

Medical group practice in primary care in six European countries, and the Canadian provinces of Ontario and Quebec: what are the lessons for France?

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Medical group practice in primary care remains comparatively undeveloped in France compared to other countries. In Finland and Sweden, doctors are grouped in local public structures with multidisciplinary teams, whereas in Canada, the Netherlands and the United Kingdom, they are organised in private units run by independent health professionals on a contractual basis.

Among the factors explaining this trend, mention should in particular be made of a genuine political determination to place primary care at the heart of the health system and a definite change in health care supply and demand: increased demand for care in a context of decreasing medical density, need for improved health care coordination, the quest for less onerous working conditions and hours, etc.

This grouping often goes hand in hand with new rules and practices: voluntary registration procedures for patients with a doctor in group practice, greater cooperation between health professionals, changes in doctors' remuneration and new contracts between groups and health authorities. Certain signs are already visible in France, doubtless presaging an acceleration in the trend towards medical group practice.

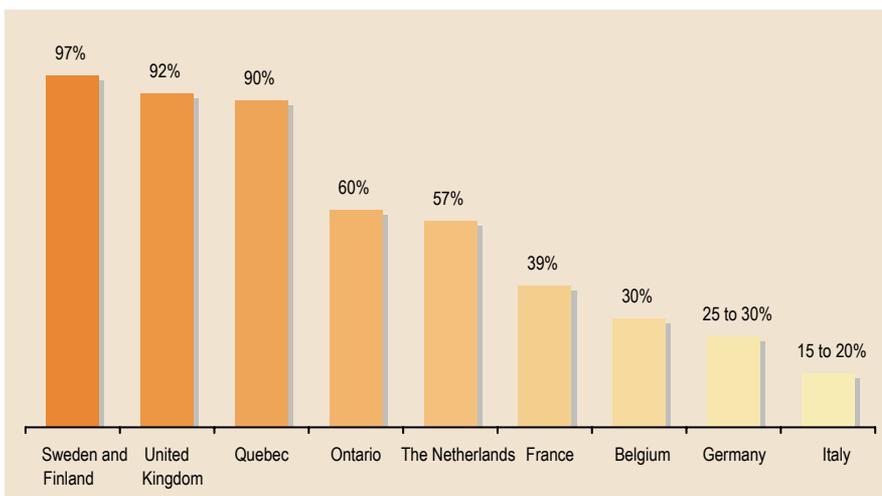
The question of transforming the organisation of what is known in France as "ambulatory medicine" (médecine ambulatoire) and in many other countries as "primary care" (see box on page 4) is becoming of pressing importance both inside and outside France. It raises the issue not only of the organisation but also of the financing of the health care system and the development of medical and paramedical professional practices. The question is part of a quickly changing situation characterised by an increasing and changing demand for health care and a supply likely to be burdened by diminishing medical density in the years ahead.

Against this background, one of the striking developments in most modern countries has been the emergence of a more collective and interprofessional approach to medical practice, principally expressed in one of two forms: firstly group practices or health centres, and secondly modes of grouping in networks. This study focuses on the first of these two categories.

Group medical practice is on the increase in France but remains less widespread than in other countries, particularly in clinical primary disciplines such as general medicine.

With a view to casting light on the situation in France, the grouping of general practitioners has been analysed in six European countries and two Canadian

Proportion of general practitioners working in group practice (estimation)



provinces: Germany, Belgium, Finland, Italy, the Netherlands, the United Kingdom, Sweden, Ontario and Quebec.

In France: a moderate grouping of general practitioners in private practice, on the increase

France is one of the countries in which group medical practice is a minority

We may distinguish two groups of countries depending on whether the exercise of primary care in group practice constitutes a majority or minority phenomenon (*see the tables on page 3 for a detailed approach per country*).

Group practice is a dominant feature of Finland, Sweden and the United Kingdom, and is in the majority in Canada (Ontario and Quebec) and the Netherlands. It is in the minority in France, Belgium, Germany and Italy.

In France, a distinction should be made between two structures of group practice: health centres and groups of doctors in private practice. The former accounts for a very small part of the supply of health care (more particularly in deprived or out-of-the-way areas), and it is the latter category which should be the focus of attention in France.

According to a survey conducted by the Department of Research in Evaluation and Statistics Studies (Direction de la Recherche, des Etudes, de l'Evaluation et des Statistiques – DREES)¹, an estimated 39% of general practitioners exercised their profession in a group practice in 2003, compared to an estimated 30% in the early 1980s. A single medical practice thus remains the norm.

Group practices are essentially mono-specialist, i.e. the members exercise the same discipline. Only 16% of general practitioners working as part of a group specialise in disciplines differing from those of their partners. The groups are small in size: about 55% of doctors have only one partner.

A growing interest for this type of organisation

Although group practices remain in the minority in France, they are increasingly seen as an approach worthy of consideration², as can be seen by professional initiatives and measures recently taken by the public authorities. Thus, in the context of the Medical Demography Plan of 2006, the health insurance system implemented an incentive designed principally to facilitate medical practice in areas where there is a shortage of doctors: on 18 January 2007 an agreement was signed providing for a fixed annual aid equivalent to 20% of the amount of the consultations and visits made by general practitioners exercising in a group practice or a nursing home in under-medicalised areas. Similarly, the creation of the general practitioner contract within the framework of the Law of 2 August 2005, although not directly concerning the grouping of doctors, is often presented as a means of facilitating the association of doctors in the long term. Lastly, various projects of multi-disciplinary medical centres have emerged over the last few years, alongside the development of the policy of networking health care, with the financial backing granted by innovation funds – Fund for the Improvement of Community Care Quality (Fonds d'Aide à l'Amélioration de la Qualité des Soins de Ville) and Regional Networking Funds (Dotations Régionales de Développement des Réseaux) – and the regional authorities.

This attraction for group practice may also be seen in Germany, Belgium and Italy, but remains less pronounced than in other countries where the group practice is by far the most common framework, and which we shall now examine in greater detail.

Countries where group practice is the norm: a variety of forms and processes for the grouping of doctors

Widely diverging operating modes from one country to another

In countries where group medical practice predominates, two categories may be

This international survey was financed by the social security division of the Ministry of Health and is part of the work carried out by the IRDES (Institut de Recherche et Documentation en Economie de Santé) on the organisation of health systems. The study is based on the findings of an international network of experts – researchers, representatives of public institutions and professional associations – and on-site visits carried out in each of the countries/provinces concerned. It provides a picture of the level and forms taken by the grouping of general practitioners, identifies the processes prompting its development and the changes in the health systems. The study was conducted in 2004 and 2005 and was updated in 2007.

distinguished depending on the context – public or private – in which the doctors exercise their profession. In Sweden and Finland, grouping takes place within health centres where doctors are either employees or remunerated on a capitation basis, whereas in Canada, the Netherlands and the United Kingdom, it is organised in private practices managed by professionals exercising as self-employed persons and remunerated in various forms (fee-for-service, capitation, fixed sum).

In Finland and Sweden, doctors work in primary care health centres managed and financed by the local authorities. These centres form the core of the system and dispense both curative and preventive health care. They provide their patients with a wide range of health care and medical, social and collective services (health promotion, prevention, and diagnostic, curative, palliative, rehabilitation care, etc.). Their size varies according to the geographical area, with large centres in urban zones and small ones in outlying

1 Audric S. (2004), L'exercice en groupe des médecins libéraux, Études et résultats, DREES, No. 314.2

2 See in particular: Juilhard J.-M. (10/2007), Rapport d'information fait au nom de la commission des affaires sociales sur la démographie médicale; ONDPS (2005), Rapport annuel de l'Observatoire national de la démographie des professions de santé.

areas. General practitioners, nursing staff and other health care professionals (laboratory assistants, midwives, physiotherapists and on occasion specialists such as paediatricians, gynaecologists and psychiatrists) together form an interdisciplinary team responsible for dispensing most of these services.

In the United Kingdom, general practitioners contract with the local health authority (Primary Care Trust) and offer an array of primary care services. The doctors are registered with the National Health Service (NHS) and have the status of self-employed persons. Nowadays, only 8% of general practitioners work on their own. The most remarkable trend is the increasing size of the group practices. While the average group comprises, in addition to administrative staff, 4.8 general practitioners plus a nurse, over 45% of general practitioners today work in groups of 5 doctors or more compared to only 17% in 1975.

In the Netherlands, 57% of general practitioners work in a group practice consisting for the most part of two doctors. In 1941, a gate-keeping system was established under which the doctors are all independent service providers. Doctors working in a group or on their own are not associated with nurses or multidisciplinary teams. However, as in Germany, medical assistants play an important role in the practices³. Only a small minority of doctors work in health centres (which serve about 10% of the population and include multidisciplinary teams). It should be noted that a pilot scheme consisting of a vast network of community and integrated primary care was introduced in a new town, Almere, in the 1970s and 1980s, as the first step towards adoption on a national scale. In the event, the experiment was not developed, but it remains an exemplary (and still operational) model of new approaches to the organisation of health care.

In Quebec, primary care is provided for the most part by private medical practices in which doctors are remunerated by fee-for-service. In these practices, 6 out of 7 general practitioners work in groups consisting of an average of 5 doctors. A few of these practices (about 17%) include one or more nurses in their personnel. They also comprise specialists (almost 50%), psychologists (40%), dieticians (30%) and physiotherapists (12%). In Ontario, unlike Quebec, general practitioners usually work together, less often with specialists or other health care professionals.

In short, it cannot be said that there is a single form of grouping in the countries where the group practice is the norm. These groupings are by turns mono-specialised, i.e. associations of doctors exercising the same speciality (the Netherlands and Ontario), multi-professional, i.e. association between general practitioners and other paramedical professionals (the United Kingdom), and both multi-professional and multi-specialist, i.e. association between general practitioners and other specialist doctors (Quebec, Sweden and Finland).

On the other hand, in countries where the norm is constituted of doctors working on their own, the predominant form of grouping is always mono-specialist, as is the case in France, Germany, Belgium and Italy (*see table opposite*).

Moreover, countries in which most doctors work in group practice do not necessarily follow the same model for the organisation of primary care. We may distinguish the community model and the professional model⁴. In the former

Countries in which the group medical practice (general practitioners) is in the majority					
	Average rate of grouping of general practitioners	Predominant framework of exercise of the group	Professionals concerned	Average number of doctors per group	Mode of doctors' remuneration
Finland	Over 90%	Public health centre	Principally multi-professional	nd	Salaried/capitation
Sweden	98%	Public health centre	Multi-specialist and multi-professional	nd	Salaried
United Kingdom	92%	Private practice under contract with the local authority	Multi-professional	4, 8	Capitation/ fixed sum/ fee-for-service
Quebec	About 90%	Private practice	Multi-specialist and multi-professional	5, 2	Fee-for-service
Ontario	About 60%	Private practice	Mono-specialist	4, 8	Fee-for-service
The Netherlands	57%	Private practice	Mono-specialist	2	Capitation

Countries in which group medical practice (general practitioners) is in the minority					
	Average rate of grouping of general practitioners	Predominant framework of exercise of the group	Professionals concerned	Average number of doctors per group	Mode of doctors' remuneration
France	39%	Private practice	Mono-specialist	About 3	Fee-for-service
Belgium	30%	Private practice	Mono-specialist	nd	Fee-for-service
Germany	25 to 30%	Private practice	Mono-specialist	Groups of 2 doctors in the majority	Fee-for-service
Italy	15 to 20%	Private practice	Mono-specialist	nd	Capitation

For a more detailed account of these countries, see the corresponding IRDES report (cf. page 8)

3 These carry out medical secretariat work (making appointments, preparing consultations, keeping records, issuing prescription forms, etc.) and clinical tasks requiring limited technical acumen (removing stitches, carrying out electrocardiograms, simple audiometry, dressings, taking blood samples, injections, measuring blood pressure, etc.). At the same time, these practices are not considered as multi-professional practices.

4 Beaulieu M.-D., Contandriopoulos A.-P., Denis J. L., Haggerty J., Lamarche P. A., Pineault R. (November 2003), Sur la voie du changement : pistes à suivre pour restructurer les services de santé de première ligne au Canada, Fondation canadienne de la recherche sur les services de santé (Canadian research foundation on health services).

Primary care

In this study, we have opted to focus our analysis on group medicine in the field of “primary care” (a denomination used in certain countries but not very often in France) and referring to the notions of first recourse, accessibility and permanence of health care. The general practitioner is everywhere a key element but, depending on the organisations in force, other professionals may also be involved, particularly nursing

staff. There is no universal definition covering the range of services included in primary care. Apart from local ambulatory health care, prevention, health education, information and advice services are frequently included. Some countries have also sought to incorporate social services.

For the purposes of this study, we have chosen to define health care as including, over and above health care dispensed in the practice or the

health centre, home care provided by nurses to dependent persons. On the other hand, health care dispensed in follow-up care, residential and rehabilitation centres – which involve a large number of professionals, in particular nurses – are not included in the scope of this study. Nevertheless, it should be borne in mind that it is not always easy, on the basis of the information collected, to distinguish between the two categories.

case, the doctor is part of a multi-professional structure (the health centre) which provides health care (promotion, prevention, curative) and social services to a defined population. In the latter case, the doctor lies at the heart of the organisation of health care and supplies services to his/her clientele. In certain cases, the client’s registration with the doctor or group confers on the said doctor or group missions of health care coordination, prevention and promotion (professional coordination model).

In our sample, the only health systems corresponding to the community model are those pertaining in Finland and Sweden. The Netherlands, the United Kingdom, Ontario and Quebec correspond to a professional model for the organisation of primary care.

Finland and Sweden: a commitment on the part of the public authorities to promote primary care

The development of health centres in Finland and Sweden is linked to the wish of the public authorities, in the 1970s and 1980s, to promote the status of primary health care. In both cases, the administration of the health system is characterised by a high degree of decentralisation, at regional level in Sweden and at municipal level in the case of Finland.

In Sweden, it was decided at the outset of the 1980s that primary care should be

dispensed exclusively in health centres whose numbers were to double in the space of five years. Doctors are for the most part salaried and various incentive schemes are introduced in order to encourage activity. In Finland, the law of 1972 governing primary care, set out certain requirements and standards designed to make primary care the cornerstone of the health system, leaving the municipal authorities with responsibility for implementing them at local level. These health centres were to become the heart of the system, a radical departure at the time. Prior to this founding law, health care had been mostly dispensed by doctors in private practice; these doctors have since become, so to speak, civil servants.

United Kingdom: a gradual movement towards the group practice

The group practice has emerged gradually over a long period in the United Kingdom. After the Second World War, when the social insurance system was transformed into a national health system, the Health Minister even then expressed an interest in the development of group practices or health centres, but it was towards the end of the 1960s, when the country was faced with a great shortage of general practitioners, that several measures were taken, designed in particular to encourage the establishment of group practices: abolition of the liberty for doctors to set up where they pleased plus the obligation to

respect a minimum size of 1000 patients; encouragement, with a view to increasing the activity of the practices, for the recruitment of nurses (70% of their salaries financed by the NHS); lastly, payment of a special group allowance amounting to 5% of the practice’s total revenue for those belonging to a health centre.

But the movement towards grouping and reorganisation was above all stimulated by the reforms of the 1990s which introduced budget management structures for the purchase of ambulatory and hospital health care. Today, all the primary care services (group and individual practices, home care, social services, etc.) are administered by PCTs or Primary Care Trusts. The PCTs are run by a board of directors representing general practitioners, nurses, social services, the local health authority and the local population. They comprise not only an administrative unit (managers and financial staff) but also pharmaceutical consultants, quality managers, etc.

The introduction of the New General Practitioner Contract in April 2004 has confirmed the trend towards group practice. Henceforth, the NHS directly concludes a contract both with the practices and with the doctors as individuals. There is no longer an individual list of patients for each doctor but a list per practice. This method of funding acts as an incentive to optimising the organisation of work and logistic elements in order to increase income. In this way, the government expects to see the disappearance of the last individual practices.

Quebec: a reaction to the government’s decision to establish health centres

In Quebec, general practitioners were above all persuaded to forsake individual practices for group practices as a result of the introduction of Centres of Local Community Services (CLSCs) in the 1970s. Indeed, when the public health system was set up in the 1970s, the authorities created public bodies, the CLSCs, with a view to making them the principal gateway to the health care system. The

CLSCs were to take charge of all the social and health needs of their local population through multidisciplinary teams facilitating the continuity of health care and inter-professional cooperation, particularly between doctors, nurses and social workers. But the implementation of the CLSC network, which took place over a period of 15 years, was to prove difficult. Most of the associations representing the interests of doctors were somewhat hostile, and few general practitioners chose to exercise their profession within these structures, mostly for fear of losing their predominant role in the access of patients to health care and in the coordination of this care.

It is against this background that doctors are accelerating the development of group practices. The gateway for primary care in Quebec is chiefly made up of private group practices and hospital casualty departments⁵.

In Ontario, the Community Health Centres or CHCs, the equivalent of the CLSCs, have made little headway. There are fewer doctors exercising within the CHCs (about 5%) than in the CLSCs in Quebec (20%).

New contexts for the exercise of the medical profession have recently emerged in Ontario and Quebec, the main aim being to improve access to first-line services while promoting the role of the family doctor. The Family Medicine Groups (GMFs) in Quebec and the Family Health Teams (FHTs) in Ontario have gradually taken shape in the years since 2000, catering for a voluntarily registered clientele. The GMFs consist of a dozen or so doctors working in association with nurses and offering a range of first-line medical services. The Health Ministry eventually hopes to see 75 to 80% of the insured population registered with a family doctor belonging to a GMF. For the time being, only a minority of doctors exercise in GMFs in Quebec and FHTs in Ontario.

Practicing group medicine: new rules and practices

The policies in favour of group practices are often associated with innovations

which may pave the way to profound changes in the system.

The registration of patients with a doctor exercising in a group practice

A first innovation consists in the implementation of mechanisms for the voluntary registration of patients with a general practitioner working in a group practice. This logic of the patient list – as put into practice by the Canadian provinces of Ontario and Quebec in their experiments concerning networks or groups of family doctors – is leading to a gradual change in the primary care systems.

Thus the models for the delivery of health care, rooted in a logic of treating a clientele, are moving towards a logic of treating a population. This is a change which may turn out to be of structural importance for the development of primary care, particularly with regard to prevention and public health approach.

The development of cooperation between health care professionals

A second innovation consists in facilitating the development of cooperation or the delegation of tasks, particularly between general practitioners and nurses⁶. This cooperation is facilitated thanks to the financing of all or part of the nurse's salary, or by assigning the nursing staff previously employed in public health organisations to group practices, as can happen in the United Kingdom (PCT) or in Canadian experiments (GMF and CLSC).

In countries where specialist doctors traditionally work in a hospital environment, grouping is accompanied by a move towards specialist consultations in practices and by a relative specialisation on the part of general practitioners.

In countries such as Canada and the United Kingdom, where general practitioners are at a premium, it is this shortage which is probably one of the key factors explaining the accelerated pace of the move towards grouping. For the group

practice does indeed allow general practitioners to better meet the demand made on their services.

Changes in doctors' remuneration and new contracts

The economic incentives in favour of group practice are accompanied by changes to the traditional method of remuneration which may either apply exclusively to the doctor working in group practice, or partly to the practice itself and partly to the doctor. Thus fee-for-service payment may be replaced in part by payment by capitation when systems based on lists of patients are introduced, e.g. networks or groups of family doctors in Ontario and Quebec. Or again, modes of fixed-sum remuneration may emerge (equipment, coordination, etc.), or the concept of payment by performance may be introduced.

These new modes of remuneration are in particular designed to foster the development of new activities with respect to the patient, e.g. improved follow-up of diabetics, persons suffering from high blood pressure, asthmatic patients, etc., to provide greater accessibility to the services provided by the practice (extended opening hours and/or a commitment to respond in case of emergencies), or to endow the practice with more logistic and human resources (computerisation, salaries for nursing staff).

The nature of the contract (state health service contract) between the supervisory authority and the doctor is usually radically altered when the policies in favour of grouping are put into practice. Thus, alongside the traditional "national contract" binding each doctor and the supervisory authority, we are witness to the emergence of collective contracts between the local health authority and

5 Contandriopoulos A-P, Diene C. P., Fournier M-A, Trottier L-H., Les soins de santé primaires au Québec, Groupe de recherche interdisciplinaire en santé, Université de Montréal, July 2003.

6 Bourqueil Y., Marek A., Mousquès J. (2006), Soins primaires : vers une coopération entre médecins et infirmières. L'apport d'expériences européennes et canadiennes, Rapport IRDES.

groups of doctors. These contracts rule on the scope or range of the health care and services proposed to registered patients, and even direct the way in which this care is dispensed. Special remuneration applies in such cases to the groups, as in the United Kingdom or in the Family Health Networks model in Ontario. In the United Kingdom, the remuneration of the group practice is partially linked to performance criteria (rate of screening, vaccination of the registered patients, health results, etc.).

Factors explaining the development of group medicine

The priority given by the public authorities to primary care in the health system

From a more systemic point of view, international comparison shows that the level and form of the grouping of general practitioners is to a large degree related to the definition of the health care missions and operators in the health system.

The importance attached to primary care, as far as the regulation and structuring of ambulatory medicine within the health system is concerned, seems to go a long way towards explaining the degree to which group practice is developed. There is in fact a primary care policy in existence, to a greater or less degree, in countries where there is a high level of grouping: Sweden, Finland, the United Kingdom, the Netherlands, Ontario and Quebec. In these countries, the public authorities have taken greater steps to shape the system for organising health care, to differentiate primary from secondary care and to give primary care major status in the health system. The grouping of general practitioners is also more developed in countries where these doctors play a pivotal role in the organisation of health care. In these countries, health care professionals involved in primary care enjoy greater recognition – particularly general practitioners and nurses. At institutio-

nal level, this recognition is expressed by the existence of a research and university capacity backed up by well-represented professional organisations, by the acknowledgement of the role and importance of these professionals in the treatment of primary care (compared to that of specialists), particularly in the supervision and coordination of health care on the model of the “gatekeeper general practitioner”, and finally by the financial status of these professionals, particularly with regard to their remuneration compared to other specialists⁷.

The fact is that none of these characteristics feature so prominently in countries where grouping constitutes a minority phenomenon. Belgium and Germany, like France, are above all characterised by the lack of formalised coordination and planned organisation in the field of primary care. There is no explicit global primary care project, that is to say no overall plan for the organisation of health care grounded in a population-based and prioritised approach. Here, medicine is in most cases exercised on a private basis; doctors are remunerated by fee-for-service (except in the case of Italy) and there are rarely other health care professionals, in particular nurses, in their practices.

When tracing the development of primary care group practice, we may, for the sake of simplicity, distinguish two key periods: the 1970s and 1980s and the years since the 1990s.

The implementation of policies in favour of primary care and grouping in the 1970s and 1980s

This first movement formed part of a determination to provide a global response at local level, that is to say to provide a wide and extensive range of services, particularly emergency health care, as close as possible to the patient’s locality (prevention, health promotion, curative care, rehabilitation care, etc.). This refers back to the definition of primary care then set out by WHO at the Alma-Ata and Ottawa conferences in 1974 and 1986 res-

pectively, and adopted in several western countries. The primary care planning policies and the resulting reforms generally led to changes in the way general medicine was exercised, with particular emphasis on the grouping of general practitioners and cooperation between health care professionals.

While the concept of primary health care as defined in Alma-Ata has regularly surfaced over the past forty years and served as a justification for policies seeking to reform and develop primary care, different countries have embarked on this course in different ways. Scandinavian countries such as Sweden and Finland simultaneously promoted the decentralisation of health and social policies and the organisation of health centres. Quebec, with the promotion of the CLSCs, the United Kingdom, with measures in favour of grouping, and the Netherlands, with their health centre experiments in new towns, attempted to introduce certain principles in the realm of primary care. In Italy, the nationalisation and decentralisation of the health system constituted at the time the first (uncompleted) step towards a policy of primary care⁸. Lastly, the initiatives taken in Belgium, Germany, Ontario and Quebec in the 1970s and 1980s for the development of health centres, in many cases stopped or slowed down as a result of the economic crisis, opposition from the medical federations and public spending cuts.

The impact of changes in the supply and demand of health care since the 1990s

The grouping of doctors and, more generally, the reorganisation of primary

7 Comité d’interface Inserm/Médecine générale, Colloque « L’avenir de la recherche de la médecine générale en France », 24 mai 2006 ; Bourgueil et al. (2006), op cit.

8 In Italy, the transition from an insurance-based scheme to a national health system in 1978 constituted a clean break with the previous organisation of primary care, characterised by the implementation of a gatekeeping system and the organisation of the provision of primary care along regional lines.

Gains in effectiveness and efficiency from the grouping of doctors: unresolved questions¹

Limitations: studies focusing chiefly on economies of scale and with little variety in the type of site observed

It is difficult to ascertain whether the policies in favour of grouping have actually resulted in an improvement in the quality of the response to demand (effectiveness) and in efficiency, or whether they have merely shifted the balance between professionals (group versus single practices).

Grouping is most often marked by a logic of work in teams, as a complement rather than a substitution, via the association of doctors exercising different disciplines and other professionals. In this type of grouping, the search for gains in effectiveness and efficiency involves the implementation of economies of scale as much as of range.

Grouping typically generates economies of scale since an increase in the size of the medical practice helps to spread fixed costs (e.g. property and personnel charges, etc.) over a larger production in

volume terms. Alongside the increased size, economies of range (linked to the scope of the expertise present in the practice) also increase. This makes it possible to diversify the health care and services offered and thus to share out the fixed costs on a larger production in terms of both quantity and quality.

Nevertheless, such few research studies as exist that attempt to analyse any additional benefit arising from grouping from the point of view of effectiveness and efficiency, concentrate in most cases on the analysis of economies of scale, thereby limiting the interest of this research. In addition, there is little variety in the actual sites observed: the research is mostly limited to case studies in the United States and the United Kingdom.

A few conclusions on grouping taken from the literature²

From the point of view of effectiveness, it appears that the quality of health care is at least identical, and at best improved, when doc-

tors exercise in a group with other professionals, particularly nurses. The most obvious improvements concern the follow-up of chronic pathologies (e.g. diabetes, asthma, COPD, heart failure, coronary failure). This follow-up is principally based on the presence of nurses and a quality information system – crucial to the improvement of performance and optimum patient follow-up.

In the United Kingdom, and in the context of the experiment with payment by performance introduced in 1998 and adopted generally in 2004, the improvements observed are more marked in group practices than in other practices with regard to the follow-up of patients suffering from these pathologies.

As for efficiency, the short-term results of the “disease management” programmes in the USA are contradictory and are expected to shed more light over a longer period.

In the United Kingdom, it is more difficult to draw conclusions on gains in efficiency in a context

where, with the introduction of payment by performance in 2004, substantial readjustments were made between 2004 and 2006. These may be attributed to retrospective financing of a previous but none the less real improvement in performance (1998-2004).

It follows, therefore, that the gains in efficiency are above all expected to materialise over the long term since they are closely linked to a reduced risk of the occurrence of complications leading to costly hospitalisations. It is therefore somewhat surprising to note that efficiency is in most cases evaluated over a short period.

¹ Effectiveness expresses an improvement in the result of an intervention/operation or a product. Productivity expresses the volume of service rendered in relation to the resources used. Efficiency expresses the result of an intervention/operation or product in relation to the resources used.

² For the complete bibliography, please refer to the IRDES report (see page 8).

care along integrated and more collective lines, seems to have found its way back onto the agenda since the 1990s (the Canadians even referring to “primary care renewal”). Going beyond the equation of the idea of primary care with the exercise of medicine by salaried personnel working in public health centres, the concept of primary care is nowadays perceived as a framework providing a definition of the nature of the local and front-line services to be offered to the population as a whole, without their necessarily being reflected in a single model for the dispensing of health care. The way in which the imperatives of public health are reconciled with professional dynamics and the private forms of professional practice vary according to country and context, but there is everywhere a trend towards the grouping of doctors.

Responding better to growing demand with limited human responses

The first reason for the trend towards group practice is to be found in the need to respond to an anticipated increase and change in demand, either for health reasons (growing demand for health care linked to the ageing of the population and epidemiological transition) or for social reasons (growing social demand, especially in terms of accessibility to health care, and particularly “new” health care). It transpires that the current and future productivity of the providers of primary care is not in a position to meet this change in demand. The fact is that many countries have felt the impact of policies limiting the number of medical students and the establishment of new medical practices, and of others facilitating early retirement. But while the regularly evoked shortage is indeed sometimes a question of numbers of doctors, it is also

very often a problem of the availability of medical resources which can be explained by the expectations of young professionals seeking less restrictive working conditions and hours compared to those experienced by their elders.

Improving conditions of work

Group medicine is seen as a means of improving both productivity and working conditions. The bringing together of health care professionals – doctors and non-doctors – under the same roof is a way of facing up to increasing demand. As far as working conditions are concerned, newly established doctors look upon group practice as a solution for a more equitable sharing out of the constraints resulting from the need to provide continuous and permanent health care, and for new challenges connected with health care coordination. As for doctors already in practice,

they see the group practice as an opportunity in the long term to find replacements and to reduce their activity more gradually in the run-up to retirement.

The sociological changes among health care professionals, (understood in the broadest sense and including such aspects as age, sex, professional expectations in terms of lifestyle, etc.), seem to be a driving force behind the trend towards group practice. In France both the DREES study and a survey conducted with a panel of general practitioners in Brittany in 2006⁹, highlight the fact that the youngest doctors are most concerned by the idea of group practice.

Moreover, the feminisation of the profession continues apace: more than 65% of students in second-year medical school are women¹⁰. Although this is not necessarily expressed in a reduction of working hours, it certainly coincides with a change in attitude towards work on the part of young doctors of both sexes. The desire to reconcile family and professional life now ranks high among doctors' requirements, leading them to take a different view of their profession and the way they organise their professional life.

We find these same characteristics in all developed countries, and particularly those in which group practices are in the minority (Germany, Belgium, etc.) and which are therefore moving more in this direction.

Growing demands in terms of efficiency

It is also quite clear that the countries in question are making greater demands in terms of efficiency and are seeking to meet this objective by organising primary care in a different way. Policies involving the drastic reorganisation of hospitals have been implemented in most countries, and this has led to the current reflection on the feasibility of moving even

further down the road towards an "outpatient" approach by redressing the balance between the financing of primary, secondary and tertiary care. In this context, the experiments in group medicine, particularly those involving multi-professionals and multi-specialists, are viewed as constituting an efficient mechanism for confronting the greater number of services dispensed in primary care (cf. box, page 7).



The regulation and organisation of ambulatory medicine in France is for the most part

governed by the principles of private practice medicine: fee-for-service payment and the right to charge more than the statutory fee; freedom of professionals to set up and prescribe; freedom for patients to choose their doctor but financial incentives to having a declared general practitioner and consulting this doctor for other referrals.

Unlike the situation in Scandinavia and the Anglo-Saxon countries, primary care is not a central thread of French health policy. Thus, although recent demographic changes have added weight to the prospect of developments in the organisation of health care and professional practices, the policies devised to deal with these changes are for the most part specific to a particular problem or situation (emergency services, networks per pathology, plans per health problem – Mental Health Plan, National Nutrition-Health Plan, Medical Demography Plan, Cancer Plan, etc.), and strive to respect the essentials of an ambulatory health care system based on the principles of private practice medicine.

However, changes may be discerned. For example, the patient's right to choose his or her doctor is called into question: the reform in this area means that in practice there is a very strong pressure in virtually all cases for the patient to register with a particular doctor. This is a notable develop-

ment which may lead the way towards the implementation of policies based on the logic of population rather than of clientele. In addition, the movement towards regionalisation which took place up to 2002 attempted to inject a certain flexibility for negotiation in implementing new rules in the organisation of community health care (local health contracts). Moreover, the Regional Health Organisation Plans (SROS 3) introduce an element of territorialisation with, in certain regions, procedures for drawing up territorial medical projects associating professionals working in the ambulatory and community health sectors. This determination to organise ambulatory care may also be seen in the recent installation of the Regional Health Missions (MRS) which contribute to the organisation and permanence of health care services provided and the introduction of incentives in priority zones, with the approval of the Prefect of the region.

Moving beyond this superimposition of sector-based and local measures and actions, the question arises of a more integrated approach to the organisation of primary care in France. The policies put into practice in Ontario and Quebec show that it is possible to devise a public policy which encourages grouping within the framework of a private practice system. These incentives seek to foster work in teams and to introduce mixed remuneration schemes in order to promote activities corresponding to the growing needs of the population.



FURTHER INFORMATION

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