
Top-Down and Bottom-Up Approaches to Health Pathways Through Population Responsibility

1.1. Introduction

In order to address the challenges of chronic diseases and aging, our healthcare systems must transform themselves, overcome their conventional fragmentation and evolve towards more integrated models that are focused on the needs of the population and prevention (OECD 2023). According to Berwick et al. (2008), they must aim for a triple objective: better health for a defined population, better care for each individual in that population and greater efficiency in the use of resources.

This raises the question of our healthcare organizations' capacity for change (Boileau et al. 2019) and, in particular, the most effective ways to create, promote and support collaboration between professionals, based on state-of-the-art practices for the benefit of and with the participation of patients.

On the one hand, there is the organizing state (Bergeron and Hassenteufel 2018): the state no longer organizes itself, but organizes collaboration by setting up dedicated structures (such as CPTS, GHT, MSP) or according to a standard strategy for change management, aimed at promoting collaboration (e.g. by certifying local hospitals). However, research in organizational sociology – organizational sciences, implementation sciences, etc. – shows that these institutional frameworks are likely to have little impact on practices, treatment and ultimately health outcomes (Aubert et al. 2020). There is significant difficulty in promoting cooperation within the framework of a standard strategy for change management, as the healthcare sector is characterized

by professional logic, which does not align with bureaucratic logic (Mintzberg 2004; Bourgueil 2010).

Conversely, bottom-up approaches to innovation are more likely to involve actors in the field and thus have an impact on actual practices, both among professionals and in their interactions with users (Berchi and Cueille 2022). There has been a major paradigm shift around the care pathway (Bloch and Hénaut 2014), which refocuses care around the patient and requires managerial support in order for it to be implemented (Bloch et al. 2018). However, this raises the question of whether these local innovations can be extended or even adopted, as well as their sustainability once the promoters have left. It also raises further questions about their adoption, and whether they can move beyond their highly localized nature if they are not part of a system (institutional or otherwise) that specifically allows for this adoption. In other words, these innovations remain dependent on the people, the place and the context in which they take place.

The aim of this chapter is to bring these two approaches together, showing how local actors were able to adopt a model of clinical but non-institutional integration, then ensure its effectiveness by mobilizing institutional tools. The lessons from this local experience could be far reaching, as, on the one side, the clinical integration model (Population Responsibility) is scalable by design, and is in fact already widely implemented, and, on the other side, the regulatory framework leveraged by local stakeholders to institutionalize their work also has national scope. The key question therefore becomes: “What type of work was performed by local stakeholders to bring the two together?”.

To do this, we draw on the framework developed by Cloutier et al. (2016), which identifies four types of institutional work that must be undertaken in a complementary manner in order to create the conditions for real results: conceptual, operational and structural work, all supported by relational work.

We examine this bottom-up institutionalization dynamic through a case study conducted in a local community over a nine-month period. We show how four types of institutional work were used to combine top-down institutionalization and bottom-up innovation, as part of a generalizable approach based on measurable indicators. We use this analytical framework to highlight how healthcare actors in a given region were able to leverage a national regulatory framework organizing certification of Local Hospitals (*Hôpitaux de Proximité*) to support a clinical integration model that was itself designed to be generalizable, but has so far lacked institutional support in France. The results of this research could inspire public decision-makers and healthcare actors, providing insights that are directly applicable

to practice, particularly for developing sustainable cooperation that guarantees a strengthened and sustainable patient pathway at the local level.

1.2. Context

The interaction and mutual support between bottom-up and top-down innovations are illustrated by the link between a highly localized clinical integration model focused on volunteer-based professional practices – the population responsibility model – and an institutional innovation promoted by the French Ministry of Health, relating to local hospitals.

1.2.1. *The clinical integration model based on population responsibility (PR)*

In light of the challenges brought about by chronic diseases and an aging population, there is a consensus that our healthcare systems need to evolve towards more integrated and preventive models (OECD 2023). In its 2017 policy platform, the French Hospitals Federation (FHF)¹ called for “rebuilding our healthcare system on the basis of the principle of population responsibility” for all stakeholders in a given region (FHF 2017). This principle is now included in the French Public Health Code (L1434-10).

To implement this principle, the FHF has developed a clinical integration model (Berwick et al. 2008) aimed at bringing together all healthcare providers in a given area, in order to work as a single clinical system focused on a target population, ranging from people at risk of developing a disease to complex patients. It aims to systematically implement best practices based on the health needs of the individual (Malone 2021). It was developed around two target populations: people with or at risk of type 2 diabetes, and people with or at risk of heart failure (Gomez et al. 2019).

The model is based on a national stratification of the two target populations, matching health needs with demand on the healthcare system. This stratification is both medical-economic and clinical, and must be immediately usable by professionals. It can be projected onto each health region (Malone et al. 2021) to indicate the number of residents corresponding to each stratum. Each profile is associated with one or more treatment flowcharts, summarizing the state of the art on a given issue for a given profile. These flowcharts can either be used directly by

¹ *Fédération hospitalière de France.*

professionals based on the patient's profile, or to build local care pathways by combining them with regional stratification.

In order to develop, deploy and test the model, the FHF has been working with five pioneering volunteer regions since 2018 – including Aube and Sézannais – which share the same target populations, tools and methods. However, each region develops its own health programs based on its specific characteristics. Each region also develops its own deployment and implementation strategy and decides on its own priorities for action. Thus, a region's entry into population responsibility, followed by its local deployment, is strictly based on the voluntary participation of healthcare actors in that region. Even though the FHF provides the material to carry it out and guarantees its medical and scientific soundness, the approach is based on a bottom-up approach of local ownership and development. There is currently no national administrative framework governing the deployment of the approach, nor even a regional framework formalized by a regional health agency.

Currently, the population responsibility model is being implemented in 10 territories: the five “pioneers” (Aube-Sézannais, Cornouaille, Deux-Sèvres, Douaisis, Haute-Saône) and five new ones that have joined the model since the end of 2023: Belfort-Montbéliard, South Lorraine, the Southern Alps, the Alpes-Maritimes and Mayenne. A dozen others have expressed interest in implementing it in their own areas.

In the five pioneering territories, since its large-scale launch in January 2022, there have been 928 professionals actively participating, 86 patient partners and 129 partner organizations involved in the initiative in the field. More than 950 prevention/outreach initiatives have been carried out, raising awareness among 17,000 people at risk and screening 14,000 individuals. A total of 4,979 patients are being monitored in integrated care pathways².

1.2.2. *Creating local hospitals*

One of the commitments of the French National Public Health Plan 2018–2022 was to “make local hospitals laboratories for regional cooperation” (Friot-Guichard 2023), re-establishing them as key actors in public healthcare in local areas. Local hospitals were given a specific legal status comprising a set of specific services that they must provide in 2019.

2 Source: FHF internal document (2024).

National regulation states that local hospitals must provide medical care, rehabilitation services and consultations in several specialties. They have to provide access to technical facilities for imaging, medical biology and telehealth equipment, but do not perform surgery or obstetrics. With a triple focus on health, medical-social, primary care and home care, they can serve as “drivers for revitalizing healthcare services in the regions” (Rabillier and Friot-Guichard 2023).

As healthcare facilities, local hospitals play a key role in the gradation of hospital services and in referring patients in need to specialized healthcare facilities, within the framework of Territorial Hospital Groups (GHT) and their shared medical and nursing projects, which plan for integrated care pathways.

Local hospitals may be required to diagnose, monitor and treat patients, particularly in medical departments, and to carry out preventive and health education activities, provide care, including palliative care where necessary, with or without accommodation, on an outpatient basis or at home, or even in a nursing home. They help to coordinate care with healthcare professionals working in private practices in primary care and medical-social establishments and services.

In this regard, in 2022, the national authorities (HCAAM)³ reiterated the need to “recognize and organize collective responsibility for access to healthcare in the regions” (HCAAM 2022, p. 41).

This is where the missions of local hospitals are particularly evident, in their coordination with other healthcare providers. Local hospitals must consider the healthcare plans of local healthcare professional communities⁴, which they are often affiliated with, and work in cooperation with outpatient medical facilities and professionals, medical and social institutions and services, as well as all other healthcare institutions and actors (home hospitalization, mental health institutions and services, etc.).

Article 35 of the Law on the Organization and Transformation of the Healthcare System of July 24, 2019⁵ states that “the missions of local hospitals are carried out with the joint participation of outpatient medical facilities and professionals with whom they share territorial responsibility”, which must translate into coordinated care pathways for patients.

3 *Haut Conseil pour l'Avenir de l'Assurance-Maladie*.

4 Particularly the “*Communautés Professionnelles Territoriales de Santé*” (CPTS/Territorial Healthcare Professional Community), a national framework to organize primary care.

5 See: https://www.legifrance.gouv.fr/jorf/article_jo/JORFARTI000038821320.

1.3. Materials and methods

1.3.1. *Exploratory case study on a living area*

We base our findings on a case study of a living area located in one of the five Territorial Hospital Groups (GHT) that are members of the “pioneering regions for population responsibility” group, between 2018 and 2023.

The research team includes a participant observer, who is the deputy director general of the GHT. She has been involved in the various phases of developing the experimental population responsibility program since its inception and has been able to test its implementation in her role, particularly in terms of mobilizing stakeholders around organizational transformation in healthcare. She is joined by the head of the “population responsibility” program at the Hospital Federation of France, who introduced the population responsibility model, adapting it to the specificities of the French healthcare system and implementing it with teams in the five pioneering regions. He has been involved in many key stages of the development of the experimental population responsibility program in the region concerned.

The methodology adopted is a long-term study, as part of an action research approach. The data comes from notes, presentations and documents accumulated throughout the project, as well as from the experience of the main researcher, who was involved in the epistemological aspect of the population responsibility project.

1.3.2. *Observation framework*

1.3.2.1. *The Aube-Sézannais regional hospital group (GHT) and the Bar-sur-Seine living area*

The Aube-Sézannais territorial hospital group (GHT) was created in July 2016. It was formed from a joint management structure established in 2015, comprising all five public health establishments in the Aube department. It includes a large General Hospital, a public mental health establishment in Aube, two local hospitals and two public nursing homes.

The GHT provides all medical, surgical, obstetric, psychiatric, home care, medical and rehabilitation services in the Aube department, as well as nursing home and long-term care services, and has access to almost all technical facilities. It is a referral center for local hospitals. The shared medical and nursing care project has enabled the creation of graduated care pathways that have promoted cooperation with other health and medical-social actors, so as to guarantee equal access to quality care for all citizens.

The Aube-Sézannais Territorial Hospital Group has been a part of the GHT “Pioneers Group” experimenting with the “PR” model since 2018. It is currently implementing the model for type 2 diabetes.

As of September 1, 2024, 328 professionals in the region were participating in the “PR” model, including 32 patient partners. One hundred and forty-five prevention initiatives had been carried out, raising awareness among 4,177 people and leading to the screening of 1,585 individuals. Six hundred and seventy-nine people are included in the “stratified” pathways of Aube-Sézannais⁶.

The Troyes Hospital Center (CHT)⁷, which is the supporting institution for the Aube-Sézannais Territorial Hospital Group (GHT), is located in the heart of a 7,000-km² area with a population of 340,000. Most of the inhabitants are concentrated around Troyes (200,000) and Romilly (50,000), the two areas where the population is growing.

This healthcare facility in the Aube department offers the most comprehensive range of services: it has 1,010 beds and spaces spread across three sites, including a level 3 maternity ward. It is the headquarters of emergency services and handles 50,000 visits to the emergency room. It includes a state-of-the-art technical platform with 10 operating rooms, one of which is a hybrid room equipped with a da Vinci X surgical robot, a complete imaging platform, including interventional radiology and radiotherapy, as well as a complete biology platform, including a pathology laboratory and nuclear medicine, with a PET scan and gamma camera.

1.3.2.2. *The local hospital in Bar-sur-Seine*

The Bar-sur-Seine living area, located 30 km from Troyes, covers a population of 20,000. The local hospital provides medical care, follow-up care and rehabilitation (FCR), and nursing home care (Ehpad). It has 10 medical beds, 22 FCR beds, including 10 beds reserved for patients in a prolonged vegetative state, 30 long-term care unit (LTCU) beds and 175 nursing home beds. It provides outpatient consultations.

A Territorial Healthcare Professionals Community (CPTS)⁸ was created in 2021 and is chaired by a General Practitioner who is also the head of a multi-professional healthcare center (MSP)⁹ located on the hospital site, reflecting the long-standing, constructive and visionary coordination efforts undertaken over several years by the various actors.

⁶ Source: FHF internal document (2024).

⁷ *Centre hospitalier de Troyes*.

⁸ *Communauté professionnelle territoriale de santé*.

⁹ *Maison de santé pluriprofessionnelle*.

Various public health initiatives are being carried out by the local hospital in Bar-sur-Seine with its CPTS partners: Covid patient pathway (testing, vaccination center, etc.), patient pathway for heart failure patients (advanced practice nurse (APN), advanced cardiology consultations, etc.), patient pathways for type 2 diabetes, pathways for the elderly (identification of frailty/public–private system, direct admissions, hospital APNs, Prescri'mouv/health and fitness, etc.).

It is one of the first 24 local hospitals to be certified in 2021 by the Grand Est Regional Health Agency (ARS)¹⁰.

1.3.2.3. *The conceptual framework: “institutional work”*

To understand how both the fieldwork and the link between bottom-up innovation (population responsibility) and top-down innovation (local hospitals) are developed, we use the conceptual framework developed by Cloutier et al. (2016), which highlights the “institutional work” undertaken by health managers and actors to implement a major reform of the Quebec healthcare system.

More specifically, the authors highlight four “types” of institutional work undertaken by these professionals, aimed at defining both their own role and that of their organization, as well as how work should be carried out, while clarifying and implementing the “reform mandate” issued by the authorities. In short, this is a twofold dynamic aimed at enabling local health actors to do what they want to do, while deploying and appropriating top-down institutional frameworks.

In practice, the authors highlight four types of institutional “work” carried out by the actors involved in this reform at the “meso” level of health organizations: conceptual work, operational work, structural work and, lastly, relational work. These four types of work take place simultaneously and fuel one another. Their interaction is shown in Figure 1.1.

This framework seems particularly appropriate in this case, as it was developed on the basis of a field study on the implementation of a reform of the Quebec healthcare system, a process that involved the strong integration of hospitals, outpatient services and primary care within Health and Social Services Centers (CSSS)¹¹, while tasking the latter with implementing population responsibility (Bourque and Quesnel-Vallée 2014).

10 ARS Decree No. 2021/4940 of December 30, 2021, establishing the regional list of local hospitals for the Grand Est region.

11 *Centres de Santé et de Services Sociaux*.

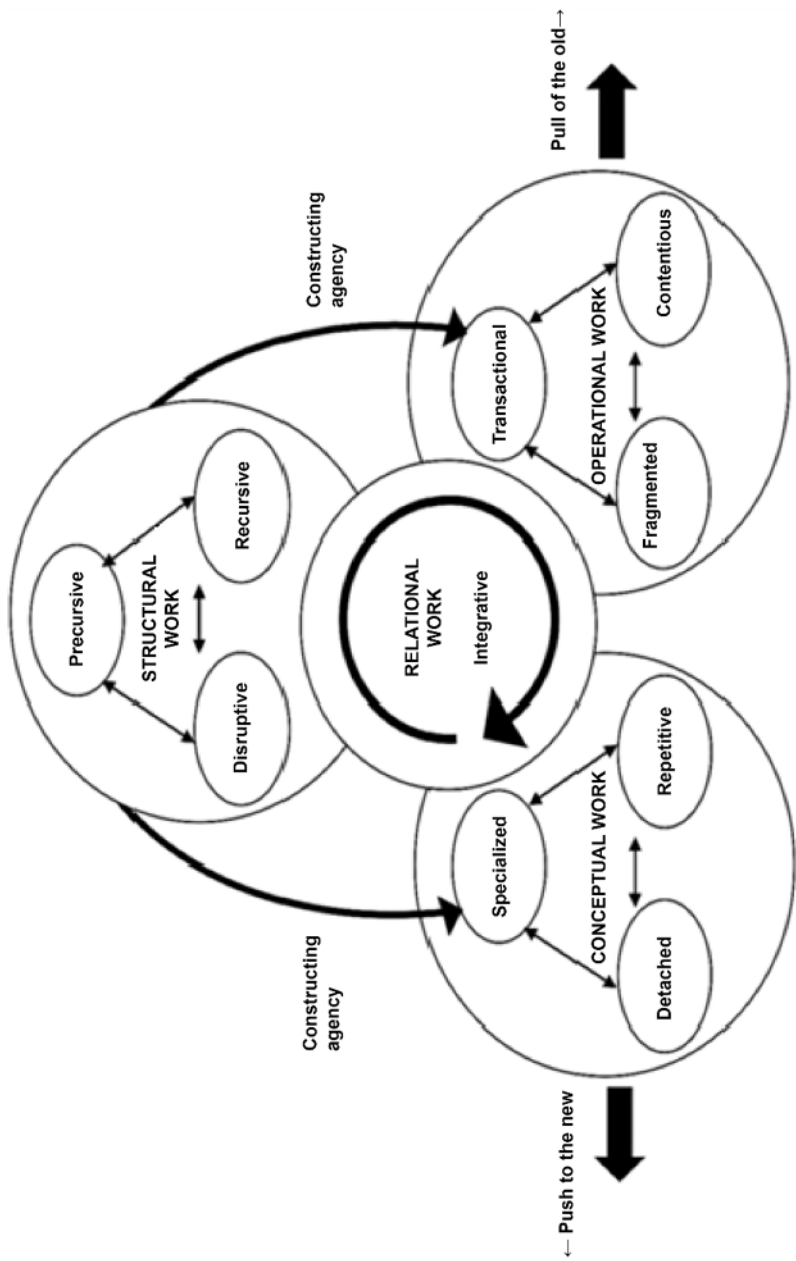


Figure 1.1. Conceptual model of the four forms of institutionalization (source: Cloutier et al., 2016, p. 10)

1.4. Combining top-down and bottom-up approaches: institutional work in action

In this section, we illustrate the four types of institutional work carried out by managers to ensure the growth and sustainability of the PR model, using the leverage provided by the national regulatory framework for Local Hospitals.

Our work is grounded in the typology of institutional work developed by Cloutier et al. (2016).

1.4.1. Conceptual work

According to Cloutier et al. (2016), conceptual work aims to enable actors to understand what is involved, what the change may mean for them and what it implies collectively. In other words: What is population responsibility, what are its objectives, how does it work, what does it require of professionals and what results can they expect?

From this perspective, numerous informational meetings and discussions were organized with healthcare professionals and other potential partners at the GHT level. Although these were largely based on content, data and information produced by the FHF national team, the meetings were always organized and led by local actors, with representatives from the national team playing a limited role.

The aim of this approach was to encourage local ownership of the model and its key concepts: stratification, flowcharts, pathways, etc.

The aim here was to help actors familiar with the PR experiment, who had a long-standing culture of cooperation around the local hospital, formalized by the joint creation of a CPTS, understand how the clinical approach proposed by PR could translate into better coordinated care pathways in their local area and permanent private healthcare, improving their joint practices and directly benefiting patients and even the population.

This enabled private and hospital doctors to discuss the state of the art in the care pathway for patients with type 2 diabetes and the situations that led them to seek specialist advice, as well as the conditions for good understanding and compliance with treatment by identified patients, so as to avoid worsening their condition and resorting to emergency care.

1.4.2. Operational work

Operational work refers to the design and implementation of concrete actions by healthcare professionals. An initial operational framework, described as experimental, was established through clinical meetings held at the GHT¹² level, with approximately 30 professionals from all backgrounds and patients. Based on material provided by the FHF, the aim of these meetings was to reach a consensus on three areas: the health needs of the population (using stratified population data), the best practices to be implemented for each individual according to their needs (using flowcharts) and, above all, how to be organized to systematically implement best practices for everyone. In other words, the aim was to create local pathways, stage by stage, and to define primary prevention actions for at-risk populations. A second “institutional” framework took shape during the decision-making process, aimed at applying for certification as a Local Hospital. The progress of this application through the various stages of the national procedure implemented by the ARS is shown in Figure 1.2.

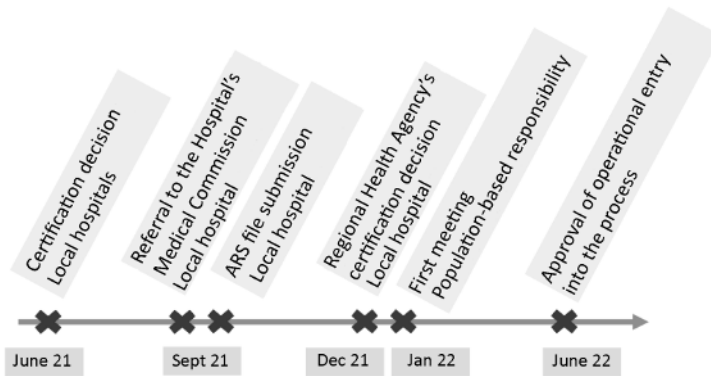


Figure 1.2. *Implementation timeline of action research*

These two operational frameworks came together to give rise to the project on locally identified health pathways, based on the actors' reflections on the content to be included in the agreement.

A regional PR foresight group was then set up, with the PR pilot in the GHT territory holding four local meetings. Its composition is presented in Table 1.1.

¹² Who included it in their shared healthcare plan for 2023–2028, which was being developed at the time of the action research project: https://hopitauxchampagnesud.fr/sites/default/files/2023-06/PMSP%25202023-2028_0.pdf%22.

	At the GHT level	At the local hospital level	At the CPTS level
Private doctor, president of the CPTS	Member of the medical commission of the group (CMG)	Member of the CME	<i>President of the CPTS</i> MSP Founder
Private doctor	–	<i>Vice-President of the CME of the local hospital</i>	<i>MSP Manager</i> Member of the CPTS board
Hospital practitioner, president of the CME of the local hospital	Member of the medical commission of the group Member of the strategic committee of the GHT (Costrat)	<i>President of the CME of the local hospital</i>	Member of the CPTS
Director of the local hospital	Member of the medical commission of the group Member of the strategic committee of the GHT	<i>Director of the local hospital</i> Member of the CME of the local hospital	Member of the CPTS
Doctor in the regional medical information department (DIM), responsible for population-based healthcare in the GHT	<i>Regional DIM doctor</i> Member of the medical commission of the group Member of the strategic committee of the GHT	Member of the board of directors of the local hospital Member of the CME of the local hospital	–
Deputy director general	<i>Deputy Director General</i> Member of the CMG Member of the Constrat of the GHT	Member of the board of directors of the local hospital Member of the CME of the local hospital	–

Table 1.1. Composition of the regional foresight group and interactions

Table 1.1 shows that the first phase of exploratory work involves six key actors: the local hospital, the CPTS and the GHT. This choice was based on the fact that these six actors are involved in the local hospital's strategy and are all members of the local hospital's medical commission (CME), which decides on the institution's medical strategy. The CME is consulted on the certification of the local hospital and on the content of the agreements with the GHT and the CPTS. The main functions of each member are shown in *italics*. Coordination is facilitated by the participation of each of these actors in CPTS or GHT bodies. The roles offered to private practitioners, following the opening up of the governance of public health establishments to promote cooperation, are shown in **bold**: the president of the CPTS is a member of the group's medical commission. The head of the MSP is vice-president of the CME of the local hospital.

This work to deploy the PR was replicated and expanded upon in the local area. This could involve, for example, identifying the resources available in the area to provide care for diabetic foot conditions, or determining when local actors needed to consult a diabetologist. Under what conditions could this be done in the local area? What role could actors play with regard to the patients identified?

Three health pathways relating to three target populations were considered to be of major importance, both in terms of conceptual work and epidemiological needs in the region: frailty in the elderly, heart failure and diabetes. An initial inventory of existing resources in the region for working on these pathways was carried out, taking into account the future prospects of medical professionals (advanced cardiologist consultations and recruitment of a geriatrician at the local hospital) and caregivers, with the ongoing training of two advanced practice nurses, one private and one hospital-based (on heart failure and the elderly), and in collaboration with the specialized nurses (*Infirmières Asalée*) already working at the MSP.

The implementation of the project was divided into three stages: 1) identifying individuals from various sources (pharmacists, hospitals, etc.), cross-referenced with data from the department's PR database on heart failure patients and patients with type 2 diabetes; 2) structuring individualized care pathways, based on a clinical program under the scope of PR; 3) regional organization, specifying the contributions of the actors involved in the implementation of these health pathways.

1.4.3. Structural work

Structural work “refers to managerial efforts to establish formalized roles, rule systems, organizing principles, and resource allocation models that support a new policy framework” (Cloutier et al., 2016, p.11).

To be certified by the ARS, local hospitals must meet certain conditions and apply using the form specified in the decree of June 4, 2021. In addition to the “cooperation requirements” (Denise et al. 2022) included in the application, a dual agreement (Article L6111-3-1 of the French Public Health Code) must be established within one year: an agreement with the GHT to which the local hospital belongs, and an agreement with structured primary care providers, which in this case is a CPTS created in 2021.

This principle of two agreements was an opportunity to launch a discussion with the local hospital on the content of each of these agreements, as well as on areas of common interest between the CPTS, local hospitals and the GHT.

The flexible governance of local hospitals, which has extended the composition of the medical commission to include primary care providers, meant that this discussion could take place within the CME, with the participation of representatives from the GHT who are also members of the joint management structure.

PR was thus incorporated into the institutional framework of local hospitals designed to promote cooperation between the GHT, local hospitals and community actors.

From the perspective of the GHT leading the PR experiment in Aube, the experiment in Bar-sur-Seine provides an interesting level of implementation. This area already had a well-established level of cooperation between actors, which was strengthened by the joint work carried out in this local area during the Covid crisis, particularly for the vaccination campaign, accelerating and amplifying the adoption and implementation of clinical programs. Ultimately, this will make it possible to measure the impact on patients more quickly.

1.4.4. Relational work

According to Cloutier et al. (2016), relational work refers to efforts to build “links, trust, and collaboration between people involved in implementation” (p. 17). Relational work is the foundation of the whole effort and enhances its potential. As the authors point out, “new concepts, structures, and operational projects can be presented on paper, but without relational work, they will not get very far” (ibid.).

	Definitions according to Cloutier et al. (2016)	Implementation in the local area
Conceptual work	What change can mean for healthcare actors ... <i>understanding and implementing population responsibility</i>	PR model, France Implementation of GHTs (clinical meetings) Type 2 diabetes clinical program
Operational work	Design and implementation of concrete actions by healthcare actors ... <i>implementing actions and pathways</i>	Stratification of the population across the region Census of resources across the region Structuring of care pathways according to standards
Structural work	Action to implement a reform that changes the rules and practices of healthcare actors ... <i>using the standardization of rules and procedures</i>	PR registration in local hospital – CPTS agreement PR registration in local hospital – GHT agreement
Relational work	Efforts to build “links, trust, and collaboration” between healthcare actors ... <i>creating a collective</i>	Sharing information on the actions taken by each of the actors Sharing a regional vision for a population-based approach based on “exploration partnerships” (Cazin et al. 2022); harmonization of practices and standards

Table 1.2. Summary of main results

As a result, throughout the life of the project, an intense “social life” developed, aimed at creating interpersonal trust between participants. This social life is what makes healthcare professionals want to work together, beyond the appeal of a particular model or system, especially when this work leads to changes in medical practice.

The establishment of the GHTs is part of a new system of governance that provides actors with objects of governance, such as pathways capable of triggering new learning dynamics through “exploration partnerships” (Cazin et al. 2022), which could be extended to this experiment.

Remaining a pioneer was a goal for the CPTS president, who said: “I’m all for putting our heads together. We are interested in anything that helps build structure!”. The principle of meeting every six weeks at lunchtime was agreed upon by everyone in the meeting room of the local hospital, which agreed to provide a set meal. Beyond consensus and a friendly atmosphere, this allowed the meetings to remain informal. In practice, half of these exchanges were opportunities for local actors to share information about projects led by both the local hospital and the CPTS.

As the president of the MSP pointed out: “The health center was established on the hospital site because private doctors have always understood that they need to work in conjunction with their local hospital”. This has enabled doctors to gradually address issues that are increasingly related to their own practice, such as polymedication in the elderly, or how they can ensure their continuous professional training.

1.4.5. *Changes and actions implemented in the local area*

The four types of institutional work carried out have led to the development of a set of actions based on the PR clinical model, which has been validated by the local hospital’s certification. A day hospital has been created. Diabetes consultations have been set up. The two newly qualified advanced practice nurses (APNs) have been integrated into the project alongside a specialized (Asalée) nurse.

These four types of work also enabled the effective implementation of three care pathways, particularly for patients with type 2 diabetes enrolled in the PR program, as well as for elderly people, by involving various professionals, including two APNs, one trained in chronic diseases and the other in elderly care. These two APNs completed their internships in private practices and in hospitals, and have become the main coordinators for continuity of care pathways in the local area.

Beyond new actions proposed to patients as part of a care pathway and new methods of coordination between actors, this work has prompted a regional medical

debate on practices and, consequently, on the standards that would be adopted and applied by all. During the Covid crisis, this had already been a topic of discussion, but no single common protocol had been agreed upon. This essential topic was revisited through the standards of the professional associations on which the PR approach is based, and was welcomed as an added value.

1.5. Discussion and conclusion

This work aims to show how it is possible to combine top-down institutionalization and bottom-up innovation, with the latter providing content and effective implementation to the former, and the former enabling the latter to be protected and disseminated. This study effectively provides some answers to a dilemma: on the one hand, it is clear that tangible results are produced by changes in professional practices, which are difficult for public authorities to control, especially when they are carried out directly with the patient, including in their own journey through the care pathway. However, on the other hand, it is equally clear that collaborative approaches must be institutionalized, in other words, integrated into the professional practice framework, and to enrich that framework.

The experience in Bar-sur-Seine not only shows that this is possible, but also highlights the types of institutional work that need to be carried out to ensure its success.

In the Aube-Sézanne region, more than 300 professionals are now involved in PR, along with 32 patient partners. Nearly 700 patients are now being monitored as part of care pathways.

Building on the experience gained in Bar-sur-Seine, this dual dynamic of bottom-up dissemination and institutional investment has continued and even intensified. The “population responsibility” approach is key to the creation of the Troyes Champagne Métropole CPTS. It is part of the shared medical and healthcare project of the Champagne Sud Hospitals GHT¹³, all local health contracts (CLS) in Aube and the Grand Est ARS 2023–2028 regional health project¹⁴.

Furthermore, the population responsibility approach has been extended to new areas, beyond the five pioneering areas: southern Lorraine, the Belfort Montbéliard area, the Southern Alps, the Alpes-Maritimes around Nice University Hospital and Mayenne. There are now approximately 10 areas implementing this model.

13 See: https://hopitauxchampagnesud.fr/sites/default/files/2023-06/PMSP%25202023-2028_0.pdf.

14 See: <https://www.grand-est.ars.sante.fr/media/115986/download?inline>.

The conceptual framework developed by Cloutier et al. (2016) provides a useful framework for understanding the activities that take place there. In all these regions, it is possible to find the same types of institutional work: conceptual, operational, structural and relational. In all these cases, local actors invest in institutional structures, both to provide them with meaning and to ensure the sustainability of their PR approach. It would also be interesting to study the “learning” process (Cazin et al. 2022) of this method of “population responsibility” in institutional projects and, more generally, in the medical and healthcare projects of the GHTs, or even the healthcare projects of the CPTSs in these regions.

In conclusion, it is interesting to note that despite renewed interest from public authorities in “care pathways”, which are now included in the French Public Health Code as a major part of the health policy¹⁵, and the emergence of population responsibility in law (Article 20 of the LOTSS of 2019), these same public authorities are still struggling to implement these approaches in a systemic fashion. The various actors (French Ministry of Health (HAS), Health Insurance) are each working separately on “care pathways” that ultimately target the same patients. The strengthening of territorial health councils¹⁶, supported by the public authorities and reaffirmed in the December 2023 law aimed at improving access to care through the regional involvement of healthcare professionals, could help to implement population responsibility. However, for the moment, this issue is rarely discussed. In an insightful article on healthcare system reforms, Denis and Forest (2012, p. 633) pointed out that “creating new organizations is not enough. True reform requires an environment that allows these organizations to continuously innovate and flourish”. It is perhaps this environment that public authorities should focus on if they really want to make care pathways a reality.

1.6. References

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¹⁵ Article L1411-1 of the French Public Health Code states that “health policy includes [...] the organization of care pathways. Through the coordination of health, social, and medical-social actors, in coordination with users and local authorities, these pathways aim to guarantee the continuity, accessibility, quality, safety, and efficiency of care for the population, taking into account the geographical, demographic, and seasonal specificities of each region, in order to contribute to regional equality”.

¹⁶ *Conseils Territoriaux de Santé* (CTS).

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