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New Primary Care Organisation for the French Health Care System

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Introduction

To date, three reasons have been put forward to explain the deficiencies in the French health care system, namely lack of transparency in our care organizations, rnishandling of incentive measures and waste combined with lack of productivity.

The complexity of the system is such that no one expert can follow the evolution of all its component sectors. The hospital specialist has very little idea of developments in the fee for service system, while the subtleties involved in the rate of exchange between outpatient surgical beds and classical hospital beds largely escape those who work in the field of medication. Nobody has an overall view of the situation. A global view is however an absolute necessity to determine the impact of policies implemented and to understand the reactions of the professionals concemed without this general view, we quickly become the prisoner of the information provided by existing pressure groups and the vocabulary they use.

For a long time, this complex system worked like the agricultural cornmon market. It guaranteed prices for everyone working in the sector with no productivity ceiling. A posteriori reimbursement and per unit payment removed responsibility from those active in the field and was an incitement to increased spending.

Now, and this is the third and last observation, it is not at all sure that more is always better, the law of diminishing retums applying in medicine as elsewhere. The quantity and the quality of care are not necessarily the same thing.

Today, the system no longer works on an open basis, but behind closed doors, in the fee for service system since the agreements between physicians, sickness funds and public authorities on keeping a check on health care expenditure so as to optimize the use of resources is considered as an ethical necessity. These agreements are respected. Budgetary restrictions may be increased or relaxed, but everyone recognises that it is no longer possible to do everything for all patients with the best resources. There are costs that can no longer be considered acceptable. All sectors of economic life function under budgetary constraints and health care organizations are no exception, even if the official line is to deny their existence. The specifically French third way that we claim to have invented and named “medicalized regulation” is a political and strategic expedient rather than a reality. The aim is to give the impression that we can achieve technical effectiveness before being blocked by economic considerations and that eliminating waste is sufficient to give the health system the margin of freedom that it needs so badly. This is not the case and the need for a selective approach is becoming clearer every day. The result will be a change in medical practices, a new way of delivering health care and a new division of responsibility between those involved in the health system. [1]

Changes in Medical Practices

In tomorrow’s world, medicine will have to change its outlook, its logic and its ethics.

Changes in outlook: from a narrow short-term vision to a global prospective approach

Instead of concerning himself solely with clinical results obtained in the here and now, tomorrow’ s physician will have to interest himself in what is going on outside his immediate

field of activity (his cabinet or his department) and in the long-term fate of his patient (prevention and prospective care). The transformation in the structure of pathologies and the passage from acute infections to degenerative diseases requires that patients be followed throughout their lives. This is the domain of decisional analysis.

Changes in logic: from a logic of conviction to a logic of responsibility

Changes in logic are just as predictable. Until now, the quantity of health care accorded to a patient has been the sigh of the physician's interest in him. Failure to use available measures to their fullest was seen as refusal to help a person in danger. Tomorrow, the simple evocation of a potential benefit will no longer be sufficient. We will see a transition from the desire to "do everything possible" for the patient to the desire to "do nothing at all" unless it has been scientifically proven. Therapeutic interventions will be subordinated to proof of their effectiveness. The patient is still at the heart of this new outlook, but we have passed from a medicine of conviction or belief to a medicine of responsibilities supposing documented exercise of the medical arts. The requirement that the daily practice of medicine be based on established scientific facts will have the force of law. This raised the question of the quality of scientific evidence required to legitimise the therapeutic approach. Medical teaching will have to integrate the new dimension as students will have to learn to distinguish between good and bad evidence and to regard the medical literature with a critical eye.

Changes in ethics: from an individual approach to a population-based approach

Up until now, the physician was exclusively responsible for defending the interests of his patient in the framework of the singular colloquy. In future, he will also have to consider the interests of the population to which he is responsible. No business, even the health care business, can spend more that it earns, and this is true whatever the methods of functioning of the health system, whether it is public or private, whether the organization's resources depend on market dynamics or are provided by the authorities as a budgetary allocation. It is important to change our reasoning to forget the macro-economic accounts of the older millennium and even the micro-economic concept of effectiveness that followed in the decade 2000-2010. Professionals must ask questions concerning the resources mobilised and the benefits obtained when they accept that they have duties and responsibilities to groups of patients, whom they consider they serve. It is no longer possible to ignore what economists term the opportunity cost, i.e., the value of what could not be done because of what was done. To do utmost for one patient, is to deprive the others of the resources mobilised to treat the first. The virtual benefits scarified are the real cost of treatment. To judge whether it is worth the price, it is necessary to consider the benefits expected. The goal is not to cut costs blindly but to save more lives within the financial budget allocated to the department or the establishment. High cost is not a synonyrn of condemnation, withdrawal or prescription refusal, but it is impossible to meet the objective (defence of the interests of a cornrnunity of patients) without having first studied the cost-effectiveness ratio of the different therapeutic strategies available.

New System of Health-Care Delivery

Limits of isolated practice

Health is no longer merely the absence of diagnosed and diagnosable diseases. It is also the absence of risk factors such as anxiety, smocking, obesity and the presence of positive factors related to personal behaviour and way of life. This globality of health requires complete management of the individual and supposes that alI health care professionals, whether or not they are physicians, contribute to its defence. In the current system, every doctor has a network of contacts and enjoys privileged relationships with laboratories or hospital structures. This set of fratemal links or informal relationships defines the health care path the patient will follow as a function of the decisions made on his behalf. There is therefore a real "chain" which covers the totality of needs of the population. However, the large number of members compromises the continuity of care and prevents close links between the fee for service and the hospital sectors. There is a co-ordination problem between the actors in the health care system. Due to the complexity of the medico-social problems, the physician cannot solve alI health problems by himself. He must be surrounded by alI the professionals involved, whether they belong to the medical or social sector. The introduction of networks is an institutional response designed to solve these problems.

Need for networks

The Co-ordinated Care Networks (Reseaux de Soins Coordonnés, R.S.C.) are groups of health care professionals, led by a general practitioner and chosen by the patient, who offer a complete, homogenous and co-ordinated system of health care management to a quantitatively determined population of subscribers for a set annual fee. In this new system, a contract exists between users and health care professionals to ensure complete and co-ordinated management of individuals: the client agrees to be treated exclusively by the R.S.C. for a limited duration, while the R.S.C. guarantees that he will receive alI treatment he may need whatever its nature. Therapeutic decisions are made by teams in the R.S.C. whether they concem care, prevention or re-adaptation. This means that the effectiveness of the medical decision is increased in a logic of responsibility. The fundamental structures of the social security system are maintained and it conserves its monopoly. Insurance deductions are still made pro rata of salary. The employers and employees share of the contributions does not have to be changed, nor do the mechanisms of compensation between regimes.

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Financing of the networks is assured on the basis of a global annual fee whose amount is up to the directors of the organization. The sickness funds participate in the costs by me ans of a fixed annual health payment (forfeit annuel de santé, F.A.S.) whose amount is identical for alI networks but whose value depends on the age and sex of the managed population. The insured person, whose contribution is limited to the difference between the overall fee and the amount of the sickness fund payment, is given more financial responsibility but on the whole solidarity is maintained; solidarity within a risk class as the social security contribution is independent of the personal vulnerability of the individual; solidarity between risk classes in a particular network as the personal contribution of alI members is the same; solidarity between the rich and the poor on a community level, as social security deductions remain a percentage of salary.

Need for an information system

It is important to create reference data on cost and performance in the outpatient and hospital domains. Medico-economic evaluations should be aimed at assessing the overall net cost of the entire sequence of health care measures. The existing information must therefore permit calculation of costs incurred by each therapeutic attitude and the complications it gives rise to, as weIl as the costs avoided through, its use. Generally, the heaviest weight is the cost of hospitalisation linked to complications. The approach should therefore by systematic from the outset so as to evaluate the impact of the entire set of professional behaviours, taking into account alI the repercussions of the initiatives taken, which implies longitudinal information covering alI goods and services dispensed to the patient together with the results obtained. Decisions should be made in full knowledge of this data.

Emergence of New Responsibilities

Re-introduce a collegial dimension into medical thinking

Medicine has become too complicated a science for a physician to master alI its intricacies in the secrecy of his cabinet. Collective reflection in learned societies or subsets of professionals organized in a network permits alI data in the national or international literature to be used to make the decision most appropriate at the local level and to arbitrate the best service to be given to the population when the resources available are limited. Prevention and care activities must be re- examined as a function of the overall benefits to the population.

Extension of mammography for the prevention of breast cancer to women under 50 mobilises considerable resources for very small returns. The medical community must reflect on this problem and accept to renounce case finding in women of this age group in favour of irnproved and truly effective prevention campaigns by mammography in women over 50. (This is the domain of medical reflection).

Re-adjust the singular colloquy

There are four concepts of singular colloquy. The most traditional is that of president Portès, the most utopic that of informed consent but between total paternalism and the sovereignty of the consumer, there is room for a pro-active relationship between the physician and the patient, the physician being the one to either reveal the patient's value judgements or to educate him. Louis Portès ès' position is clear: "a patient is and should be a child in the eyes of his physician, a child to be tamed, a child to be consoled not abused, a child to be saved".

It is therefore up to the physician to make alI decisions in the patient's name and in his place. Guessing at individual preferences and his greater knowledge of disease are not sufficient. Often, with the best of intentions, trying to protect the patient from his irrational and poorly informed self, the physician can go against his preferences. B. McNeil has clearly shown the danger of such behaviour. Two strategies can be used in the treatment of lung cancer surgery and radiation. The first has a 5-year survival rate of 33% but is associated with a per-operative mortality risk of 10%. The second is risk-free but is associated with a less favourable 5-year survival rate of only 22%. Confronted with the choice, the patient prefers safety. How can the surgeon be justified in suggesting that the first strategy is preferable to the second when the patient is positively repelled by the risk? It is therefore necessary to bring patients to express their preferences clearly with regard to a range of health states integrating the various dimensions of their negative effects on quality of life.

This vision corresponds to the theory of informed consent in which the physician presents the range of technically possible therapeutic measures to the patient, and the latter chooses among these solutions as a function of his own value judgements. Whilst, from the technical viewpoint, the physician is informed and the patient is not, from the viewpoint of value judgements, the position is reversed, the patient knows his own set of values but the physician does not. Between these two extremes, a third route may be opened where the physician does not substitute his own value judgements for the patient's but forces himself to bring the patient to realize his own true priorities. Tomorrow's goal is therefore to put the patient in the centre of the singular colloquium again by introducing his preferences into therapeutic decisions. (This is the domain of quality-of-life indicators).

Increase the rights of the insured

Arbitration will be necessary given the budgetary constraints and it should not be left entirely to medical experts or administrators. Health choices are never dictated entirely by scientific considerations. They are explained by a certain idea of "good" and are based on a hierarchy of values. The general population should be able to participate in defaming these values. This implies that patient-consumer representatives are

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involved in the decision-making process conceming health issues at a regional and national level. In an open pluralist democracy, it is normal that there should be debate about the goals, but the interested parties should be allowed to express themselves. (This is the domain of collective priorities).

Use of Experiment for Evaluating Public Health Policy

The challenge of real-life complexity

Increasingly exploited by healthcare players in France and around the world, real-life data are broadening the scope of scientific evidence. Whatever their origin - medico-administrative databases, cohorts or randomized pragmatic trials - real-life data aim to be representative of the target population, and offer the means to gather the information sought at reasonable cost.

The definition of their scope varies from one author to another. [2] A 2017 review of the literature (1) sheds some light on the concept of real-life data. After analysing the definitions used in the latest scientific studies on the subject, the authors highlight three definitions:

- Any data not derived from a conventional Phase III randomized clinical trial.
- Any data originating from a non-controlled, non-interventional methodology.
- Any data originating from a non-experimental setting, i.e., retrospective and without protocol.

Certain types of data can thus be considered as real-life according to one definition and not according to another. This is the case of pragmatic clinical trials, in which patients are randomly assigned to a treatment or control group, but whose management after randomization is subject to minimal protocolization. This type of study is a source of real-life data according to definition 1, but not according to definitions 2 or 1997, whose protocols are reduced to the schema of the proposed observational study. [3-6]

The paradox of medico-economic studies currently conducted in real life, according to their authors, is that they have not succeeded in freeing themselves from the techniques of randomized trials, from which they claim to be freed. They strive to neutralize the influence of social actors and the contextual environment, deeming them to be confounding factors liable to bias the results obtained, and prohibiting the establishment of a single, stable relationship between cause and effect. While experimental methods are appropriate in simple cases, where cause always precedes effect in a linear fashion, they are inappropriate in complex situations, where the context is inseparable from the experiment being carried out, and where there are multiple interactions between actors. When it comes to real-life situations, attention to context, the interplay of players and social relations is essential.

Limits of randomized and quasi-experimental studies

Randomized or quasi-experimental trials (with control groups, but without randomization) are not designed to explain why and how the observed results were obtained. They do not provide answers to the questions that immediately spring to the mind of decision-makers: “What elements of the intervention or its context were responsible for the results? “What elements of the experiment did or did not work well?” “Was it the very design of the experiment that was or “was it the way it was implemented that went wrong? Randomized trials can tell us whether the experiment works, but the how is unattainable. Experimental study designs, because they don’t ask such questions, are black boxes. The results obtained, or the absence of results, are evaluated without being linked to the processes that helped produce them.

Co-construction of specifications by stakeholders

Evaluations co-constructed by stakeholders on the basis of a jointly-developed conceptual framework help to fill these gaps. Going beyond the question “Does it work?”, they strive to better understand “How does it work?” by exploring two dimensions:

- The normative approach, which specifies the strategic objectives set by national or regional authorities
- The causal approach, which describes the operational mechanisms that the initiators of the experimental project propose to implement to achieve the desired goals.

The distinction between these two approaches - normative and causal - is at the heart of the process of co-production of the evaluation between the supervisory bodies who have defined the objectives and framework of the experimentation, and the healthcare professionals who were at the origin of the project and who will be the linchpins of its implementation.

The normative dimension integrates the strategic objectives of those commissioning the evaluation. It specifies the actions (what needs to be done) that need to be implemented to achieve them. By proposing a strategy for transforming the healthcare system based on the values of effectiveness, efficiency and transposability, this approach specifies the paths that changes will have to take to produce their effects and suggests a logic for action. In so doing, it identifies the “acting components” of experimentation, going beyond the simple analysis of its final results. This should make it possible to predict what should happen if the experiment were to function in accordance with the objectives assigned to it, and to specify the elements that constitute the prerequisites for achieving the final result.

The decomposition of the logical framework of experimental results enables this analysis. It specifies what the intervention must do to trigger change. A program’s logic model identifies and describes how its components relate to each other, by presenting them visually in a sequence: resources/ activities/ outputs/

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effects/ impact; linked by arrows and equipped with indicators to measure the degree to which the expected results have been achieved. Thinking begins, as it were, with a vision of what an ideal situation might be, but then requires a more precise description of the mechanisms that will enable us to achieve it.

The causal dimension is concerned with the specific set of processes and activities that need to be implemented to make the experiment operational. It requires us to think about the mechanisms that need to be put in place to achieve the ultimate objective; it provides the keys to successful experimentation by defining how, and on the basis of what hypotheses, the sequence of events (means, activities, achievements, effects, results, impact) should follow one another to obtain the expected effects. It can be seen as an enriched form of the logic model, in which the causal relationships linking the program's components to one another are made explicit.

Contextual elements, which were confounding factors to be neutralized in the experimental approach, become key factors in the participatory and realistic approach to evaluation, since depending on the case, they can increase or neutralize the reactions of stakeholders to the introduction of an organizational innovation. The logic model thus enriched does not claim to prove that in reality things happen as it describes them; it merely represents the effects hoped for on the basis of a set of hypotheses. Only by collecting data on actual effects can we see how well the observation fits in with the hypothetical-deductive approach adopted.

Specification and evaluation

To assess the effectiveness of an experiment, it is necessary to ensure that it has been implemented as planned. The criterion generally used is the proportion of activities programmed in the specifications or identified in a per-protocol analysis that have been carried out. As a reminder, some analysts (2008 agree on a minimum rate of 60%, and show that the more faithful the implementation, the more reliable the effects measured. This statement needs to be qualified, however, because in highly complex interventions characterized by the interdependence of their components, other factors need to be taken into account. [7]

These factors, identified as potential moderators (also referred to as influencers) of effective implementation of experimentation, include: the complexity of the intervention, regulatory strategies for developing new organizational modes, initiatives taken to facilitate implementation of the system (setting up dedicated training courses, drafting best-practice protocols, standardizing assessments and tests), the quality of the actions that contributed to their implementation, and the mental model and responsiveness of the players involved. Consequently, social systems, inter-organizational relations and events taking place at the same time - all elements that characterize an ever-changing context - need to be taken into account during assessment.

In a dynamic environment where everything is in motion at the same time, it would make no sense to focus on a systematic quest for fidelity, even if such an attitude were merely a reflection of the dominant evaluation approaches of the moment. In truth, for the evaluator, it's less a question of knowing whether the initial objectives have been met, but of finding out in what way the experiment has created genuine added value for the system, for the organization of care and for all those who were supposed to benefit from it. The important thing is not so much to do what we said we would do, as to choose from among the active ingredients of the experimentation "those that work best", adapting them as necessary to the context in which the experimentation might be called upon to be reproduced.

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