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# The Entrepreneurial Role of Doctors in the Transformation of Primary Healthcare. An Analysis of the Conditions of the Private Project Leaders' Participation in the IPEP and PEPS Experiments

Vincent Schlegel (IRDES, Cresppa-CSU)

**The two five-year pilot programs introduced in Article 51 of the 2018 Social Security Funding Act (*Loi de Financement de la Sécurité Sociale*, LFSS) – one with additional performance-type payment to improve coordination between hospital and primary care (IPEP, *Incitation à une prise en charge partagée*), and another one with a lump sum payment scheme for primary care teams for GPs and nurses (PEPS, *Paiement en équipe de professionnels de santé en ville*) –, allow for pilot experiment that derogate from standard funding and organizational rules for health care delivery organisations. Their participation in these experimental schemes was based on a call for expression of interest, inviting the healthcare professionals concerned to submit an application file and present a project for implementation. The selections made by the national teams resulted in the significant involvement of professional and union representatives.**

**Anchored in the sociological part of the programme of assessment of the experiments aimed at finding alternatives to fee-for-service payments in the context of Article 51 (*Évaluation d'expérimentations Article 51 de rémunération alternative à l'acte*, Era2), this study is based on interviews conducted with private doctors designated as IPEP or PEPS project leaders. Focusing on their professional careers enables us to understand how they have helped them to take such opportunities and meet the demands of the public authorities. The survey shows that these doctors are particularly interested in institutional change and are able to consider the structural transformation of primary healthcare through successive projects. Their familiarity with the healthcare system and participation in previous experiments helped them to take part in the IPEP and PEPS experiments. Lastly, this study highlights the conditions that need to be met to meet the expectations of the public authorities and initiate the planned projects, which raises questions about the generalisation and replicability of this kind of experiment.**

From the outset, private-practice medicine has been torn between two contrasting stances –that of "small independent entrepreneurs" dedicated to defending individual freedom, and that of the "major servants of the State", the defenders of the general interest (Steffen, 1987) – at the origin of recurrent conflicts with the French State and the National Health Insurance system (*Assurance Maladie*) [Hassenteufel, 1999]. Over recent decades, primary healthcare has undergone major transformations that have affected relations between the State and the medical profession. These include the development of Multiprofessional Group Practices (*Maisons de santé pluriprofessionnelles*, MSP), which was a major turning point, as it brought together primary care teams around a shared healthcare project and facilitated the coordina-

tion of private healthcare professionals. The promotion of this approach was linked to the ongoing transformation of the relations between the State and certain segments of private-practice medicine (Vezinat, 2019). The latter accepted, at least to some extent, the rationalisation of their practices by the public authorities, as it enabled them to establish certain implemented practices over the long term, and even develop new ones (Moyal, 2019).

Continuing on from the Experiments with New Mechanisms of Remuneration (*Experimentations de nouveaux modes de rémuneration*, ENMR) [Bourgeois and Fournier, 2020; Fournier et al., 2014], Article 51 of the 2018 Social Security Funding Act (LFSS) introduced the possibility of derogating from standard funding and organizational rules for health care delivery organisations to create new healthcare models on various regional scales. In this framework, three national calls for expressions of interest (*Appels à manifestations d'intérêt*, AMI) were launched during 2018, relating to experimentation with additional financial incentives combining advanced payment and shared savings aiming to improve coordination between hospital and primary care teams (*Incitation à une prise en charge partagée*, IPEP), another experimentation with a lump sum payment sheme 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), and an episode-based bundled payment system (*Paiement à l'épisode de soins*, EDS). Primary healthcare professionals are mainly concerned by the first two: in the case of IPEP, the professionals benefit from collective profit-sharing, calculated according to the quality indicators and efficiency gains attained; in the case of PEPS, fee-for-service remuneration has been partly or totally replaced by a capitation payment. The projects selected after the calls for expressions of interest led to a phase of joint definition of the specifications (Obled et al., 2020).

A first phase in the survey showed how the selection applied on a national level resulted in a significant presence of union and professional representatives amongst the IPEP and PEPS experimenters (Morize et al., 2021). By focusing on private-practice project leaders, we have analysed in this article the social conditions of their involvement in the current reforms of primary healthcare and their predisposition to meeting the expectations of the public authorities. More specifically, we see these doctors as veritable "entrepreneurs" of these reforms, even though not all of them would equate with this term. From a sociological perspective, this equation with entrepreneurship was made possible by applying a deliberately broad definition of the term, detached from the notion of a stakeholder solely motivated by economic interests (Bergeron et al., 2013). In fact, we will see that these stakeholders are motivated by a cause, rather than by the maximisation of their profits: the transformation of institutional rules in the medical sector to facilitate the structuring of primary healthcare. The Article 51 experiments are clearly part of this process.

Before analysing the entrepreneurial work undertaken by the project leaders, we would like to identify the unique profiles of these GPs. The survey (see the "Method" and "Context" insets) shows that they share a desire for change and a tendency to conceive collective actions in the form of projects, while practising their profession in a context that favours the implementation of new experiments. Rather than essentialising the entrepreneurs, who are often attributed with certain qualities described as "natural" (Chauvin et al., 2014), this entrepreneurial spirit is related to their trade union and professional socialisation. Then, we observed how their commitment in the IPEP and PEPS experiments highlights certain characteristics that are specific to entrepreneurial work; and how all these elements are combined as part of these experiments in the form of a true team effort whose main components are presented. Hence, this *Issues in Health Economics* focuses on the initiation phase of the projects and temporarily leaves aside their implementation, which will be the focus of future analyses.

## Method

This *Issues in Health Economics* focuses on doctors' involvement in the current primary healthcare reforms. Without overlooking the commitment of other professional groups in IPEP and PEPS experiments, doctors play a key role in these reforms, and more generally in primary healthcare. Also, while hospitals and health facilities also take part in these experiments, the focus is placed on private doctors, based on the hypothesis that this form of practice favours entrepreneurial work. The interviewed persons were designated as "project leaders" in the application files or, more rarely, "interlocutors participating in studies", when the leader was not a doctor. Around 20 private practices were selected to take part in the PEPS and IPEP experiments. For this study, 17 interviews were conducted in 2021, with doctors representing a number of different projects, including four by Noémie Morize, as part of her doctoral thesis in sociology, which is being written at Sciences Po at the Centre de Sociologie des Organisations (CSO), in collaboration with the IRDES (the Institute for Research and Information in Health Economics). Only three of the persons interviewed were women, which highlights the gender-based division of entrepreneurial work. Also, this work is largely carried out by doctors who are in the second phase of their career, as more than half of the interviewed people were aged fifty or over. The interviews were intended to rebuild the project leaders' social and professional careers, and characterise current working conditions, and relations within and outside the practice. The second part of the interview focused on the experiments studied, from the initial interest to their everyday implementation, as well as the constitution of the application file, and the joint definition phase.

## Context

This *Issues in Health Economics* is based on material collected as part of the sociological section of the ERA2[a] project supervised by Cécile Fournier and funded by the *Assurance Maladie* (French National Health Insurance System). The aim is to assess the effects of the introduction of alternatives to fee-for-service remuneration, with regard to both the organisation of primary healthcare in France and professional practices.

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

## "Entrepreneurial doctors"

The doctors involved in an IPEP or PEPS project tended to share certain characteristics. Firstly, they claimed that they opted for general medicine out of "choice", while presenting it as a pillar of the health system. Then, they no longer saw the promotion of general medicine as arising from university research or teaching, but rather via the structural transformation of medical institutions, allotting a central role to primary care. Lastly, these

project leaders promoted certain aspects of private practice that gave them the freedom of action required to realise their project.

## General medicine as a pillar of primary healthcare

Firstly, the project leaders presented general medicine as a veritable "choice", contributing to the revalorisation of a specialty long considered as a secondary branch by medical students (Bloy and Schweyer, 2010). This was particularly true of end-of-career project leaders who made the decision to not sit the examinations that take place prior to internships, at a time when exam failure generally implied mandatory orientation towards general medicine. In contrast, the youngest project leaders benefitted from the recent reforms concerning both the status of general medicine – this became an entirely separate speciality since 2004 – and the organisation of primary care, particularly via the structuring of multidisciplinary work and coordinated care, similar to certain characteristics of hospital practice (see below). Yet, the "generalist" nature of primary care exists in different forms. Firstly, certain doctors declared that during their studies they set up their practices in an area where secondary and tertiary healthcare provision was largely lacking – in both rural and non-rural areas:

> "This is exactly why I wanted to set up a medical practice in the countryside: so that the patients aren't obliged to only consult specialists and they can come and see me when the specialist is not available."
>
> **Interview no. 11, male, aged over 60, IPEP**

> "So, my idea was to say: "*It's not medicine by default; I'm going to practise that medicine, but I don't want to be merely a prescription dispenser. I want to be a doctor and when I require the input of secondary or tertiary care, it's because there is a demand for secondary or tertiary care*"."
>
> **Interview no. 3, female, aged 40–50, IPEP**

From this standpoint, these GPs believed they could compensate for the deficiencies linked to the absence of specialists in a given region. Furthermore, the GPs could also orientate their practice to treat specific kinds of patients (children, the elderly, and women), and even claim they had a form of informal specialisation (Bloy and Schweyer, 2010). Hence, they boasted that they had an activity that enabled them –at least in theory– to provide global care based on a global vision of healthcare. This was particularly highlighted by the doctors interviewed:

> "General medicine (...) for me it was about human beings as a whole. So specialising in a field has never been an ideal for me."
>
> **Interview no. 11, male, aged over 60, IPEP**

Secondly, general medicine also reconciled the profession's "relational" and "technical" aspects, without prioritising the latter over the former. Its practice was presented as a way of guaranteeing a varied approach, and minimising the repetition of the same medical acts:

> "And then, afterwards, the decision to go into general medicine was a deliberate choice, because during my studies I realised that general medicine was definitely the medical discipline that had the most to offer, both in terms of human relations and its diverse applications."
>
> **Interview no. 15, male, aged 50–60, IPEP and PEPS**

In particular, general medicine had a specific relation with time, establishing long-term treatments, unlike hospital treatments that were more often dictated by urgency. This idea was particularly evident in the notions of accompanying treatment programmes, which was evident in the GPs' statements:

> "And well no, above all because being an organ specialist would have restricted me and I liked these long-term treatments, helping people, being someone who accompanies the patients with their treatments. There you go! A friend to the patients as they undergo and continue their treatments (*laughs*); that's what I am. And specialisation didn't really seem to go in that direction and that didn't suit me. (...) And being a specialist in a clinic, honestly... No, I'm not interested (*laughs*). Yes they do a good job, but it's rather technical. For me, it's a technical platform, and I'm not interested in being a technician who "tightens up bolts"."
>
> **Interview no. 2, male, aged 50–60, IPEP**

All these elements established general medicine and primary healthcare as the pillar of the health system, a status that it therefore brandished to attain recognition by acting on an organisational level. From the standpoint of the surveys, private medicine may not only be the first port of call for a patient, but also the only one, on condition that it benefits from specific working conditions.

## Participation in the reforms as a promotional tool

The recognition of general medicine as a speciality in itself has enabled it to be integrated into universities. GPs can now occupy a university position, while continuing with their private or salaried activity, which helps to establish the role of primary care in the French healthcare system. Yet, none of the doctors interviewed chose to follow this path. Although three of them were appointed associate professors in a faculty of medicine, only one of them was working in this capacity at the time of the interview. In general, the interviewed individuals had an ambivalent relation with the university. Most of them actively participated in the training of young doctors by supervising (intern and extern) medical students, or more rarely by supervising theses. Nevertheless, they were also critical of the university as a place for training doctors, because they considered that it placed too much emphasis on theoretical knowledge and technique to the detriment of patient relations, public health, and the organisation of healthcare:

> "A medical professor, (...) he'll never learn general medicine, because general medicine cannot be taught in a university; it's acquired through contact with the patients."
>
> **Interview no. 13, male, aged over 60, IPEP**

> "Even with the interns, I get the impression that the level's gone down. And as time moves on, the more I realise that they require an increasingly large investment."
>
> **Interview no. 3, female, aged 40–50, IPEP**

As highlighted by the statement above, doctors' training was being criticised, nurturing the hypothesis of a 'deteriorating' French healthcare system, which we will return to.

To compensate for what they believed were at the origin of the deficiencies in the university system, some of them sometimes set out innovative educational formats, while evoking content that differed from the standard content, particularly in relation to the current dynamics of certain professions and the latest approaches to organising primary healthcare in France:

> "We were asked, as tutors, to do a very pedagogical thing about clinical accounts of cases, etc. And after a while, I'd had enough. And they were bored too, so I realised that no one was happy, neither them nor us (*laughs*). So, afterwards, I tried to hold debates in the afternoon and we quickly did obligatory stylistic exercises, and then I invited external people to speak, advanced practice nurses, (...) osteopaths, about things that aren't in their standard training, in standard practice."
>
> **Interview no. 2, male, aged 50–60, IPEP**

Their disinterest with regard to hospitals and the process of integrating universi-

ties a priori gave these doctors little influence over the transformation of the institutional rules. But this observation was qualified by other factors. The doctors' active participation in the current primary healthcare reforms made it possible to envisage a modification in the structure of the medical sector which would ultimately be advantageous for them (Robelet, 2003); because these doctors were highly experienced and committed to this process, which aimed – just like integrating general medicine into universities – to modify the asymmetry that usually characterises the relations between ambulatory practice and hospitals, making the GP into the first port of call in the healthcare system.

To implement such a project, most of the project leaders were supported by the collective organisations they represent, such as trade unions or professional representative bodies, particularly the National Federation of Multiprofessional Group Practices (*Fédération nationale des maisons de santé*, AVECsanté) and its regional branches. In this framework, they had to maintain close relations with the public authorities, and the Federation played the role of a community of interest (Vezinat, 2020). Also, their professional, union, and political commitment meant they had certain skills, which the project leaders could use to deal with the demands of the public authorities in the framework of the PEPS and IPEP experiments (see below).

### Medical private practice and entrepreneurship

Lastly, the project leaders spoke about their attachment to private practice. Indeed, their rejection of specialisation was also partly linked to the fact that this mostly results in hospital work, where the doctors are employees. Their preference for the private approach, in particular the absence of hierarchical structures, was sometimes explicitly accompanied by a rejection of the hospital system and the hierarchy that exists within some departments:

> "I was one of the rare doctors who didn't want to be a specialist. I wanted to be a private doctor."
>
> **Interview no. 11, male, aged over 60, IPEP**

> "There was a truly pyramidal system, with the big boss at the top, highly-regarded people, and less well-regarded people."
>
> **Interview no. 2, male, aged 50–60, IPEP**

Private practice work was therefore seen as a mark of independence and a way of monitoring working conditions –mainly the hours and remuneration–, in contrast with employed work, which introduced an element of subordination and material constraints with regard to work. As such, the promotion of private practice was complemented by an entrepreneurial rhetoric that was particularly evident amongst the project leaders:

> "I'm a fan of the private practice approach, because, in fact, private practice also implies the possibility of creating, innovating, coming away from the beaten path, and having some freedom."
>
> **Interview no. 15, male, aged 50–60, IPEP and PEPS**

> "And the real choice was the variety of the fields to explore and probably something relating to entrepreneurship, not being employed, and a liberal stance."
>
> **Interview no. 9, female, aged 30-40, IPEP**

This rhetoric was based on the idea of a certain freedom of action – innovation in terms of the organisation of healthcare, and overriding rules imposed from the outside – that only private practice offers.

## The social conditions that make entrepreneurial work possible

The union or political socialisation of the project leaders strengthened their inclination to support change rather than maintain the status quo, on the one hand, and, on the other, encouraged them to carry out collective action in the form of successive projects. Furthermore, the Article 51 experiments were conducted in a local context that was favourable to their implementation, which was both the condition and result of the primary healthcare reforms that are still underway.

### A desire for change

The project leaders underlined their great interest in the experimental aspects of the IPEP and PEPS experiments. The trade union or political experience of the project leaders played a crucial role in their desire for change.

> "Also, I prefer to be a part of change rather than have change imposed on me afterwards; and I'll be told: "*that's how you should do it*". (...) I'm a union member, so I'm already involved and naturally I'd like to be a part of any developments."
>
> **Interview no. 1, male, aged over 60, PEPS**

> "In any case, in our frame of mind, we were like all the other teams that were there and that's what was so enriching about the exchanges we had in Paris, it's a pioneering and groundbreaking approach, and we didn't know whether it would work or not."
>
> **Interview no. 5, male, aged 40–50, IPEP**

The above quotation also underlines the valorisation of risk taking, whose result is still uncertain. Considering change as inevitable, they expressed their desire to be a part of change rather than be subject to it. In practice, they were clear about not following a path imposed on them, as was already the case for the joint exercise initiated by the stakeholders on the ground before being promoted by the public authorities. They chose to follow other paths to promote the development of structural change:

> "I eventually learned to "break down the barriers" because, otherwise, we would never have made any headway."
>
> **Interview no. 11, male, aged over 60, IPEP**

While they frequently referred to individual and local situations, one might imagine that this propensity for contesting – and even transgressing – imposed rules developed more broadly in their union activities, within the regional unions of healthcare professionals (*Unions régionales des professionnels de santé*, URPS), or as part of the promotion of coordinated practice. Amongst some of them, the need for change was self-evident because it coincided with the idea of a crisis in the private practice system. Several elements in their statements also supported the notion of France "lagging behind" other countries, in particular Anglo-Saxon countries – lags that can only be overcome via a fundamental transformation of the structure of primary healthcare:

> "We are twenty years behind Canadian nurses. (...) My idea was why not? There's also the way the German nurses work. They don't have the same training, but why shouldn't they succeed? Because we are very corporatist in France."
>
> **Interview no. 3, female, aged 40–50, IPEP**

> "So, we continue to have doctors who spend half their time doing things in their practices they could just as well delegate to others. But unfortunately we're in a system that doesn't allow us to experiment with different approaches."
>
> **Interview no. 13, male, aged over 60, IPEP**

The model of the isolated doctor who focuses on his patients, whose approach is anchored in curative treatments, is now faced with a new paradigm that is emerg-

ing in coordinated practices, in which multidisciplinary work can flourish, with the aim of treating the population in a given area, by carrying out public health missions in complement to the healthcare dispensed:

> "If we want our private practice approach to continue, we need to leave our practices and get to grips with the healthcare policies and actively participate in the regional healthcare policy. And, as we leave our practices we need to learn to also change mentalities and not say: "*It's my patient, my practice, and as for the rest I don't give a damn*". Otherwise, in five years' time, this will lead to failure and private practice will disappear, because there will be no other solution for future governments than to introduce measures to prevent the freedom to set oneself up in private practice, employ doctors, and create healthcare centres with salaried doctors."
>
> **Interview no. 4, male, aged 50–60, IPEP**

Hence, the project leaders broadly supported the public discourse concerning the inadequacy of the healthcare provision, the quest for a better quality of healthcare, and even the monitoring of expenditure (Schweyer and Hassenteufel, 2020). Hence, they put forward the consolidation of primary healthcare as a solution to these different "problems", through the grouping of healthcare professionals and multidisciplinary practices.

## The organisational thinking: the implementation of a primary healthcare project

The project leaders also shared a specific vision of primary healthcare. While traditional private practice gave a central role to individual consultations in the activity of GPs, the experimenters saw their activity in a more diversified way. In particular, the organisational prism through which they perceived primary healthcare distinguished them from their colleagues, sometimes even within their practice, in which they managed to generate a collective dynamic. One of the leaders used the term "PME" (a small and medium-sized company) to describe the Multiprofessional Group Practice (MSP)he worked in (Interview no. 4, male, aged 50–60, IPEP), while another explicitly compared himself to a "company director". The latter saw healthcare as a "production line", which, in practice, implies a division of extra tasks, thereby relieving the doctor of having to cope with some of them:

> "So, we created production lines. (…) In a MSP (Multiprofessional Group Practice), I need my secretary, who arranges the consultations and deals with my patients' problems, but in the long term I need a nurse to examine them before they see me; and, eventually, I need blood samples, ECGs, and lung function tests (…); I need to be there to establish my treatment programme, do an examination, and carry out a clinical assessment; I need the pharmacist to deliver my prescription and we need to check together that we haven't made any silly mistakes; and I need people to work on my software programme and my medical file, which is superb, and so on."
>
> **Interview no. 7, male, aged over 60, IPEP**

More practically, the experimenters highlighted their ability to think in "project" mode: they managed to develop a series of steps that needed to be completed, based on an initial observation and the resultant goals that needed to be attained, as attested by the application files. They drew upon their great familiarity with the healthcare system, the current issues, and local and national actors. Also, they employed different means of objectivation, particularly in written form, which enabled the "projects" to be formalised and submitted to the financers. There again, the project leaders' union and professional experience – and what this facilitated in terms of acculturation to the French health system and their contact with the various administrations – seems to have contributed to the interiorisation of such schemes, as attested in the following extracts:

> "Yes, that's it, (…) it's the ability to be able to communicate with the institutions while being familiar with the application files. If we're not familiar with the files, we're turned down, as they tell us that it doesn't meet (…) the specific requirements … So, in fact, it was a question of comprehension. Understanding and making proposals (…)."
>
> **Interview no. 12, female, aged 40–50, IPEP**

> "We were in contact with the interlocutors, so we knew how to talk the language of the "ARS" [Régional Health Authority] and the "CPAM" [Frenc Local Health Insurance Fund], and we were familiar with the administrative and regulatory language, etc. so the relations with our institutional partners were already well established."
>
> **Interview no. 5, male, aged 40–50, IPEP**

In particular, these doctors acquired certain skills and ways of thinking from the economic field. In a context of increased control over healthcare expenditure, these skills were very useful when it came to negotiating with the public authorities, as was the case in the joint definition phase.

Ultimately, the prolonged contact with the health administration not only facilitated familiarisation with the workings of the healthcare system, but also accelerated the interiorisation of budgetary thinking. In fact, their participation in the experiment seemed to speed up this process, particularly via the transmission of numerical indicators relating to the "expenditure" for healthcare provided in a Multiprofessional Group Practice:

> "What we've already learned is that we've realised that a Multiprofessional Group Practice that employs a dozen health professionals and treats 7,000 patients already costs the *Assurance Maladie* ([the French National Health insurance system] 10 million euros per year. It's colossal. (…) It means we can calculate the true cost of our activity, because ultimately the goal is to limit healthcare expenditure – we should make no mistake about it."
>
> **Interview no. 5, male, aged 40–50, IPEP**

Hence, the budgetary constraints formulated by the public authorities were gradually interiorised by the healthcare professionals responsible for providing, and even organising, care.

## A favourable context: the long-term transformation of primary healthcare

The project leaders had often been involved in other local or national schemes before joining the IPEP or PEPS schemes, such as the ENMR (Experiments with new modes of remuneration) and its developments (negotiated settlements, followed by Conventional interprofessional agreements (*Accords conventionnels interprofessionnels*, ACI) relating to multiprofessional healthcare practices) and the ASALEE experiment (*Action de Santé Libérale en Équipe*: the project to coordinate care between GPs and nurses). The experiments studied occurred exactly at a time when the project leaders were testing out new organisational methods. The previous experiments helped to forge the project leaders' ability to meet the demands of the public authorities and, more pragmatically, to respond to calls for projects. Nevertheless, these organisational methods were both the product of the reforms already carried out, and the condition to be able to participate in subsequent reforms. For this reason, the Multiprofessional Group Practices (MSP) and Healthcare Networks (*Pôles de santé*) were a structuring phase that preceded the subsequent reforms, as they opened the way to a new approach of collective remuneration, with the aim of implementing a joint healthcare project. These structures constituted an initial experience of multiprofessional work, which the pri-

mary healthcare professionals then promoted. Likewise, the formation of new professional groups that worked in MSPs – exclusively or not – also helped to create greater interdependence between the primary healthcare professionals. Hence, the coordinated practices could be supported by new professional segments – medical assistants, accompanying nurses, and coordinators –, which were also responsible for entrepreneurial work.

## Different reasons for commitment depending on the experiments

The reasons that encouraged the professionals to take part in one or other of these experiments highlighted an essential characteristic of entrepreneurial work: the continual quest for material and symbolic resources that legitimise change. The reasons for commitment were not the same for the various experiments. In the case of IPEP, by placing themselves at the forefront of developments in the field of primary healthcare, the project leaders acknowledged that they were looking for the slightest opportunity to obtain additional funding to bring their own projects to fruition:

> "Because with IPEP, I've become a little… it was (a GP friend) who said that one day – that he had become a "*money chaser*". For me it's practically the same thing, as I'll look for money to try and encourage the professionals to work in a different way."
>
> **Interview no. 13, male, aged over 60, IPEP**

Also, from their standpoint, the IPEP experiment seemed to be a minor risk, because this new means of remuneration has been added to fee-for-service remuneration, rather than replacing it. It does not have a direct impact on the amount of the remuneration of healthcare professionals:

> "And, in any case, IPEP is structured like that: (…) initiatives are launched, and if they don't work we're not penalised, but if they do work, we receive an incentive remuneration, because that's how it works."
>
> **Interview no. 5, male, aged 40–50, IPEP**

> "It's also a driving force in the dynamics a driving force for change. (…) And then IPEP turned up, and that was it, but without the risk taking. I suppose it was a bonus for the team. So we thought that we may as well go ahead. (…) above all, because we're already doing those things!"
>
> **Interview no. 15, male, aged 50–60, IPEP and PEPS**

The obtention of budget allocations was both a way of promoting an extension of treatments through the greater involvement of certain stakeholders or by reinforcing interdependence between healthcare professionals, and a means of legitimising certain activities that already existed.

The PEPS experiment offers a different conception of the remuneration of healthcare professionals, which partly or totally replaces the fee-for-service remuneration. In practice, the capitation payment only concerns the "GP patients"; all the others are always invoiced per fee-for-service. With the regard to the PEPS project leaders, this resulted in a stronger rejection of the fee-for-service system, even though they remained fundamentally attached to other elements that characterise private practice. In at least one partnership this criticism took the form of the prior introduction of a fee-sharing arrangement amongst the doctors in the MSP. Hence, PEPS helped to legitimise practices that were already well established amongst private doctors. The change of approach promoted as part of the experiment aimed to establish an organisation of healthcare seen as "ideal" or, at least, give it more legitimacy, for example by fostering collaboration between nurses and doctors:

> "Well, we chose PEPS (…), it's about taking collaboration between nurses and doctors further. So, it means going beyond fee-for-service and embracing new arrangements between doctors and nurses, new work organisations, and also new treatment methods."
>
> **Interview no. 15, male, aged 50–60, IPEP and PEPS**

In particular, the experiment theoretically makes it possible to rethink the division of labour and the distribution of tasks in MSPs, thanks, in particular, to the implementation of procedures to delegate jobs, whether the latter are done in the framework of the competence statutes that regulate each professional group or in the framework of exemption protocols. Yet, capitation payments theoretically encourage the delegation of some medical work to other stakeholders, thereby freeing up medical time, from the perspective that the remuneration of the doctors was less related to the number of medical acts:

> "So, we chose PEPS because it seemed to be much more advantageous. And also more directly linked with what we imagined our activity to be if it were to be remunerated at a capitation rate with regard to the sharing or transfer of competencies. (…) I'm very impressed by the Choosing Wisely programmes in Canada (…); it's about efficiency and pertinence. It's about trying to choose the right professional solution at the right time and in the right place for the right patient. I dreamed of transferring that system to my own activity."
>
> **Interview no. 17, male, aged 50–60, PEPS and IPEP**

Although the introduction of capitation payment meant openly challenging one of the historical pillars of private practice medicine, the project leaders have – in the same way as those taking part in the IPEP – tried to limit the risk-taking linked to the experimental dimension. As it happens, they tried to obtain a remuneration that was at least as high as that obtained when they were paid on the fee-for-service basis:

> "So I trusted them to make sure we weren't going to lose out (*laughs ironically*). I mean, I even understand their methods of calculation, and, for the moment, we haven't lost anything, quite the opposite! (…) unlike what we initially thought, I said to myself: "*it's a way of making savings*", but it wasn't that at all! It's just a way of optimising our expenditure. So, I'm quite happy with that…"
>
> **Interview no. 1, male, aged over 60, PEPS**

This issue of remuneration seemed to be a particularly sensitive one in the MSPs that took part in the PEPS experiment, probably even more so than in health centres where the issue was less prevalent due to the presence of salaried staff. Hence, several of them left the experiment before it ended, abandoning the project to transition to capitation remuneration.

## The role of entrepreneurial work in the construction of the IPEP and PEPS projects

The construction of the PEPS and IPEP projects was based on three essential phases: controlling information through monitoring, file creation, and the joint definition phase.

### Being alert and taking every opportunity

In the framework of the Article 51 projects, the entrepreneurial work depended primarily on the continual control of information, which enabled one to be at the forefront of the transformation of primary healthcare. Calls for projects were often tracked in practices to ensure funding opportunities were not missed. This

tracking was often the job of the coordinator or other professionals:

"... In the operational framework of the institution, of which I'm the treasurer, I kept track of the calls for projects in order to find possible funding sources to be able to realise the projects we had. And so it was in this framework that I spotted the Article 51 experiment."

**Interview no. 9, female, aged 30–40, IPEP**

The implementation of such tracking seemed to be the product of training undergone by the MSPs coordinators. The organisational effects of this kind of training enabled the project leaders to be on the lookout for new ideas. Also, the leaders who were members of a professional association or union could also benefit from proactive information from them, as the tracking was delegated to stakeholders who were external to the practice.

"Via our national federation, AVECsanté, we are constantly in touch with the Ministries, the CNAM [French National Health Insurance], etc., so that's how we heard about it."

**Interview no. 2, male, aged 50–60, IPEP**

"I'm a member of the regional union of private healthcare professionals, the URPS-ML, in which I have a role in the bureau. And, as a result, I have been privy to special information, compared with others, as I was soon informed that there was a request from the ARS about Article 51 experiments. And, as it happened, the ARS asked me to do it."

**Interview no. 1, male, aged over 60, PEPS**

In this context, they were not only aware of the existence of such calls, but were often encouraged to apply, including by the supervisory bodies, with whom they often had special relations, while sometimes benefitting from support in creating their application file. In any case, the system that enabled them to keep track of opportunities highlighted the leaders' latent interest in these kinds of experiments, which brought together organisational methods considered innovative by the public authorities – even though they have existed for many years – and various means of funding healthcare.

## Using the right language, correctly handling form

The practices' participation in these experiments was based on the response to a call for expressions of interest (AMI). All the same, the call for projects – a new standard part of public action that was not unilaterally imposed – required the depositors to understand the criteria on which it was based, as they were eager to obtain a positive assessment of the submitted file (Breton, 2014). The project leaders then had to draft an application files. This was relatively undemanding as it only required the project leaders to describe the area in which they worked, their partnership, their expectations concerning the experiment, the initiatives already implemented, and those envisaged to meet the population's healthcare needs, and the available support functions:

"It was a description; we followed the framework, which was well put together, and then we submitted all the information; and there were things we were already doing and things we wanted to do, and everything seemed to be quite clear. Also, I think that as soon as we had a little time to think about our professional practice – and we're not completely obsessed with the turnover –, it was possible to see what could help, what could be developed, and what was pointless, but which we did, nonetheless, because that's how we earn our living, etc. We said to ourselves: "*Let's create a sort of ideal system, an ideal situation in which we can earn our living honestly*"."

**Interview no. 17, male, aged 50–60, PEPS and IPEP**

This framework should not only be viewed as a purely administrative obligation that facilitated the examination of the submitted application. It imposed a certain way of thinking on the doctors, by encouraging them to link together certain factual elements that raised questions about the organisation of care, with concrete propositions as a solution. In the framework of IPEP, for example, the application file required them to present the partnership by emphasising the "strong points" and "weak points", the "impediments", and the "levers" for improvement. In this context, they were also asked to characterise their area of practice by specifying the "main issues" involved. Then, they described the envisaged organisation of care, the local dynamics, and coherence with other measures aimed at the regional structuring of healthcare provision; then the initiatives carried out by the partnership in regard to each theme – those already implemented and those envisaged. Hence, the application file was considered a veritable performative support for the successful development of entrepreneurial work (Giraudeau, 2007). Responding in a convincing way meant being capable of providing information based on categories and concepts that were likely to convince the public authorities:

"But I think that developing a project is not everyone's cup of tea. (...) There won't always be elected people like us to develop good projects. People really depend on us, and yet, at the same time, once the project has been launched, if it fails, we're blamed for its failure."

**Interview no. 12, female, aged 40–50, IPEP**

The drawing up of the application file was often the result of a collective effort, and several professionals were often involved in drafting the file, in particular the female coordinators, sometimes described as "project leaders". In the interviews conducted, the collective aspect of the entrepreneurial work was sometimes given second place – and consequently so was the work carried out by the female coordinators of these practices –, compared with the individual efforts made by the doctors to correctly handle their practice's application:

"*- And with regard to your interest in "change", at any rate the Multiprofessional Group Practice construction project and the PEPS application file ... Was that a significant workload?*
- Yes, it was — huge even! But I'm hyperactive and work a lot; I don't take any holidays or have weekends off. So, obviously it's not for everyone, but that's just the way it is. It's a huge commitment."

**Interview no. 1, male, aged over 60, PEPS**

The Article 51 experiments followed other experiments relating to the reform of primary healthcare, and many measures had to be combined. In particular, the healthcare projects already drafted as part of the creation of the MSPs, and even more so in the framework of the Local Health Professionals Communities (*Communautés professionnelles territoriales de santé,* CPTS), facilitated the responses to the calls for expressions of interest:

"That's why I was able to do it in 72 hours; it's because everything is there, everything is developing and evolving. So, when the IPEP project emerged, we did it, and I was already considering the CPTS project."

**Interview no. 4, male, aged 50–60, IPEP**

Without disregarding the workload on the shoulders of the interviewed doctors, it is important to highlight the participation of other actors, the performative role of the application file, and the ability to be able to capitalise on their experiences of other innovative schemes.

## Joint definition: a decidedly collective effort

Once their application file was validated, the project leaders selected after the calls for expressions of interest took part in the

joint definition phase of the experiments' specifications[1]. In this framework, the public authorities and the stakeholders on the ground required the support of specific expertise. In particular, the doctors who took part in this initial stage very often used their field experience to counter other stakeholders, in particular those from the "Ministry". They saw the latter as having a disembodied vision of the health system, focusing on other interests than theirs:

> "When I met the people from the Ministry, I had the impression that they were not used to dealing with someone working in the field, and I'm just that. So, if you like, I think it's really important that those working in the field make their opinions known to the people who manage healthcare."
>
> **Interview no. 1, male, aged over 60, PEPS**

The project leaders' experiences as stakeholders on the ground complemented the top-down vision of the public authorities. This encounter was facilitated by the selection process implemented, which resulted in the presence of doctors who were familiar with administrative language and the health system, and often highly aware of economic issues. All the same, the joint definition phase also prompted strong relations between the partnerships conducting experiments. Indeed, the national team regularly organised seminars, working groups, and follow-up meetings with the project leaders. Hence, there was a sort of "collectivisation of entrepreneurial work" (Giraudeau, 2007).

* * *

The IPEP and PEPS project leader doctors were distinguished from their GP colleagues through their active involvement in the current primary healthcare reforms. The strong presence of trade union and professional representatives in the experiments seemed to be linked to certain competencies that were unequally distributed amongst GPs, and a practice setting – a product of the implemented reforms, as already suggested by the publication of the initial results of the survey that highlighted the selection choices made by the public authorities (Morize et al., 2021). The analysis also shows that the eminently collective nature of the entrepreneurial work completed – both in creating the measures on which this was based, as well as in its everyday implementation –, was supported by other professional groups and the public authorities. Not only did they take part in the PEPS and IPEP experiments, but they also took every opportunity to realise their project. Such a result questions the replicability and generalisation of such experiments. The next analyses devoted to salaried project leaders conducted by other members of the ERA2 collective will make it possible, in comparison, to specify the role played by private practice in the development of entrepreneurial work. ♦

1 For a further insight into the joint definition phase, its progress, and the way in which the specifications were negotiated amongst the various stakeholders, see Noémie Morize's thesis, which is underway.

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