Seminar ENSP-Fiocruz / EHESP / Sciences Po's Chaire Santé

"Health policies, territorial issues, and primary care in Brazil and France"

« Les maisons de santé pluriprofessionnelles : Un tournant dans la réforme des soins primaires et dans les relations entre autorités publiques et profession médicale »

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"Multidisciplinary Primary Care Groups: A turning point in primary care reform and in the relationship between public authorities and the medical profession"

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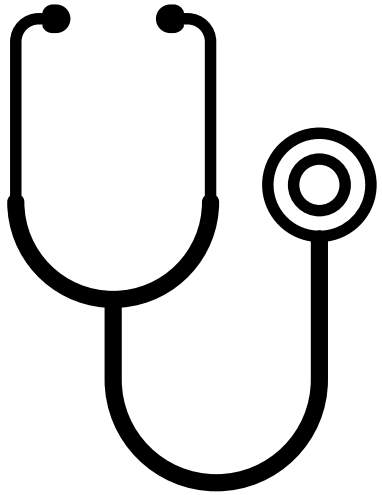
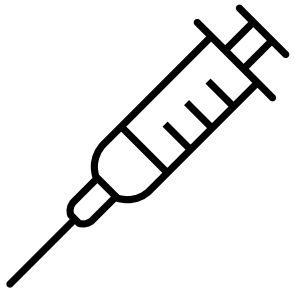
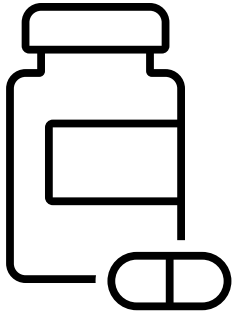
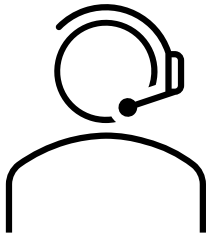
October 2024

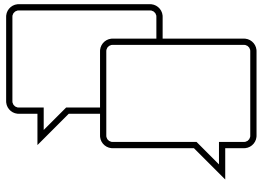
EHESP

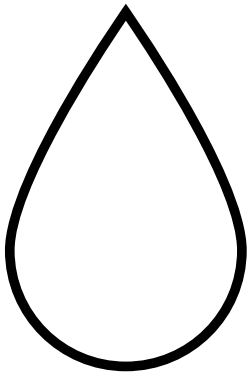












Context

A limited role of the French state in health care delivery: a corporatist and health-insurance based system + predominantly private in the primary care sector.

Organization of primary care as a secondary issue until the 2000s: attending physician's scheme (2004), maisons de santé pluriprofessionnelles-MSP (2007)…

Government choice of incentive-based policies to encourage private providers (especially GPs) to make their practices evolve.

Maisons de santé pluriprofessionnels* (MSPs)

MSPs brings together GPs, nurses, and allied care providers.

MSP providers collectively sign a contract with public partners (both the regional health agency [*Agence Régionale de Santé*, ARS] and the local health insurance fund [*Caisse Primaire d'Assurance Maladie*, CPAM]) – called ACI (*Accord Conventionnel Interprofessionnel*).

Introduction of neo managerial rules and procedures aimed at reorganizing access to care, reinforcing coordination, and expanding the range of care services (e.g. public health services).

- Providers documenting compliance with the ACI contract…
- … and receiving collective payments by public partners in addition to their individual fee-for-service revenues.

➔ **An unprecedented contractual framework.**

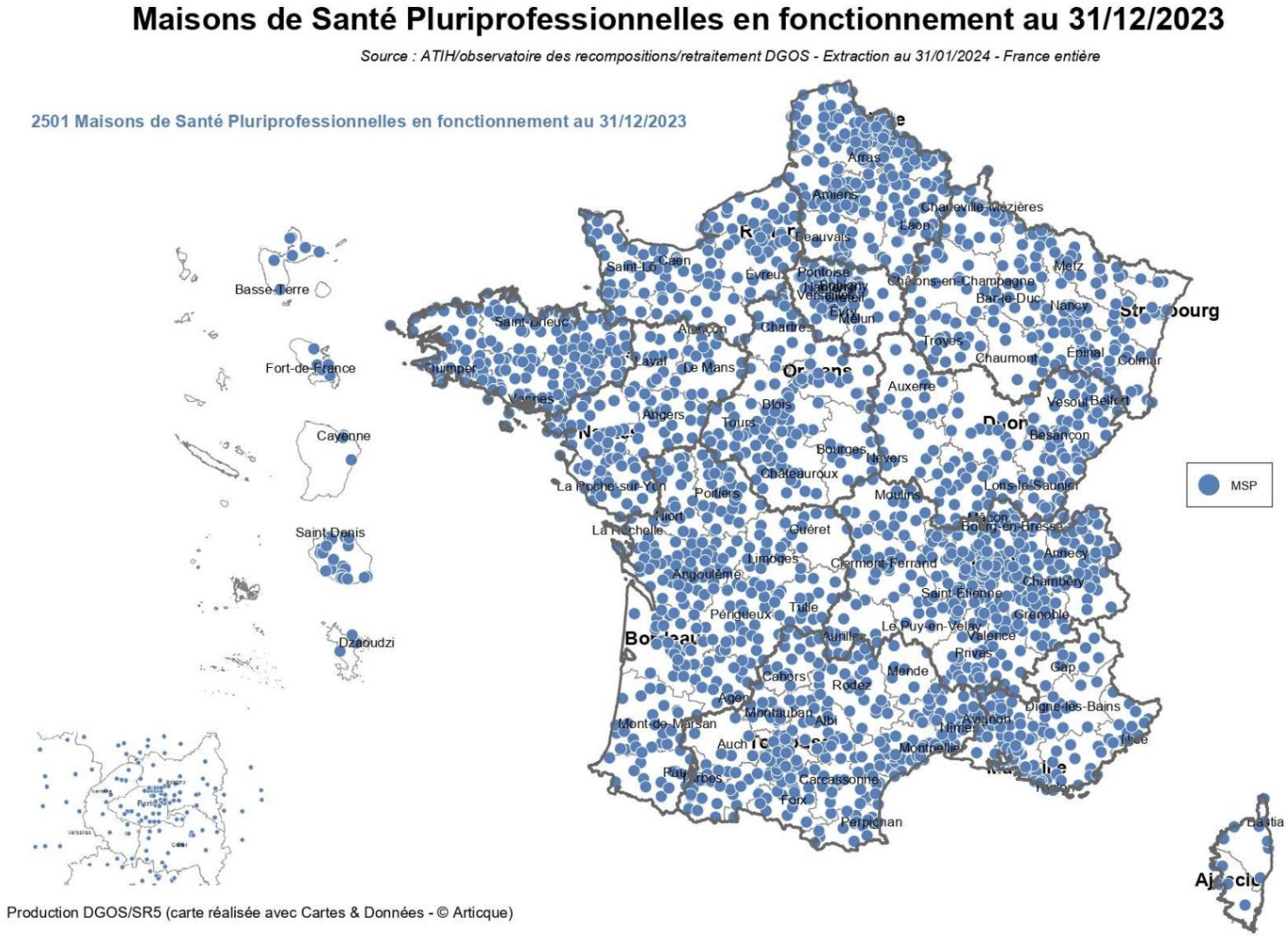
*Multidisciplinary Primary Care Groups

Maisons de santé pluriprofessionnels (MSPs)

From around 20 MSPs in 2008… to more than 2500 in 2023.

17% of GPs working in these structures.

In 2020, 73% of GPs younger than 40 considering the possibility of integrating a multiprofessional structure as a key motivation for setting up practice (27% of those older than 60).



(Fournier, Morize, Moyal 2024)	**Traditional private practice** **An individual and private approach**	**Private practice in MSP:** **A hybrid approach**
Care delivery organization	Solo or monodisciplinary practice	Multidisciplinary practice
	No mandatory organization of care delivery	Mandatory organization of care delivery: Opening hours Continuity of medical care Walk-in medical consultations
Coordination organization	Informal coordination according to GPs appreciation of patients' needs	Mandatory coordination procedures: Multidisciplinary staff meetings Multidisciplinary clinical protocols Shared information system Identification of an administrative coordinator
Types of care	Mainly curative care	Curative and preventive care, patient education programs
Remuneration system	Individual remunerations: Individual fee-for-service remunerations paid by patients + For GPs only: residual remuneration by capitation and for performance, paid by the public health insurance fund	Mixed remuneration scheme: Individual fee-for-service remunerations + For GPs only: residual remuneration by capitation and for performance + Complementary collective flat remunerations (coordination and public health activities)
Institutional partners	Professional boards, Unions, Public health insurance fund	Professional boards, unions, public health insurance fund, regional health agency, elected officials, others (depending on each case)

How did MSPs emerge and establish themselves in the French landscape?

How did this incentive-based & contractual mode of state intervention affect the implementation of this primary care reform?

What lessons can be drawn regarding the relationship between the medical profession and the state?

Method

PhD dissertation in Sociology (Sciences Po Paris, Center for the Sociology of Organizations & Laboratory for Interdisciplinary Evaluation of Public Policies).

Sociologie de l'action publique, sociologie des organisations et des professions.

Multi-level field survey:

- National level: tracing the emergence of MSPs and the debates surrounding their definition.
  - Documentary analysis
  - Semi-structured interviews (N=29)
- Local level: understanding different experiences in implementation of the ACI contract → comparative case study of six MSPs (variety of organizational situations, and contract compliance as a key factor in the selection of these structures).
  - Observation
  - Documentary analysis
  - Semi-structured interviews (N=129)

Main results

1. A coupling process between a problem and a preexisting solution

“Medical deserts”: the legitimation of a not-so-new public problem in the 2000s

MSPs: a ready-made solution to the problem of access to medical care

An “instrument constituency” around MSPs: an alignment of governmental and medical interests

2. The contract, a consensual but ambivalent solution

The most politically acceptable strategy, addressing governmental and professional concerns

An ambivalent solution, oscillating between centralizing regulation and local variations

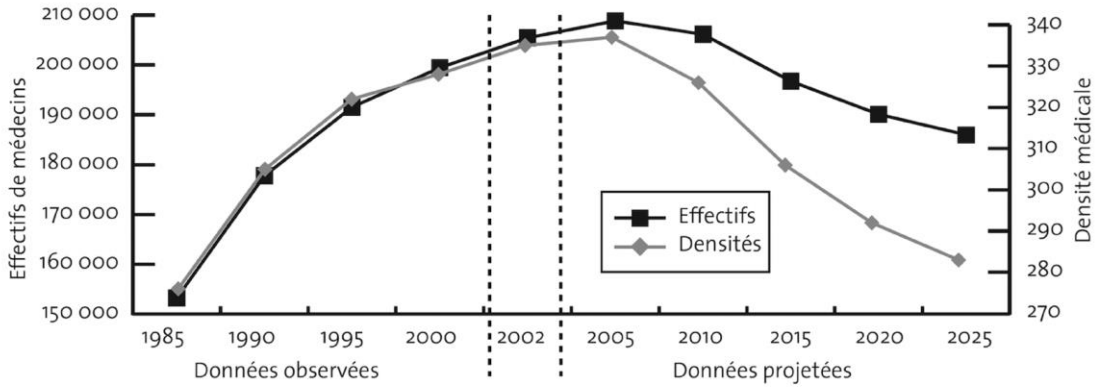


Figure 1 Number and density of doctors in France, 1985–2025.

Source: ONDPS 2004.

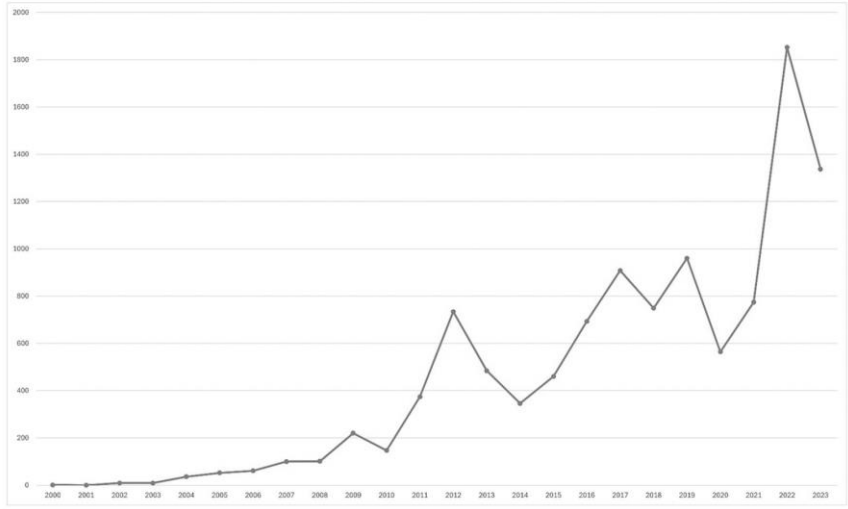


Figure 2 Use of the phrase "medical deserts" in the French press, 2000–2020.

Notes: Analysis conducted with Factiva database. Press sources: *Agence France-Presse*, *La Croix*, *Le Monde*, *Le Figaro*, *L'Humanite*, *Les Echos*, *Libération*, and *Ouest France*. Terms searched: "déserts médicaux," "désert medical," and "desertification médicale."

Medical deserts: a not-so-new problem at the top of the political agenda since the 2000s

- First concerns raised about inequalities in access to health care (particularly GPs) date back to the 1970s
- The cumulative effect of the *"numerus clausus"* and a growing number of doctors retiring led to a significant decline in the supply of medical providers.
- Apparition of the "medical deserts" in public reports, press articles, and political speeches.

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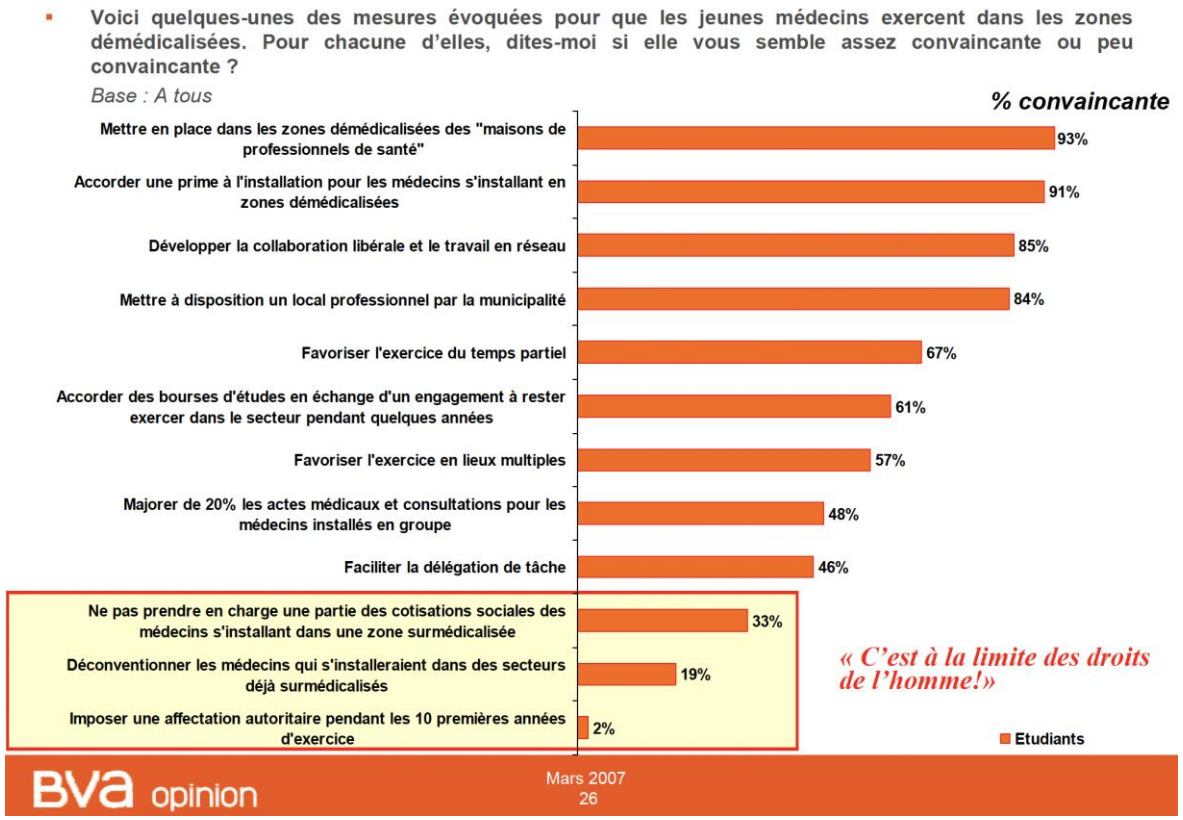

N° 14

SÉNAT

SESSION ORDINAIRE DE 2007-2008

Annexe au procès-verbal de la séance du 3 octobre 2007

RAPPORT D'INFORMATION

FAIT

au nom de la commission des Affaires sociales (1) sur la **démographie médicale**,

Par M. Jean-Marc JUILHARD,

Sénateur.

MSPs: a ready-made solution to the problem of access to medical care

- Public reports identify team practices as more likely than financial incentives to attract young GPs to underserved areas.
- They also cite a few initiatives carried out locally by GPs.

(Kingdon 1984; Wildavsky 1979; Hassenteufel 2024)

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*"I believe that **politicians have seized on the MSPs that were appearing here and there**, because they were totally helpless. (...) They cannot find the key because **they are faced with private professionals** who are free to establish themselves wherever they want to, and politicians wonder how to deal with the problem. But all of a sudden, they see the MSPs and think it's **the solution to all the problems**. The only ones who had another solution were a team of deputies **who dared to talk about regulating doctors' settlement**! And by the way, I think this would be the only real solution. . . . (...) But could you imagine the protest? Because, you know, there is a **historical opposition between the state and the medical profession**. Politicians have always been afraid of health care professionals, because of all the protests. (...) The result is that politicians don't know how to deal with the organization of primary care and they need professionals to find the solutions. **So we're a few leaders in the profession doing that, particularly through our federation, and politicians support us.**"*

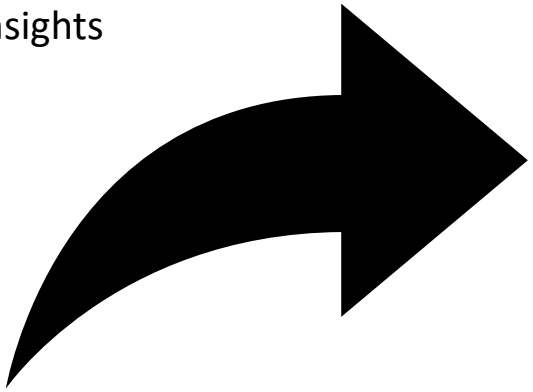
(Former president of the FFMPS and leader of an MSP)

An "instrument constituency" around MSPs

- GPs who share similar motivations: responding to patients' increasingly complex needs, improving working conditions, and attracting young GPs.
- GPs who share similar backgrounds: at the end of their careers, very involved locally in different initiatives, members of (or at least sympathizers with) the MG France medical union (Moyal 2022).
- GPs distancing themselves from the traditional medical unions to create an a-political and inter-professional federation (2008): FFMPS.

(Beland & Howlett 2015; Voss & Simons 2014)

Insights



A coupling between a ready-made solution and a latent public problem: The story of medical deserts in France is essentially that of a latent issue that started to dominate the political agenda at the turn of the 2000s, when policymakers identified a viable solution for it.

The emergence of an instrument constituency: Although values and interests of governmental actors and GPs may differ, they eventually converged on a common solution to the problem of medical deserts.

A recomposed medical corporatism: The MSP reform breaks away from the recent pattern of weakening of the medical profession: the alliance between a group of GPs with public actors – paradoxically through an a-political and inter-professional federation – is favorable to GPs, who manage to assert their role as the fulcrum of the health care system and as drivers of reform.

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A consensual solution, addressing governmental and professional concerns

- Private providers seem to have everything to gain from the MSP reform:
  - Team practice in MSP meets their aspiration for improved working conditions (reduced workload and psychological burden, easier communication, broader scope of tasks [paramedics]…)
  - MSP label is a positive signal to attract young GPs
  - The new compensation payments make it possible to value coordination and public health activities… and even to recognize existing patterns.
- … event if some of them point out the administrative burden attached to the ACI contract and the cost associated with coordination activities.

- Public decision-makers see MSPs as the solution for regulating without coercion
  - This incentive-based policy limits the cost of interfering with doctors' sacrosanct freedom of practice and location, while also minimizing political opposition.
  - This contractual policy provides a (limited?) control over private providers' practices and organization.

(Berrivin & Musselin 1996; Musselin 2022)

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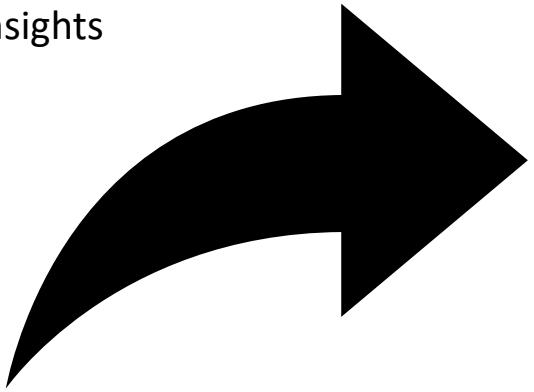
- A generic framework open to assimilation and adaptation by private providers:
  - Formalizing preexisting practices.
  - Tinkering with the contracts rules to adapt them to local context and needs.
  - Making strategic use of the contract to develop new practices.
- Different contract path: resistant / conforming / innovative MSP.
- Unprecedented accountability and latent irreversibility.

- Limited control by public authorities:
  - Activity monitoring mostly declarative and day-to-day activities largely invisible.
  - Public authorities' flexibility with contractual breaches.

"When a measure comes out, it's extremely theoretical. But the text has to live. And in application, ***it's quite flexible****. For example, for the protocols, if you read the contract specifications, you think it's really constraining. But in fact,* ***we never refuse the protocols professionals submit to us****.We always manage to link them to one national priority or another.* ***The national insurance fund is quite tolerant because they want it to work!"*** *(CPAM official)*

(Castel & Merle 2002; Waring & Currie 2009; Numerato et al. 2012; Moyal 2019)

Insights



The need for autonomy and flexibility throughout implementation: MSP providers managed to assimilate the procedures likely to constrain them, to protect their existing practices and develop new ones that better respond to their needs. This professional discretion is not only difficult to avoid but also necessary to enroll private providers and to encourage innovation to emerge from the field.

A relationship of interdependence currently favorable to private professionals: A new compact between medical professional and governmental actors has emerged with MSPs, relying on a reciprocal dependence. As long as this contractual mode of practice remains optional, however, this relation of interdependence will arguably remain favorable to private providers, and GPs in particular, without whom the state would not be able to implement this reform.

Discussion

- Difficulty to assess the impacts of the MSP reform at this stage, as many health care providers seem to maintain most of their existing patterns.
  - ➢ However, recent studies conclude MSPs have a positive impact on care accessibility, efficiency and coordination (Chevillard & Mousquès 2020; Mousquès & Daniel 2015; Bergeat & Cassou 2023).
- Is the dual process of assimilation and variation of the MSP policy responsible for these existing but limited effects? Or wouldn't this status quo in some MSP be the price to pay for changes to occur in others, where professionals manage to improvise and ultimately develop new practices?

Merci !

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