

Conference

**Improving primary care in Europe and the US:  
Towards patient-centered, proactive and coordinated systems of care**

The Rockefeller Foundation Bellagio Study and Conference Center, Italy  
April 2 to 6, 2008

**Country Case Study:  
Primary care in France**

Marianne Samuelson  
Yann Bourgueil



Marianne Samuelson, Professeur associé des Universités, Directrice du Département de médecine générale, Université de Caen – Basse Normandie, 11 Rue Montebello, 50100 Cherbourg, France. Email: [marianne.samuelson@free.fr](mailto:marianne.samuelson@free.fr), Telephone: +33 (0)2 33 10 00 50.

Yann Bourgueil, Médecin spécialiste en Santé Publique, Directeur de Recherches IRDES, 10, rue Vauvenargues, 75018 Paris, France. Email: [bourgueil@irdes.fr](mailto:bourgueil@irdes.fr), telephone: +33 (0)1 53 93 43 18

**Table of contents**

- Preliminaries..... 3**
- 1. Summary information..... 3**
  - 1.1 Governance in primary care ..... 3**
  - 1.2 Financing/remuneration in primary care ..... 4**
  - 1.4 Drivers for reform in primary care ..... 5**
  - 1.5 Barriers to primary care reform..... 5**
  - 1.6 Practical management/policy challenges to improve primary care..... 5**
- 2 Macro Level ..... 6**
  - 2.1 Health system..... 6**
  - 2.2 Delivery system design ..... 9**
- 3 Meso level..... 10**
  - 3.1 The community ..... 10**
- 4 Micro level..... 11**
  - 4.1 Self management support ..... 11**
  - 4.2 Decision support ..... 12**
  - 4.3 Clinical information system..... 12**
- 5 Key findings from the country case study..... 12**

## **Preliminaries**

We base our answers on the following definition of primary care:

Primary care is a large range of services delivered to people in their environment at home or in ambulatory care. Primary care includes: First access of patients (accessibility), curative care, preventive care, counselling /patient education, social care, rehabilitation, palliative care. (Comprehensiveness), coordination of care (coordination) and out of hours (continuity)

### **1. Summary information**

#### **1.1 Governance in primary care**

- There is no general law defining primary care in France. The French system is characterised by a lack of a clear definition of the roles of the different healthcare providers (specialist versus generalists, hospital sector versus ambulatory sector). Particularly, there is no gate keeping system even if a list system (médecin traitant) has been introduced in 2004 (see below). The existence of specialists in ambulatory care (in liberal exercise) is a French specificity. Free access to specialists is one of the main characteristics of our system. Direct access to specialised care can be done in ambulatory as well as in hospitals (out patients, or at emergency units).

- The principles of “liberal” medicine (freedom to settle down where you want without any restriction, freedom of choice for the patient to visit any doctor he wants in direct access...) is a strong legacy especially for doctors but also nurses, physiotherapists, dentists, podologists in ambulatory care and thus, primary care. This leads to a great variation of medical demography between the regions of France. (The variation can be one to five, higher in the south and Paris than in the North for some medical specialties).

There are four levels of political organisation in health care; national, regional (22 regions), Departments (100 départements) and local (36 500 municipalities). Each level concerns more or less primary care:

- Governance in ambulatory care is mostly defined by the national contract between professional organizations and the national insurance company (convention nationale). Most health care providers in primary care working in private practice are regulated through this contract. Pharmacists are the unique primary care profession regulated by district authority (department), following national ratios.

Beside healthcare providers working in private practice regulated at the national level, specific services exist in primary care. They are under the control of departmental or local authorities.

- A special service for mothers and children (Protection Maternelle et Infantile) is under control of district communities (Département) since 1962. Providers (doctors, midwives, nurses and social workers) are civil servants. They are salaried and provide preventive care for pregnant women, contraception for the young, follow up. These services target mainly people in deprived areas or having social problems. The level of development and the organization varies according to the policy of each department.

- Departments are also in charge of dependent patients and allocate subsidies for maintaining elderly people at home. Departments also plan building and managed home care.
- Municipalities provide home care for elderly and home services with specific services in which nurses manage a team of professionals who take care of people at home.
- Schools have their specific healthcare providers who practice mainly preventive care and systematic screening (nurses and medical doctors). The service is under the control of the Ministry of Education.
- Hospitals are organized on a territorial basis and are controlled by a regional authority (Agence Régionale d'Hospitalisation). In some regions, local hospitals can be considered as part of primary care. GPs are usually doctors in those hospitals. They can follow their patients when they need hospitalization. Those local hospitals are governed by regional health authorities.
- Mental health care has its own specific organisation and governance. Psychiatric hospital organisation is divided between territories, patients have to refer to the service of the territory where they live. Each service is free to organize the mix between hospital care and ambulatory care and thus primary care. Healthcare professionals are salaried. GPs and psychiatrists in private practice are also primary care providers for mental health. Patients who visit psychologists in private practice are not refunded by the national insurance fund. If patients cannot pay they have to see psychologists of the psychiatric hospital sector.

The above account shows that governance of primary care in France and the whole French health care delivery can be considered as fragmented. The control systems, contracting bodies and levels may vary. Primary care services may be provided in very different ways.

The French health care system can be regarded as not primary care centered according to the indicators developed by Barbara Starfield. The concept of primary care has never really been developed in France, access to healthcare services is unclear and navigation of patients within the healthcare system complicated.

## **1.2 Financing/remuneration in primary care**

Most of primary care providers work on a fee for service base (GPs, nurses...)

An attempt to introduce a capitation part for GPs has been made in 1994 (Loi Juppé) on a voluntary basis through a contract between a GP and a patient. This “médecin référent” contract included the engagement for the contracting patient to attend this doctor (could only be a GP) first for any health problem. The patient had nothing to pay directly to the doctor first and then ask their insurance for refunding. Insurance directly reimbursed doctors. On the doctor’s side the commitment was to keep a good medical record including preventive actions and make a synthesis every year, attend CME courses and prescribe a certain proportion of generic drugs. The contract was related to a capitation fee of about 40 Euros per adult patient. The contract was for one year and was renewed every year unless denounced by the patient.

After the 2004 reform France abolished the médecin référent and introduced a list system with a doctor called “medecin traitant” (not necessarily a GP, but most patients (ie. 98%) choose a GP) Each citizen in order to be refunded has to register with a doctor called “medecin traitant”, the patient has to attend this doctor to be referred to some other specialists (except gynaecologist, paediatricians, ophthalmologists and psychiatrists...) There is no capitation fee related to the contract, and no commitment of any kind neither for the doctor, nor for the patient, and no duration for the contract (patients can change “medecin traitant” at any time). There is no real content in the contract between the doctor and the patient.

Capitation fees are now restricted to patients with defined chronic illnesses after acceptance of the control doctor of the insurance, this leads to more fee for service payment. For doctors who were engaged in “médecin référent” contract it is a step backwards.

### **1.3 HHR in primary care**

If primary care is defined as “proximity” and “first access” care – curative and preventive – a large range of professions and organisations in France are providing primary care services: general practitioners, most of the specialists (especially paediatrician and gynaecologists...) nurses, midwives, social workers, auxiliary nurses, pharmacists, senior residencies, long-term care homes, “hospitalisation at home”. Nurse practitioners with master degrees and authorisation to prescribe do not yet exist in France.

### **1.4 Drivers for reform in primary care**

- The actual and projected lack of medical doctors and a desire for better working conditions of young doctors (group practices, better out-of-hour organisation, lower workload...). Those changes in expectations can be seen as a lever to restructure service delivery and skill mix in primary care. The actual discussion to better plan primary care provision points to the “primary care” sector as an emerging policy issue, which has not been the case until today.
- The perspective of fewer physicians in the next eight years has contributed to developing studies on task delegation, and on the division of competences between doctors and nurses, and other primary care providers. These studies and experiences have already taken place in countries that present similarities with the French healthcare system.

### **1.5 Barriers to primary care reform**

- Mainly the conservatism of French medical profession.
- Too many unions fighting each other instead of cooperating to improve medical care and working condition. This can be explained by huge remuneration and income discrepancies between medical specialists.
- Fee-for-service as unique payment system for GPs.
- No clearly defined population responsibility for primary care doctors and nurses.

### **1.6 Practical management/policy challenges to improve primary care**

Many elements – ageing, development of chronic diseases, amount of health care, reduction of number of doctors – tend to guide and influence the reflection on primary care advancements.

The drivers and motivations for organisational change in primary care are the need to counterbalance specialisation, the need for better coordination and better access; the need for increasing economic and administrative efficiency, i.e. sharing premises; need to help the patient navigate in the system according to his specific needs and for a global follow up instead of many isolated, unconnected events of care; the development of evaluation/quality improvement approaches. The latter are considered as a part of professional practice.

These changes could be achieved by encouraging group practice including different health care providers and social workers. Sharing premises could reduce costs and offer better

services to patients. All of this could also improve working conditions for health care providers. Expectations are not only to reduce workload and improve working conditions but also to provide better services to patients.

Geographical variation among health care providers across the French territory is also a concern and recent reports and reform attempts try to tackle this issue.

Policies have been implemented in order to improve cooperation between professionals and encourage networking between structures, in hospitals and ambulatory care. Organised networks have been promoted by a law in 1996. Group practices gathering various health care professionals have been encouraged with incentives of local policies (out-of-hour problems have been primarily the starting point and the objective).

## **2 Macro Level**

### **2.1 Health system**

*Which policies are in place that promote better cooperation and coordination between providers of health and social care?*

There is no national policy to promote better cooperation or coordination between providers of health and social care. Some specific policies have been implemented for certain population groups, generally on an experimental basis.

- For elderly, several programs succeeded in improving care focusing on coordination (“coordination gérontologique”). The objective of these programs is to increase information exchange of patient data between providers concerning planning of care. The most recent innovation (CLIC, Comités Locaux d’Information et de Coordination) has been introduced in 2000 to improve information of senior citizens (60 years old and above) and their families and coordinate care and social aspects. CLICs are not focused on patients with chronic illnesses especially, but mainly on disabled elderly who often have chronic illnesses.

The innovation was to promote cooperation and pool financial contributions across levels and between institutions (state, municipalities, departments, national insurance company) on a population basis (one CLIC for 60 000 people). In 2000, the government planned the creation of 1000 CLICs in France for 2006. This aim hasn’t been achieved yet, but 60% of population above 60 years of age is covered by a CLIC, but with varying levels of coverage and services, dependency on local commitment and available resources.

In 2006 a new plan for the elderly has been launched. One objective is to promote better coordination between home care and hospital care. The coordination between GPs, home care, social services and hospitals will develop through the concept of networks for health of elderly. This organizational model is defined by a general framework, a regulation that integrates all types of intervention toward “elderly”, including CLIC. This can be considered as the most recent policy to integrate social and health care.

Two new plans, to improve quality of life of patients with chronic illnesses and for persons with dementia have been launched in 2007 and 2008. They also include measures to improve better cooperation and coordination between providers of health and social care.

- For children and mothers, there are also policies to improve coordination using the network approach. Following the same process as defined above for elderly, health authorities have

defined a general framework to integrate different kinds of interventions and actors with particular attention paid to pregnant women. There is a guideline defining a range of items including scope, actors, aims and tools for coordination.

- These policies, aimed at integrating providers through networks, are the result of a “network model” from the eighties supposed to work as a stimulus for better cooperation among health care professionals in the whole system. At this time the HIV-AIDS epidemic led to the development of local organizations managed by patients and professionals to tackle problems met by young gay patients. The strong organisation of gay patients in an active association “AIDES” and the fact that professionals were all without immediate solutions to cure the illness created conditions for more concern about both social care and health care. The health administration funded the development of specific “networks”. Those networks, initially called “ville-hôpital” for VIH i.e. HIV, can be considered as a spontaneous form of coordination between social care and health care. They usually offered joint continuing medical education to different professionals (GPs, hospital doctors, nurses, social workers...), information for patients or professionals about the resources available for follow up when staying at home, and help with finding skilled professionals to take care of them. They have been described by researchers as collective learning processes, similar to quality circles for both professionals of primary care and hospitals. Some “networks” offered more than information, particularly coordination for patients in some cases.

The French health administration stimulated the development of those organizations for other specific problems or populations (drug addicts, palliative care, and then for chronic diseases such as diabetes, chronic heart failure, asthma etc). During the nineties, networks were considered by politicians as a good option to organize health care and appeared as an option to solve many problems. Even though the concept was used by many actors in the system and as a policy, there wasn't any global framework (no guideline). Thus, the buzz concept of network had different meanings depending on the position of their representatives. For some authors those networks were interesting to develop innovative practices and functions, but without being a model or organization of care in itself. The professional initiators of networks organized themselves in an advocacy group and asked for recognition as specific organizations of health care crossing borders between the hospital and the ambulatory sector, aiming at becoming real organizations in order to change the whole system of health care with a new philosophy. Some authors considered that the mission of these networks was to fill the gap within the healthcare system, and mainly substitute the lack of policy to coordinate social care and health care, without modifying the social compromise on ambulatory care from 1927 (private practice, public funding, fee for services, freedom of choice for patient, freedom of practice for physician). Finally these network organisations received specific national funds and a formal definition that oriented them toward population health at a local level in early 2000.

However, a recent state evaluation showed the global inefficiencies of the network policy, few patients are enrolled and very little evidence is available on their efficiency. These conclusions have been criticized, though, because the expectations on the networks are not adapted to their aim: should they be a space for innovation to change culture, or an organization to produce care? Today the policy of network promotion seems stopped and more emphasis is put on multidisciplinary work, like teamwork in primary care in group practice.

*How do health policies on chronic, primary and specialist care affect meso and micro levels of care?*

Since many years, patients with a chronic illness have full insurance coverage. They are refunded 100% by the “*sécurité sociale*” for all health care expenses in relation to their illness. Health conditions entering in this type of contract are described in a list and patient rights are regulated by control through a doctor of the health insurance “*sécurité sociale*”. Since the 2004 reform, the “*médecin traitant*” receives an extra fee of 40 Euro per year per patient enrolled in this program (*affection longue durée*) to coordinate care of those patients. It is the only part of capitation payment of GP’s.

The High Authority for Health (*Haute Autorité de Santé – HAS*) produces guidelines for all the health conditions of that list. The impact of this reform, still in process, is not clear yet.

Moreover, the impact of the “*médecin traitant*” reform is still discussed. As said before, most of the people have now registered with a doctor (84%, and most of them with a GP (98%)). In surveys patients declare having limited direct access to specialists. Some specialists claim having experienced a loss of income. The impact on access and quality remains unknown. Impact may also vary among French regions due to the great variation of medical demography.

*In how far does the remuneration system for primary care providers reward or induce better cooperation between providers? What are the remuneration schemes or incentives for prevention, follow-up care and continuous patient support?*

There is no real incentive for better cooperation between providers. Exclusive fee for service payment does not encourage preventive actions either.

On the contrary, fee for service can be regarded as a disincentive to promote quality. Cooperation between health care providers is time consuming.

The only part where capitation payment is a fixed amount is for patients with a condition of the list mentioned above. Capitation is supposed to be an incentive to improve follow up of these patients.

*How are structure, process and outcomes of primary care measured? How are providers encouraged to evaluate their performance? What about the evaluation culture in your country? Of course, evaluation – either external or internal, of structure, process and/or outcomes – is a cross-cutting issue that should be described for all levels (macro, meso and micro).*

- There is no systematic or comprehensive measure of structures, process, and outcome in primary care in France.
- The only systematic procedure is that 3 times a year every doctor receives a description of his activity from the insurance (*sécurité sociale*). This includes the number of contacts, home visits, drug prescriptions, sick leave prescription. This description is compared to the distribution or mean of GPs of his region.
- CME is mandatory since 1996 for all doctors and has been recently connected with QI methods. But until now uptake and participation in CME is unclear and not controlled. Thus, it is impossible to have precise information on the implementation of this mandatory process.



- The national insurance company (*sécurité sociale*) produces surveys on practices on specific topics such as follow-up of patients with diabetes 2.
- Patient satisfaction surveys among the population are being realized by IRDES in the general population for 6 years now; by hospitals at discharge and some approach of satisfaction (KABP) by INPES (*Institut National de la Prévention et de l'Éducation en Santé*) (*Baromètre santé*, ESPS).

## 2.2 Delivery system design

*What is the current focus of the primary care delivery system in your country: is it on acute care, on continuous care (i.e. care that not only takes place in the physician's office but also before and after physician visit)? In how far is prevention a key role of primary care providers?*

The French primary care delivery system is focused on curative care. Patients declare since many years in surveys that they have a GP they attend on a regular basis. The recent reform introducing the list system has confirmed these results. There is no capitation fee related to the list system and no incentives for GPs to perform prevention and continuity, although surveys show that GPs perform these activities.

*In your opinion, how well is the primary care system in your country suited to provide comprehensive care, i.e. are there, for example, multidisciplinary care teams or case managers for complex cases? If not, what are the key obstacles?*

- Professionals mainly practice very individually (even if they are in group practice). The number of group practices is increasing but very few of them have providers of various professional backgrounds (nurses, specialists, psychotherapists...) Teamwork isn't well developed. Coordination and cooperation are mainly informal and rely on trust between different providers.
- Since twenty five years some innovations have been developed in the field of primary care (eg. networks, see above). Initially motivated by the HIV AIDS epidemic, those local initiatives have been supported and promoted by the state with specific yet unstable funds. Many locally organized networks of care that focused on various health conditions (diabetes, hypertension...) or populations (drug addicts, elderly, pregnancy...) have been developed. Some of them were organized top down (from secondary care to primary care), others bottom up. These organizations are usually coordinated similar to case management. This has been done only on an experimental basis though. There is still no recognition of a formal case manager function, even if it is taken on by coordinators in networks. Research shows that coordinators can be either social workers or professionals, generally highly experienced.

*Please describe the status quo of primary care delivery: i.e. do physicians work mostly in solo practices, group practices, polyclinics?*

Medical doctors and especially primary care doctors (GPs, pediatricians, gynaecologists, psychiatrists) work in solo practice. The proportion of GPs working in solo practice is about 40%. Group practices have developed between 2000 and 2003, and the number of doctors working in solo practices has reduced, while the number of doctors working in group has increased by 18%.

At present gone down, about 44% of all doctors working in ambulatory care work in groups, and 11% share their premises with other professionals. About 45% of liberal doctors work individually, and the majority (53%) of these are general practitioners. There are big variations according to the specialty: from 15% for psychiatrists to 80% for radiologists working in group practices. Broadly speaking, technical specialties (radiology, anaesthesia, pneumology) tend to practice in groups sharing premises and costs. Group practice varies according to geographical areas. It is more frequent in the region of Paris, in the West, and in the East Centre of France (from 49 to 57%). It is less frequent in the North, in the East and in the Mediterranean area (29 to 38%). There is no significant difference between rural and urban areas. Younger doctors tend to prefer group practices. More than 1/3 of doctors working in groups are 45 years old maximum, compared to 1/4 of those working individually. Men tend to work more in group than women: 45% and 40%. About 1/4 of doctors working in group have associates who work with other specialties. 47% have only one associate. 2% of doctors share their activity between several groups.

2/3 of the doctors are organised in non trading companies ("*société civile de moyens*"), which gives the possibility to share premises, equipment, and staff. Organization in group practices tends to lower the costs.

Group practices more often employ staff. 58% of doctors working in group employ at least 2 persons, compared to only 11% of those working individually.

*How are providers trained to take on a coordinating role for their patients?*

Very little emphasis is put on coordination during the medical curriculum. For GPs this issue is developed in the curriculum of most university departments. Students spend most of their time in and are trained in teaching hospitals, with very little insight into other delivering systems outside the hospitals.

*What is the role of health services research/population care research?*

It depends on the definition of HSR/population care research. Research in health economics is more developed than health services research. The role isn't oriented toward primary care. Epidemiology takes a large part of resources in public health research. There are very few multidisciplinary teams in HSA. Primary care or HSR are not recognized as academic disciplines. Research in general practice is developing but still rare.

### **3 Meso level**

#### **3.1 The community**

*In how far do primary health care providers (GPs, certain specialists) collaborate with non physician actors in the community?*

There isn't any systematic analysis at the country level of this type of actions. Many initiatives exist and are managed by individual actors in the health care system. They are based on trust, good will, individual knowledge and interpersonal communication.

## **4 Micro level**

### **4.1 Self management support**

*What kind of patient support strategies and resources exist that help the patient better manage their disease?*

Patients associations are developing in France. They focus on specific diseases (diabetes, kidney failure, Myofibrosis - Duchenne...). The funding comes from donors (for instance media campaign on AIDS or for Myofibrosis), and since the law on health democracy in 2002, some patient associations are partly financed by the state (the amount of the budget has been divided by ten recently). Patient associations give advice to patients and in some cases support for living with disabilities. They are also grouped in a joint committee (CISS), play a role as a lobby group, and have representatives in different commissions and advisory bodies, both at the national level and the local level, such as public hospitals boards.

*How is the patient-doctor relationship? In how far are patients involved in the treatment process, in decision making on treatment plans, goals, and problems?*

It is difficult to answer this question in general terms. Patient-doctor relationship is a great subject of research by various disciplines (sociology, anthropology, economy). Some authors consider different models that exist in the system, each depending on the cultural lens that the doctor has on his job (paternalism, partnership, shared decision-making, informed patient...). The development of patient education by a specific research and training university promotes a model of relationship geared toward more patient autonomy.

## 4.2 Decision support

*Do evidence-based treatment guidelines exist, if yes, who defines them, which masters are used, and do providers use them? Are there decision support systems in place that help providers use the guidelines and if yes which ones?*

Guidelines are being produced by agencies (ANEM then ANAES and now the High Authority for Health (HAS)) for more than 10 years now. Until recently they were mainly oriented towards professionals. More recently, some versions have been adapted to patients, especially the chronically ill. An abundant work has been done to show the poor use of guidelines by professionals. There are no studies to evaluate guideline use by patients.

## 4.3 Clinical information system

*Are patient registries in place that help better organize care for certain patient groups? If yes, please describe in how far providers make use of them.*

Most of the practices have computer-based medical records but they are not standardized and do not communicate. There are about 100 different types of software.

At the moment there are no specific data bases for certain groups of patients.

The national insurance data base contains a lot of information based on billing. Even if prescriptions are available in those databases, they contain no medical information about diagnosis. Providers have no access yet to those databases.

*What role do electronic patient/medical records play in your country? To what extent is data on patients available to different primary care provider?*

After having launched an ambitious program of electronic medical records for all in 2004, health authorities have recognized their failure to achieve its development in the previous agenda. There is no electronic medical/patient record shared by primary care providers for the moment. Secured mail systems seem more developed in an informal way.

## 5 Key findings from the country case study

### **Three main barriers to improving primary care in France**

- First, the lack of a national and global (integrating both ambulatory, hospital and social sector) policy to organize care and in particular define primary care. The field of primary care is fragmented and divided between institutions, levels of regulation (macro, meso and micro) and professional actors. This is due to difficult agreements with a conservative medical profession and the introduction of national insurance for every citizen created in 1945. Teaching hospitals (academic health centers) have been created in 1958 as the cornerstone of the healthcare system and are very resistant to change.
- Second, the dominance of fee for service payment for doctors in ambulatory care. This reinforces individual ways of practicing and limits the development of preventive care and coordination of care.

- Third, the lack of research and practice in primary care and moreover in general practice. And if any research is done, it lacks implementation of results into practice.

### **Three main successes for primary care**

- First: Really good access from a financial, time and geographical point of view. The introduction of medical insurance for everybody and more recently a specific agreement for people with very low or no income (*Couverture Maladie Universelle – CMU*) in 1999 grants everybody fair access to care. Even people who are not in a regular status in France can have free access to care under specific rules.
- Second, the introduction of a list system, with every citizen having to register by a doctor. This system may allow better use of resources, population based research.
- Third: In the last 10 years there have been major improvements in teaching and training future GPs. In 1997, under the pressure of European regulation, a training period of 6 month in general practice has been introduced during professional medical training. This training period has been extended in some medical schools to one year. General Practice is acknowledged as a full speciality, and the academic situation of general practice has improved a lot.