" (...) In the National Health Insurance system, we've always heard them say: "*Yes, they want to take over our health insurance role; they're playing an increasingly important role, so we have to be present, be there, and show them that we exist*". There's an ever-present fear of the ARS in the National Health Insurance system."
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> **DCGDR, Region C**

Although communication between these institutions was poor, it was nevertheless established at the start of the scheme and a joint working arrangement was set up in the four surveyed regions. This success is partly explained by two processes. The first process was the advisors' investment in interpersonal relations in the field. The second process was driven by the national framework, which served as a model with a joint working arrangement between the National Health Insurance system and the Ministry of Health, visible to the regional and local actors.

The referents in the ARS and the DCGDR all basically noted that their traditional institutional cultures were being challenged. In the wake of cultural transformations initiated through the support provided for Multiprofessional Group Practices (*Maisons de santé pluriprofessionnelles*, MSP) as part of experiments with new modes of remuneration (*Expérimentation des Nouveaux Modes de Rémunération*, ENMR) (Fournier et al., 2014) and the interprofessional conventional agreement (ACI) that followed, the entire *Article 51* scheme, with a substantial flow of regional projects, is now seriously challenging the institutional cultures. The AMIs in the PEPS and IPEP pilot programs were not the only source of these changes. The regional referents stated that they experienced tension between an automatic top-down bureaucratic process of checking projects for compliance and a new institutional approach, stemming from *Article 51* and a quest to complete projects.

> "At the time, the idea was to say: "*The approach of the ARS and the National Health Insurance system needs to change; it's an approach that consists, a priori, of saying no, and then adopting a stance of seeing what might be of value in a project*"."
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> **ARS, Region C**

Article 51 obliged ARS professionals to adopt a new approach:

> "[There was] a problem, we put it on the table and tried to find a solution. It sounds crazy, but that wasn't our way of working. (...) It was a pragmatic and operational approach that we didn't have before."
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> **ARS, Region A**

The working methods have changed. The relations between the healthcare professionals and healthcare facilities have also changed. They were already in the process of changing in the drive to structure primary care, in which they became collective interlocutors and partners through an interprofessional conventional agreement (ACI). *Article 51* has overturned the relation of institutional authority to healthcare professionals. A larger number of institutional actors and healthcare professionals worked together to complete a project implemented by the healthcare professionals and validated at the national level, with the mediation of regional referents at various levels.

Institutional action was implemented at various levels: regional referents had little control over the PEPS and IPEP projects

The institutional domain can be divided into three levels: the national institutional level (that of the State project teams), the regional institutional level (ARS and DCGDR), and the departmental and local institutional level (the departmental offices of the ARS and the French Local Health Insurance Fund (CPAM)), and a fourth level, that of the projects, which will be examined in a future study. Collaboration was established –and there was some tension– between the various levels, whose aims in the process of issuing AMIs in the PEPS and IPEP pilot programs were not always the same. The idea here was to understand the issues specific to each of the three levels, and the way in which the regional institutional level –caught between the other two levels– tried to articulate them.

At the national institutional level, the aim was to communicate projects, and, in the case of AMIs in the PEPS and IPEP pilot programs, obtain commitment to a sufficient number of diverse projects, whose initiators in the healthcare organisations adhered to the principles behind the experiments. For the executive teams, the regional institutional level therefore represented a gateway to the 'field' that they described as "local", and which they believed was in a position to identify and support projects that were likely to respond to the AMIs:

> "We always liaised with the ARS, which –because a paper file is always a paper file–, sometimes enabled us to say: "*Basically, that's just hot air*", or: "*A very difficult person*"... that sort of thing that enabled us to separate the wheat from the chaff."
>
> **State project team, CNAM, IPEP**

> "By studying the dossiers, we could discern whether or not they understood PEPS. And the ARS explained to us how they operated. Were they quite dynamic? Did they work together?"
>
> **State project team, Ministry of Health, PEPS**

The spontaneous perception of the regional institutional level as an entry point to gain access to the field stemmed from the history of the creation of the ARS, as the regional institutional level gradually became the common law territorial level at which public policy on healthcare was managed (Pierru, Rolland, 2016; Juhle et al., 2021).

However, in this case, the regional institutional level had to simultaneously meet two challenges: in its region, it had to manage the flow of projects from which it had to select viable projects, while meeting the requirements laid down at the national institutional level. Hence, the management of the flow of *Article 51* projects with different statuses proved difficult (regional projects at various levels, AMIs, interregional projects, regional projects reoriented towards existing national schemes, etc.), so much so that the statements made by referents about the status of the

projects submitted to them were sometimes confused. Furthermore, the national institutional level tended to confuse the other two institutional levels when liaising with the "field"–the proximity that for the national institutional level was represented by the *Article 51* referents who often worked in the main offices of the ARS and the DCGDR, whereas the latter logically had to endeavour to involve their more local interlocutors. The regional referents did in fact express their amazement that they were considered by the executive teams as the local "field", whereas decisions had to be made in the regions to decide how to coordinate projects at the local institutional level. At the beginning of 2020, when the interviews were conducted, the situations were heterogeneous and unstable. The regional referents were not the usual interlocuters of the project leaders, and the team members in the departmental offices of the ARS and the French Local Health Insurance Fund (CPAM), their usual interlocutors, were not always involved in monitoring *Article 51* projects.

Furthermore, the regional institutional level faced tension between the top-down pressure to produce projects and the demand for creativity associated with projects conceived in the field, which required time. However, the links between the national and regional institutional levels were nurtured–representatives of the executive teams were perceived as being available and ready to listen. Nevertheless, this did not prevent the issue of liaising with the 'field' in the AMIs in the PEPS and IPEP pilot programs, which was sometimes dogmatic, from sometimes being pushed aside in the case of some national projects, at least in the initial period examined in this study.

Since the roles of the regional and local institutional actors remained poorly defined in a scheme implemented "from the top-down", the regional referents said that they were waiting for their roles to be defined. Some of them remained on the sidelines, while others defined their roles themselves. Some referents were surprised by the lack of progress in certain projects, others noted that there were projects that were not being managed and projects that sometimes seemed to be unrealistic, and others discovered projects that developed independently–the initiators interacted directly with the national institutional level. The regional referents, who felt excluded from the projects, sometimes expressed their feelings of powerlessness vis-à-vis project leaders, especially as their traditional management role had no place in this open scheme.

> "*"But, in fact, they haven't really thought about their project*". (Sometimes) it seemed that it was just an idea, but I thought that it was more advanced than that. Yes, we said: "*Is that where we're at?*" (...) Sometimes, I guess, we could have helped, but we didn't really know how to."
>
> **ARS, Region A**

So there were regional referents who observed and waited and others who became heavily involved in monitoring projects and worked extensively on project development. As mentioned above, they did in fact have little control over certain projects that had a somewhat national scope, and, generally, had no control over the management of the PEPS and IPEP projects. However, a consolidation of the information circuits between the regional and local institutional levels could be seen over time. The regional institutional level studied and acquainted itself at the national level with the general framework of the *Article 51* scheme. At the same time, the regional institutional level enlightened and informed the local institutional level about the scheme, by sending out newsletters, via information given to the French Local Health Insurance Fund (CPAM) offices by the DCGDR, by inviting team members to participate in seminars, and so on.

And at the same time, the local institutional level informed the regional institutional level about the dynamics associated with an *Article 51* project-based approach in the selection of applicants from the two waves of applications in response to the AMIs in the PEPS and IPEP pilot programs, and in the assessment of letters of intent for the regional projects. The teams in the departmental offices (*Délégations Départementales*, DD) of the ARS and the French Local Health Insurance Fund (CPAM), who were in fact acquainted with the teams of healthcare professionals, were able to inform the regional institutional level about specific elements relating to the projects and their initiators, such as whether there was a project to set up a regional group of health professionals (*Communauté Professionnelle Territoriale de Santé*, CPTS), for example, or the project leaders' previous experience.

A learning process nurtured by the scheme: a cognitive framework that developed through experience

In addition to the organisational, territorial, and institutional issues, we observed, during the implementation of *Article 51* in the four regions, that the actors endeavoured to understand the new scheme that changed some of their working methods and way of thinking. The apprehension and adoption of the *Article 51* scheme was based on a learning process. It was a cross-sectoral issue.

> "There was a phase in which the literature was studied (...) Reading's all well and good, but that's not the be-all and end-all. Then there were meetings and we met the project leaders (...). That's how I apprehended the scheme–in meetings with the project leaders. (...) Then there was all the time spent communicating with the ministry, by phone and during seminars that were held regularly in Paris. So, it was a whole set of things."
>
> **ARS, Region B**

There was a mismatch at the outset between the national discourse about the scheme, perceived by the healthcare professionals as being very open, and a framework in the texts, which, although it existed from the very beginning, was adopted progressively. The mismatch was particularly evident in the monitoring of regional projects, in which the referents were more involved.

> "That is to say: "*Everything's possible. Submit innovative projects*". Except that we then said: "*What's meant by exemption?*" (...) There was the case of the CHU university hospital (...) that had a project (...) and he said: "*I don't understand, what does exemption from payment mean?*" So this was the start of the *Article 51* scheme and he was wondering what it was. (...) So, once again, I had to explain what it meant. But why was all that necessary? Because, in fact, they didn't necessarily read the texts for various reasons to do with time, interest... (...) What they retained (...), is that anything's possible in the *Article 51* scheme as long as it's innovative. (...) So, we thought that, generally, it would become clear in the long run. (...) I also think that people slowly started to understand the scheme, that is to say that people knew exactly when they were in the *Article 51* scheme and when they weren't."
>
> **ARS, Region B**

This is how the regional actors learned 'by doing', by dealing with the projects, meeting the participants –the members of the executive teams and their counterparts in the regional and territorial institutions–, and by getting involved in the scheme. The two processes – the AMIs and the *Article 51* projects on the initiative of the actors– fed one another.

A set of participatory approaches, based on tools that they discovered in exotic venues, were made available to them to help them learn about the scheme: meetings at the regional and national levels, which not only provided access to information, but also to a network, which itself generated knowledge, and methods. The working methods employed (brainstorming, "performance accelerators" proposed by the Inter-Ministerial Delegation for Public Transformation (*Délégation interministérielle de la transformation publique*), etc.) were, in fact, considered effective by some.

> "For example, everything that was followed by AMIs was done in different venues, every time. Anything to do with accelerators was always done in different venues, in a sort of start-up mode, you know?"
>
> **DCGDR, Region A**

The venues were exotic and there was a sort of alternative culture linked to the involvement of consulting services that specialised in innovation, but there was more to it than that. The working methods, whose aim was to invite the participants to resolve a common problem (to which they were unaccustomed), made it possible to share different types of knowledge and thus enrich thinking by pooling them. Other referents noted that the working method consisted of entering a project 'into the pipeline' at an early stage, and not creating a dossier of several tens of pages that then need to be analysed and recompiled, which made it possible to save time.

It was an approach that challenged the traditional working methods, which had hitherto focused on the establishment of procedures and verifying compliance with these procedures. The regional referents involved in the Article 51 pilot programs learned not to lay down criteria and to accept uncertainty. To achieve this, some stressed that –at least at the beginning– they thought backwards, questioning instead what an Article 51 project was not, or developing a doctrine by promoting, for example, cross-sectoral projects (involving, in particular, ambulatory practices and hospitals), to which they were unaccustomed.

The importance of disseminating information to keep everyone updated arose from the diverse and distributed nature of the required expertise. For the regional referents, participation in the joint definition phase constituted a period of learning that gave them a better understanding of the expectations of the State project teams, and thus enabled them to provide better support for the regional projects through a renewed policy framework.

* * *

During its apprehension and initiation in four pilot regions, the *Article 51* scheme led to several conflicting developments –the formalisation and loosening of existing administrative frameworks– which were modelled by the regional institutional actors, while complying with the national frameworks. Indeed, an initial national framework for this unique scheme, which has the particularity of remaining very open with regard to the definition of eligible projects, was outlined in a circular, and then in presentation meetings and through the appointment of regional interlocutors. The latter worked within this framework, while inventing new forms of work organisation and experimenting with various transversal management methods, prompting interchange between the ARS and the National Health Insurance system's network, and mobilising various departments in these administrative bodies. The aim –through local implementation of the scheme– was to manage all the projects, while taking into account the transversal nature of a scheme that was new for all the actors involved.

The *Article 51* scheme has also challenged the various institutional frameworks, established for the scheme or prior to it. The *Article 51* referents in the various regions invested time in developing relations with their counterparts and the project leaders, or their local interlocutors. They learned to change their approach, shifting from a role in which they checked projects for compliance to one in which they provided support for projects. They thus established a cognitive framework "by doing", based on their experience, and which, for those who participated, began during the meetings in which the specifications for the PEPS and IPEP national pilot programs were jointly defined. What about the referents in the other regions, who joined the scheme at a later stage? It will be interesting to monitor the way in which the documented feedback, or the issuing of guidelines, enabled the regional referents who did not participate in the joint definition phase to adopt the scheme.

Studying the implementation of the PEPS and IPEP pilot programs in the regions made it possible to question the role of the regional institutional level in a territorial political-administrative landscape, which has become more complex following waves of public policy decentralisation at territorial level, the decentralisation of government departments, and the redefinition of the relevance of the various territorial levels (Epstein, 2020). At the same time as the ARS are experimenting with the development of policies at the regional level through the management of *Article 51* projects "on the initiative of the actors", our study shows flows and mutual learning between the management of this part of the scheme and that of the calls for expressions of interest (AMI) in the PEPS and IPEP national pilot programs that we specifically studied. The four ARS surveyed, in conjunction with the Regional Risk Management Coordination Centres (DCGDR), implemented the proposed framework and invented new institutional practices with the PEPS and IPEP project leaders and the executive teams. While drawing inspiration for other projects, they agreed, in the case of the PEPS and IPEP pilot programs, to adopt the role of implementing healthcare policies –developed at the national level– at the regional level, as enshrined in the law establishing them, which gave them little control over the definition and selection of the PEPS and IPEP projects. ♦

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