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Unexpected Experimenters and Promoters: The Implementation, Effects, and Applications of the PEPS Pilot Programme in 16 Health Centres

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The national pilot programme based on a collective lump sum payment scheme for primary care teams for GPs and nurses (PEPS, *Paiement en équipe de professionnels de santé en ville*) is one of the new collective remuneration methods, an alternative to fee-for-service remuneration, enabled by Statement 51 of the 2018 French Social Security Funding Act (Article 51, *Loi de Financement de la Sécurité Sociale*, LFSS). This scheme was designed to reinforce coordination between healthcare professionals. Amongst the primary healthcare teams, 16 health centres (*Centres de santé*, CDS) took part in the national pilot programme, which initially targeted the Multiprofessional Group Practices (*Maisons desanté pluriprofessionnelles*, MSP).

The sociological survey, based on 57 interviews conducted with healthcare professionals and observations made in 6 CDS between 2021 and 2023, studied the conditions of the CDS' commitment to the pilot programme and the effects of this collective lump sum payment on the work carried out by primary healthcare teams. It highlighted a paradox: initially intended as an incentive to change aimed at self-employed healthcare professionals in coordinated practice, the lump sum payment emerged as an instrument of solvency and legitimisation of the practices of coordination and healthcare work developed by the CDS, which employ salaried healthcare professionals.

In the beginning, the national pilot programme based on a collective lump sum payment scheme for primary care teams for GPs and nurses (*Paiement en équipe de professionnels de santé*, PEPS), implemented by the French Ministry of Health and the National Health Insurance Fund (*Caisse nationale de l'Assurance maladie*, CNAM), was designed for self-employed healthcare professionals working in Multiprofessional Group Practices (*Maisons de santé pluriprofessionnelles*, MSP) [see Inset "Definitions"; Morize and Schlegel, 2023]. However, as shown by studies carried out into the development of this pilot programme, "to implement these developments at the local level, the State teams – in the Ministry of Health and the National Health Insurance Fund (*Caisse nationale de l'Assurance maladie*, CNAM) [had to] deal with the issues faced by the various actors in the scheme in order to conduct joint trials, while creating generalisable schemes" (Morize et al., 2021). The non-profit-making health centres (*Centres de santé*, CDS) were the unexpected participants in this scheme. They have even applied to join the scheme in higher proportions than the MSPs, with 11 CDS in 2018 (350 multiprofessional CDS existed at the time) and 15 MSPs (910 existed in 2018). A majority of them took part in the experiment over the long term: in 2019, 16 CDS, and more than 11 MSPs; in 2023, 3 of these MSPs (about the MSPs in PEPS, see Morize and Schlegel, 2023) and 16 CDS. The CDS' massive adherence to the experiment altered the initial goal. Originally designed by the public authorities to encourage self-employed healthcare professionals working in coordinated practice to change their working practice, the PEPS scheme was used as a solvency instrument by the CDS. These structures have long

adopted coordinated and multiprofessional practice and a global approach to healthcare promoted by the scheme, and a number of reports highlighted the unsuitability of fee-for-service remuneration for their activities (IGAS, 2007, 2013, and 2020). The scheme has thus given non-profit health centres a fresh opportunity to argue in favour of an alternative healthcare remuneration to fee-for-service remuneration. Focusing on this unexcepted aspect of the PEPS scheme, we studied the role of both political and economic levers in incentives to change.

After setting out the initial goals of the PEPS scheme, we studied the characteristics of the health centres that participated in this experiment, the conditions of their involvement, and the effects of lump sum payment on the work of primary healthcare teams studied. Lastly, we assessed the applications of the experiment by the CDS, the interaction with the experiment's promoters, and the adjustments made over time.

The initial objectives of the PEPS pilot programme

The PEPS pilot programme had many goals (see "Specifications"):

- A strategic goal: "Improving the service provided to patients, with a better quality of care, and reinforcing the efficiency of healthcare expenses by making better use of the available resources" (*ibid.*: 5). The aim was to improve the quality and pertinence of the treatments by placing the patients at the heart of the treatment process.
- Operational goals: "Improving access to healthcare, in particular in areas with less medical provision: by freeing up medical time thanks to collaborative work, by increasing the size of the patient list (PEPS patients), thanks to the incentive of the lump sum payment, and by facilitating the presence of healthcare professionals working in teams in the areas with the least healthcare provision; improving the quality of the patients' care pathways via coordinated follow-up and financial incentives to promote quality; and making treatments more pertinent, by reducing the number of avoidable medical acts". (*ibid.*)

Modalities for calculating the lump sum payment

The collective lump sum payment is based on a fixed payment that the facility receives annually per "GP" patient – this constitutes an incentive for patient retention, as the fixed payment does not apply to "non-GP" patients. Also taken into account is "a risk-adjusted remuneration, adapted to the typology of the patients", and determined, on the one hand, on the basis of the medical and sociodemographic characteristics of the patients based on a representative national sample of the French population and, on the other hand, on the area concerned.

The PEPS remuneration distinguishes three types of situations: the "PEPS consumers"[1] (treated in the CDS during the year N-1), "AME" patients (beneficiaries of State medical aid or *Aide Médicale de l'État*), and "non-consumer" patients. The calculation of the annual PEPS remuneration paid to each CDS involved in the experiment cumulated these three modulated fixed payments for the first two situations. This was done in proportion with the number of "GP" patients (exclusively for the lump sum "consumers" payment), the "patient loyalty rate" (calculated on the basis of all the "GP" and "consumer" patients in the same CDS)[2], the activity of the GPs (the number of medical acts per patient), the quality of the treatment (i.e. a "presumption of quality during the experimental phase", set at 5% of the PEPS remuneration), and the poverty rate of the area in which the CDS was located (for the "consumer" and "AME" lump sum payments),

Definition

The collective lump sum payment scheme for primary care teams for GPs and nurses (*Paiement en équipe de professionnels de santé en ville,* PEPS), instigated by the Directorate of Social Security (*Direction de la Sécurité sociale*, DSS) and the National Health Insurance Fund (*Caisse nationale de l'Assurance maladie*, CNAM), is one of the collective remuneration experiments of primary healthcare professionals, launched in 2019 in the framework of Statement 51 of the 2018 French Social Security Funding Act (Article 51, *Loi de financement de la Sécurité sociale*, LFSS) [L'Atlas du 51, 2022]. The team taking part in this scheme is necessarily multiprofessional and consists of at least 5 healthcare professionals, "with a minimum of 3 GPs and 1 nurse" and a GP patient base "comprising a minimum of 250 patients" (the PEPS scheme specifications, 2019). The PEPS scheme offers teams of GPs and nurses a chance to replace fee-for-service remuneration by a lump sum payment, paid collectively to the healthcare facility, for all the patients or sub-groups of patients (for example, diabetic or elderly patients).

PEPS is a pilot programme open to self-employed teams that work in Multiprofessional Group Practices (*Maisons de santé pluriprofessionnelles*, MSPs) and salaried teams that work in non-profit Health centres (*Centres de santé*, CDS) (municipal, community-oriented cooperative, and associative CDS).

Context

This study is anchored in the sociological part of the programme of assessment of the experiments aimed at finding alternatives to fee-for-service payments in the framework of Statement 51 of the 2018 French Social Security Funding Act (Article 51, *Loi de Financement de la Sécurité sociale*, LFSS) [ERA2]. Funded by the French health insurance system (*Assurance maladie*), its aim is to assess the conditions, effects, and applications of the introduction of alternatives to fee-for-service remuneration, both with regard to the organisation of primary healthcare in France and the practices of the healthcare professionals. Various publications have already been published by IRDES about this subject: Issues 261, 262, 273, and 275 of *Questions d'Économie de la Santé* ("Issues in Health Economics").

1 A patient is considered to be a consumer if he or she has had at least one private consultation in year N-1, whatever the treatment and the professional involved.

2 This loyalty rate is calculated according to the healthcare consumption data of the patients in the facility on 31/12 of the year N-1.

MATERIALS AND METHOD

Qualitative surveys were conducted at 6 of the 16 municipal CDS, in community-oriented cooperative enterprises (or cooperatives), and community-based associative facilities.

The research into the 3 municipal and cooperative CDS was conducted between October 2021 and July 2023. 21 salaried professionals were interviewed, mainly in person. These GPs, psychologists, reception staff, nurses, administrative and financial managers, municipal healthcare directors, and mediators sometimes had a specific status as a "leader" or "adviser" in framework of the experiment. These interviews were complemented by observations of the patients' reception and coding of the consultation activity in two of these CDS.

The survey of community-based associative CDS was conducted between April 2021 and June 2023, with a section comprising direct observation of the practices of primary healthcare teams (11 days). 36 interviews were conducted with various professional groups from the 3 CDS studied (reception staff, healthcare mediators, medical-social coordinators, managers, marital and family counsellors, social care assistants, social workers, nurses, speech therapists, physiotherapists, and GPs), to assess the extent to which the teams were implementing the PEPS scheme.

At the same time, throughout the assessment, we participated as observers of the interactions between the PEPS national team and the professionals who participated in the experiment ("PEPS days", "accelerators", meetings, etc.).

The names of the facilities and individuals have been changed to maintain their anonymity.

applied at the level of the commune or the *Quartier prioritaire de la politique de la ville* (QPV, a public policy category for urban distressed areas). The geographic scale used to determine this poverty rate, that is the calculation of the "poverty-based" modulation, were discussed over the course of the experiment. In the PEPS model, "the remuneration is increased if the poverty rate of the area (…) in which the facility is located is higher than the national poverty rate average, in a linear fashion, and up to an increase of 20% if the poverty rate attained 25%" (Specifications of the PEPS scheme, 2019, p. 21).

Based on the above, the PEPS remuneration was calculated for each facility, established annually, and adjusted in July of the following year in the event of a change in the numbers or characteristics of the "GP" patients. It has been paid on a quarterly basis since 2021.

The profiles of the CDS involved in the PEPS pilot programme

The CDS — non-profit, coordinated health structures of salaried professionals — are expected to develop a healthcare project that attests (in conjunction with the Regional Health Authorities) to their coordinated practice and to implement the third-party payment system. In France in 2021, there were more than 2,500 CDS, 582 of which were multiprofessional. Almost all of them (87%) were non-profit-making CDS (Carini-Belloni, 2022, p. 334).

Multiprofessional CDS with different histories

Almost half of the multiprofessional CDS have associative status ("*Loi 1901*" associations, run by a bureau and a management board); and the municipal CDS represent one fifth of the multiprofessional CDS. The last third comprises mutualist CDS or those managed by the special schemes of the French Social Security (Carini-Belloni, 2022). Only a few multiprofessional CDS have been established as community-oriented cooperatives, a status authorised by a decree of January 2018. The salaries of the GPs working in CDS are – for 35 working hours per week – between €4,500 and €5,200 net per month in municipal CDS (Joubert, 2023, p. 402), between €3,800 and €4,700 in cooperative CDS, and around €2,200 in community-orientated associative CDS (Pitti, 2023, p. 177). They are lower than the income of self-employed doctors in MSPs, on average a drop of €7,600 in 2017 (Dixte, Vergier, 2022, p. 3). However, the weekly working hours in a MSP are higher (on average 53 hours declared).

The municipal CDS are some of the oldest facilities: heirs of the nineteenth-century dispensaries, they were regulated by a decree issued in August 1946. In the Ile-de-France region, their history merges with that of the working-class suburbs, which explains their over-representation in the popular districts of the inner suburbs of Paris. Amongst the associative CDS, community-orientated facilities have emerged over the last fifteen years; these facilities aim to identify and meet healthcare needs on the scale of a local community. Their history is different from that of the municipal CDS: they are the result of alternative and localised experiments in healthcare organisation tested in South America in the 1950s, followed by North America and Europe in the 1960s–1970s. They lie at the crossroads of various related fields: popular education, humanitarianism, and its critiques, as well as calling into question the primacy of private-practice medicine (Pitti, 2021; 2023).

The financial set-ups of these CDS are complex and unique to each facility. Nevertheless, the centres that took part in the experiment share some common characteristics: half of the resources for the associative and cooperative CDS, and three quarters for the municipal CDS, came from the *Assurance maladie* in 2019 (IGAS, 2022). Before the PEPS scheme, these resources were provided by the pricing of medical acts and their reimbursement by the *Assurance maladie*, goal-based remunerations (such as the remuneration based on a goal of public health), and lump sum payments (GPs, chronic conditions, conventional interprofessional agreements (*Accord conventionnel interprofessionnel*, ACI) of the signatory CDS). Hence, the CDS depend on complementary funding to cover between half and a quarter of their budget: subsidies from the municipality, from other regional authorities, subsidies provided by the RHAs' regional and departmental funds, and from the *French National Agency* for the *Cohesion of*

Territories (*Agence nationale de la cohésion des territoires*) for facilities located in "*Politique de la ville*" (QPV) zones (a public policy category for urban distressed areas). The CDS are developing different activities that are not funded by the *Assurance maladie* (prevention, users' entitlement to social benefits, healthcare mediation, translation services, etc.). While there is little detailed information about the economic model of the CDS (IGAS, 2020), it appears to be intrinsically skewed towards a fee-for-service remuneration model. This model is more fragile in the associative and cooperative CDS than in the municipal ones. The former cannot benefit from municipal subsidies, which the latter receive to help balance their budget:

> *"In a municipal health centre, you are given a balancing subsidy, so you aren't worried about the future and your facility's economic model. In a centre like ours, you need to attain a budgetary balance, otherwise you end up closing down".*
>
> Administrative manager, Cooperative Health Centre in Rupois, November 2022

The complexity and fragility of the operational budgets of the CDS, non-profit-making organisations that are subject to the variations in subsidies – even more so for private facilities –, provides an explanation for their involvement in the PEPS scheme.

Which CDS are in the PEPS scheme?

In the first half of 2019, 11 CDS (9 municipal, 1 cooperative, and 1 associative) took part in drafting the specifications of the experiment, published in June 2019. They were part of the first wave of experimental facilities (JORF, 3 July 2019). In 2020, 5 new CDS (3 associative, including 1 that has since become cooperative, 1 municipal, and 1 communal) joined the experiment, forming the second wave of participants (JORF, 12 January 2020).

The CDS that participated in the PEPS pilot programme did so on the basis of their entire patient population, as opposed to just a segment of the patients (diabetic persons, the elderly). They largely went beyond the prerequisites of PEPS in terms of the size of the teams and the numbers of patients.

	Number...		
	of GPs*	of nurses*	Average number of patients covered by PEPS
Municipal CDS	9 to 19	5 to 8	6,805
Cooperative CDS	7 to 8	1	3,297
Associative CDS	5 to 7	1 to 2	2,469

2020 data: *numbers of active persons (external trainees excluded for doctors)

The 16 CDS that experimented with the PEPS scheme were all non-profit facilities (another experiment, "Primordial", was launched a year after PEPS, in 2020, specifically aimed at private profit-making CDS[3] that the Ramsay group is intending to open in coming years). These 16 CDS, with different management and organisational modes, reflect the heterogeneity of the CDS model. They are either managed by local authorities (11 municipal CDS), by non-profit associations (3 associative CDS), or by community-oriented cooperatives (2 cooperative CDS). Twelve of them are located in the Ile-de-France region, a spatial concentration that reflects the high proportion of municipal CDS amongst the facilities in the experiment. The over-representation of municipal CDS amongst the experimental facilities highlights the fact that the motivation for the commitment to join the PEPS scheme is not exclusively economic: municipal CDS are indeed under less economic pressure than associative CDS, due to the balancing subsidies; yet more of them take part in the PEPS scheme. While the commitment to PEPS and other "Article 51" experiments — such as the establishment of groups of care providers who come together to provide patients with coordinated high-quality care (*Incitation pour une prise en charge partagée, IPEP*) for 3 groups of CDS (2 municipal and 1 cooperative) and the "*Structures d'exercice coordonné participatives*" (SECPA) experiment for 3 associative CDS and a cooperative one — stemmed from the need to find funding to stabilise the economic model of the CDS, *a fortiori* for the associative or cooperative CDS, for all the CDS their participation in the experiment was motivated by the abandonment of fee-for-service remuneration and the desire to promote a medico-social multiprofessional model (both curative and preventive) of the CDS in healthcare organisation.

These sources of funding are also seen as "powerful levers" for "moving the biomedical model forward" (former Medical Director, cooperative health centre in Rupois, May 2022).

Participation in the PEPS pilot programme depends on…

The number of CDS taking part in the PEPS scheme has remained unchanged to this day, while that of the MSPs has constantly decreased since the beginning of the experiment. Organisational conditions and the backgrounds of the project leaders explain this long-term commitment.

... organisational conditions

The success of the CDS' adherence to the PEPS scheme is partly due to the fact that the salaried healthcare professionals who work in these facilities are familiar with collective funding, as this operational approach preceded the experiment — unlike that of the private facilities such as the MSPs. The CDS employ professionals who are familiar with obtaining funding and budget monitoring (administrative and financial managers in municipal CDS, coordinators in associative CDS, directors in cooperative CDS), who have the necessary experience to respond to calls for projects, and who sometimes have time dedicated specifically to this task. Because the doctors working in CDS are already paid wages by the facility, the distribution of the PEPS money amongst the professionals is not a subject of debate: directly paid into the

[3] «Arrêté du 21 octobre 2020, relatif à l'expérimentation Primordial», *JORF*, 31 October 2020, p. 35.

facility's operational budget, it does not constitute a resource whose allocation is decided by the doctors as in the MSPs (Morize et al., 2021). In addition, the adherence of the doctors who work in municipal CDS to the PEPS scheme can be explained historically, as they have long received "function-based remuneration" for their global activity, rather than per medical act:

"By their very nature the health centres, compared with the other facilities, promote function-based remuneration. That is to say that the doctors are our employees, hence their remuneration is not based on medical acts".

Director,
municipal CDS in Bonnart,
November 2021

In municipal CDS, the administrative managers are responsible for handling calls for projects and monitoring and accounting. In the cooperative facilities, the administrative directors are also responsible for these tasks. In the associative CDS, this budgetary management is mainly the responsibility of the CDS coordinators. Most of them have received training in project management, including the financial aspects, not necessarily in the medico-social sector.

In addition to expertise certified by a diploma or experience in the associative sector, the competencies in research and responding to calls for projects are also developed "on the job":

"If there are funds to be had, I'll obtain them. I have to find them. I'm on financial standby and I'm registered everywhere, even on the Regional Council... in any case, it's the same thing — time needs to be spent to follow everything up. It could actually be a full-time job to seek out, monitor, and assess the funding".

Administrative Manager,
Municipal Health Centre in Bonnart,
February 2022

... familial, professional, or activist backgrounds

The commitment to the experiments was also partly connected with the backgrounds of the experiment's leaders (family origins, professional careers, or activist experiences). A shared characteristic of the three types of CDS was the relation with the prior commitments of the experiment's leaders. However, the nature of their commitments depended on their familial and professional backgrounds. On this level, the leaders of the municipal and cooperative CDS were distinguished from those of the associative CDS.

The municipal and cooperative CDS are either directed by a single person (a GP), or operate under dual management (with an administrative professional). During the interchange with the national teams in charge of the PEPS scheme, the medical directors of the municipal CDS were the spokespersons for their facilities, and, beyond this, for the profession's salaried employees. The social origins of these directors explain their decision to practice "social medicine": some of them were the children of employees and blue-collar workers, others had had professional backgrounds in less affluent regions. The professional, socio-spatial, and political backgrounds of these doctors also directly guided their vision of medicine in terms of healthcare access, and even social inequities in healthcare. Most of them rejected the pressure of hierarchical systems and the rhythms of hospital life, despite an interest in public health service careers and salaried practice. Most of them also indicated that they were involved in professional representation activities (within the *Fédération nationale des centres de santé*-FNCS or the *Union syndicale des médecins des centres de santé*-USMCS); a minority also worked in the local healthcare administration (healthcare director), which matched the profiles of the MSP doctors involved with the PEPS scheme, who were active on multiple levels and involved in union activities (Morize et al., 2021).

The associative CDS are self-managed; the teams are highly familiar with collective work, which means that they are regularly referred to as "mature organisations" by the national team responsible for the PEPS scheme. During the interactions with this team, the coordinators of the associative centres assessed and discussed the implementation of the experiment, sometimes working hand-in-hand with a member of the reception staff. None of the spokespersons for the associative CDS was a doctor — although some had studied medicine in the initial phase of their studies. Their social origins were generally middle class, even upper middle class (their parents worked in the public sector or senior executives in the private sector). They had no union involvement and were not partisan, but had had experience in the humanitarian field, in popular associations, and in feminist movements. This commitment played a central role in the involvement of these professionals in the establishment or management of associative CDS, all located in deprived areas; it was linked to a conception of healthcare work seen as a mission of serving the general public and a way of combatting social inequalities in healthcare in these poorer districts.

The PEPS resource: how much, for what purpose, and for whom?

The PEPS funding complements the other sources of funding provided to these establishments, which are free to use the funds as they wish. The perimeter of the medical acts replaced under the PEPS scheme represents between 21 and 28% of the direct resources in associative CDS, and between 20 and 30% in municipal CDS. This funding replaces fee-for-service remuneration, and only slightly increases the budget of the CDS. Hence, the PEPS resource seems to be a necessary, although insufficient condition for the economic viability of the latter.

The PEPS remuneration does not modify the way the CDS function with regard to the process of discussion and decision-making relating to the allocation of the resources. These decisions vary in accordance with the centres' healthcare project and organisation.

This remuneration takes into account the different ways in which the MSPs and the CDS are run: whereas 3 of the 4 experimental MSPs in 2021 did not reach the capping imposed by the tran-

sition from fee-for-service to lump sum payment (which could not exceed 15% of the remuneration that the facilities received under the fee-for-services system), all the 16 CDS attained it. This difference was due to the modulations (poverty, chronic conditions…) that increased the lump sum payment compared with the simple average of the procedures. Amongst the experimental CDS, the "bonus" paid in 2021 for the year 2020[4] revealed these patient characteristics. Of all the CDS involved in the experiment, only one municipal CDS received nothing in relation to poverty-based modulation, as the poverty rate for the town in question (13%) was lower than that of the national scale (13.9%). Half of the experimental CDS received the maximum of the lump sum modulation related to the poverty rate (20%), which applied to none of the MSPs participating in the experiment. The effect of the poverty-based modulation highlights the spatial distribution of the CDS, which are generally located in deprived areas.

The PEPS remuneration also took into account the differentiated loyalty of the patients according to the types of CDS (non-profit-making public/private facilities). With regard to the "bonus" for the year 2020, paid in September 2021, the municipal centres received – depending on the facility – between 60 and 85 euros per "GP" patient for general medical procedures and nursing procedures, while the associative centres received between 97 and 153 euros per patient, due in particular to a higher loyalty rate for general medicine (between 75 and 80% in municipal CDS and between 84 and 93% in associative CDS, with the cooperative centres in an intermediary position).

But the effects of the collective lump sum payment experiment are not solely financial. They are also evident in the work of primary healthcare teams in CDS, in particular in the relations between the reception services and the healthcare professionals.

Delegating tasks and focusing on reception services…

In CDS, shared work and the delegation of medical work to the nurses have existed longer than in MSPs. The PEPS remuneration not only tends to make this model viable and sustainable, but also modifies and formalises other tasks, such as those associated with reception services.

The implementation of the experiment involves work to identify the patients because the calculation of the lump sum payment per patient is only based on the "GP" CDS patients, which initially increases the administrative aspects of reception. This work is less present in the associative CDS than in the other types of centres: the "GP" patients in the associative CDS generally constituted a larger proportion of the total number of patients. More recent than the municipal CDS and mainly located in QPV (a public policy category for urban distressed areas) zones, 86% of which had no primary healthcare facility in 2019 (ANRU, 2021, p. 20), the associative CDS soon succeeded in retaining the loyalty of their patients.

In the second phase, once each facility completed the PEPS codification for the "GP" patients on the centres' software programs, the experiment resulted in a modification of the reception work within CDS: the time saved by the single PEPS codification was used in the reception services for social welfare and healthcare coordination in the municipal and associative CDS.

"With regard to invoicing, there's almost nothing left to do, so while it used to take two minutes to produce an invoice, it now takes only twenty seconds (…). Most importantly, one can spend this extra time with the patient! You save time with not having to answer the telephone, there's less pressure. This has freed up time for the reception services; in fact, it's true that at this point we have worked very hard to do everything we can to improve our services".

Reception Manager,
Associative CDS "L'Espace Santé-Belle Île",
July 2022

This reconfiguration of the reception services has also transformed the reception work, increasing the role and tasks of the persons in charge of these services, and has liberated the doctors from certain tasks that are not strictly medical.

"What they call medical assistants … well, in fact, there's something of that in the work we are now doing — without the medical part (…). Ultimately, this is what we too have developed with the PEPS scheme. We help people, and welcome them, (…) we're more vigilant about respecting people's rights. (…) So yes it's true that we do a lot of things that we didn't do before: travel passes to help the doctors; we help people to arrange their consultations; and we help to coordinate things with the patients and coordinate their care pathways. (…) I think we've taken some of the pressure off the doctors by taking on certain tasks".

Reception Manager,
Associative CDS "L'Espace Santé-Belle Île",
July 2022

The patients of the non-profit-making CDS are characterised by their precarious situations (Afrite, Mousquès, 2011), in particular for CDS located in working-class districts – whether municipal or associative centres, a number of which recruit staff amongst persons who live in the area and who have the same social backgrounds as the patients; the reception work plays a major role in the access to social rights and the continuity of care, which improve the care quality and the effectiveness of the treatments.

… to free up medical time and improve healthcare continuity and quality

The working time of the salaried doctors in CDS includes non-curative tasks (mediation, referrals, the use of interpreters), which take up time compared with other curative activities, which are better identified and more standardised (prescriptions for examinations, drug prescriptions, etc.).

"Because in fact all the procedure performed in a day are not segmented: (…) we provide support, (…) and we provide mediation".

GP and Director,
Municipal CDS in Bonnart,
November 2021

[4] This bonus corresponds to the difference between the amount the experimental facilities would have received in 2020 with a fee-for-service remuneration and the funding they received with flat-rate remuneration.

The CDS are open to the general public (the French public health code provides a framework for their operations in these terms). The patients are often in more precarious situations than elsewhere, less likely to be French-speaking than elsewhere, and often suffer from a number of pathologies. These characteristics explain why the consultation times are usually longer in CDS than in private individual practices or in the profit-making private sector, in which patients tend to be selected (Albouy, Déprez, 2009).

To meet these specific healthcare needs, the consultation times in the associative CDS are fixed at 20 minutes (aside from emergency consultations). In certain municipal CDS, the PEPS scheme has extended the GPs' consultation time from 15 to 20 minutes. According to these doctors, the aim behind the increase in the length of consultations is to provide better healthcare for the patients, that is to say stabilising their state of health to ensure that they are less likely to consult in the future – this observation may be tested on a larger scale in the study's quantitative section, for the year 2023. At the same time, one of these municipal CDS has extended its opening hours, by setting up a night-time service: thus, the improvements in healthcare are complemented by an increase in healthcare provision.

The implementation of the PEPS scheme has also generated discussions within the CDS teams on the use of the collective remuneration paid to the facilities, and, in particular, on the role of medical time. For some CDS, the use of the lump sum payment has taken the form of an alternative between increasing the duration of the consultations and relieving the "medical time" of the part of care work which may not be the responsibility of doctors. As a result, the doctors are no longer necessarily in a central position with regard to care pathway coordination.

"Instead of adopting a medical assistant model, which is promoted these days, that is to say just the doctors, their time spent on administrative duties is taken away because (...) they need to be able to practise their medicine, so we tried (...) to enable the reception staff to become genuine coordinators of the patients' care pathways. We have increased the quality and, actually, it's not merely about a transfer of responsibilities. (...) We now have reception staff who are recognised by the patients as their main reception assistant, to whom they can ask questions, which is often far simpler than catching a doctor who's in his office dealing with consultations, while the reception staff are by definition at the reception desk. There you go!".

Coordinator,
Associative CDS "L'Île en Santé",
March 2022

In areas with limited healthcare services, the CDS teams used the PEPS scheme to improve healthcare coordination, aside from reception services, *via* medical delegation to nurses who were acquiring greater skills, particularly the Advanced Practice Nurses (*Infirmières de pratique avancée*, IPA). This drive was complemented by greater care continuity – the night-time service implemented by a municipal CDS took the burden off hospital emergency services – and an improvement in the quality of the care provided. The operational goal of the PEPS scheme to improve healthcare access, in particular in low-density areas, by freeing up medical time thanks to collaborative work and by increasing the size of the patient list, seems to have been attained.

Ensuring that non-consultation activities are acknowledged

Aside from reconfiguring the division of labour between professional groups, the experiment also generated extra work to ensure that activities involving healthcare – but which "lacked nomenclature" up to that point in the fee-for-service remuneration (collective workshops about prevention, referrals to specialist doctors, etc.) – would be recognised. Thus the experiment was a way for the CDS to highlight an approach to care that was not limited to the work carried out by doctors. The experiment enabled care acts – which already existed but had not been encoded prior to its implementation and which consequently were not remunerated " to be formalised, symbolically valorised, and made financially viable. The fact that all the medical procedures performed are not officially listed explains why the consultations in CDS do not seem to be productive when compared to private facilities.

"The idea is to create so-called "new" activities, but which, in fact, are not new and on which we can depend... we can also get our act together to organise that in a better way, and then give it the green light, while up until this point we were constantly negotiating, because our governance is careful to limit expenditure".

GP and Director,
Municipal CDS de Bonnart,
November 2021

On this basis, the experiment led to extra coding work for the "experimental" CDS, which were eager to highlight the preventive work they carried out.

"In the new activities, (...) we said to ourselves: 'We're finally going to be able to communicate about all the work we do!'. So, we did more than 2,000 reports, (...) before I understood the situation and said: 'No, no, everyone, stop! In fact, this isn't what they're looking for!' (Laughter) (...) they don't want to hear about everything because they cannot see that this is new. There is always a mismatch: being a health centre where we already operate like that. The impact is definitely positive, but when it comes to the question of 'what will come from it?', we'd rather do lobbying".

Coordinator, Associative CDS
"La Maison en Santé",
October 2021

The forum for discussion constituted by the phases of interaction with the CNAM and DSS teams in charge of the experiment about the implementation and its adjustments over time highlighted the platform that this experiment represented for the CDS, which were keen to promote their model(s).

An innovative model for organising healthcare: the CDS as adjusters of the reform

The PEPS scheme was an opportunity to render visible and legitimise the medical procedures that the salaried doctors working in deprived areas performed in their consultations. "Bringing to the attention" of the project's national team (ENP) these practices that lacked nomenclature "procedures which until now had not been remunerated" was a

way of making it economically viable and symbolically legitimate:

> *"When I presented the PEPS scheme [to the team], I said: 'We are going to try and valorise all the types of procedure for which we have no nomenclature'".*
>
> Director,
> Municipal CDS in Charmandy,
> January 2023

Aside from the economic stakes, it was also more broadly an innovative conception of healthcare work that was valorised:

> *"This already matched our approach, in which medical consultations are not the only way to treat people. So, in fact, it was also a form of recognition of (...) an approach that we had already adopted".*
>
> Coordinator,
> Associative CDS "L'Île en Santé",
> March 2022

The evaluation of the PEPS economic model during the joint definition phase

During the PEPS "joint definition" phase, during which 11 of the 16 CDS began to experiment with lump sum payment, there was regular interaction between the teams in charge of the project on a national scale and the representatives of the facilities involved in the experiment, with the aim of improving the economic model.

The ENP sought to understand certain "unexplained effects" of the PEPS economic model. The strategy did indeed seem to improve remuneration in facilities located in deprived areas, which did not necessarily imply that all the patients treated there were in precarious situations. For the ENP, the experiment was not intended to be a regional one, because the model was intended to be generalised throughout France as a whole, rather than adapted to "geographical particularities"; it was intended to be implemented everywhere, including in profit-making facilities, whose patient base was not necessarily precarious. Thus, the members of the ENP sought to weight what they considered to be a financial "overrating" of certain lump sum payments, with the aim of avoiding an eventual effect of opportunism that a more "financially profitable" area might generate during the generalisation of the lump sum payment scheme; while the CDS sought to have their work in areas with inadequate healthcare services acknowledged.

They described the territorial constraints that had a negative impact on their practices, such as the lack of specialists and the specificities of the CDS patients, consisting of people who use less healthcare, with the result that many health problems exacerbated social problems. As this coordinator explained:

> *"[We're told] 'You're outside the curves, but if we remove the poverty premium, you'll be inside the curves'. It's (...) truly disconnected from reality. The more precise data one provides, the more complex it becomes, and the more it's discarded. What they [the agents in charge of the experiment] underestimate is the precarity of certain populations in France, for whom the issue of health is absolutely primordial. (...) When we see the problems here, housing, work, diseases, it's a huge problem (...). How can this fit into the equation?".*
>
> Coordinator,
> Associative CDS "La Maison En Santé",
> October 2021

The PEPS scheme advisers in CDS reported the effects of social inequalities in healthcare on the specific social morphology of their patients, as attested by a healthcare director in a town in the Parisian suburbs:

> *"We would like (...) to see the effect of the age category, the C2S [Complementary Health Solidarity scheme], chronic conditions [Affections Longue Durée, ALD]. (...) We know that there is under-consumption in medical healthcare in the field of organ specialty, due to social inequalities. Specialties would need to be added: paediatrics, gynaecology... [of which the non-use] would explain the over-consumption of general medicine".*
>
> Healthcare Director, municipal CDS in Jolyfont,
> PEPS 'accelerator' meeting, February 2022

Hence, the CDS teams underlined that the "social vulnerability" of their patients (Director, municipal CDS at Dolorinsk), the non-use of healthcare, and "healthcare needs" (Coordinator, Associative CDS "*Ailleurs Santé*") are the blind spots of the PEPS scheme, irreducible to the indicators that mobilise the economic model on which it is based.

After some discussion, a compromise was reached, which attests to the reciprocal forms of hybridisation of the national team's and experimental teams' ways of thinking and doing. The national team decided to implement a "corridor", that is to say a limitation on the "over-valorisation" of the model which would be generated by the high poverty rate in the areas where the CDS were located. The "corridor" limited the unforeseeable effects of the economic model – remunerating the healthcare facilities too much or too little – by establishing a ceiling that limited the PEPS remuneration, and a minimal level that would ensure minimal funding.

PEPS: an arena for discussions about the meaning of healthcare

The discussions revealed different approaches to healthcare, which evolved during the interchange. While the choice of a "corridor" was presented as being motivated by practical factors (controlling the unexpected effects of the model, avoiding deadweight effect, etc.), it highlighted some friction and the different ways in which the scope of the experiment was viewed. For the ENP, the idea behind the PEPS scheme was to develop an economic model that could introduce "substitutive remuneration" to replace the fee-for-service approach and provide remuneration as close as possible to the funding the professionals would have received if they had been paid per medical procedure. This goal was constrained by budgetary imperatives – experimenting with fixed funds – and by an egalitarian framework: proposing a lump sum economic model that could be implemented in all the regions in the same way (eventually, by dealing with specific cases through exceptional funding adjustments).

In reality, various visions of healthcare developed through the evaluation of the economic model, which the ENP and the CDS spokespersons contended with. At the beginning of the evaluation, in a context and the constraint of a reform with fixed funds, the CNAM and the DSS did not consider that the amount of the lump sum payment,

intended to be "substitutive", might differ from the global cost of the medical procedures. Furthermore, the initial goal was to remunerate actions *initiated* by the experiment. For the CDS taking part in the experiment, this new means of remuneration aimed to resolve a situation: to fund the "acts without nomenclature", which should have been remunerated but were not (yet) under the fee-for-service system. For the experimental CDS, the PEPS funding did not replace the fee-for-service remuneration that preceded it, but aimed to be higher. The goal to revalorise the activity of the CDS reflects a conception of healthcare work that takes into account social healthcare determinants.

In the healthcare sector, like elsewhere, operating via the experiment had little effect on the opinions of the actors with regard to reform, but it may have led them to alter their argumentation (Arrignon, 2019). Over the course of the bilateral and plenary meetings held with all the facilities that participated in the experiment, they and the members of the ENP reciprocally adjusted their stance with regard to the issue of the targets of the PEPS remuneration. A consensus emerged in relation to the activities 'without nomenclature', which without being entirely "new", could legitimately be remunerated by the PEPS scheme, from the perspective that they matched the goals of a collective remuneration of activities that improved care quality. While this goal was an incentive for the MSPs, it represented a legitimisation for the CDS.

***

PEPS is an example, amongst others (Arrignon, 2019), of the limitations of economic levers to initiate or fundamentally modify practices – in this case professional practices. Nevertheless, the experiment has had unexpected and welcome effects amongst primary healthcare teams convinced of the benefits of the approach, who made the most of it to "bring up from the field" the obstacles to quality care for all. With their collective work organisation, their mission of general interest, and their location in areas with limited medical services or in a districts designated as "*Politique de la ville*" areas (QPV, a public policy category for urban distressed areas), the CDS match the operational goal of PEPS to improve access to healthcare, in particular in less dense areas, by freeing up medical time through multiprofessional cooperation, by increasing the size of the active patient list, and by improving the continuity and quality of healthcare, with constant medical demographics.

However, the shift to the lump sum system is a necessary but not sufficient condition to make the CDS model viable and sustainable, particularly the non-profit-making ones. The modalities of its generalisation will therefore be decisive for the future of the healthcare system. Indeed, in the context of decreasing medical services in certain areas and an increase in social inequalities in healthcare, which are greater in France than elsewhere in Europe (Bérut et al., 2023), one of the stakes of generalising the lump sum system is to take into account the precarity of an area and to financially value it in the model, while preventing deadweight effects and the risks of patient selection by healthcare facilities that are not obliged to provide care for all. ♦

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