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Renewing Public Policy on Healthcare: Experimenting with Healthcare Organisations under *Article 51* Scheme

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Statement 51 of the 2018 Social Security Funding Act (*Article 51, Loi de Financement de la Sécurité Sociale*, LFSS) allows for pilot experiment that derogate from standard funding and organizational rules for health care delivery organisations. These include two five-year pilot programs, one with a risk-adjusted capitation payment 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 another one 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). Both aim to change the way in which primary healthcare is funded in France; primary care has hitherto largely been provided by self-employed healthcare professionals who are mainly paid on a fee-for-service basis. However, to implement these developments at the local level, the executive teams of the pilot program in the Ministry of Health and the French National Health Insurance Fund (*Caisse nationale de l'Assurance maladie*, CNAM)–have to coordinate two objectives: dealing with the issues faced by the health care professionals and executive teams of the program in the scheme in order to experiment together, while creating generalisable schemes that will benefit as many healthcare teams as possible and that are adapted to the constraints of the health system. How do the executive teams of the pilot program coordinate these two dimensions?

This study is based on a qualitative methodology involving an analysis of documents and around thirty semi-structured interviews, conducted between October 2019 and June 2021 (see Inset Source and Method). It shows how the executive teams have organised themselves to conduct pilot projects and break away from standard practice, by first describing the way in which the scheme under *Article 51* and the pilot programs were devised. Then an analysis of the procedures used to select the experiment teams and the process of drawing up the specifications, which will precisely define the pilot economic models, highlights how the framework of interaction between healthcare professionals and the public authorities is being renewed.

On 30 December 2017, the Social Security Funding Act (LFSS) for 2018 proposed, through the statement 51 (so-called and for the remaining of the paper *Article 51* scheme) pilot programs that derogate from standard funding and organisational rules in the health care delivery sector. This scheme is part of a drive to reorganise the French healthcare system, against the backdrop of an increase in experimental public policies since the 2000s (Jatteau, 2013), and the systematic assessment of public policies in a process of developing evidence-based policies (Barbier, 2010; Cairney, 2016). The public authorities are committed to meeting the needs of an ageing population with an increasing prevalence of chronic illness, dealing with the problem of medically underserved areas (Chevillard and Mousquès, 2018), emergency department overcrowding, and the increase in hospital expenditures (Hassenteufel et al., 2020), in the context of an economic crisis. Experimenting with new organisation and funding is considered as a way of finding solutions to improve the quality and effectiveness of healthcare.

As part of the *Article 51* scheme, two pilot programs have focused on the reinforcement of primary healthcare supply, in the context of a

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"shift to ambulatory care", which would make it possible to move away from a hospital-based system to a system centered around patient and its primary care services. Hence, they promote the development of coordination between the various healthcare professionals, between the ambulatory and hospital healthcare professionals, and between the health, medico-social, and social sectors (Douguet, Fillaut and Hontebeyrie, 2016). Primary healthcare is not very structured in France and is largely provided by self-employed healthcare professionals, who are mainly paid on a fee-for-service basis. However, over the last fifteen years, the relations between the public authorities and primary healthcare professionals have changed, and some of the latter wish to be involved in the reforms (Vézinat, 2019), and solo practice as well as the predominancy of fee-for-service payment system is gradually being called into question by some primary healthcare professionals.

These experimental schemes are renewing public policy on healthcare, in particular by changing the relations between the Ministry of Health and the French National Health Insurance Fund (*Caisse Nationale de l'Assurance Maladie*, CNAM), and their relations with healthcare professionals. Studying these processes, from the perspective of the sociology of public policy, provides an understanding of the transformation of the healthcare system. Indeed, the experiments under *Article 51* enable members of the Ministry of Health and the National Health Insurance Fund to go beyond the conventional framework (in legislative and contractual negotiation processes, and in conception and public policy implementation processes), with an intentional bottom-up approach, which refocuses the processes around professionals in healthcare organisations. These processes, developed by the teams of the Ministry of Health and the National Health Insurance Fund, are not without a framework. This is linked to tension between, on the one hand, the objectives of joint experimentation (breaking out of the frameworks) in order to adapt the objectives to the issues faced by the various actors in the scheme and, on the other hand, the objective of creating long-term generalisable schemes (reframing), which will benefit as many people as possible and are adapted to the constraints of the healthcare system. How do the executive teams coordinate these two dimensions?

Adopting a chronological approach, we will first show how the two public authorities have organised themselves to go beyond the usual contractual framework in order to conduct experiments, by describing the perspectives from which the *Article 51* scheme and the pilot programs were devised (see Inset Definitions); this will be followed by an analysis of the work of the executive teams piloting the experiments and the way in which they have organised themselves; we will show how, to develop the pilot programs, the executive teams try to encourage the participants to work within predetermined frameworks, while engaging them in the experiments: initially via a selection procedure, and then during sessions in which the economic models are jointly defined (see Diagram 1).

Source and method

With the aim of retracing the timeline of the events and describing the actors' involvement, a set of documents was compiled and analysed: grey literature, official reports, documents produced during meetings, applications, and email exchanges between the institutional actors. Most of these documents were provided by members of the executive teams. Providing invaluable insight into the whole process, they made it possible to precisely analyse the institutional actors' frameworks for action, the reflection and selection processes, and the various stages of the design of the pilot programs.

In addition, retrospective semi-structured interviews, conducted between October 2019 and June 2021, shed light on the career paths of the actors who created the schemes, and made it possible to study their representation and their interactions, contextualise the texts produced, and understand the issues related to the design of the pilot programs. In total, 30 semi-structured interviews were conducted nationally with administrative and political decision-makers (5), members of the executive PEPS and IPEP teams (10), assessors (2), healthcare professionals from healthcare delivery organisations (6), members of health agencies (4), and consultants from private consulting firms (3). In order to preserve the anonymity of the actors interviewed, all the interviews were made anonymous and the institutional affiliations described broadly.

Context

This study is anchored in the sociological part of the programme of assessment of the pilot programs aimed at finding alternatives to fee-for-service payments in the context of *Article 51* (*Evaluation d'expérimentations de rémunération alternative à l'acte dans le cadre de l'article 51*, Era2). It was funded by the French National Health insurance system and is part of a doctoral thesis in sociology, written 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.

Article 51 scheme is being transforming the way in which the French Ministry of Health and the National Health Insurance Fund organise their work

Article 51 makes it possible to go beyond the framework of the legislative processes, which require a lengthy prior examination of the texts by the French parliament (*Assemblée Nationale* and *Sénat*). This scheme has concrete effects on the way in which work is organised in the pub-

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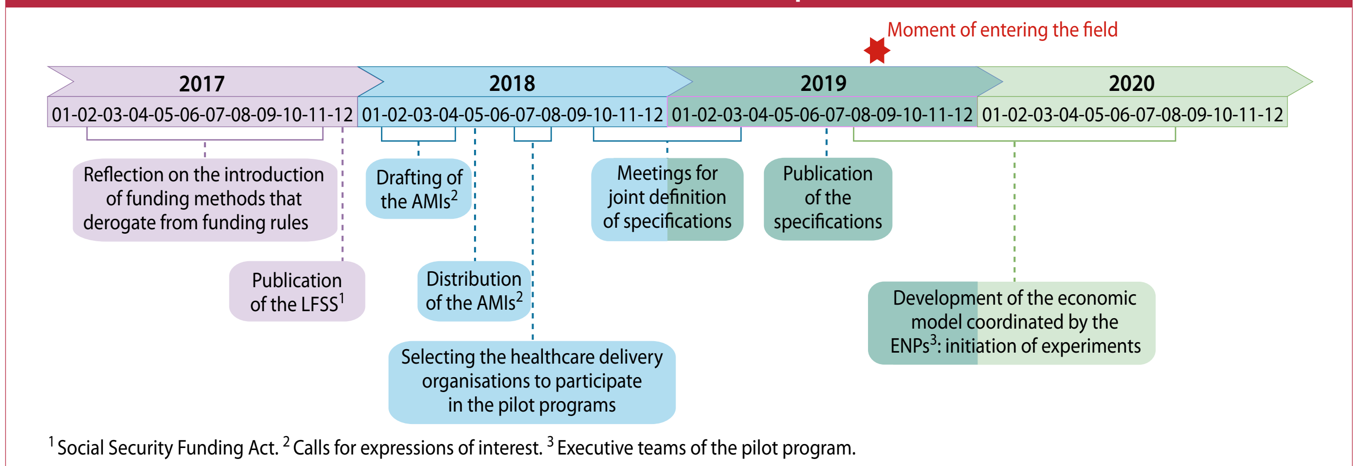
Timeline of the launch of the experiments



[1] Social Security Funding Act. [2] Calls for expressions of interest. [3] Executive teams of the pilot program.

lic authorities: teams act as a bridge between the Ministry of Health and the National Health Insurance Fund and conduct the pilot programs. Due to the flexibility inherent to the experimental nature of the schemes, the members of these teams have had to reorganise their work and go through a learning process.

Going beyond the conventional framework: from *Article 51* to the conception of the PEPS and IPEP pilot programs

Article 51, **an administrative reform based on an alliance between the French National Health Insurance Fund and the Ministry of Health**. In 2017, Emmanuel Macron's new government wished to implement important reforms. The idea of a scheme focusing on innovation in healthcare emerged in an international context in which many countries, such as the United States and Germany, have already launched such schemes.

> "The *Article 51* scheme is part of an international drive, for example in Germany, the United States, with the 'Innovation Center', and in Great Britain."
> **Report presented to the Strategic Council for Healthcare Innovation (*Conseil Stratégique de l'Innovation en Santé*, CSIS), 04/2018**

This scheme is therefore part of a process of "Policy transfer" (Dolowitz and Marsh, 2000), as international policies are a source of inspiration for French policies, while providing a competitive environment in which France has to position itself to avoid giving the impression that the country is "lagging behind":

> "We're lagging so far behind other countries. The Northern European countries, and also those in North America have understood how important it is to move in this direction."
> **Olivier Véran, General Rapporteur, examination of the text, French parliament (*Assemblée Nationale*), 10/2017**

Hence, *Article 51* was presented in 2017 as the heart of the new government's healthcare reforms: "It is probably the most important statement in the Social Security Funding Act" (Agnès Buzyn, public session, French parliament (*Assemblée Nationale*), 10/2017). The scheme has also generated enthusiasm amongst the authorities of the National Health Insurance Fund: the first version of the statement was drafted by the 2017 National Health Insurance Fund's Report, *Charges et Produits*. The authorities of the Ministry of Health quickly became involved in this process.

> "From the outset, we had even written in the report that we were adopting a partnership-based approach (…). Obviously, if something is run by the State or by the French health insurance system, it wouldn't work."
> **Executive PEPS team**

This partnership-based approach is a fundamental originality of *Article 51* and has led to the creation of ad hoc forms of work organisation, acting as a bridge between the two bodies.

Another novelty of the statement is that it unifies the funding of healthcare innovation at a national level, by adding it to or substituting it for pre-existing healthcare innovation funding: local projects implemented by the Regional Health Agencies (*Agences Régionales de Santé*, ARS) with the support of the Regional Intervention Fund (*Fonds d'Intervention Régional*, FIR), and annual and national common law experiments, conducted as part of the Social Security Funding Act (LFSS) or occasional decrees. As for the Regional Intervention Fund, the innovative projects implemented in their context are not systematically assessed, so they cannot be a source of inspiration for national policies.

> "On the one hand, there was a Regional Intervention Fund that funded many things, but there was little clarity with regard to what it produced in terms of results."
> **Administrative decision-maker**

From the perspective of evidence-based policy-making, *Article 51* aims to assess all the pilot experiments conducted. Hence, it enables the two public authorities to take a decision –following consultation of the Strategic Council for Healthcare Innovation (*Conseil Stratégique de l'Innovation en Santé*, CSIS)– to stop, continue, or expand pilot experiments nationwide.

The pilot programs conducted under *Article 51* also replace experiments included in the annual Social Security Funding Acts (LFSS), which were submitted for consideration to the French parliament: this will no longer be the case for *Articles 51*. Hence, the uniform legal framework has simplified the procedures for the actors in the Ministry of Health and the National Health Insurance Fund, and routine decisions are left to them.

> "There are still a lot of things that fall within a legal framework that is beyond our reach. (…) There's an extremely restrictive legal framework, which means that everything has to be done systematically in accordance with the law; the law has to specify exactly what the experiment is, and we've got to wait for decrees, by-laws, and this and that. We can't make any headway, it doesn't work."
> **Administrative decision maker**

However, Article 51 reflects a bottom-up approach desired by the political majority, with the approval of the heads of the two public authorities. As part of a project-based approach, in which the funded actors have to compete and put forward solutions to the issues raised by the funders (Breton, 2014), this scheme invites the healthcare providers, in its "on the initiative of the actors" experiments, to both define the issues and devise the solutions.

> "I don't think we can theorise –consider all the many potential aspects– at a central level. So, this is something the actors –I would say initiators– should primarily do."
> **Administrative decision maker**

This bottom-up approach has resulted in organisational changes for the actors in the bodies, as the healthcare providers propose projects which then have to be formalised so that they fall within the legal and procedural framework of *Article 51*. An experiment support system has been developed, accompanied both by the National Agency to Support the Performance of Health and Social Institutions (*Agence Nationale d'Appui à la Performance des Établissements de Santé et Médico-Sociaux*, ANAP) and consulting services, who bring with them new methods and new management tools.

A combination of a bottom-up approach and a call for projects: the calls for expressions of interest (*Appels à Manifestation d'Intérêt*, AMI). In this *Article 51* scheme, the unique characteristic of the PEPS and IPEP projects is that they are the subject of calls for expressions of interest (AMI): the two pilots have not been entirely devised by the bodies, nor

Definitions

In **the *Article 51* scheme**, two major avenues for experimentation are provided for: experiments that are 'on the initiative of the actors', suggested by healthcare professionals in healthcare delivery organisations and which are conducted at regional, interregional, or national level, which have not been studied in this paper; and experiments devised nationally by a central directorate in the Ministry of Health and the National Health Insurance Fund (CNAM), such as the PEPS (*Paiement en équipe de professionnels de santé en ville*) and IPEP (*Incitation à une prise en charge partagée*) pilot programs.

The IPEP pilot program is an additional to individual fee-for-services payment that combines advanced payment and shared savings, if any. It aims to improve coordination between hospital and primary care, via additional financial incentives depending on savings regarding patients health care expenditure. This **Accountable Care Organisation (ACO) like contract is** based on quality indicators, and an assessment of the development of a partnership in terms of efficiency.

The PEPS pilot program is an alternative to individual fee-for-service payment that includes a practice level prospective risk-adjusted capitation payment according to the characteristics of the patients concerned (all patients, diabetic patients, or over 65 years old patients), only for GPs indeed nurses and for a subset of care and services, practicing in Primary Care Teams. It includes also a retrospective performance-related payment based on the achievement of a set of quality indicators.

are they open door projects. Indeed, the AMI, documents of around thirty pages, explain the application process and the procedures for participation in the drafting of the experiment's specifications and its objectives. The specifications –documents with the same number of pages– are published after "joint definition" sessions in conjunction with the participants and delineate, in a detailed way, the scope of the economic model and the remuneration calculation method. Before embarking on the second phase in designing experiments, they are set up within a classical administrative framework, at the same time as the drafting of the Social Security Funding Act (PLFSS).

IPEP: French Accountable Care Organizations (ACO). The IPEP pilot program was devised by a working group for innovative funding methods, which met on six occasions between March and July 2017. The group, coordinated by members of the Directorate of Health Care Supply (French Ministry of Health) [*Direction Générale de l'Offre de Soins*, DGOS] and the National Health Insurance Fund (CNAM), also brings together members from the Directorate for Research, Studies, Assessment and Statistics (French Ministry of Health) [*Direction de la Recherche, des Études, de l'Évaluation et des Statistiques*, DREES], the Directorate of Social Security (French Ministry of Health) [*Direction de la Sécurité Sociale*, DSS], the Technical Agency for Information on Hospital Care (*Agence Technique de l'Information sur l'Hospitalisation*, ATIH), the French National Authority for Health (*Haute Autorité de Santé*, HAS), and the Institute for Research and Information in Health Economics (IRDES). Many participants are doctors, who often specialised in public health, or economists. Furthermore, there is a very strong influence from international policies, due to the presence of actors who have studied or worked abroad, particularly in Belgium, England, and the United States.

"We began to reflect, (…) a public health medical student produced a study report on the ACOs for us; we had a bit of information. We went to England, because they were introducing new funding methods (…). We began to think that we were going to be able to propose something."
Executive IPEP team

Each of the three countries has launched primary healthcare coordination schemes. The American ACOs aroused much interest in the working group, as an economist was given a grant to study the subject. The IPEP model has been developed using a voluntary policy transfer process (Dolowitz and Marsh, 2000), transposing the ACO model by adapting it to the French context (Lemaire, 2017; Mousquès and Lenormand, 2017). The members of the working group reflect on the construction of the economic model, which must necessarily allow to improve coordination between hospital services and primary healthcare. It is hoped that the development of coordination will result in an improvement in the quality of healthcare and its efficiency. The model is based on an additional to individual fee-for-service payment that combines advanced payment and shared savings, and on quality indicators aimed at quantifying the effects. The working groups make it possible to identify the patient population (those registered with the family doctor) on which the pilot program is based, preselect certain indicators, and set the objectives of the experiment.

PEPS: a continuity in the primary healthcare organisation policies. The PEPS pilot program was devised by a smaller group of actors in the French Directorate of Social Security (DSS), in conjunction with actors in the National Health Insurance Fund. The actors in the Directorate of Social Security (DSS) have been working for several years on primary healthcare organisation policies, as they conducted the experiments on the Multiprofessional Group practice with self-employed professionals (*Maisons de santé pluriprofessionnelles*, MSP), the ASALEE project aimed at improving coordination between GPs and public health nurses, and the PAERPA scheme, designed for improving the coordinated care of frail elderly people. In the PEPS experiment, the fee-for-service payment has been replaced by a practice level prospective risk-adjusted capitation payment, and a retrospective performance-related payment based on the achievement of a set of quality indicators, as part of the policies relating to healthcare organisation and Experiments with New Mechanisms of Remuneration (*Expérimentation des Nouveaux Modes de Rémunération*, ENMR) [Mousquès et al., 2014], which encountered opposition from the general medical unions in 2007.

"When the Experiments with New Mechanisms of Remuneration were set up (ENMR), there was the much talked about Module 4, the capitation payment module, or fixed-rate payment, and it wasn't possible to implement it because there was too much opposition from the unions. (…) It's seven years later and I can see that the actors' stance has changed."
Executive PEPS team

Hence, the scheme was initially created for self-employed professionals working in Multiprofessional Group practice (MSP), and was subsequently opened to salaried healthcare professionals in Healthcare centres (*Centres de santé*, CDS). The executive team devised the scheme through informal interaction with healthcare professionals, in particular union officials, in order to ensure that their project was acceptable. There is a strong influence from policies abroad relating to fixed-rate remuneration in the pilot program's design, resulting notably from reading documents and interchange with experimental teams in the OECD (Organisation for Economic Cooperation and Development) countries. Indeed, the call for expressions of interest (AMI) developed by the PEPS team was inspired by various policies abroad, notably a model for diabetic patients, like the Bundled Payment system in the Netherlands (OECD, 2016). The actors in the National Health Insurance Fund did, however, suggest that the pilot program could be conducted amongst other populations, from a global health perspective. The experiment's framework remains broad, whether in terms of the population concerned, the development of indicators, or the healthcare professionals that are included.

Coordinating the *Article 51* scheme: building a bridge between two public authorities

Organisations operating at the administrative frameworks boundaries. The *Article 51* scheme involves the appraisal of a large number of projects, with an approach based on a partnership between the National Health Insurance Fund and the Ministry of Health. To meet this requirement, the government set up ad hoc organisations in the Ministry of Health and the National Health Insurance Fund)[see Diagram 2] at the beginning of 2018.

Two decision-making bodies were set up: the Strategic Council for Health Care Innovation (*Conseil Stratégique de l'Innovation en Santé*, CSIS) makes recommendations on the framework of the experiments at an early stage, and issues an opinion on the widespread use of experiments or their termination at a later stage. Chaired by the Health Minister, it is composed of 61 actors in the "health ecosystem" and three qualified figures. It holds a meeting once or twice a year. The Technical Committee on Healthcare Innovation (*Comité Technique de l'Innovation en Santé*, CTIS) holds meetings more regularly to make decisions on the setting up of experiments (validation of the specifications, the applicant selection process, validation of the economic model, etc.). The CTIS, chaired by the General Rapporteur, is composed of eight representatives of the National Health Insurance Fund, the General Secretariat of Social Ministries (*Secrétariat Général des Ministères Sociaux*, SGMAS), the authorities of the Ministry of Health, and Regional Health Agencies. It held meetings every other week in 2018, then every month. Lastly, a general rapporteur and a dedicated team, with people

seconded from the various authorities of the Ministry of Health and the National Health Insurance Fund, were appointed to coordinate and manage the various actors in the *Article 51* pilot programs.

For the PEPS and IPEP pilot programs, two executive teams, composed of actors in the Ministry of Health and the National Health Insurance Fund, have been entrusted with the implementation of the schemes. They interact with several other institutional actors who operate in a more timely manner: the Technical Agency for Information on Hospital Care (ATIH) and the French National Authority for Health (HAS) provide expertise, particularly in the development of indicators, and the Institute for Research and Information in Health Economics (IRDES) provides expertise in evaluation issues and certain aspects of the development of economic models; various consulting firms step in at different points in the coordination of the projects, in particular to handle logistics and organise meetings; as of 2019, the National Agency to Support the Performance of Healthcare and Social Institutions (ANAP) has provided support for healthcare delivery organisations. In the various regions, the Regional Health Agencies coordinate the scheme with the National Health Insurance system's network. The executive teams maintain relations with the 17 Regional Health Agencies, through steering committees that meet bi-monthly with the regional advisers or in bilateral exchanges upon request.

The executive teams conducting the pilot programs are partly composed of actors who were involved in designing the PEPS and IPEP projects. There are two teams of around six people, with their respective team leaders in the Ministry of Health and the National Health Insurance Fund, both of whom hold senior positions in their respective bodies. Furthermore, younger members of the teams, who are often female, operationally manage the experiments on a part-time basis. They are trained in economics, medicine, statistics, or political sciences. They work within a dual hierarchy of authority, inherent to their work within the framework of the general law and *Article 51*. This sometimes makes decision-making more difficult: the team leaders involved in the projects are not always present at every meeting; the actors sometimes have to negotiate with participants or members of other bodies without necessarily knowing what their room for manoeuvre is:

> "You see, he (the Ministry of Health team leader) is senior to me in position. And he didn't have people on the same level facing him. So how much hierarchy is needed in these 'joint definition' sessions? And... who's responsible for making the final decision?"
> **Executive PEPS team**

Learning to introduce new frameworks. Designing the PEPS and IPEP pilot programs in conjunction with the participants is a new way of working for the members of the executive teams, which involves the introduction of new frameworks that come with a learning process.

> "We succeeded in initiating something which is quite unusual, particularly with regard to the 'joint definition' phase with the healthcare professionals that followed, and which is something that is relatively new in France and in our working environment–and it went quite well."
> **Executive IPEP team**

The members of the executive teams are no longer just involved in developing calls for projects and monitoring the compliance of the proposed projects–they also work with the participants. In the "joint definition" sessions, they ask them for their opinions, and sometimes negotiate with them and persuade them about something, which gives rise to a learning process on their part.

> "There's really something special about *Article 51*, because there's all this work, expertise, the transversal approach, and the tools. It makes a big difference, with respect to the people we were at the beginning of the experiment, as professionals. (...) With regard to the skills required, it really is an extremely important learning process. (...) That is to say that liking innovation isn't enough, (...) to be someone who is good at supporting innovation."
> **Executive PEPS team**

This learning process and the interaction with the participants are, as a whole, perceived as positive by the members of the executive teams. However, the interaction with the participants is not always easy, as they try to negotiate certain aspects of the economic models.

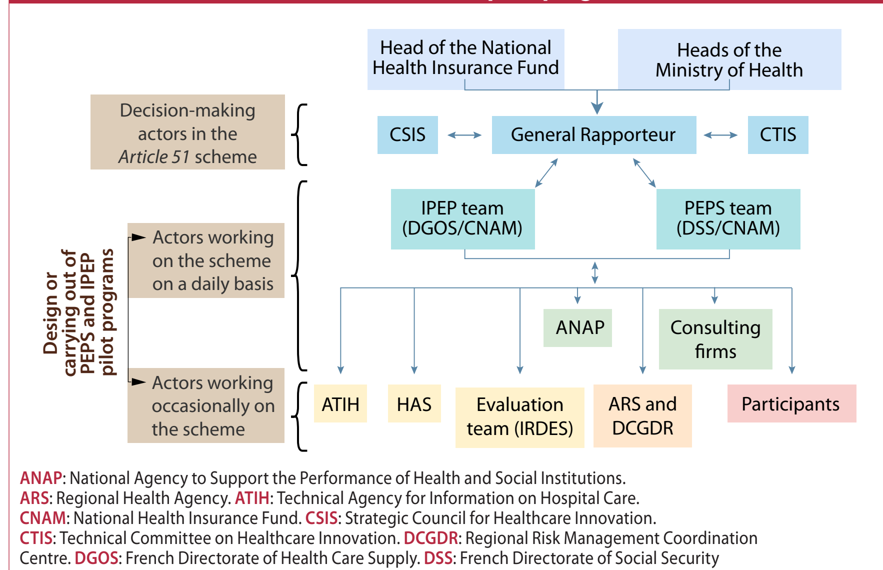
> "For the people who implement these experiments and who are in regular contact with the project leaders, it's at once exciting, and, sometimes, they're caught between the two."
> **Executive IPEP team**

These difficulties are compounded by the ad hoc organisation of the executive teams, as the team leaders are not always there to mediate. Furthermore, the participants, most of whom are experienced doctors, are often men who are older and have a higher social status than the young women who are starting out on their careers.

A significant turnover. Of the 16 actors in the executive teams who participated in the "joint definition" sessions in 2019, only three were still members at the beginning of 2021. There is a veritable career culture in the Ministry of Health and the National Health Insurance Fund, and it is not unusual for one of the actors to leave their position for a another one after two or three years. The actors, who are also of parental age, take parental leave. In the long term, this turnover of team members weakens the State teams, especially as the skills gained from the learning process are important in these experimental schemes, and the participants remain relatively unchanged.

Furthermore, the executive teams have a substantial amount of work to do –even though it generates much enthusiasm– within a tight timescale and in conjunction with a large number of institutions. There is a heavy workload at every stage of the beginning of the pilot programs.

D2 **Actors involved in the *Article 51* scheme and the setting up of the PEPS and IPEP pilot programs**



ANAP: National Agency to Support the Performance of Health and Social Institutions.
ARS: Regional Health Agency. ATIH: Technical Agency for Information on Hospital Care.
CNAM: National Health Insurance Fund. CSIS: Strategic Council for Healthcare Innovation.
CTIS: Technical Committee on Healthcare Innovation. DCGDR: Regional Risk Management Coordination Centre. DGOS: French Directorate of Health Care Supply. DSS: French Directorate of Social Security

"The work was intense –sometimes too intense–, particularly the 'joint definition' work. That's because I was also working on other projects at the same time, (...) that was a lot of work."
Executive IPEP team

On the threshold of experimentation: involving the participants while maintaining the upper hand

The specific framework of *Article 51* makes it possible to go beyond the usual frameworks for developing and implementing policies. Once the AMI have been drafted, the first stage consists of selecting the healthcare delivery organisations to participate in the pilot experiments. Then, during the drafting of the specifications, the aim is to gain the commitment of the actors involved in these experiments by adapting the models to their healthcare delivery organisation (breaking out the framework), while developing a more precise definition of the economic models, taking institutional constraints into account (recreating a framework).

A collaborative selection process

Objective selection criteria. Selecting the healthcare delivery organisations follows a process that is part of the *Article 51* scheme and specific to each pilot program. The two executive teams integrate objective criteria into these selection procedures, in conjunction with members of the Regional Health Agencies.

The IPEP team received 78 applications following the AMI and selected 18, based on objective criteria such as the number of patients included in the pilot program and healthcare partnerships that favoured a broad approach to the patients in an area. The first compromise was made on this point: because of their medical specialisation, applications from healthcare professionals in hospitals were all based on one or two diseases and they would have been excluded from the experiment.

"There was a large number of applications from networks initiated in hospitals. (...) It was clear that this didn't correspond with the project's philosophy. (...) We succeeded in changing the criteria: "All the applicants specialising in one disease are automatically excluded. It really is a populational approach with a specialisation in at least two diseases–a decisive criteria"."
Executive IPEP team

The IPEP team accepted applicants specialising in at least two chronic diseases in order to be able to include hospital actors. The IPEP team selected 18 healthcare partnerships (one of which was also selected by the PEPS team) in ten different regions: seven of them were led by hospitals, four were partnerships between ambulatory healthcare delivery organisations and hospitals, and seven by multiprofessional group practices.

The PEPS pilot program received 39 applications and selected 11 (four of which did not sign the specifications). The PEPS team initially sorted the projects according to the patients on which they were based, and selected the projects on diabetes, the elderly, or a healthcare facility's entire patient population.

"We constructed an analytical grid, with the number of healthcare professionals in the team and the number of patients. It was quantitative data. With regard to the project in general, did they understand the PEPS project? What were they aiming to do?"
Executive PEPS team

The PEPS team then tried to assess the healthcare professionals' motivation for shifting to a fixed-rate payment system. The team selected 11 applicants, comprising 28 healthcare facilities, 17 of which were multiprofessional group practices, 10 municipal healthcare centres, and one healthcare centre run by a non-profit organisation.

Regional Health Agencies (ARS) became involved in the projects. The objective criteria provided a framework for the interaction between the executive teams and the actors in the Regional Health Agencies (ARS), as the members of the Technical Committee on Healthcare Innovation (CTIS) and the future participants altered the selection procedure. Hence, the members of the ARS were entrusted with the task of assessing the applications –with the executive teams– by the Technical Committee on Healthcare Innovation. The Committee is the decision-making body, under the authority of ministers. The members of the ARS are asked by the executive teams to give their opinions in writing and during phone and email interactions. However, the selection process took place in a relatively short period of time, in the summer of 2018, and involved challenging technical questions for the ARS, who were just starting to become involved in the projects. Nevertheless, the executive teams underline the value of these interactions; the members of the ARS are recognised as actors who have a good knowledge of the field, as they are familiar with the healthcare professionals and the local health ecosystems. In a minority of cases, when there were differences of opinion between the executive teams and the ARS (for example, 20 out of the 78 IPEP applications received an opinion from the ARS that differed from that of the executive team), there was another round of discussions aimed at convincing the other party, and in three cases when no agreement was reached, the CTIS took the final decision. Overall, although the ARS had an effective influence on the selection process, it was limited.

Healthcare professionals adapted to the frameworks with ease. The healthcare professionals can influence the selection process. The applications selected to take part in the pilot programs were often from organisations represented by union representatives, representatives of Regional Unions of Healthcare Professionals (*Unions Régionales des Professionnels de Santé*, URPS), or national/regional federations of health care centres and multidisciplinary group practice, some of which had been participating for several decades in the successive experiments proposed by the Ministry of Health and the National Health Insurance Fund. Amongst the 18 IPEP partnerships[1], 14 were represented by at least one union or professional representative, and amongst the 11 PEPS partnerships, six were represented by a union or professional representative. The healthcare professionals in question were involved in primary care organisations of self-employed healthcare professionals, such as Regional Unions of Healthcare professionals (URPS), the MG France union, the Confederation of French Medical Unions (*Confédération des Syndicats Médicaux Français*, CSMF), or the French Federation of Multiprofessional Group Practices (*Fédération Française des Maisons et Pôles de Santé*, FFMPS), or employee organisations such as the Trade Union of Doctors in Healthcare Centres (*Union Syndicale des Médecins de Centre de Santé*, USMCS) or the National Federation of Healthcare Centres (*Fédération Nationale des Centres de Santé*, FNCS). Amongst the IPEP partnerships, five hospital partnerships were represented by the French Hospital Federation (*Fédération Hospitalière de France*, FHF). These healthcare professionals represented two parties: they represented the interests of their organisation, which was involved in the pilot program, and, as elected representatives or representatives, they represented part of their profession or part of a multidisciplinary stream. The executive teams explained that these actors were key to conducting the experiments due to the scope and the quality of their projects.

"There were some project leaders who, ultimately, just couldn't be excluded. In any case, the applications they submitted were good."
Executive IPEP team

1 To count the number of representatives, the names of the healthcare professionals who took part in at least one "joint definition" session were found on the Internet. The results were confirmed by cross-checking several sources (Internet sites of the unions, federations, and the regional unions of healthcare professionals (URPS); LinkedIn profiles, etc.). it is possible, however, that some of the professionals involved were not identified through this method and that the number of representatives is slightly higher.

These actors, forming a network of participants in primary healthcare, had resources that they mobilised at every stage of the selection process. Hence, the AMI for the two pilot programs were issued in a short time frame, and the representatives had better access to them via their pre-existing links with members of the Regional Health Agencies or executive teams, or via their membership of certain networks of actors.

> "As participants who'd been experimenting with all sorts of things for ages; they (the executive team) came to us."
>
> **Self-employed GP, Multiprofessional Group Practice**

Furthermore, these healthcare professionals, who were familiar with calls for projects, acquired expertise to meet the expectations of the public authorities: their applications comprised literature and statistics, in stark contrast with those from healthcare professionals who were less familiar with such procedures. They also attest to the ease with which they were able to complete their applications, due to their previous experience.

> "(for the application), all I had to do was copy and paste (...), there's not much of a difference between submitting a project to participate in a PAERPA experiment and (...) an *Article 51* experiment."
>
> **Self-employed GP, Multiprofessional Group Practice**

Lastly, due to their previous participation in other pilot programs, they had become acquainted with some of the members of the executive teams, which made it easier for them to be selected. Regional Health Agency advisers also said that, despite their negative opinions, certain projects "were still accepted". Many of the participants selected to participate in the PEPS and IPEP projects were therefore actors who had previous experience in such procedures, and whose positions enabled them to benefit from many resources they could fall back on to support their points of view during the drafting of the specifications.

Developing economic models with the participants

The economic models at the heart of the discussions. The specifications for the pilot programs were drafted between September 2018 and March 2019, during twelve days of group work (six days for the IPEP project, and six days for the PEPS project) in Paris. Each session brought together around 30 participants. Although the content of the meetings differed according to the experiments, the PEPS and IPEP projects had similar time frames. The frameworks of the "joint definition" sessions were established at an early stage by the executive teams and the sessions focused on the definition of the economic models. In the case of the IPEP project, the sessions mainly focused on the definition of the quality indicators, the drawing up of a questionnaire on patient experience, and the procedures for assessing the development of the effectiveness of the healthcare delivery organisations. In the case of the PEPS project, the sessions focused more on determining the scope and adjusting the fixed- rate. The elements raised in the discussions by the executive team during these very technical sessions focused on specific aspects of designing economic models: for example, the choice of quality indicators for the IPEP project; the weighting adjustment patient or environmental variables for the fixed-rate for the PEPS project. The executive teams devised the pilot programs as innovative funding experiments, whose resulting organisational innovation would be fostered locally by the healthcare professionals and was therefore not discussed in the sessions. The technical nature of the discussions left no room for the policy issues that are usually raised –at least initially– by the professional organisations. Furthermore, the healthcare professionals were not experts on these matters and relied –to varying degrees according to their familiarity with the issues– on information provided by the executive teams to understand the content of the sessions.

> "In 2019, I participated in the meetings on the bedrock indicators, the I-don't-know-what indicators; I left because it was giving me hives. You don't need working groups to come up with ideas, to conceptualise. No, we're dealing with concrete everyday problems and things need to be implemented straight away, not in a year and a half."
>
> **GP, IPEP**

This gave rise to a mismatch between a project-based approach that was developed over five years, adopted by the executive team, and participants who came to resolve everyday problems: the participants responded to the explanations about the quality indicators with practical cases, which the executive team had to reinterpret with regard to the economic model.

A renewed but constrained framework for interaction. The "joint definition" sessions provided new frameworks for interaction between the public authorities and healthcare professionals, compared with traditional negotiations for the National Agreements between doctors' representatives and the Health Insurance Fund (Hassenteufel, 2010). The frameworks were renewed by the actors participating in the sessions: on the executive side, the Ministry of Health and the National Health Insurance Fund were both raised in the discussions at the same level. The members of the Ministry and the Health Insurance Fund teams had no influence on the decision, unlike traditional negotiations in which the managing director of the National Health Insurance Fund conducts the sessions. The decisions were taken a posteriori by the Technical Committee on Healthcare Innovation (CTIS), with which the healthcare professionals had no direct interaction, even though, in the majority of cases, the Committee validated –rather than mediated– the negotiations between the healthcare professionals and the executive teams. Furthermore, the "joint definition" sessions made it possible to include healthcare professionals who did not usually take part in more formal negotiations: for example coordinators doing administrative and managerial work in multiprofessional group practice, who did not have the benefit of union representation, and, more generally, healthcare professionals who were not involved with unions or major federations.

The "joint definition" sessions led the executive teams –from the Ministry of Health and the National Health Insurance Fund – to use relatively innovative tools. In the two pilot programs, the healthcare professionals' opinions were mobilised through various means: workshops, questionnaires, discussion sessions, written accounts, focus groups, and so on. These more or less participatory methods provided a framework for the discussions. The IPEP team mobilised the healthcare professionals in a representative way and in an ad hoc manner around key issues, thanks to a voting system, and organised joint discussions to consider the issues. The PEPS team sought the opinions of each healthcare facility, notably through questionnaires sent out before each session. The decisions were mainly guided by the principle of representation: the members of the PEPS team counted the votes of the representatives of the healthcare delivery organisations. The "joint definition" sessions per se were therefore limited to very specific subjects.

> "The 'joint definition' sessions were, of course, restricted because they were managed by the Ministry of Health and the National Health Insurance Fund. They had their biases and their objective, which was to bring the group round to accepting the economic model they'developed; it was the rule of the game."
>
> **Salaried GP, PEPS**

This limitation was not perceived negatively by the participants interviewed, who accepted the rules of the game when they joined the scheme. These constraints primarily depended on the technical constraints imposed by the need to innovate by building on the existing economic model. For example, for the quality indicators, at the heart of the IPEP model, the first selection criteria was the fact that the collection of these indicators was already computerised in the National Health Data System (*Système National des Données de Santé*, SNDS).

"We reviewed the existing quality indicators, used in the various systems to assess the coordination and effectiveness of the health systems. (…) We applied them to the IPEP groups in the 'joint definition' phase. (…) The criteria of feasibility was the most important because the indicators had to be fully computerisable. Our objective was not to have reporting indicators that placed an additional burden on the teams by requiring them to collect data, and therefore data that wasn't necessarily reliable, and which did not make it possible to make a comparison with a national average."

Executive IPEP team

These technical constraints had a significant impact on the conception of the economic models and this led the participants to focus on the use of healthcare services and healthcare expenditure.

Circumventing the frameworks and negotiating behind the scenes. Although the "joint definition" sessions had a framework, some of the federation and union representatives mobilised resources to get round the rules of the game. Hence, some of the representatives, who were more familiar with traditional negotiations, made demands or combined the interests of the healthcare delivery organisations they represented with those of their union or federation.

"The healthcare professionals who participated in the 'joint definition' sessions (…) were leaders, people who were visionaries –sometimes a little militant, sometimes a little utopian–, but who also had to represent the grassroots of their healthcare delivery organisations. Otherwise, if the suggestion was really crazy, they'd come a cropper when they consulted their teams."

Self-employed GP, Multiprofessional Group Practice

These healthcare professionals tried to negotiate certain aspects of the specifications. The negotiations were largely conducted outside the "joint definition" sessions in email exchanges or in discussions on the phone, even though some of the participants were particularly resentful in the sessions. Some of them mobilised resources linked to their positions in the unions or federations, for example, by sending letters to the minister's office or expressing their opposition through the media. These actions achieved mixed results and were not always successful.

Beyond these actions, which were closely linked to the resources of the union or federation representatives, the executive teams had the difficult challenge of gaining the commitment of the participants. Hence, for some of the healthcare professionals, considering leaving the experiment was sometimes used as lever for negotiation, enabling them to highlight the urgency of their concerns, but it was also a last resort when they could no longer see themselves taking part in the experiment.

"PEPS was on a razor's edge. We had the impression that they were going to leave overnight; they all almost left, at least on one occasion."

Executive PEPS team

In the PEPS pilot program, in particular the professionals from the healthcare delivery organisations cautiously participate in an experiment that completely changes the way in which they are paid, and shift some of the financial risk, which had until then been borne by the French National Health insurance system, onto their healthcare facility.

* * *

The PEPS and IPEP pilot programs were designed to meet a major challenge: changing the way that primary healthcare is funded in France in order to improve the coordination of care and the quality of patients' treatment programmes. These new schemes are based on the idea of developing public policies "from the bottom-up". These ongoing experiments are leading to changes in the organisational routines of the teams in the Ministry of Health and the National Health Insurance Fund), who are learning to adopt a partnership approach, and also work in conjunction with healthcare professionals. However, these developments are accompanied by certain weaknesses. Firstly, in terms of the very organisation of the executive teams, this requires considerable work, undoubtedly well beyond the amount of work that was initially estimated. There is a high turnover of members in the teams, which has an impact on their work, as it is based on a process of learning new methods. Secondly, the interaction with the healthcare professionals is a major issue, because many of them are familiar with negotiations with the public authorities, and have characteristics –such as their gender, age, and social status– which place the executive teams at a disadvantage in the interaction. Hence, there are power relations between the negotiating actors, and the approach to the experiments is less bottom-up than one might expect, as the executive teams establish a rather strict framework for the interaction, but at the same time some of the healthcare professionals have resources to circumvent the frameworks. In the observations made after the publication of the specifications, certain aspects of the economic models are continuing to be negotiated between the executive teams and the participants. This shows the need –when conducting complex experiments involving a large number of actors– for a sufficiently long period of time to facilitate the process of reciprocal acculturation and the establishment of a relationship of trust, to find new ways of thinking about public policy. ♦

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