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## The Impact of Multi-professional Group Practices on Healthcare Supply

### Evaluation Aims and Methods for "Maisons", "Pôles de Santé" and "Centres de Santé" within the Framework of Experiments with New Mechanisms of Remuneration

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Mono-disciplinary group practices, attractive for young general practitioners, are currently in the majority. Over the last ten years, the French public authorities have set up incentives to encourage multidisciplinary primary health care organisations and clusters of the type "maisons de santé", "pôles de santé" and "centres de santé". Within this framework, experiments in new mechanisms of remuneration (ENMR) aimed at these structures were implemented in 2010 to finance improvements in the organisation and coordination of care, the provision of new services for patients and the development of inter-professional cooperation.

Based on the observation of sites identified by the Observatory of Health Service Supply Re-structuring or sites participating in ENMR, this article presents evaluation aims and methods for multidisciplinary group practices, knowledge of which remains fragmentary. Two key questions are asked: do multidisciplinary group practices have an impact on maintaining health care supply in under-resourced areas? Are they more effective in terms of activity and productivity, consumption and quality of care?

Introducing the methodological framework, this edition of *Issues in Health Economics* is the first in a series of publications presenting the results of the study.

Over the past ten years, the organisation of primary care delivery in France has been reinforced by three key leverage factors: the introduction of the "preferred doctor" scheme in 2004 whereby patients designate a physician to act as gate-keeper and care pathway coordinator, revealing patients' preference for general practitioners; the 2009 Hospital, Patients, Health and Territories Act that clarified the perimeters of primary care

supply down to neighbourhood level and finally, policies supporting the development of multidisciplinary group practices in primary care, both the more recent "maison" or "pôle de santé" and the more traditional health centre, the "centre de santé" (Baudier and Thomas, 2009; Juilhard *et al.*, 2010).

With 54% of general practitioners (GPs) working in a group structure in 2009 (Baudier *et al.*, 2010) against 43% in 1998,

group practices are now in the majority. The attractiveness of group practices is even more apparent among GPs aged less than 40 with eight out of ten working in a group practice, notably because it allows a better work-life balance (Bourgueil *et alii*, 2009a; Aulagnier *et al.*, 2007). Group practices are, however, less well developed and less

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multidisciplinary in France than in other countries (Bourgueil *et alii*, 2009b). They are also smaller as three quarters of group practices are composed of two or three general practitioners. Numerous barriers still impede the development of group practices (Igas, 2004) despite the fact that they offer interesting perspectives in terms of efficiency gains (Mousquès, 2011). From an empirical point of view, the effective contribution of group practices in ambulatory care supply remains a challenge for research and public decision-making.

This edition of *Issues in Health Economics* provides a brief reminder of multidisciplinary group practice support policy contents, notably the recent experiments with new mechanisms of remuneration (ENMR) aimed at "*maisons*", "*pôles*" and "*centres de santé*". It presents the main aim of the study and the general methodology used to assess the impact of multidisciplinary group practices as observed in sites identified by the Observatory of Health Service Supply Re-structuring or those participating in the ENMR. The latter have been subject to specific analyses to measure both the impact of these organisations in terms of attractiveness for GPs and the territorial structure of primary care supply. ENMR sites have also been subject to economic analyses measuring activity and productivity and also the quality and consumption of care. The aim of this evaluation is not, therefore, a case of simply measuring the impact of funding received by ENMR sites. Introducing the methodological framework, this edition of *Issues in Health Economics* is the first in a series of publications presenting the results of the study.

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### Multidisciplinary group practices: progressive support from public authorities, notably in rural areas and underprivileged urban areas

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A group practice, defined as being composed of at least two health professionals sharing the same premises, exists in various forms: the mono-disciplinary practice (single speciality medical practices), the multidisciplinary practice (multi-speciality medical practices) and finally multi-professional team practices that associate medical practitioners with other health profession-

als (notably midwives, dentists and podiatrist-chiro-podists), paramedics (nurses, physiotherapist-masseurs, etc.) or other professions such as medical secretaries. In this form, which interests us most particularly here, health professionals practicing in multi-professional structures known as "*maisons de santé*" or "*pôles de santé*" can be self-employed as opposed to the mainly salaried practitioners working in "*centres de santé*", ambulatory care structures governed by the National Health Insurance (NHI).

Knowledge concerning the impact of group practices remains fragmentary in France as sources of information are limited to a few cross-sectional studies (by Humières and Gottely, 1989; Audric, 2004; Baudier *et al.*, 2010). Group practices have never been systematically inventoried: the registration of private practitioners with a health institution is carried out at individual level. The NHI health centres are allocated an establishment number (National Register of health and social care establishments, *Fichier national des établissements sanitaires et sociaux*, Finess) but no information is collected concerning individual practitioners.

Since 2007, several laws have enabled the identification of multi-professional group practices under the denominations "*maisons de santé*" and "*pôles de santé*" [Social Security Financing Act (2007), the Hospital, Patients, Health and Territories Act (2009) and the Fourcade law (2011)]. Despite their differences, "*maisons de santé*", "*pôles de santé*" and "*centres de santé*" have several points in common: they integrate various categories of health professionals (medical staff, medical assistants or even pharmacists), who provide ambulatory care at primary or even secondary level, and participate in public health actions, prevention, health education and social actions.

The main distinguishing factor between the "*centres de santé*" and "*maisons de santé*" or "*pôles de santé*" is the fact that the majority of practitioners are salaried. Another difference is their contractual agreement with the National Health Insurance. If the "*centres de santé*" are essentially financed under the fee-for-service system, practitioners are under the obligation to apply third-party payment rules for statutory health insurance expenses (many centres also apply this for all or part of the expenses covered by



Research on group practices constitutes one of the main themes studied by the Prospere team ([www.irdes.fr/Prospere](http://www.irdes.fr/Prospere)).

The evaluation of experiments with new mechanisms of remuneration is carried out by Irdes within the framework of its partnership with the Prospere team.

complementary insurance) and to respect sector 1 government-regulated fees.

The "*maisons de santé*" differ from "*pôles de santé*" in that their activities, in most cases, are all housed on the same premises even if legally speaking this distinction no longer exists. Both types of structure are grouped together under the term "*maisons de santé*" from the moment they are a registered legal entity with a formal health project compatible with the Regional Strategic Health Plan for the organisation of ambulatory care, signed by all the members and transmitted to the Regional Health Agency (*Agence régionale de santé*, ARS) for information. However, this distinction between "*maison*" and "*pôle*" will be maintained in our study so as to be able to distinguish multi-professional group practices sharing the same premises from the others.

These developments were confirmed by the introduction of a new legal status in 2012, the Inter-professional Ambulatory Care Organisation (*Société interprofessionnelle de soins ambulatoires*, Sisa) under which establishments are allocated a Finess number authorising the remuneration (notably by the NHI) of group practice activities carried out in common by different health professionals, whilst maintaining the "*maisons*" and "*pôles de santé*" private practice status.

Today, information sharing between health professionals in these healthcare structures is legally possible with the patient's assent. In terms of information systems, the Shared Healthcare Information Systems Agency (*Agence des systèmes d'information partagés de santé*, Asip) is charged with labelling the multi-professional nature of patient records on request.

Although there is no recognised organisation currently charged with granting the label "*maison*" or "*pôle de santé*", public

financing can often only be obtained on condition that, in addition to aforementioned criteria, the structure is composed of at least two general practitioners associated with at least one paramedic and that it applies statutory sector 1 tariffs.

The High Authority for Health (*Haute autorité de santé*, HAS) has furthermore specified the main characteristics of group medical practices in general, based on the notion of health project and continuity of care as well as the coordination and standardisation of practices (elaboration and adoption of protocols, coordination, analysis and exchange of information concerning practices...)[HAS, 2007].

Finally, it involves granting financial support for group practice initiatives, notably in the form of investment grants and/or operating aid from multiple sources such as the State, the National Health Insurance or regional authorities.

Financial aid from the National Health Insurance, originally provided by the Fund for Action on the Quality and Coordination of Care (*Fonds d'intervention pour la qualité et la coordination des soins*) now comes under the Regional Response Fund (*Fonds d'intervention régional*) whose scope has been extended. It contributes to financing feasibility studies, project engineering, and aid for the launching or operating of group practices. The number of funded projects has increased steadily from 20 in 2007 to 185 in 2011 with 9.1 million euros allocated at 75% to "*maisons de santé*" (Cnamts, 2012).

Within the framework of territorial development policy, the State and regional authorities also provide investment grants for group practices. On the one hand, the Centre of Excellence in Rural Health label co-finances inter-communal projects favouring economic development, essentially in rural development zones<sup>1, 2</sup>. In 2010, a national plan was launched<sup>3</sup> with the aim of co-financing 250 "*maisons de santé*" or "*pôles de santé*" over the period 2010-2013 in rural areas in which healthcare supply was considered fragile or in need of reinforcement. Within the framework of the National Public Health Strategy, this has been extended to 300 "*maisons de santé*" or "*pôles de santé*" before the end of 2014. In urban areas, the "*Espoir Banlieues*" initiative aims at creating 10 "*maisons de santé*"

per year among the 215 urban policy priority neighbourhoods (sensitive urban zones (*Zones urbaines sensibles*, Zus) and urban social cohesion contracts (*Contrats urbains de cohésion sociale*, Cucs)). Investment grants amount to an average fixed sum of 100,000 euros per "*maison de santé*", that is a global budget of around 25 million euros.

In total, 291 "*maisons*" and "*pôles de santé*" are currently operational, of which 246 with a health project according to data transmitted in 2013 by the Ministry of Health's Observatory of "*maisons de santé*" and "*pôles de santé*". We also count approximately 400 polyvalent health centres the majority of which are located in urban areas (IGAS, 2013).

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### Experiments with collective and fixed-rate remunerations in "*maisons*", "*pôles*" and "*centres de santé*"

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Experiments with new mechanisms of remuneration for health professionals (ENMR) introduced in the 2008 Social Security Funding Act<sup>4</sup> to co-finance group practices over the period from 2009 to 2013, have recently been extended to the end of 2014. The amounts allocated to healthcare structures are aimed at improving the organisation of care, developing collaboration between health professionals and favouring the creation of new services for patients. These experiments fall within the framework of policies aimed at reinforcing regional care networks and assessing the pertinence of these more attractive forms of practice, notably for young professionals. Managed by the Department of Social Security (*Direction de la Sécurité sociale*, DSS), the ENMR are implemented at local level by the Regional Health Agencies (ARS) that are also in charge of selecting and monitoring sites<sup>5</sup>. These experiments carried out in 19 French regions concerned 151 structures in 2012 of which 115 "*maisons de santé*" or "*pôles de santé*" [Map].

These new modes of remuneration consist in a contract signed between the ARS and a voluntary structure representing a group practice composed of a minimum number of general practitioners and nurses. The contract stipulates fixed-rate funding agree-

ments, distinct from fee-for-service funding, in exchange for expected improvements in the quality and efficiency of care<sup>6</sup> and without obligations in the way allocated resources are distributed. The underlying hypothesis being that fixed-rate funding encourages greater efficiency in group practice structures than fee-for-service funding.

Three types of fixed-rate funding have been introduced: fixed-rate funding for coordinated missions (known as module 1), fixed-rate funding for new service provision for patients (module 2) and in 2013, fixed-rate funding for cooperation between health professionals (module 3).

The first module aims at remunerating time spent in coordinating activities (structure management and inter-professional coordination); today, the second essentially focuses on patients therapeutic education but is not limited to this in the long-term; the third concerns inter-professional cooperation through the transferral of interventions and medical activities to nursing staff. All sites included in the ENMR are signatories to module 1, apart from certain exceptions, modules 2 and 3 can be cumulated with module 1 and modules 2 and 3 under certain conditions. Initial fixed rates are calculated separately for each module and are principally based on team size at full-time equivalents (FTE), the number of patients registered on the "preferred doctor" scheme for module 1, the number of patients included for module 2 and the number of FTE nurses for module 3.

Although planned initially, and after a "lost" year setting it up, the modulation of fixed-rate amounts according to perfor-

<sup>1</sup> Articles : L.6323-1, L. 6323-3, L. 6323-4 of the Public Health code and L 162-32 of the Social Security for the "*centres de santé*".

<sup>2</sup> <http://poles-excellence-rurale.datar.gouv.fr>

<sup>3</sup> Circular NORn°EATV1018866C of July 27th 2010.

<sup>4</sup> Article n° 44 of Law n° 2007-1786 of December 19th 2007 on Social Security financing for 2008. Journal Officiel, 21st December 2007b : p. 20603.

<sup>5</sup> Health professionals constitute an additional partnership either as federations of "*maisons*", "*pôles*" or "*centres de santé*" or trade union membership within the National Union of Health Professionals (UNPS). Finally, the Cnamts, the MSA and the FNMF also participate as financiers.

<sup>6</sup> See the three ENMR newsletters:

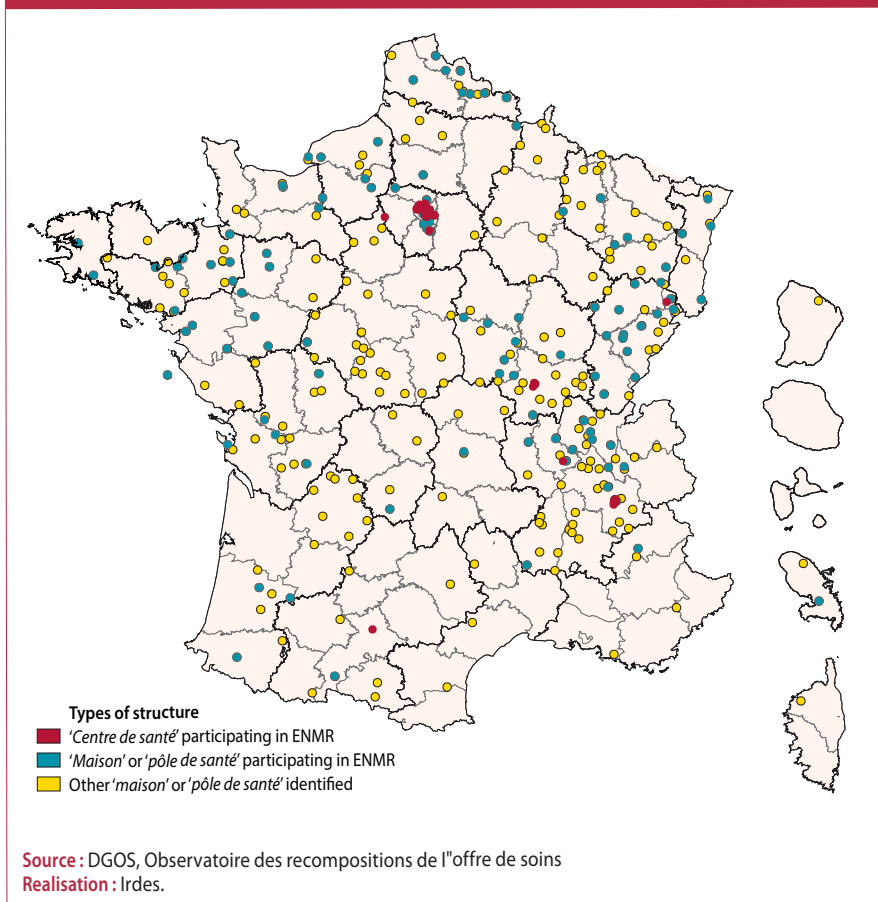
- [http://www.ars.sante.fr/fileadmin/PORTAIL/Fichiers\\_DSS/presentation\\_DSS/Newsletter\\_ENMR\\_N1.pdf](http://www.ars.sante.fr/fileadmin/PORTAIL/Fichiers_DSS/presentation_DSS/Newsletter_ENMR_N1.pdf)

- <http://www.scribd.com/doc/54766013/Newsletter-ENMR-2>

- [http://www.ars.sante.fr/fileadmin/PORTAIL/Fichiers\\_DSS/presentation\\_DSS/Newsletter\\_ENMR\\_N3.pdf](http://www.ars.sante.fr/fileadmin/PORTAIL/Fichiers_DSS/presentation_DSS/Newsletter_ENMR_N3.pdf)

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## Establishment of ENMR sites according to their status



mance objectives having been achieved, calculated on the aggregated results of all group practice members, was abandoned for practical reasons.

The indicators, defined beforehand by the DSS and validated by the Cnamts and the HAS, are calculated for all the experimentation sites as a whole. They are based on the following three dimensions: quality of practices, the coordination of multi-professional practices, and prescription effectiveness. Target achievement level is evaluated by associating one or more indicators (24 in total) to each dimension. Each site chooses a minimum of four "quality of practice" indicators from the twelve proposed, a minimum of four "coordination and continuity of care" indicators from the seven proposed, efficiency indicators being the same for all sites. Some of the indicators are assessed on declarative information.

During the course of the experiment, certain "quality of practice" indicators, calculated from Health Insurance data and initially validated, were subsequently dropped due to the impossibility of using the data necessary

to calculate them (colon cancer screening, flu vaccinations administered by nurses, the dispensing of medical devices by nurses).

The first two ENMR modules were implemented as of January 2010, with a first inclusion wave comprising 39 sites distributed between 6 pilot regions (Brittany, Burgundy, Franche-Comté, Ile-de-France, Lorraine and Rhône-Alpes) as follows: 17 "maisons de santé" 3 sites associating "maison de santé" and "pôle de santé" characteristics (for 27 addresses), and 19 "centres de santé". This first inclusion wave represented 87 general practitioners working in "maisons de santé" or "pôles de santé", 176,331 health insurance beneficiaries in the general practitioners' active patient lists, of which 84,268 registered with a "preferred" GP in 2010.

A second inclusion wave took place between January 2011 and January 2012. It concerned 112 new sites, 61 "maisons de santé", 11 "maisons/pôles de santé" (89 addresses), 23 "pôles de santé" (245 addresses) and 17 "centres de santé" across 19 regions. This second inclusion wave represented 474 gen-

eral practitioners working in "maisons" or "pôles de santé", 669,844 health insurance beneficiaries in the general practitioners' active patient lists of which 329,359 registered with a "preferred" GP in 2010.

The total budget allocated to fixed-rate funding is estimated at 7 million euros per year.

### Objectives, hypotheses and analytical framework for the assessment of sites

Beyond the monitoring of sites included in the ENMR, the main aim in carrying out this evaluation is to offer a quantitative viewpoint on the contribution of multi-professional group practices on the regional network of general practitioners and its effectiveness. It also allows identifying the phases to be respected or the precautions to be taken for a reasoned and general application of these new modes of remuneration in collective structures. Two main hypotheses are explored.

First hypothesis: inter-professional group practices are more attractive and bring greater satisfaction to health professionals through better working conditions and a better work-life balance. In this sense, they have a positional advantage in maintaining the provision of primary care services in currently disadvantaged areas.

Second hypothesis: inter-professional group practices are more efficient in terms of the care and services provided (quality, efficiency, equity). Efficiency gains would be achieved through economies of scope (reduced production costs through extending the "scope" of dispensed care and services) and scale (average costs reduced through increased production) generated by vertical integration (between professionals in different professions or disciplines) and horizontal integration (between professionals in the same profession or discipline).

The analytical framework retained is based on public policy assessment models (Duran, 2010; Fougère, 2010), and organisation of care and professional practice assessment models (Donabedian 2005; Contandriopoulos *et al.*, 2000; Kelley and Hurst, 2006) as well as the teachings from

our previous experiments: literature reviews and international comparisons of group practices and cooperation between GPs and nurses, qualitative and quantitative assessments of care supply networks, group practice in "maisons de santé" or "centres de santé" and finally, studies on GP-nursing staff cooperation.

In this context, the impact or results of multi-professional group practice sites are analysed in organisational and operational terms (structure and processes) compared not only to control sites but also in terms of environment and context. For each of these components, specific methodologies and data sources are used.

### An assessment based on a quasi-experimental method

The geographical environment is analysed in terms of healthcare supply and care needs based on resident population characteristics and the spatial structure of each territory. This analysis is based on two typologies, one based on living areas for sites located outside predominantly rural areas, and the other at *pseudo-canton* level for sites in predominantly urban areas based on population census data. These typologies allow the comparison between types of areas in which "maisons de santé" and "pôles de santé" have been created and those without either, and to analyse their specificities.

Site organisation and operation are studied by means of a typology constituted from a survey carried out among the totality of sites participating in the ENMR using standardised questionnaires administered via the Internet in 2011-2012 and again in 2013. The survey provides a detailed description of the organisation and delivery of care, site operation and equipment, and ENMR sites' work processes providing an insight into the collaboration between professionals, the existence of innovative practices and the characteristics and usage of information systems.

In order to answer the question of whether a multi-professional practice provides added value, in other words whether it has an impact in terms of attractiveness (hypothesis 1) efficiency of care and services deliv-

ered (hypothesis 2), two methodological constraints must be circumvented.

The first comes from the fact that the causal effects of multi-professional group practices as defined in the ENMR are not directly observable; the majority of ENMR sites and the professionals composing them operated as multi-professional group practices prior to the experiment.

The second comes from the fact that it is a priori difficult to dissociate pre-existing differences resulting from the selection pro-

cess (territories attracting certain types of structure, group practices attracting a certain type of medical profile, groups accepting to participate in ENMR, etc.)

Two methods, based on quasi-experimental analyses, circumvent these constraints. Whether for the attractiveness or performance analyses, case-control studies are carried out using longitudinal data.

For the attractiveness analysis (hypothesis 1), we observe private GP density and its evolution over two consecutive periods

## SOURCE AND METHODS

### Sites participating in experiments with new mechanisms of remuneration (ENMR): health professionals and patients composing them

The general practitioners taken into account are those considered as being "established" for all or part of a given year and ENMR convention signatories. Signatory health professionals on experimental sites identified by the ARS are then identified in Cnamts data by the evaluation team. In cases where there is a mismatch, a final validation is jointly decided by the ARS, Irdes and the ENMR sites concerned.

### Local control zones (zones locales témoins, ZLT): definition and composition

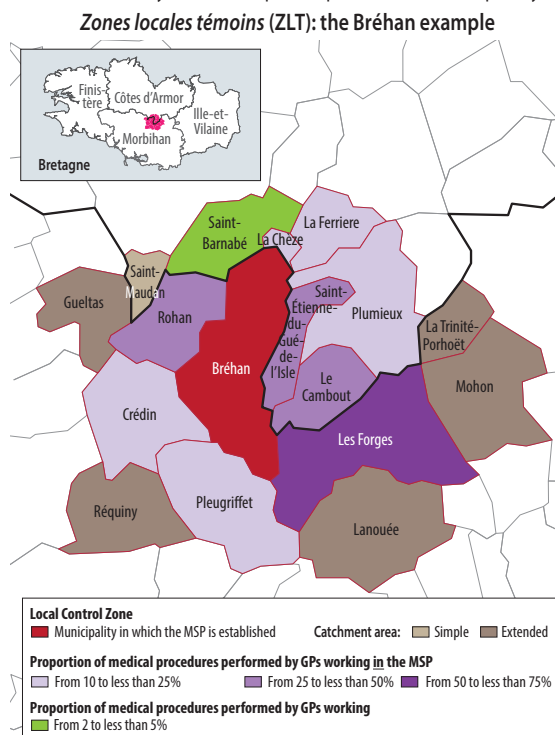
Our main control sample is composed of general practitioners who are not working in an experimental site but situated within its main catchment area, the local control zone (ZLT), as well as the patients on their active patient list.

The ZLT is defined as an aggregate of municipalities within the ENMR site's main catchment area in which at least 10% of medical tasks are carried out by GPs working on the experimental site. To these municipalities are added those in which primary care delivered to residents represents over 5% of the experimental site's activity, or 500 consultations or visits during the year. Adjacent municipalities were then associated.

In cases where the number of general practitioners is less than 10, an extension criterion is applied step by step so that the number of GPs is equivalent to at least 10 in an ZLT. In cases where the number of GPs is over 30, a weighted random selection is applied so as to retain only 30 GPs. As well as belonging to a ZLT, control GPs share the following characteristics with those working on experimental sites:

- they must be "truly active" practitioners; that is to say in full-time private practice over a complete year and have performed between 1,500 and 13,500 medical tasks within the same year;
- apply statutory sector 1 National Health Service fees, without charging excess fees;
- be without a specific mode of practice, either declared or observed from the moment 100% of medical tasks performed are technical;
- carry out less than 10% technical procedures;
- carry out less than 25% continuity of care procedures;
- be registered as "preferred GP" with at least a hundred patients or over.

Finally, we used the percentage of general medical task performed in a municipality within a multi-professional "maison de santé" (MSP) to adjust the weight of different ZLT GPs (a GP's activity has a greater weighting the higher the ENMR site's market share within the municipality in which the GP practices).



(2004-2008, 2008-2011) at living area or "pseudo-canton" level (the key date being 2008 as it marks a turning point in the development of "maisons de santé" and "pôles de santé") and according to whether the area includes (case) or not (control) at least one identified "maison" or "pôle de santé" in the Observatory of Health Service Supply Re-structuring or the ENMR; method known as the difference in differences method. The case-control analysis is carried out between similar spaces as defined in the typologies. The assessment was carried out on a sample of 10,349 municipalities with working general practitioners.

For the performance analysis, cases are a sub-sample of sites participating in ENMR (hypothesis 2), the health professionals composing them and monitored patients compared with similar control sites (areas without ENMR sites), in other words private practitioners (GPs, nurses or physiotherapist-masseurs) and their patients, working in solo-practices or mono-disciplinary practice groups (Sources and Methods insert).

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## Numbers participating in the evaluation

	Cases	Controls (LCZ)
Number of sites or ZLT	94	94
Number of general practitioners	280	2,123
Number of patients aged 16 and over in the active patient list	368,774	2,678,880
Number of patients registered on the preferred GP scheme in the active patient list	219,127	1,482,055

**Sources :** Géo : Sniiram, Irdes, permanent equipment database (PED), annual health establishment statistics (SAE), CépiDC (Inserm), census (Insee). Eco: National Health Insurance Cross-schemes Information System (Sniiram, Cnamts) and more precisely: Datamart for cross-scheme consumption (DCIR) matched with PMSI-MCO data, National Health Insurance Cross-scheme Information System for Health Professionals (SNIR-PS).

The cases (experimental site GPs and patients having chosen them as their "preferred GP" or present on the GP's active patient list) are compared with control GPs working in local control zones (*zones locales témoins*, ZLT). The ZLT, defined as municipality aggregates, are constituted on the basis of experimental sites' main "catchment" areas, proper to each site (Sources and Methods insert). This comparison, carried out over a four year period (2009-2012), provides a dynamic analysis of the

period concerned and allows us an a posteriori reconstitution of a "before" (2008 and 2009 for wave 1, 2009 and 2010 for wave 2) and "after" (2011 and 2012 for wave 1, 2012 for wave 2) entry into the experiment (2010 for wave 1 and 2011 for wave 2). This assessment is based on a sub-sample of 94 sites, 65 "maisons" or "pôles de santé" with a total 280 general practitioners, 29 "centres de santé" and 2,123 control GPs and 1.7 million patients registered on the "preferred GP" scheme. ♦

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