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Opinion of the actors for the planning of care for the elderly, territorial organization of the response, and mortality in the nursing homes. An attempt at understanding covid epidemy.

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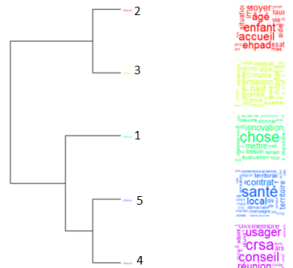
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Introduction

The 14 May 2021 there have been 26307 deaths in housing facilities for the elderly dependent or for the disabled in France. While research on the health needs of the population is conducted mainly in quantitative form, we need more qualitative analyses of the discourses of social policy stakeholders, users, professionals, elected officials and association. Our hypothesis is that social representations and health resources are of equal importance to drive planning of social care for elderly.

Method

We interviewed 23 people in 3 ideal-typic regions of France: professionals from the territorial delegations, departmental councils, municipalities and intercommunity, associations or professional federations. The discussions focused on their views and their role in the reforms as well as the contribution of the provisions of the services. We tried to categorize the discursive formations of the medico-social field with the use of



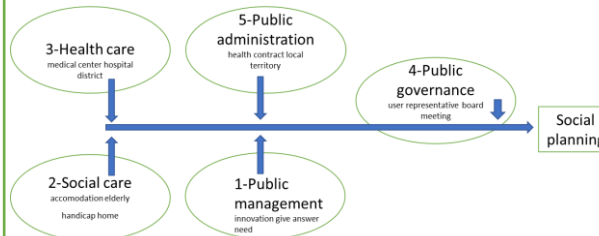
The 5 groups of social representations.

The classical public administration (class 5) and the new public governance (class 4), centralized, express a common interest in the territorial policies undertaken by the State, the discursive formations of the territorial actors of social care and health (classes 2 and 3) have in common their peripheral position and their expertise of the field, and finally the formations of the new public management (Class 1), present themselves as integrative forces of the medical-social sector.

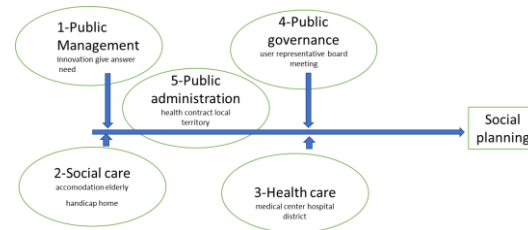
Health representations

Three ideal-typical regions have been chosen to take into account the diversity of environments in which the players in the "medicosocial" sector in France.

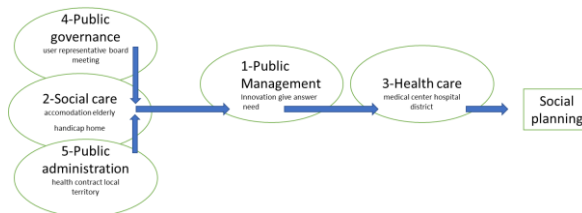
In the region A administration and management combine, as well as health and medico social. It is only in a second step that the process of healthy democracy makes it possible to close the device.



In the Region B, the health and social sectors are independently linked to the center, the former by management the latter by health democracy.



In the region C the organization of social planning follows a linear process of management administration towards a democracy that is ultimately enriched towards health.



Health resources

Region A representative of others with healthy population, well endowed with care professionals, although under-endowed with health and social institutions and more dependent on social benefits.

Region C, representing disadvantaged, in worse health and poverty, more poorly endowed with professionals. On the other hand, the rate of equipment in short-stay beds compensates for a rather unfavorable situation in terms of care provision.

Region B, representative of others with poor health indicators, less affected by extreme poverty and more by low wages. It has better resources in psychiatry, for disability and the elderly in institutions.

Observation of mortality in nursing homes during the pandemics

Establishments affected by Covid-19 during the first and second waves				
Region	First wave		Second wave	
	Percentage of nursing homes affected	Percentage of nursing homes who have experienced a critical episode	Percentage of nursing homes affected	Percentage of nursing homes who have experienced a critical episode
A	37,6	4,5	65,9	12,8
B	35,2	0,6	31,2	1,2
C	64,2	22,6	48,2	9

Mortality in the nursing homes (EHPAD) was higher during the first wave of the pandemics in Region C (May 2020), but Region A was higher during the second wave (November 2020).

Immunization coverage of fully vaccinated residents 2021-11-02 in nursing homes

Region	Immunization coverage of fully vaccinated residents 2021-11-02
A	90,55
B	94,2
C	92,85
France métro	91,3

This phenomenon continues in 2021 when Region A was affected more strongly, especially with a lower vaccination rate..

Discussion

One region has consistently experienced a lower mortality rate and has achieved a high vaccination rate. It is not the better endowed or equipped region. The construction of its social planning was done by a double approach, social administration and health democracy, the administration being in these four poles of representation.

Another region experienced a serious onset of crisis, followed by a reversal of the situation, controlling the epidemic in nursing homes, while having an average vaccination rate. This region is the poorest, its system is public. Its policy was developed from an alliance of the administration and local authorities on the theme of the social care in order to build a managerial form before completing the health dimension.

The third region was well placed at the beginning of the epidemic, it lost its advantage thereafter and did not develop a significant vaccination campaign. It was also the region with the best health workforce. Politics was built on management and medico-social as in the first, but administration and health, democracy intervenes only as a last resort.

If we consider that region B provides better management, we can analyze the two other regions from this reference .

In A the fact of linking administration and health, without democratic regulation (CRSA) may represent an obstacle because the link between governance (local democracy) and health does not work effectively.

In C, activating the social care and administration to build a management system that will support the health system is an alternative and cumbersome system to meet the requirements of the epidemic.