Developing multi-professional group practices in France

Overview

In response to anticipated declines and regional disparities in the number of general practitioners working in France, particularly in rural areas, a number of regional and national efforts have been directed towards supporting the reorganization of primary care providers into multi-professional group practices (MSPs). MSPs are designed to co-locate a minimum of two general practitioners with at least one additional health professional in primary care. Since conception of the model in 2007, the development and proliferation of MSPs across the country has been guided with financial incentives and a supportive policy framework. Initially, efforts to encourage the establishment of MSPs were led by Regional Health Agencies in response to local challenges in the distribution of general practitioners. Regional successes stimulated a national government initiative in 2010 to co-finance the start-up costs for MSPs and experiment with new methods of paying providers. Under direction from the Department of Social Security, Regional Health Agencies were responsible for managing the initiative and recruiting MSPs to participate. Contracts between MSPs and Regional Health Agencies awarded each participating MSP approximately €50 000 of additional funding in exchange for group-based performance improvements on quality and efficiency measures. MSPs were assessed through claims data reported to the National Health Insurance. Results of the evaluation show that MSPs increased access to care. Compared to traditional practices, MSPs are open for longer hours on more days of the week and offer a wider selection of services. Government support for the reorganization of providers into MSPs will continue and the popularity of MSPs is increasing.

Problem definition

Declining numbers of general practitioners, particularly in rural areas, triggered local government concerns regarding access to care (Box 1). With many general practitioners anticipated to retire in the coming years, and few incentives for younger physicians to take up vacant practices in rural areas, geographic disparities in access to providers were expected to widen. Additionally, the focus on independent practices left general practitioners with limited flexibility in work schedules and isolated from peers, leading to professional dissatisfaction, notably among younger professionals who were eager to work in different, more collaborative arrangements.[1]

Box 1
What problems did the initiative seek to address?

- Anticipated decline in the number of general practitioners, particularly in rural areas.
- Widening geographic disparities in access to primary care.
- Growing dissatisfaction among general practitioners with the current model of primary practice.

Health services delivery transformations

Timeline of transformations

Growing concerns regarding the organization and availability of general practitioners, particularly in rural areas, triggered action to work towards a new model for the organization of primary care providers. Starting in 2007, regional and national government actions were taken to encourage the development of multi-professional group practices, known in French as “maisons de santé pluriprofessionelle” (MSPs) (Table 1). As a result of these efforts, approximately 700 MSPs are now operational across the country, with a target of reaching 1000 by 2017.

Description of transformations

Selecting services. In addition to the comprehensive package of primary care services offered by all general practitioners in France, MSPs may provide a wider scope of services through other health professionals co-located in the practice. Complementary services that could be offered include prenatal care, physiotherapy, mental health services and dental care.

Designing care. MSPs have been incentivized through government subsidies to develop protocols to improve the coordination of services. However, development and

Table 1
What were the chronological milestones for the initiative?

2007	MSPs first defined and introduced into the public health code; MSPs positioned to contribute to the development of a new model for the delivery of primary care and increasingly awarded funding to support establishment in underserved areas.
2009	Regional Health Agencies established to expand local authority over provision of care; Regional Health Agencies begin offering financial incentives to support MSPs.
2010–2014	National government initiative co-finances development MSPs and experiments with new payment-for-performance mechanisms for providers.
2015	Evaluation of national government initiative completed; results show increased access to care, increased productivity and delivery of better quality services, notably around diabetic monitoring, vaccination screenings and prescribing efficiency.[2,3]
Present	MSPs continue to operate across the country and increase in popularity; 700 MSPs are in operation, with a target of 1000 by 2017.

implementation of protocols is at the discretion of MSPs, which are free to organize care as they see fit.

Organizing providers. The majority of general practitioners now work in group practices, with MSPs being one form of these. MSPs are distinct from other group practices in that they co-locate a minimum of two general practitioners with at least one other health professional such as a nurse, physiotherapist or dietician. While MSPs require co-location of three providers at minimum, documentation shows that up to 21 health professionals may be found, spanning as many as eight different specialties. In addition to general practitioners, the most common providers found in MSPs are nurses, midwives, psychologists, dentists and physiotherapists.

Managing services. As private practices, MSPs are primarily financed by primary care providers. However, unlike independent private practices, initial financial investments are divided among multiple partners, thus decreasing individual financial risk. Furthermore, MSPs have received considerable financial assistance with start-up costs through government channels, particularly in underserved areas. MSPs are each responsible for attracting professionals and organizing the services they provide. Health professionals within MSPs are individually contracted to provide services by Regional Health Agencies, but do so in cooperation with other providers working within the practice.

On average, MSPs are open more days a week (5.5 days) for longer periods of time per day (11.5 hours) than other practices, increasing patients' access to care. Despite this, general practitioners in MSPs do not typically work more hours than peers in other practice settings, as scheduling flexibility allows sharing of patient rosters and distribution of work hours as needed. "The idea is that it is not only in the same place, but working together."

Improving performance. The initiative is monitored through claims data as reported to the national insurance fund. This information, in addition to a survey designed to report on the structure and organization of MSPs, formed the basis for the evaluation completed in 2015.

Health system enabling factors

Over the past decade, changes to legislation and increased flexibility with health-financing schemes have supported the development and expansion of MSPs (Table 3). A trend towards decentralization for the planning and organizing of regional health care provision has given greater autonomy to France's 26 Regional Health Agencies, fostering the development of innovative models of care designed to meet local needs. Many Regional Health Agencies were able to financially support the development of MSPs by taking advantage of Regional Response Funds allocated to them from a variety of different sources, including centres for rural development. The number of regionally-funded MSP projects rose steadily from 20 in 2007 to 185 in 2011, which can be attributed in part to the regional incentives in place.

Observing regional support for MSPs, the national government ran an initiative to co-finance the establishment of MSPs and experiment with new payment-for-performance mechanisms between 2010 and 2014, focusing the introduction of incentives on rural or underserved areas. The Department of Social Security managed the project, with responsibility for implementation delegated to Regional Health Agencies. Eligible MSPs entered into contracts with Regional Health

Table 2
How was the delivery of health services transformed through the initiative?

Before	After
Selecting services	
National health insurance covers comprehensive range of services for population.	MSPs typically offer a wider scope of services than other primary care practices.
Designing care	
Informal coordination of services within primary care practices.	MSPs incentivized to self-develop protocols to improve coordination and increase patient involvement in care.
Organizing providers	
Majority of general practitioners work in isolation in individual private practices.	Majority of general practitioners organized in some form of group practice; providers in MSPs co-locate and collaborate across disciplines to deliver care.
Managing services	
National health insurance contracts individual providers to deliver services.	Regional Health Agencies contract individual providers within MSPs to deliver services; each MSP responsible for self-financing practice costs, attracting providers and organizing services; government funding assisted MSPs with start-up costs. MSPs typically open more days a week for longer hours.
Improving performance	
No performance improvement mechanisms in place.	Information on MSPs gathered from claims data submitted to the national insurance fund.

Table 3
How has the health system supported transformations in health services delivery?

System enablers	Example
Accountability	• Legislation enacted to define MSPs and recognize them as official legal entities. • Regional Health Agencies have oversight of MSPs, with contracts between these actors setting standards for practice. • Formalization of MSP contracts for continued remuneration based on piloted model.
Incentives	• MSPs offered government funding to help finance start-up costs. • Fixed-rate funding incentives based on performance improvements offered to MSPs.
Information	• Information on MSPs collected from claims data reported to the national health insurance fund.

Agencies which awarded fixed-rate funding incentives, in addition to traditional fee-for-service payments, in exchange for care improvements. Approximately 150 MSPs enrolled in the initiative and received around €50 000 per year in performance incentives. Importantly, funding was awarded on a group basis to incentivize achievement of performance goals through teamwork. Performance improvements were measured via selected indicators designed to quantify efficiency and quality based on performance through claims data submitted to the national health insurance fund. At the end of 2014,

legislation was passed to formalize the development of contracts with individual MSPs to continue remuneration based on the model used during experimentation. These contracts stipulate remuneration based on access to care, team dynamics and the use of information systems.

Outcomes

Since their introduction, approximately 700 MSPs have been established across France, predominantly in rural areas. These practices provide a more comprehensive range of services and increased access to care for patients (Box 2). Despite this, providers within MSPs generally report improved work-life balance and do not appear to work more hours than peers in independent practices; around a quarter of MSP providers declare less than 34 hours a week. In addition, global expenditure for MSPs is lower than other forms of general medicine as MSPs typically have lower referrals to specialists, instead being able to offer these services in-house at the primary care level.

Box 2

What were the main outcomes of the initiative?

- Proliferation of MSPs across the country, predominantly in rural areas.
- Improved access to care as a result of MSPs offering a wider range of services with extended opening hours.
- Increased productivity when compared with control independent practices, with an active patient list 13.4% higher and 15.6% more patients registered than controls.[3]
- Improved work-life balance for general practitioners working in MSPs.
- Annual expenditures on ambulatory care between the period of 2009–2012 moderately lower (9%) for patients registered in MSPs.[3]

Change management

Key actors

Development of MSPs was initially provider-led, emerging organically in response to the limited number of providers in certain regions and growing workload for general practitioners working in independent practices (Box 3). MSPs were supported and encouraged by Regional Health Agencies who saw advantages of the model for addressing local provider challenges. Regional success of MSPs ultimately secured national government support, enabling scaling up of the initiative assisted by the development and passing of legislation and application of financial incentives.

Box 3.

Who were the key actors and what were their defining roles?

- **National government.** Supported the development of MSPs through favourable legislation; implemented national project to financially incentivize development of MSPs.
- **Regional Health Agencies.** Led early efforts to support the establishment of MSPs; provide regional oversight for MSPs.
- **Primary care providers**. Own and operate MSPs.

Initiating change

A political context supporting greater regional control over the health system helped drive local innovation to observed challenges, leading to the development of MSPs to address regional shortages of general practitioners. Regional success of MSPs stimulated national interest in the model, leading the national government to promote the proliferation of MSPs through various financial incentives and supportive legislation. Working in MSPs was entirely voluntary, but with appropriate legislation and financial incentives in place, providers were encouraged to self-organize and adopt the MSP structure.

Implementation

As the majority of primary care providers are privately contracted, setting up MSPs was led by health professionals themselves, with support and guidance provided through government channels. Initially, it was primarily younger health professionals who took advantage of available funding to establish MSPs, as they wanted to work in different conditions outside of individual practice. Providers who organized themselves into MSPs reportedly appreciate the peer support and improved work-life balance offered, as well as the reduced financial risk of opening a co-owned practice where start-up costs were partially funded by the government. The development of MSPs is voluntary, health professionals who prefer to work in independent practices are still free to do so, thus limiting the ability of these stakeholders to resist implementation of the new model.

Moving forward

Provider acceptance of MSPs continues as the benefits of the model become increasingly recognized. Results from the evaluation on the national government's MSP initiative have provided insights into the benefits of this practice. While 700 MSPs are currently operational across France, targets have been set to increase this number to 1000 before 2017.

Highlights

- Local actors were given sufficient autonomy over services delivery, which spurred innovation of solutions to local health system challenges.
- National rollout of changes relied on the adoption of supportive national frameworks and policies.
- Financial incentives, including funding for initial start-up costs and payment-for-performance bonuses, stimulated voluntary provider uptake of new organizational models.
- Voluntary participation reduced stakeholder conflicts by allowing those resistant to change to abstain from the initiative.

1 Afrite, A., Bourgueil, Y., Fabien, D., & Mousques, J. (2013). The Impact of Multi-Professional Group Practices on Healthcare Supply. *Question D'économie de La Santé, 189.*

2 Mousques, J & Daniel, F. (2015). The impact of multiprofessional group practices on the quality of general practice. *Questions d'économie de la santé, 211.* Retrieved from http://www.irdes.fr/english/issues-in-health-economics/210-multiprofessional-group-practices-generate-gains-in-terms-of-productivity-and-expenditures.pdf

3 Mousques, J and Daniel, F. (2015). Multiprofessional group practices generate gains in terms of productivity and expenditures. *Questions d'économie de la santé, 210.* Retrieved from http://www.irdes.fr/english/issues-in-health-economics/210-multiprofessional-group-practices-generate-gains-in-terms-of-productivity-and-expenditures.pdf