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Multidisciplinary call for contributions on:

Reforms in the organisation of primary care

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This call for contributions is addressed to researchers in sociology, political science, economics, management, geography, demography, and law as well as to actors in the health and medico-social field.

Articles are due by Monday, 2 September 2019.

The challenge of reorganizing "community-based care" is at the heart of the current reform agenda. Announced by the government in September 2018, *Ma santé 2022* [my health 2022] plan makes the strengthening of first recourse to medical care one of its main objectives. It was preceded by the May 2018 HCAAM report, which proposed a strategy for reforming the health system by focusing on a "breakthrough scenario", based on the services to be provided to the population, strengthening the active role of patients, redefining the roles and working conditions of

professionals, and changing the supply of care. In recent years, public speeches and ministerial announcements have increasingly emphasized the call for a turn towards ambulatory care.

The objective of this issue is to ask how this declared orientation relates to the current transformation of the health system. This question seems even more necessary as this dimension of health policies has rarely been the object of studies. Indeed, in recent years social science research on the transformations of health systems (Bergeron, Castel, 2014; Palier, 2015; Pavolini, Guilen, 2013) has mainly focused on three aspects that have remained highly focused on hospitals, at least in France. These are market reforms (privatization, liberalization, etc.) and managerial reforms (particularly in hospitals), institutional transformations (redefinition of competencies between the state and health insurance, creation of agencies, etc.), and the implementation of new instruments for measuring (demographic statistics, activity measurement, etc.) and evaluation (the quality of care, its efficiency, etc.). This can be interpreted as a sign of a lack of structure of health service research in France, unlike what prevails in a number of other Western countries, particularly in the United States (Lepont, 2017) and England.

The objective of this issue is to provide a comparative account of the transformations at work in the organization of primary care in France and in other Western countries (European and North American). This issue will deploy multidisciplinary perspectives that make it possible to understand the social, professional, institutional, political, financial, managerial, and legal issues involved in these reform policies and their effects, going beyond governmental discourse.

We use the concept of "primary health care", which is more widely developed in other OECD countries than in France (Bourgueuil, 2010), because it refers on the one hand to certain specific functions related to care (access to care, the coordination of care and multi-professional support services more patient-centred than pathology-oriented, etc.). It also refers to multiple actors, first of all professionals (general practitioners, certain specialists, paramedical and medico-social professions), as well as to carers and patient associations and, secondly, to a population and territorial approach to health.

Close to, but broader than the notion of *soins de premier recours* [first-recourse health care], the notion of *soins primaires* differs even more clearly from that of ambulatory medicine because, in France in particular, some specialities are practised on an outpatient basis while in other countries they are not covered by first-recourse care. But, above all, the notion of primary care makes it possible to ask the question, central in France, of the link between primary care/hospital care (through issues such as the use of hospital or non-hospital specialists, the management of care pathways, home hospitalisation, and ambulatory surgery).

The question of home primary care of the elderly—but also of children with rare or serious congenital diseases—has become particularly acute in recent years due to four main developments:

- **The development of chronic pathologies**, in connection with the ageing of the population, which is combined with a growing demand to remain at home for as long as possible. "Home" refers to the "classic" home but also to other forms of housing similar to it: residential services,

autonomous housing[1] or even some *EHPAD* [Accommodation Establishments for Dependent Elderly Persons]. This development in particular raises the question of complex or palliative care by health and social professionals in collaboration with carers for an ageing and often poly-pathological population, and therefore of the coordination between the ambulatory sector, the hospital sector—particularly the HAH [hospitalisation at home] sector—and the medico-social sector.

- **The fact that patients are increasingly "solicited" to "actively" manage their lives with their illness** (profane health work) has led to an emphasis on the importance of the educational dimension of care (Saout et al., 2008). It also emphasises the need for long-term support in conjunction with families and patient associations, in order to give patients more autonomy and empowerment (Cap Santé 2015, Bacqué et al. 2013)11

- **The ageing of general practitioners**, the lack of regulation of the installation of their medical practice, the expectations of newly trained generalists, and the evolution of existing medical activity have led to the emergence of areas under-provided with doctors, the "medical deserts" in France. This concerns other health professionals as well. These developments raise the question of territorial inequalities in access to healthcare and the need to regulate the supply of healthcare not exclusively focused on medical demographics. In addition, there has been a decline in the number of per capita acts by general practitioners since 2000 (Bras, 2016).

- **The overcrowding of emergency services**, raising the question of the broader issues of obstacles to the organisation of sharing between private practice and hospitals and the provision of unscheduled care, while the demand for "immediate medical response" is increasing.

Faced with these increasingly clearly identified and publicized issues, we can observe the emergence of six types of more or less related responses. In the French case, these are:

- **The development of new forms of grouped practice** (particularly multi-professional health clinics and centres), in connection with these multiple challenges: coordination of care, redefinition of the sharing of tasks and responsibilities and therefore potentially of professional boundaries, new methods of remuneration with an incentive purpose, etc. The strengthening of the field of general medicine within the academic field (Bloy, Schweyer, 2010), with internships outside the hospital, attempts to adapt training to multi-professionality and their multidisciplinary openness as part of the announced reform of health studies, and finally, a commitment to develop research in primary care. Transformation in territorial organization involving institutional changes (creation of regional health agencies and extending their role to primary care) and the implementation of new mechanisms aimed at territorial coordination of care at different levels. This may include territorial support platforms, territorial professional health communities, contracts with territorial authorities (local health contracts) that are increasingly involved at the communal, inter-municipal (Honta,

[1] Previously known as *foyer-logement* [hostel-housing].

Basson, 2017), and departmental (role of maternal and child protection and in conjunction with medico-social) levels.

- **Intensifying the use of various assessment devices** (recommendations for good practice, quality and results assessment, quality-based payment, patient experience, etc.) as instruments for transforming primary care practices and organisation.
- **Strengthening different mechanisms within primary care to enhance prevention** and, at different levels, education and the advancement of health care.
- **The increasing use of NICT** to develop e-health care (through the various components of telemedicine, the use of connected objects and housing, etc.), to facilitate the circulation of information (see the long-term work on shared medical files and information systems within multidisciplinary health centres, etc.), and to improve data exploitation (creation of a health hub).

The objective of this issue is therefore to report on the transformations at work in France and other Western countries facing similar challenges. It might discuss the development of integrated care centres—*Medizinische Versorgungszentren* or MVZ—and territorial reorganisation in Germany, the implementation of local experiments in care coordination and strengthening the role of nurses in England, the initiatives in Swedish counties, etc., and would focus on three aspects:

1. **Analysis of the construction of primary care reform policies**, focusing in particular on the actors playing a key role in publicising—and sometimes also politicising—the issues and promoting new ways of organising primary care. This may include political actors, particularly local elected representatives; administrative actors; professional actors, particularly from the medical profession such as the *Fédération des maisons et pôles de santé en France* [French federation of multidisciplinary group practice centres and primary health care networks]; and patients' associations and their federative umbrella organisations. It will also be a question of understanding the discursive logics underlying the announcement of a turn towards ambulatory care.

2. **Analysis of the implementation of new modes of primary care organisation at the local level**. This raises questions relating to financing, the legal framework, and—what is at the heart of such questions—the coordination both within primary care and between such care and hospital service. This also involves the interaction between the many actors involved: administrative, political (local elected officials), professional (health and medico-social), and patient associations, etc. Through this type of approach, focusing on the application of policies, we will seek to understand both the elements that promote transformations in primary care and those that hinder them.

3. **The analysis of the effects of such reorganization on professional practices**. This might include the mode through which medical practices are implemented, rationalised, and standardised; the contours of professional boundaries; the relationships between health care and medico-social professionals; relationships with patients and carers; the professionalization of certain functions, particularly coordination; and the emergence of new professions (medical assistants) or new specializations (nurses in advanced practices).

We are also particularly interested in analysing the evolution of the place and role assigned to or taken by patients, their families and associations in defining the response to health needs and the management of care in interaction with health professionals. We are also interested in evaluating management systems in primary and home care.

Finally, because of the comparative character of this issue, it will also be possible to analyse the international circulation of models of primary care organisation. Such models include the Accountable Care Organisations set up in the United States—which have been the subject of two recent administrative reports (Léandre et al. 2017, and Lemaire 2017, and which has partially inspired the experimentation of Article 51)—as well as the convergence processes at work, particularly the process of harmonisation between the health insurance and national health care systems at this level within the European Union.

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