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The Use of IPEP and PEPS Experimental Funding in Five Multiprofessional Group Practices (MSPs) Towards a redefinition of the professional boundaries in the division of care work

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New collective remuneration methods, which were alternatives to fee-for-service remuneration, were implemented within Multiprofessional Group Practices (MSPs) as part of experiments under Article 51 of the 2018 Social Security Funding Act (*Loi de Financement de la Sécurité Sociale*, LFSS). Two national pilot programmes — 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*) — aimed, in the former case, to reinforce the dynamics of coordination between the outpatient care and hospital sectors, and, in the latter case, between doctors and nurses working together as a team. By introducing new collective funding methods within MSPs, the pilot programmes could complement transformations in the organisation of primary healthcare. How does the use of these funding methods help to redefine the professional boundaries in the division of care work? Based on five qualitative monographies and 64 semi-structured interviews conducted with professionals who work in a MSP, this survey made it possible to characterise the different ways in which the experimental funding was used within teams of healthcare professionals, in particular in terms of the organisation of work. Broader transformations in the primary healthcare sector were thus clarified, such as the redefinition of the roles and work between professional groups.

Primary care designates the global care of patients by outpatient healthcare professionals, in the case of common diseases (WHO, 1978). In France, this sector is mainly organised around self-employed healthcare professionals, in particular GPs and nurses. Over the past twenty years, the public authorities have been attempting to regulate this sector, which primarily consists of self-employed professionals. In 2004, the implementation of the "GP" scheme enabled GPs to have a list of "affiliated" patients and benefit from a lump sum payment, in addition to fee-for-service remuneration (Bloy, 2010). During the 2000s, "medical desertification" became a public problem (Moyal, 2021), which the public authorities have been combatting by

promoting a new method of organising healthcare: Multiprofessional Group Practices (MSPs). The intention is to encourage young professionals to establish practices in relatively unattractive rural areas (Chevillard et al., 2018). In addition, the self-employed professionals within MSPs – brought together in multidisciplinary organisations – could benefit from collective remuneration as long as they abided by certain obligations, initially experimentally (2007), and then under common law through formal interprofessional agreements with local public authorities (2015). Increasing from around twenty structures in 2008 to more than 2,000 today – of which three quarters are funded by a conventional interprofessional agreement (*Accord Conventionnel Interprofessionnel*, ACI) [HCAAM, 2022] –, the MSPs have been popular with self-employed GPs, above all the new generations of doctors, and notably among female doctors (Biais et al., 2022).

Building on the increase in the number of MSPs, two pilot programmes involving the collective remuneration of teams of primary healthcare professionals were implemented in 2019, in the framework of Article 51 of the Social Security Funding Act (LFSS) for 2018:

- The experiment relating to a five-year pilot programme to promote the establishment of groups of care providers who come together to provide patients with coordinated high-quality care (*Incitation à une Prise en Charge Partagée*, IPEP) consists of additional incentive payments, based on quality indicators and an assessment of the development of a partnership in terms of economic performance.
- The experiment with a collective lump sum payment scheme for self-employed healthcare professionals (*Paiement en Équipe de Professionels de Santé en Ville*, PEPS) offers teams of GPs and nurses the possibility of replacing fee-for-service payments with lump sum payments, for all of their patients or certain categories of patient (patients with diabetes and/or elderly patients).

The two pilot programmes aim, amongst others, to reinforce the dynamics of coordination: in the former case, between the outpatient care and hospital sectors, and, in the latter case, within a MSP, in particular between doctors and nurses. The underlying hypothesis of these experiments is that enhanced coordination would both improve the quality of healthcare and also better distribute the funding efforts by improving disease prevention and by delegating certain tasks among sectors or professions.

Source and Method

These results are based on five qualitative and monographic studies conducted by Noémie Morize and Vincent Schlegel in Multiprofessional Group Practices (MSP) taking part in the IPEP (the establishment of groups of care providers who come together to provide patients with coordinated high-quality care) and PEPS (a collective lump sum payment for self-employed healthcare professionals) pilot programmes, between May 2019 and May 2022. The monographs were carried out through semi-structured interviews (n=64) — which were sometimes repeated — conducted with professionals, including GPs, paramedical professionals, and employees (coordinators, secretaries, reception staff, etc.), depending on their availability and their participation in the project presented as part of the pilot programmes. These interviews focused on the careers of the professionals, the way their work was organised, and the implementation of the pilot programmes within MSPs. The regions were selected according to the diversity of the pilot programmes in which they took part.

The organisations and individuals were renamed to preserve their anonymity.

Our survey was part of a case studies, conducted by a team of sociologists. Initial publications studied the national (Morize et al., 2021) and regional (Bourgeois et al., 2021) organisation of the management of these experiments by focusing on the interaction between public authorities and healthcare professionals in their implementation. A study focusing on self-employed GPs leaders showed that these "entrepreneurs" of change in primary healthcare have a unique profile that distinguishes them from their peers. This raises questions about the replicability and generalisation of such experiments (Schlegel, 2022). The results presented in this study are part of this research, which, this time, analyses how the experimental funding was used locally by healthcare professionals through the organisation of care work. How do the uses of this funding contribute to a redefinition of the professional boundaries in the division of care work? By focusing on MSPs, which are still in the minority in France, our hypothesis is that the study of the uses of experimental funding sheds light on broader transformations in the primary healthcare sector. Here the focus is placed on the MSPs, even though hospitals, healthcare centres, and Local Health Professionals Communities (*Communautés Professionnelles Territoriales de Santé*, CPTS) are also involved in similar projects in the framework of the experiments. The organisation of work in MSPs is characterised by certain specificities due to the fact that the healthcare professionals are self-employed.

Firstly, the way in which the two pilot programmes functioned highlighted the unequal constraints that they imposed on the practices of the healthcare professionals and their role in the organisational dynamics observed (1). Then, an analysis of how funding was used locally raised questions about the roles played by the various healthcare professionals in the organisation of work. On the one hand, the survey showed the important role played by the women healthcare professionals and employees in the daily implementation of these pilot programmes (2). On the other hand, the pilot programmes raised questions about the role of doctors in patient care, by encouraging them to refocus on the curative aspects of their profession (3).

Two parallel pilot programmes in primary healthcare: specific uses

Firstly, these new remuneration models placed unequal constraints on the healthcare professionals: while the IPEP pilot programme gives the healthcare professionals great freedom, even if this means shifting away from the scheme's initial objectives, PEPS

Context

This study is anchored in the sociological part of the programme of assessment of the pilot programmes aimed at finding alternatives to fee-for-service payments in the context of Article 51 (Era2). Funded by the National French Health Insurance system (*Assurance Maladie*), its aim is to assess the conditions, effects, and applications of the introduction of alternatives to fee-for-service remuneration, both with regard to the organisation of primary healthcare in France and the practices of the professionals. It is also part of a doctoral thesis in sociology, funded by the national Foundation of Political Science (*Fondation Nationale des Sciences Politiques*, FNSP), and undertaken by Noémie Morize at the Centre for the Sociology of Organisations (*Centre de Sociologie des Organisations*, CSO), in collaboration with the Institute for Research and Information in Health Economics (IRDES), under the direction of Patrick Castel and Cécile Fournier.

directly tackles the question of doctors' remuneration, partly changing their practices. Furthermore, the new collective funding within MSPs contributed less to radically reorganising work than to legitimising the pre-existing work organisation.

Pilot programmes that place unequal constraints on healthcare professionals

Incentive schemes such as IPEP provided the self-employed professionals with a certain amount of freedom – which was welcomed by them – to successfully complete their projects. During the first years of the experiment, the teams benefited from "seed money", funding to enable the implementation of initiatives. The IPEP incentive schemes is both flexible and can have uncertain outcomes – the professionals have no opportunity to anticipate the results. Indeed, the pilot programme does not place constraints on the professionals in terms of the use of the funding. In the MSPs studied, the received funding was allocated toward various purposes, including human resources (such as hiring a nurse or compensating a healthcare professional for a medical procedure not covered by the National French Health Insurance system (*Assurance Maladie*), professional training courses, medical equipment, and, less frequently, internal audits within a MSP. Hence, the implementation of the pilot programme was very different from what was envisioned by the administrative stakeholders at the Ministry of Health and the National Health Insurance Fund (*Caisse Nationale de l'Assurance Maladie*, CNAM). Hence, the primary care teams did not actively seek to influence indicators measured within the framework of this pilot program, which determined the amount of the incentive payment received, in particular those measured in relation to hospital activities:

> "Actually, we're not willing to negotiate things in the hospital to improve our IPEP remuneration".
>
> **Accompanying nurse,**
> **The "Agapanthes" MSP, 11/2021**

Therefore, the self-employed primary care teams became involved in the IPEP pilot programme expecting favorable outcomes from the economic model, based on their practices, which they considered virtuous, without thinking of developing specific initiatives to enhance coordination between GPs and hospitals. A doctor explained that the schemes did not in general correspond to the local organisation of care, hence the need to launch several schemes without pursuing the objectives assigned to them.

> "Then, faced with the actual reality, we realised that we were all camels with four or three humps (...). That is to say that, in fact, we've all got a fairly specific population of patients, a fairly specific geographic area, specific human resources, and, therefore, the [economic] models are ... you can pick certain elements, but (...) In reality, it's quite difficult to implement".
>
> **GP, male,**
> **The "Agapanthes" MSP, 11/21**

The low level of constraint of IPEP funding enabled the primary healthcare teams to prioritise the development of their own public healthcare projects, as the pilot programme contributed to promoting a local vision of the organisation of primary healthcare. These appropriations of instruments of public action are reported in sociological literature, which underlines the professionals' ability to implement managerial measures to further their own goals (Bezes et al., 2011). Furthermore, the involvement of professionals in this drive to transform the organisation of primary care may be interpreted as a way of influencing change rather than being subject to it (Monneraud, 2011; Schlegel, 2022).

For its part, the PEPS pilot programme places unequal constraints on doctors, depending on whether they decide to apply the lump sum to all of their patients or only some of them. In the MSPs surveyed, two of them ("Agapanthes" and "Camélias") joined the PEPS scheme with their "entire patient base", that is to say that the alternative payment applied to all their patients who were GP "affiliates". The "Bougainvilliers" MSP joined the scheme with its "diabetic patients", which means that the implementation of the lump sum payment only applied to patients suffering from this disease who were "affiliated" with GPs, representing a small minority of the GP patients:

> "I chose that, because, firstly, it wasn't possible to participate in the scheme with our "entire patient base" because that's a complete change of paradigm, because only health centres have operated in that way. So, this isn't a health centre; we're just self-employed doctors paid on a fee-for-service basis. So, if you will, I managed to change self-employed professionals' remuneration to a lump sum payment, and then implemented a delegation of tasks. So, we were sure that the experiment was one of a high standard".
>
> **GP, male,**
> **The "Bougainvilliers" MSP, 03/21**

Although it concerned a small proportion of their patient base, the across-the-board application of a lump sum payment was a major change for the self-employed doctors. The three MSPs were also the only self-employed teams that completed the PEPS pilot programme. Initially intended for teams of doctors and self-employed nurses, the lump sum was eventually applied solely to doctors. Furthermore, of the 16 MSPs that took part in the experimental process, 13 of them left before the end, when they wanted to participate in the pilot programme with "diabetic patients" or an "elderly patient base". These dropouts were, amongst others, due to the difficulties reported by these self-employed professionals

in creating an allocation key between them, the complexity of the process that required them to organise two billing systems within the MSP and defer the medical activities that were not part of the usual nomenclature, and the absence of overlap between the patients of the GPs and those of the nurses, limiting interprofessional cooperation.

The transition to a lump sum payment may – more so than the incentive payment – have a direct influence on practices, in particular for those who have decided to apply the lump sum to all their patients. Indeed, the lump sum directly affects the doctors' level of remuneration, which may lead to adjustments aimed at increasing it. Hence, in the "Camélias" MSP, the consultation time remained unchanged, but the doctors adjusted their frequency. Indeed, the national PEPS team told them that the number of consultations per patient – higher than the national average – results in an unremunerative lump sum. The doctors therefore tried to space out the consultations.

> "I space out the consultations, in particular the follow-up consultations, as we realised that we were seeing our patients a little too often (laughs). For example, in the consultations for prescription renewal, the patients are generally well. It's kind of automatic, (…) every three months. Now, I don't hesitate anymore: "Well, but actually you're healthy; I've seen you two/three times and everything's ok"… So let's make it every six months".
>
> **GP, female,**
> **The "Camélias" MSP, 02/22**

The PEPS lump sum payment replaced GPs' fee-for-service remuneration, which has given rise to further adjustments to the new payment method. The GPs faced few constraints regarding the application of the lump sum, but since it did not exceed – or slightly exceeded – their previous remuneration, it did not enable other projects to be funded.

Between new professional practices and the legitimisation of the pre-existing work organisation

Within the studied teams, the local reorganisation of primary healthcare was seen as a way of developing certain tasks that were not funded by the fee-for-service payment, and which focused mainly on prevention and public health (booster vaccinations, prevention in schools, group workshops, etc.); and on patient support activities (administrative assistance, help during consultations, booking appointments, patient follow-up by telephone or at home, etc.). Hence, the PEPS pilot programme gave diabetic patients at the "Bougainvilliers" MSP the chance to take part on an ad hoc basis in discussion groups run by a psychiatrist, and group workshops that focused on healthy eating. Likewise, the "Orchidées" MSP provided – as part of the IPEP pilot programme – treatment protocols for persons suffering from chronic kidney disease and heart failure, which primarily consisted of organising systematic staff meetings (*Réunions de Concertation Pluriprofessionnelle*, RCP) for these patients, as well as an individual education session run by a self-employed nurse.

Nevertheless, in the implementation of this organisation of care, the role of the pilot programmes should be put into perspective: though they may contribute to – and even give impetus to – this drive for change, they generally make it possible, more modestly, to fund existing ways of organising care that have often been put in place earlier. They may also encourage a change of scale, for example by funding additional posts or by increasing the working time devoted to certain activities. These ways of organising healthcare were most often created by drawing on other models used in the professional field (close relations with other professionals, events organised by the National Federation of Multiprofessional Group Practices (*Fédération des Maisons de Santé*).

In the "Sureaux" MSP, the IPEP pilot programme primarily facilitated funding for a programme aimed at treating patients considered vulnerable. This programme, implemented in the MSP since 2016, was initially funded by another pilot programme relating to the participation of the users; the IPEP pilot programme provided an opportunity to continue this project. This programme makes it possible for patients to receive individual support provided by paramedical professionals and group support in workshops focusing on the management of chronic pain, art therapy, meditation, or health literacy. Patients can also be referred to a healthcare mediator, who can help them with various administrative tasks. The scheme is coordinated via monthly staff meetings, in which healthcare professionals discuss patients' inclusion and orientation under the supervision of a GP. The time spent in these established staff meetings may be remunerated, as was the case mentioned in the 'Bougainvilliers' MSP, on the basis that the time spent outside the doctor-patient relationship also contributes to improving the treatment of patients, and therefore their health.

At the "Camélias" MSP, the GPs had attempted – before participating in the PEPS pilot programme – to mitigate some of the effects of the fee-for-service payment, by arranging fee splitting. In fact, they had already formalised longer consultation schedules. Likewise, in the "Agapanthes" MSP, the transition from the fee-for-service payment to a lump sum payment was accompanied by a reorganisation of the doctors' agendas, with the establishment of long consultation schedules for chronic illnesses, gynaecological and paediatric consultations, and shorter consultation schedules for acute pathologies. This reorganisation was more of a formalisation than a change.

> "Is a consultation lasting a quarter of an hour enough to evaluate a patient? I've always been convinced that it isn't (…). It [the lump sum] hasn't changed anything; I think it's purely intellectual".
>
> **GP, female,**
> **The "Agapanthes" MSP, 12/21**

Nevertheless, by focusing on the remuneration of doctors, the PEPS lump sum payment alone does not make it possible to develop multidisciplinary work. This depends on other schemes, such as the conventional interprofessional agreements (*Accords Conventionnels Inter-professionels*, ACI), MSPs, and the IPEP pilot programme, insofar as the PEPS scheme is not sufficient in itself to hire nurses in order to ensure that certain specific tasks are carried out (see below).

At the forefront of the transformations in the organisation of care – female paramedical professionals and employees

Although the financial incentives vary according to the pilot programme in question, our research highlighted similar trends in the organisation of work within MSPs. In the studied MSPs, most of the preventive care and patient support services were provided by female paramedical professionals or by the staff in the MSP, secretaires, reception staff, and sometimes mediators or coordinators, who were also predominantly women. On the one hand, the pilot programmes are largely based on the current dynamics of the nursing profession to offer a new way of organising work in primary healthcare. On the other hand, other employed professionals also play a central role in the execution of certain tasks, in addition to their participation in the pilot programmes, while contributing to the new ways of organising work within MSPs.

Nurses: the linchpins of the pilot programmes?

Whether it concerns IPEP or PEPS, the nurses play a key role in the organisation of primary healthcare advocated by the MSPs. This professional group is constantly evolving (segmentation and specialisation of certain tasks) and the pilot programmes are based on this dynamism. The PEPS pilot programme is designed for teams of doctors and employed nurses[1], in order to foster relations between these two professional groups. In the MSPs studied, these forms of coordination were mainly based on nurses employed by the ASALEE association, and who were trained in public health, "accompanying" nurses employed by the MSPs, as well as self-employed nurses. Overall, employee status seemed to facilitate the delegation of tasks, by making it possible to delegate a set of unscheduled and undefined tasks to nurses who no longer provided standard care, avoiding tensions in the distribution of remuneration in private practice. Indeed, most of the MSPs that have left the PEPS pilot programme operated on the basis of a distribution of remuneration amongst GPs and self-employed nurses. These difficulties partly explain the decision to finally apply the lump sum payment only to doctors.

On one level, the nurses may need to extend the scope of their clinical work, by performing certain preventive procedures or holding patient consultations as part of cooperation protocols or the development of advanced practice. In the "Camélias" MSP, for example, the ASALEE nurse was entrusted with holding preventive consultations for children, in order to provide regular follow-up, in particular with regard to vaccinations. In the "Agapanthes" MSP, an advanced practice nurse was responsible for renewing half the treatments for chronically ill, but stable patients. This was also the case in the "Bougainvilliers" MSP, where self-employed nurses who had undergone specific training were expected to hold follow-up consultations for diabetic patients, which was usually carried out by GPs, as part of a delegation of tasks protocol.

On another level, the nurses may also be entrusted with a deliberately undefined range of tasks, relating mainly to the coordinated care of patients. Without losing contact with their patients, they shifted away from clinical practice as they were no longer involved in the provision of care. This was the case at the "Agapanthes" MSP, where the job of the accompanying nurse consisted of being available to address an identified need:

> "The demographic problems mean that doctors are continually working on a just-in-time basis. However, general medicine is becoming less and less predictable and they never really know what's going to happen in a consultation and, so, the idea was to have a healthcare professional available".
>
> **Employed accompanying nurse, The "Agapanthes" MSP, 12/21**

In practice, part of her daily working routine was taken up with tasks relating to mediation and the coordination of care: she filled out the files for new patients enrolled with a "GP", and helped patients fill out their administrative files. She followed up patients after an episode of treatment via telephone or at home, and referred them or made appointments for them with actors in the health profession, the medico-social sector, or in the social field in the region. However, she also sometimes assisted the secretaries at the reception desk when they were too busy, or prepared patient files prior to consultations, and even prescribed tests for patients. Likewise, in the "Orchidées" MSP, two accompanying nurses were hired – one as a medical assistant under the conventional framework, and another thanks to the funds received as part of the IPEP pilot programme. They carried out a certain number of tasks relating to the coordination of care, by acting as a liaison between GPs and their patients, and also between the healthcare facilities, self-employed professionals, and the MSPs. Furthermore, they created files for new patients, in particular the most complex files, as they had more time to do so than the doctors.

In the case of hospital nurses and home helpers, Christelle Avril and Irène Ramos Vacca observed similar divisions of labour: these professionals found themselves "doing what remains to be done", in a female role of availability (2020). Beyond being a simple delegated task, the nurses' involvement contributed to the development of preventive care and patient support services, which were often insufficiently provided by the doctors, as the latter were facing an increasing demand for healthcare in a tense demographic context. Nevertheless, in certain MSPs, such as "Camélias" and "Sureaux", the nurses did not get involved in the multidisciplinary dynamics, with the intention of preserving the autonomy they benefitted from as a result of their self-employed status. The tasks mentioned above, with which they were occasionally entrusted in the other MSPs, were generally delegated to other paramedical or employed professionals.

Reception staff and secretaries: not involved in pilot programmes, but at the forefront of public health

Administrative coordinators, healthcare mediators, reception staff, medical secretaries… Furthermore, with the increase in funding, there was an

[1] These nurses were not, however, employed through the PEPS flat rate, but through other funding.

increase in the number of employed professionals who did not work directly "as healthcare professionals" within MSPs. Working in roles that provide support to the healthcare professionals or in a patient-focused way, their status as employees often comprised an extensive bundle of tasks, extending beyond their "prescribed work" outlined in their job description. Despite their frequent involvement in the MSPs' healthcare projects, the funding of their posts and the definition of their professions are emerging issues on the national scale. Therefore, François-Xavier Schweyer showed the difficulty of professionalising administrative coordinators (2022). In the pilot programme economic models, these dimensions were also rarely taken into account. The PEPS lump sum does not include a supplement for human resources, aside from the doctors' remuneration. The result-based IPEP incentive payment is sometimes too uncertain to be able to invest this funding in hiring staff, without the support of other schemes.

The study focused on professionals who had not yet been assessed in the MSP: the reception staff and the medical secretaries[2]. The hiring of this staff is often part of the doctors' expenditure, paid for from their gross remuneration. Collectives of doctors make it possible to share these expenses. However, in two of the MSPs studied, these professionals were partly remunerated by the funding from the conventional interprofessional agreement (*Accord Conventionnel Interprofessionnel*, ACI) or from the shared expenditure of the professionals working in the MSP, illustrating the financial schemes facilitated by the many sources of funding.

In these MSPs, they carry out the tasks associated with being a medical secretary: managing patient reception, answering the telephone, arranging consultations, and scanning any letters received. However, in addition to this heavy workload, they also carry out tasks connected with the MSP's administrative coordination, as well as tasks relating to treatments and prevention: the fitting of a medical device, booster vaccinations, and preventive examinations, drafting a preventive information leaflet, and so on. These tasks are not linked to the pilot programmes or to other forms of funding: implemented gradually, they are done informally, and the doctors give them "some approximate explanations once, and that's it! (laughter)" [salaried secretary, "Agapanthes" MSP, 12/21].

The extension of their 'bundle of tasks' is valued by these professionals, as it brings them away from the role of being an "ordinary secretary", as highlighted by this member of the reception staff, trained in-house to handle patient reception and deal with patients consulting for the voluntary termination of pregnancies (*Interruptions Volontaires de Grossesse,* IVG):

> "With regard to the midwives, we learned many things (…); it's a super project. It's up to us to receive the call, accompany the patient, calculate the dates of her menstrual cycle, send the prescriptions, and arrange the ultrasound tests (…). This work is different from an ordinary practice, where you just arrange consultations and that's it".
>
> **Salaried reception worker, The "Camélias" MSP, 02/22**

The extension of their 'bundle of tasks' is part of an increase in their skill level, as well as a change in their role as they are no longer just "secretaries", but also "carers", because they take an active part in the patient's care. However, this re-evaluation of work only applies to job content, as it does not complement other forms of re-evaluation: neither a modification in their job description nor an increase in their salary. Within the transformation of primary healthcare, the development of these professions is often less highlighted. Between the continuity of an existing profession (as medical secretary) and the renewal of tasks, the content of these professionals' work is likely to evolve further with the development of collective funding.

GPs' work has been reoriented towards a curative role

The doctors are at the centre of the pilot programmes: the funding is based on their patients; they are the primary professionals who bring the projects to fruition, and they also play a prominent role in the interaction with the national teams. However, the content of their work seems to be relatively unaffected by this experimental funding. In contrast with their vision of their role, doctors have refocused on the curative aspects of their profession, while the paramedical professionals and employees are increasingly taking on certain public health missions. This reorientation has affected their position on the medical ladder and the control they usually exert on the treatment programme.

The sanctification of medical time

In the MSPs studied new patient support activities and public health services developed. Often the initiators of these new ways of organising work, the GPs nevertheless did very little to develop them, as was also observed with regard to users' participation in the MSPs (Morize, 2022). Hence, in the "Sureaux" MSP, while the primary healthcare prevention programme generated considerable patient support work carried out by paramedical professionals, none of the doctors participated in this work. The paramedical professionals explained that, in any event, doctors did not have the time to carry out this support work.

In both the professionals' and in public discourse, medical time – defined as the time spent with patients as part of clinical practice – is sanctified in order to meet an increasing demand for healthcare. The delegation of tasks is justified by the need to reserve time for consultations in a context in which medical desertification is becoming a concern for healthcare professionals.

> "The MSP enabled us to rapidly understand that, if we thought about it, it was better to pay for a doctor to practise general medicine, than [firstly] drive a car, secondly answer the phone, thirdly order examination couch rolls, fourthly do the accounting, etc. All the tasks — I would say extramedical tasks — are therefore increasingly delegated, even in the MSP, which has also enabled us to delegate medical tasks, and, above all, the extra-medical tasks".
>
> **GP, male, The "Orchidées" MSP, 05/22**

[2] The reception staff and the medical secretaries carried out a similar bundle of tasks in the MSPs surveyed, which explains the decision to include in the analysis professionals whose job had a different name.

This organisation of work was seen as a way of "protecting" the medical time, by delegating tasks, enabling the doctor to focus on what was considered the most important work: making diagnoses and writing out prescriptions.

A curative role instead of a holistic vision of their profession

The experimental funding also affected the organisation of medical work: the formalisation of longer consultation schedules, an increase in the number of patients enrolled with a GP, a reduction in the number of consultations per patient, and so on. In the MSPs studied, the PEPS lump sum payment had less of an effect on job content than on the scope of the medical activity. In particular, in the two MSPs that joined the scheme with their "entire patient base", the simultaneous implementation of the lump sum payment and the development of remote consultations due to the Covid-19 epidemic have changed practices with regard to teleconsultation:

> "We do more telephone consultations than before. So, we've added time allotted to teleconsultations. So, I don't know if it's the effect of the Covid, but, in any case, PEPS has made everything run much more smoothly, because, as they are our patients and we've succeeded in putting in place a system that enables us to do the consultations by telephone, it's far easier".
>
> **GP, female,**
> **The "Agapanthes" MSP, 12/21**

The lump sum payment makes it possible to remunerate these telephone conversations, which was not the case with the fee-for-service payment.

However, the development of task delegation may help to change the content of medical work, by allowing the GPs to focus more on curative care.

> "I no longer monitor pregnancies; there are things I don't do anymore: I say to myself that any monitoring of nutrition or overweight persons… I systematically transfer it to the ASALEE nurse; I used to deal with cases involving smoking cessation, now I don't do those anymore. These are all things I delegate much more than before.'
>
> **GP, female,**
> **The "Camélias" MSP, 02/22**

The reorientation of medical activity towards the curative dimension of healthcare may seem paradoxical in view of the unique profiles of the project leaders. Indeed, the project leaders advocated a comprehensive vision of healthcare, which was embodied in particular in their practices as GPs (Schlegel, 2022). The pilot programmes were in fact presented as a means of achieving a holistic vision of health, by developing public health projects. By rethinking the division of care work within MSPs, some doctors did, however, express frustration about the content of their work, which has became more limited, as the relational and educational work have now been delegated to other professional groups.

> "What's a little sad, also, is that I tell myself, ultimately, that we're driven to do even more curative work than before, while we try to tell ourselves that we want to adopt a comprehensive approach, so it's a bit of a paradox".
>
> **GP, female,**
> **The "Camélias" MSP, 02/22**

> "I love to provide therapeutic education in consultations, but I don't have the time and I'm under pressure to meet regional financial guidelines in consultations".
>
> **GP, male,**
> **The "Orchidées" MSP, 05/22**

As highlighted by the above extract, the new way of organising work should make it possible to increase the number of patients enrolled with a GP. To some extent, this incentive may be perceived by doctors as a change in the productivity paradigm, shifting from medical acts to the number of enrolled patients: "We've gone from a race for medical procedures to a race for new patients" (GP, male, the "Camélias" MSP, 02/22).

The coexistence of objectives that are difficult to reconcile is not specific to the IPEP and PEPS experiments: this can be seen in the contractualisation in MSPs and Local Health Professionals Communities (CPTS), and in the ASALEE scheme. In the rhetoric surrounding these schemes, the doctors have to both save medical time and increase the number of their patients, while developing various initiatives and fostering the dynamics of coordination. Although some doctors took on the role of coordinator (Moyal, to be published; Schlegel, 2022), the preventive acts and public health and patient support activities were almost systematically delegated. The more extensive division of medical activity raises questions, in health facilities in which general medicine has actually been established as a discipline that provides comprehensive care to patients (Bloy, 2010).

What role is played by general medicine in treatment programmes?

General medicine was not recognised as a speciality until relatively late. In order to establish themselves as specialists, the GPs underlined the global dimension of their role, including the long-term monitoring of patients, in contrast with the fragmented care provided by specialists (Hassenteufel, 2010). Patrick Castel and Henri Bergeron explained that they wanted to take on the role of continually "following up" patients, that is play a central role in the patients' treatment programmes, which they coordinated (2010).

The "referring doctor" scheme in 1998, then the 'GP' scheme in 2004, helped to enhance the speciality, and placed the GPs at the centre of the reforms of primary care. Hence, experimental funding was calculated according to their patient numbers, and not according to the patient base of the MSP, which was not "affiliated".

These new remuneration methods have led to a vision of the organisation of primary care, in which it is not just the GP who follows up the patient, but the entire staff of the MSP. Therefore, the GP has become a care provider within these teams, who is responsible for the most important curative tasks. From their point of view, the risk would have been to lose their role as coordinators of patients' care, as "follow-up" doctors in the care chain (Ibid.), which led to resistance amongst some of the doctors. This tension was found in the studied MSPs: the tasks were delegated piecemeal and under the control of the GPs. This GP explained, for example, that he found it difficult to delegate tasks to the ASALEE nurses and the advanced practice nurses who worked in the MSP.

> "I find it hard to delegate tasks, in fact, because it's something I don't know how to do (…). For me, if I delegate, it's because I'm the one who gives the orders".
>
> **GP, female,**
> **The "Agapanthes" MSP, 12/21**

Because task delegation conflicts with the holistic vision of their profession, and perhaps a vision of medical professional independence, the role of the paramedical professionals in these structures is sometimes difficult to negotiate. In the "Bougainvilliers" MSP, some of the doctors therefore refused to participate in the PEPS pilot programme, explicitly opposing the task delegation protocol:

> "They didn't want to manage other things, they're not far from retirement (…). And they don't have much faith in a nurse's ability to implement new healthcare protocols. Lastly, they were afraid that the patients would be less well cared for than if they were in charge of it. They found it hard to delegate, even if they knew the nurses and trained them".
>
> **GP, female,**
> **The "Bougainvilliers" MSP, 03/21.**

Aside from task delegation, some of the doctors also regained a form of control by taking on roles as "coordinators", in which they carried out strategic planning to ensure the organisation of care within the MSP. The doctors thus implemented strategies to maintain their role as "follow-up" doctors.

Their centrality, which helped maintain the professional hierarchies within MSPs, was also instituted: even when the professionals attempted to break away from the control of the doctors, the institutionalised mechanisms limited their ability to do so. This was the case in the "Sureaux" MSP, where particular attention was paid to multidisciplinary equity. The patient support programme aimed at precarious patients was for a while implemented by paramedical professionals and employees, without the supervision of the doctors. However, an incident associated with the mental health of a patient led to a reassessment of the way in which the work was organised within the programme. The psychiatrist treating the patient questioned the responsibility of the team at "Sureaux".

> "The psychiatrist (…) called me and almost insulted us, telling us that what we didn't know what we were doing (…) and that bringing the law down on our heads and taking us to court wouldn't be a problem (…). This upset us quite a lot, obviously (…). And it raised many questions about our collective responsibility".
>
> **Physiotherapist, male,**
> **The "Sureaux" MSP, 11/21**

After this incident, which raised questions about well-established medical responsibility, the team decided to place a doctor at the core of the scheme, whose role was to attend coordination committee meetings and ensure patient follow-up.

> "I think that in the overhaul of the (patient support) scheme there was a real desire to systematically give medical help and advice to all the persons who were referred to us".
>
> **Physiotherapist, male,**
> **The "Sureaux" MSP, 11/21**

Hence, although the teams tried to free themselves locally from the centrality of the doctors, the established hierarchies and professional responsibilities limited their ability to do so: beyond the local organisation of work, the GPs' central role remained unchanged.

* * *

The sophistication of the economic models contrasted with the local disparities in the use of funding: nevertheless, such differences between conception and local implementation have been addressed in scientific literature on public policy (Pressman et al., 1984). This monographic study shed light on the ways in which the experimental funding was used in the MSPs, as the professionals used them to support and legitimise the ways of organising care, which had often been established prior to the pilot programmes and developed using multiple funding sources, which were often short-term. The aim of these professionals was to put in place a way of organising care that they considered to be of better quality and suited to the context of their practices, in particular through the development of preventive care and patient support services, and the coordination of their treatment programmes. This organisation of care helped to redefine the boundaries and roles of different professional groups, in this case the nurses, medical secretaries, and GPs. The nurses and the secretaries have seen the content of their work evolve. With the development of this new division of tasks, the GPs have been able to refocus on their curative role, in which they have the time (which has even increased) to make diagnoses and write out prescriptions. The coordination of the treatment programmes is no longer only managed by the doctors, but by the entire healthcare team, and in particular by the nurses. The role of the GPs is being redefined and transformed; other forthcoming studies into the division of labour in employee health centres and hospitals, where collective work has a longer history, will complement this insight into the implementation of the pilot programmes. ♦

For further information

- Avril C. et Ramos Vacca I. (2020). « Se salir les mains pour les autres. Métiers de femme et division morale du travail ». *Travail, genre et sociétés*, n° 43 n° 1. p. 85-102.
- Bergeron H. et Castel P. (2010).. « Captation, appariement, réseau : une logique professionnelle d'organisation des soins ». *Sociologie du Travail,* vol. 52, n° 4, octobre, p. 441-460.
- Bezes P., Demazière D., Le Blanc T., *et al.* (2011). « *New Public Management* et professions dans l'État : au-delà des oppositions, quelles recompositions ? ». *Sociologie du travail*, vol. 53 n° 3, septembre, p. 293-348.
- Biais M., Cassou M., et Franc C. (2022). « Des conditions de travail plus satisfaisantes pour les médecins généralistes exerçant en groupe ». *Drees, Etudes et résultats* n° 1229.
- Bloy G. (2010). « Rémunérer les médecins généralistes. La question des revenus ». *Singuliers généralistes*. Rennes : Presses de l'EHESP, collection Métiers Santé Social, p. 75-95.
- Bourgeois I., Morize N. et Fournier C. (2021). « Accompagner le renouvellement de l'action publique en santé au niveau régional : des expérimentations nationales de l'article 51 qui apprennent à (dé)cadrer ». Irdes, *Questions d'économie de la santé* n° 262, octobre.
- Cassou M., Mousquès J., et Franc C. (2021). « Exercer en maison de santé pluriprofessionnelle a un effet positif sur les revenus des médecins généralistes ». Drees-Irdes, *Etudes et résultats* n° 1193/ *Questions d'économie de la santé* n° 258, mai.
- Chevillard G. et Mousquès J. (2018) « Accessibilité aux soins et attractivité territoriale : proposition d'une typologie des territoires de vie français ». *Cybergeo*. 20 novembre, p. 1-28.
- Hcaam (2022). « Organisation des soins de proximité. Garantir l'accès de tous à des soins de qualité ». Rapport du Hcaam, septembre.
- Hassenteufel P. (2010). « La difficile affirmation d'un syndicalisme spécifique aux généralistes » in *Singuliers généralistes : sociologie de la médecine générale*. Rennes : Presses de l'EHESP, collection Métiers santé social, p. 403-418.
- Monneraud L. (2011). « Les médecins "promoteurs" dans l'action publique de la santé : un nouveau type de sacerdoce ». Drees, *Revue française des affaires sociales* n° 2, 16 décembre, p. 276-296.
- Morize N. (2022). « Des dispositifs participatifs au service d'une vision extensive de la sante´ : la division du travail de participation au sein de maisons de sante´ ». *Sciences sociales et santé*. En ligne le 19/02/2022. Vol 40, n° 1, p. 1-27.
- Morize N., Bourgeois I., et Fournier C. (2021). « Renouveler l'action publique en santé : un article (51) pour expérimenter avec les organisations de santé ». Irdes, *Questions d'économie de la santé* n° 261, septembre.
- Moyal A. (2021). *Une liberté sous contraintes ? Rationalisation des pratiques des professionnels libéraux de soins primaires en maison de santé pluriprofessionnelles en France*. Paris : Institut d'études politiques de Paris, 380 p.
- Pressman J.et Wildavsky A. (1984.). *Implementation How Great Expectations in Washington Are Dashed in Oakland; Or, Why It's Amazing that Federal Programs Work at All, This Being a Saga of the Economic Development Administration as Told by Two Sympathetic Observers Who Seek to Build Morals on a Foundation*. University of California Press, 304 p.
- Schlegel V. (2022). « Des médecins entrepreneurs de la transformation des soins primaires. Une analyse des conditions d'engagement des porteurs libéraux dans les expérimentations Ipep et Peps ». Irdes, *Questions d'économie de la santé* n° 273, décembre.
- Schweyer F.-X. (2022). « La professionnalisation des coordinatrices des maisons de santé. L'émergence incertaine d'un métier » in *Pratiques de coopération en santé. Regards sociologiques.*: Irdes, série Ouvrages n° 8, collection Sociologie, p. 195-206.

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