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Inspection Générale des Affaires Sociales

# Training of medical assistants

## Appendices

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# CONTENTS

# ANNEXE 1 : Medical assistants, their employers, recruitment pools and job opportunities

# SUMMARY

[1] This appendix describes the scope of practice and missions of medical assistants in doctor's surgeries (1), what we know about them (2) and their employers (3), the different recruitment pools (4) and possible career opportunities (5).

# 1 The scope of practice and objectives of medical assistants in private practice

## 1.1 The history of the medical assistant function up to Ma Santé 2022

[2] The role of the medical assistant has been discussed for some twenty years in our country by official reports and representatives of several specialties, particularly in the context of changes in the organization of primary care and growing difficulties in accessing care.

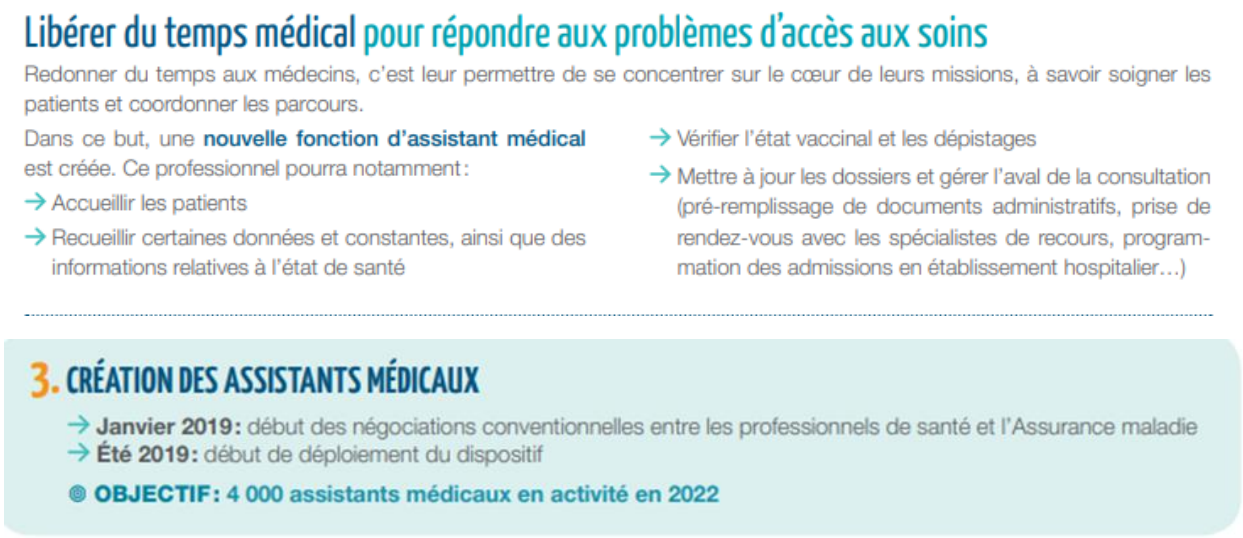
[3] Briefly mentioned in Professor Yvon Berland's 2003 report on the transfer of tasks and skills[1], the medical assistant is also mentioned in the 2010 report by CNOM President Dr Michel Legmann. The author wrote: "Running a medical practice is like running a small business. You have to be able to free up your own medical time for the benefit of the patient. There are many tasks that can be delegated to a "health assistant", such as administrative tasks (patient contact details, equipment management, cash collection, etc.) and medico-social or para-medical tasks (questionnaires, patient education, biometrics, links with the social, medico-social and health sectors, etc.)"[2] .

[4] In addition, five specialties (ophthalmologists, aesthetic physicians, dermatologists, ENT specialists, dentists[3] ...) have, since the 2000s, also advanced various "medical assistant" type projects (notably the Techniciens assistants en soins ophtalmologiques or TASO project) to develop assisted working and shorten appointment times. They were joined in the mid-2000s by certain GP organizations (MG France in particular).

[5] It was not until September 2018 and the announcement by the President of the Republic and the Minister of Health of the "Ma santé 2022" strategy that the profession was officially created[4] .

[1] Report commissioned by Jean-François Mattei, Minister of Health, from Professor Berland on cooperation between healthcare professions and the transfer of tasks and skills, and submitted in October 2003.
[2] The 2014 Senate report by Catherine Génisson and Alain Million on cooperation between healthcare professionals does not address medical assistants, nor does the 2021 report by MP Cyrille Isaac-Sibille on the future organization of healthcare professions.
[3] They obtained the creation of dental assistants.
[4] This was the third of the strategy's ten "flagship measures".

Graphique 1 : Extract from the Ma Santé 2022 press kit summary on the new medical assistant function.




*Source : Press kit - Ma santé 2022*

[6] According to the "Ma santé 2022" plan, the medical assistant's duties would include greeting patients, collecting certain data and vitals as well as information on health status, checking immunization status and screenings and, finally, updating records and managing the aftercare of the consultation (pre-filling administrative documents, making appointments with referral specialists, scheduling hospital admissions...).

## 1.2 The legal foundations of the new function

[7] They are legislative, regulatory and conventional, and run from 2019 to 2022.

[8] The first legal text in which the medical assistant function officially appears is article 1er of Addendum no. 7 to the national agreement of August 25, 2016 organizing relations between self-employed doctors and health insurance, which was signed on June 20, 2019. This article introduces aid for the deployment of medical assistants in private practices, defines the missions of the medical assistant, the profiles and training of the medical assistant, the eligibility criteria for aid in the hiring of a medical assistant, the formalization of the commitment of eligible doctors, the procedures for awarding aid for the recruitment of a medical assistant and the expected quid pro quos, as well as the evaluation of the scheme.

**The medical assistant's duties under article 1er of addendum no. 7 to the medical convention**

The contractual partners agree that this assistance function for the benefit of the doctor and the patient should free up the doctor's medical time and enable him or her to support the patient in his or her daily practice.

By way of example, the tasks entrusted to the medical assistant may fall into one of three areas:

- administrative tasks: these consist of tasks not directly related to care, such as welcoming patients, creating and managing patient records, collecting and recording administrative and medical information, supporting the implementation of telemedicine within the practice, etc.

- tasks linked to the preparation and running of the consultation: the medical assistant could help the patient to dress and undress, take vital signs, update the patient's file on screening, vaccinations and lifestyle, if necessary generating alerts for the doctor's attention, issue screening tests and kits, prepare and help perform technical procedures.

- organizational and coordinating tasks: medical assistants can play a coordinating role, in particular with other players involved in patient care.

However, these broad areas of intervention do not constitute a limitative perimeter; they outline a range of possibilities in terms of job content. The tasks that doctors entrust to medical assistants are left to their discretion, depending on their needs and organization, and on the nursing and/or administrative profile of the people recruited under the job description.

To ensure that the deployment of this new category of staff in doctors' surgeries has the full meaning and effect expected of it, the duties performed by medical assistants, which are their own specific tasks, must be distinguished from those of other job categories. For example, while a medical assistant's duties may include an administrative dimension, they should not be limited to a medical secretarial function. Similarly, while it is possible for a nurse to be entrusted with the function of medical assistant and, in this capacity, to carry out an act falling within his or her field of competence, this can only be envisaged on an ad hoc basis and in the context of a medical consultation, without it being a question of developing a routine nursing care activity that would fall within the scope of his or her own professional practice.

*Source : Medical convention*

[9] Then article 67 of the July 24, 2019 law on the organization and transformation of the healthcare system, amending article L. 4161-1 of the public health code, mentioned the medical assistant. This article of the health code defines the illegal practice of medicine and excludes medical assistants from this risk provided they hold a professional qualification included in a list set by order of the Minister of Health. This decree was issued on November 7, 2019, and specifies the diplomas required and the training obligation.

[10] It should be noted that medical secretaries and other employees or jobseekers undergoing training, who are taking courses to obtain the professional qualification certificate (CQP) or the job adaptation training (FAE) but who do not yet hold it, are not formally medical assistants but "acting medical assistants". They should not benefit from the provisions of article L. 4161-1 of the French Public Health Code concerning the illegal practice of medicine. In practice, this point does not appear to pose any particular problem.

[11] At the same time, on June 27, 2019, the social partners of the liberal practice branch negotiated a modification to the collective agreement for medical practice personnel, by means of amendment 76, which introduces the medical assistant and positions him or her in the branch's job classification among the medico-technical sector.

[12] Finally, the CQP for medical assistants, developed by the branch in conjunction with the DGOS and the OPCO EP, was entered in France Compétences' Répertoire national des certifications professionnelles (RNCP no. 36358) on April 22, 2022, for a period of three years.

## 1.3 Main objectives of the medical assistant scheme

[13] The creation of the medical assistant function meets distinct objectives, depending on the stakeholders involved:

- The public authorities are particularly keen to free up medical time to enable doctors, and GPs in particular, to improve access to GPs and reduce treatment times;
- The employee unions are particularly committed to training and validation of the skills acquired by medical secretaries, in order to ensure their professional development;
- Specialist doctors are particularly interested in the development of supported work for increasingly technical specialties, practiced within the framework of genuine healthcare companies.

[14] All in all, quantitative objectives (increasing the number of consultations per doctor to respond to unscheduled or urgent care, particularly in areas with a shortage of doctors and for specialties in short supply, to improve access to a general practitioner and to reduce waiting times for certain specialties) are combined with qualitative objectives (improving the quality of care, patient management and follow-up, by devoting more time to patients who need it ; reinforcing continuity of care; strengthening coordination between the various players) and objectives to improve doctors' working conditions (relieving doctors of tasks for which they have no added value; making the profession more attractive, particularly in under-dense areas).

[15] This discrepancy between the multiplicity and ambition of the stated objectives, on the one hand, and the reality of the medical assistants' tasks, on the other, raises questions.

## 1.4 Scope of missions and tasks

[16] Medical assistants are not healthcare professionals, and there are no regulations governing their competencies. In any case, the health authorities are not in favor of extending the list of healthcare professions to include medical assistants.

[17] However, the scope of authorized missions and tasks for medical assistants is set out in a number of texts: this is the case for rider no. 7 to the medical agreement, and for the certificate of professional qualification. We must also take into account the positions taken by the CPNEFP of the medical practice branch (see box below).

**Letter dated October 6, 2022 signed by the Chairman and Vice-Chairman of the CPNEFP and sent to doctors who are members of the OPCO EP.**

When examining the files of candidates for the Medical Assistant CQP, the CPNEFP, as part of the CQP certification commission, noted that a certain number of assistants were entrusted with tasks that went beyond the skills described in the job specifications, such as performing electrocardiograms or eye pressure examinations.

The CPNEFP firmly reiterates that a medical assistant is not a healthcare professional, and that his or her skills are limited to carrying out examinations using fully automatic equipment.

The CPNEFP for medical practice staff therefore asks you not to go beyond the training guidelines for medical assistant certification.

The CPNEFP points out that the medical practice staff branch would not support an employer who would have his or her medical assistants carry out care tasks, and points out that this could lead to their professional civil liability being called into question.

*Source : CPNEFP*

[18] All in all, the scope of medical assistants' missions is narrow (see appendix on international comparison) and marked by contradictions. There are several reasons for this:

- The official list of tasks likely to be entrusted to medical assistants is highly flexible: rider no. 7 specifies that "these major themes of intervention do not constitute a limitative perimeter" and that "the missions that doctors entrust to medical assistants are left to their discretion according to their needs and their organizational methods, and according to the nursing and/or administrative profile of the people recruited within the framework of the job reference system";
- In practice, the tasks entrusted to medical assistants vary greatly from one doctor to another, from one specialty to another, from one organization to another (single-practice doctors or multi-professional health centers), from one former medical secretary to another (particularly when she has been with the doctor for a long time or is close to the family), and from one paramedical profile to another. In the words of one of the people we spoke to, there are "as many medical assistant profiles as there are doctor/assistant pairs";
- The interpretation given by the CPNEFP to authorized technical tasks is very restrictive, which contrasts with the more extensive practice of many doctors and the approach, for example, of the CNP in cardiology;
- An unknown number of medical secretaries are already acting as medical assistants, further blurring the line between what is permitted and what is prohibited.

[19] These contradictions in the missions of medical assistants are a concern for trainers, faced with trainee and employer audiences with different expectations and practices.

[20] Rider n°7 specifies that the tasks entrusted to medical assistants are "specific tasks", which must be distinguished from those of other job categories. This notion of "specific and distinctive missions" is not self-evident.

[21] The missions of medical assistants fall into three areas, as described in the box above:

- The administrative tasks are similar or equivalent to those performed by medical secretaries in private practice and by medico-administrative assistants in hospitals, and to the skills listed in particular for the title of medico-social assistant secretary;
- Tasks "related to the preparation and conduct of the consultation": these technical tasks (preparing the history, taking vital signs, assisting in the patient's bed) are similar in principle to those performed by dental assistants in the dental chair. They are likely to develop in the

future, but are hampered by the currently vague and rather restrictive rules governing the performance of technical procedures (diagnostic examinations).

- Tasks of organization and coordination, particularly with other players involved in patient care. These organizational and coordination tasks are also carried out by care coordinators in MSPs, or by nurses.

[22] Rider no. 7 does not explicitly mention two other tasks that are likely to develop: the management of relationships/interfaces between patients and doctors, notably via electronic messaging, which requires triage and coordination skills, and the population-based management of chronically ill patients (targeting via CRM).

[23] Lastly, in a document submitted to the mission, the CNAM sets out other constraints of questionable legal value: no 100% remote activity, and no activity exclusively at patients' homes (no mileage allowance).

[24] For its part, the CQP d'assistant médical registered with the RNCP places particular emphasis on "actions linked to the preparation and conduct of the consultation" and lists four activities, which are the subject of as many blocks of skills:

- Monitoring the patient's health pathway
- Patient reception and administration
- Contaminant risk management and health safety procedures
- Operational assistance to the practitioner.

[25] In particular, the activities and skills reference framework emphasizes the risk of contamination and health safety, which are not specifically mentioned in rider no. 7. And the precise scope of operational assistance to the practitioner is hampered by the relative vagueness of what is and what is not authorized (see above).

# 2 Medical assistants in doctors' surgeries and other medical assistants

[26] Our knowledge of the current population of medical assistants is still very imperfect. Medical assistants working in private practice are neither a health profession within the meaning of the Public Health Code, nor a regulated profession subject to registration or declaration to the authorities. A small number of professionals are involved in this function or profession: 3,100 separate people according to the CNAM (or even just 400 if CQP holders are counted).

[27] Other, lesser-known professionals also carry out similar or similar functions to those of medical assistants, recognized by a certificate of professional qualification or in training and financed by the health insurance scheme in other structures.

## 2.1 Medical assistants whose employment is subsidized by the CNAM and who hold or will hold the CQP and FAE attestation

[28] The essential and best-known component of the medical assistant population is that whose employment is subsidized by a grant paid by the CNAM on the basis of Rider 7 of the agreement between liberal medical unions and the health insurance scheme, and who hold, or will hold, the CQP and have, or will have, taken the FAE.

**Recruitment and employment assistance paid by the health insurance scheme**

Aid for the recruitment of medical assistants was created by amendment no. 7 to the national agreement organizing relations between self-employed doctors and the health insurance scheme, signed on June 20, 2019 by three of the five majority representative medical unions (MG France, the SML and the CSMF), and approved by way of derogation from the six-month rule as early as August 20, 2019 to enable rapid entry into force.

The measures introduced by rider no. 7 consist in supporting the hiring of medical assistants through the payment, as soon as they are hired, of a fixed-rate financial aid that is both permanent and progressive. Physicians are free to choose the tasks to be carried out by their medical assistants from the list of those provided for, as well as the length of time the assistants are to be employed. In return for the aid, which is calibrated to the time spent on the job, the doctor undertakes to welcome and manage new patients using the time freed up by the medical assistant.

In the initial text, eligibility was subject to five strict conditions[5] : i) the doctor must practice, without possible exception, in the "opposable fees" sector (sector 1 or sector 2 adhering to Optam or Optam-Co); ii) all specialties are eligible, but certain specialties are eligible throughout France (general practitioners, special-practice doctors, pediatricians, etc.).) and others are eligible in 30% of the departments with the greatest shortage of each of these specialties; iii) unless otherwise stipulated, the doctor must have a minimum initial patient base (active file) above the 30th percentile for the specialty; iv) unless otherwise stipulated, the doctor must practice in a group (in a low-density area or outside a low-density area, but coordinating with other colleagues in their practice area). This condition is understood to mean the grouping together of at least two doctors in the same place of practice (principal place of practice), whatever the legal form (group practice, MSP...)[6] ; v) the doctor must be involved in a coordinated practice approach (MSP, primary care teams, specialized care teams or other forms of coordinated practice) within two years of hiring the medical assistant.

Once eligibility has been verified, the doctor must sign a hiring assistance contract, which sets out the reciprocal commitments between him and his caisse, and is for a renewable period of five years. The hiring subsidy is paid individually to the doctor (who may pass it on to the group). Within an employer group, the medical assistant's share of FTE assigned to the doctor corresponds to the FTE option he or she has contractually agreed with the health insurance fund. If several doctors share the same medical assistant, each of them signs a contract with their respective CPAM/CGSS, even if the medical assistant's employment contract is drawn up in the name of an SCM, SEL or SCP.

[5] Article 8 of the agreement supplements the aid scheme for the recruitment of a medical assistant introduced by agreement 7, by extending, under certain conditions, the zones in which aid for the recruitment of a medical assistant up to a maximum of one FTE is possible, and for which the doctor may be exempted from the requirement to work in a group.

[6] Doctors working in the same practice or shared practice area may belong to different specialties. On the other hand, the notion of grouped practice does not take into account the grouping of a single doctor with one or more non-physician healthcare professionals or medical professions.

The level of assistance ranges from €21,000 per year for a one-third time to €36,000 per year for a full-time position. The amount decreases as the additional activity provided by the medical assistant increases the practice's income.

**Objectifs d'augmentation de patientèles / option ETP**

Percentile de départ du médecin dans la distribution nationale

| Borne basse | Borne haute | Option 1 : recrutement d'1/3 ETP | Option 2 : recrutement d'1/2 ETP | *Option 3 spécifique zone ZIP/ ZAC recrutement d'1 ETP* |
|---|---|---|---|---|
| p_30 | p_50 | 20,0% | 25,0% | *35,0%* |
| p_50 | p_70 | 15,0% | 20,0% | *30,0%* |
| p_70 | p_90 | 7,5% | 12,5% | *20,0%* |
| p_90 | p_95 | 4,0% | 6,0% | *12,5%* |
| p_95 | p_100 | 0,0% | 0,0% | *5,0%* |

**Montants par option et année**

| | Montants maximaux de l'aide | | | Versements de l'aide (acompte + solde) |
|---|---|---|---|---|
| | Option 1 | Option 2 | Option 3 spécifique ZIP/ZAC | |
| | (1/3 ETP) | (1/2 ETP) | (1 ETP) | |
| 1ère année | 12 000 € | 18 000 € | 36 000 € | Versement intégral quelle que soit l'atteinte des objectifs |
| 2ème année | 9 000 € | 13 500 € | 27 000 € | |
| 3ème année et suivantes | 7 000 € | 10 500 € | 21 000 € | Modulation à partir de la 3ème année selon l'atteinte des objectifs |
| Aide majorée médecins ayant une patientèle les situant entre [P90 et P95[ | 8 350 € | 12 500 € | 25 000 € | |
| médecins ayant une patientèle > P95 : | Montant maximal de l'aide (= montant de la 1ère année) pendant toute la durée du contrat | | | Modulation à partir de la 3ème année selon règle spécifique en cas de non-maintien de leur patientèle |

* Avenant n°7 (20 juin 2019) et n°8 (11 mars 2020) à la convention nationale des médecins libéraux (25 août 2016)

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In the case of doctors with a very large patient base (above 90ème percentile), the amount of aid is increased from year 3ème or remains identical to the amount for year 1ère for the entire duration of the contract (doctors with a patient base above 95ème percentile).

A medical secretary previously working for a doctor recruited as a medical assistant must be replaced for the amount of secretarial time previously worked within six months of being hired as a medical assistant. It is possible to replace him or her on a fixed-term contract or alternating work-study contract, up to the amount of time previously worked, provided that the compensated job is permanent in the long term.

Aid for the recruitment of medical assistants is the only health insurance recruitment aid available, apart from that for the 1,800 Asalée nurses (1,200 FTE), delegated to public health and employed by the eponymous association (www.asalee.org), whose mission is to improve the management of chronic diseases (diabetes and pre-diabetes, cardiovascular risks, COPD or asthma, sleep disorders). It is significantly higher than the amount paid for hiring an apprentice (€6,000 paid once).

The total amount of aid paid by the health insurance scheme between 2019 and 2022 reached €119.2 million, including €106.8 million for sector 1 doctors and €12.3 million for OPTAM sector 2 doctors. In 2022, payments totaled €55.4 million, including €49.4 million for sector 1 doctors.

The arbitration rules have very recently led to a relaxation of the eligibility criteria. From now on :

-All medical specialties are eligible (except radiologists, radiotherapists, stomatologists, anesthetists, nuclear medicine physicians and anatomocytopathologists);

-Surgeons are eligible if their CCAM fees represent less than 20% of their total fees;

-Doctors must practice in Sector 1 or Sector 2, and be members of OPTAM or OPTAM-CO;

-There is no longer any requirement for coordinated or grouped practice;

Moreover, this is no longer a component of the structure package, but an independent financial aid;

Assistance is conditional on increasing the number of MT patients or the active file. Objectives have been personalized: doctors' commitments are individualized and modulated according to the initial size of their patient base. The doctor chooses one of two funding options (1/2 FTE or 1 FTE). The "restriction" criteria for the 1 FTE option have been removed from the current system (no more notion of practice in a ZIP).

*Source : CNAM*

[29] In December 2022, according to data supplied by the CNAM, there were 4,069 medical assistant recruitment assistance contracts signed by the health insurance scheme with private practitioners, corresponding to 2,537 full-time equivalent jobs and 3,100 separate individuals employed, or rather already trained or in training, as medical assistants and whose employment is subsidized by the health insurance scheme.

[30] The number of medical assistant recruitment assistance contracts has grown by an average of around 1,300 a year since 2019, but in fits and starts: with rapid growth in 2020 (+ 1,600 in one year), then a very marked slowdown in the rate of increase between 2020 and 2021 (+ around 650) and finally a return to initial growth between 2021 and 2022 (+ 1,500).

[31] There are very few contract cancellations (1 for every 200 contracts, according to the health insurance company), which are due to the vagaries of the liberal professions.

Tableau 1 : Medical assistant recruitment contracts signed

| | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|
| Number | 272 | 1 877 | 2 543 | 4 069 |
| Annual progression | + 272 | + 1 605 | + 666 | + 1 526 |

*Source : CNAM*

[32] All in all, the population of medical assistants whose employment is subsidized by the health insurance scheme is small. This can be measured by comparing it with the number of salaried employees in private practice, the number of self-employed doctors working exclusively in private practice, the number of self-employed doctors working in mixed practice, or the number of the two smallest professions. The 3,100 medical assistants thus represent :

- Only 3.4% of the 90,758 employees in the private practice sector (in 2021)[7] ;
- 3.2% in the number of sole practitioners and mixed practitioners ;
- A smaller population than that of audioprosthetists (4,121 under 62 at January 1er 2022 according to the Adeli directory) or orthoptists (5,724 under 62 at January 1er 2022 according to the same Adeli directory).

[33] If we take into account the number of medical assistants actually trained, the number is even more limited (around 400 in March 2023).

[7] In 2021, according to the Observatoire des métiers dans les professions libérales, whose scope covers almost 100,000 companies, 480,000 employees and 11 branches. In the healthcare sector, in addition to the medical practices branch, the OMPL scope includes the dental practices branch, the extra-hospital medical biology laboratories branch, the dispensing pharmacies branch and the veterinary clinics branch. The figures given by the DGT are higher: 115,000 employees.

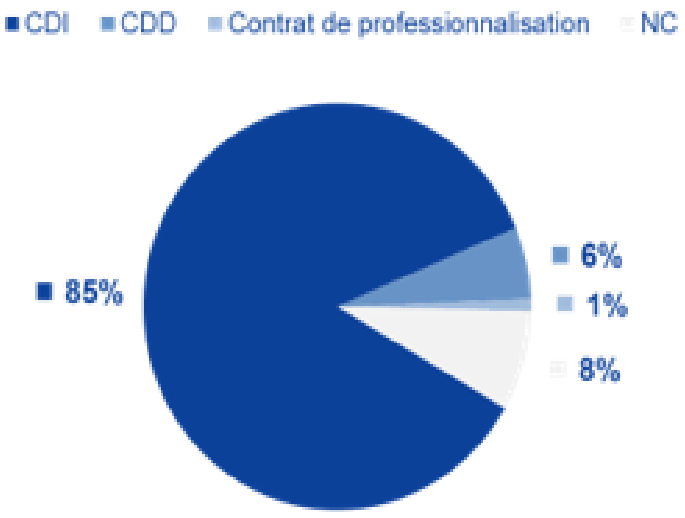
[34] The vast majority of medical assistants are women, as are employees of independent medical practices (90.8% of the total according to the OMPL in 2021). We only have the data provided by the private practice branch (CPNEFP) on trainees, a population in which 95% are women.

[35] The precise age distribution of medical assistants is also unknown. By way of comparison, on average in 2018, 25.9% of employees in private practice were under 35, 36.1% between 35 and 49 and 37.9% 50 and over. According to figures for trainees provided by the CPNEFP, their average age is 41.8.

[36] We also know little about the proportion of part-time workers among the population of medical assistants in private practice. It is clearly high, but cannot be accurately quantified. According to CNAM, in October 2022, 931 out of 2,374 medical assistants were employed by at least two signatory doctors, i.e. almost 40% of the total[8] .

[37] The vast majority of medical assistants are hired on permanent contracts. According to the CNAM, this is the case for 85% of medical assistants, compared with just 6% on fixed-term contracts. According to the CPNEFP, the figure is as high as 90%.

Graphique 2 : Breakdown of assistance contracts signed by type of medical assistant employment contract

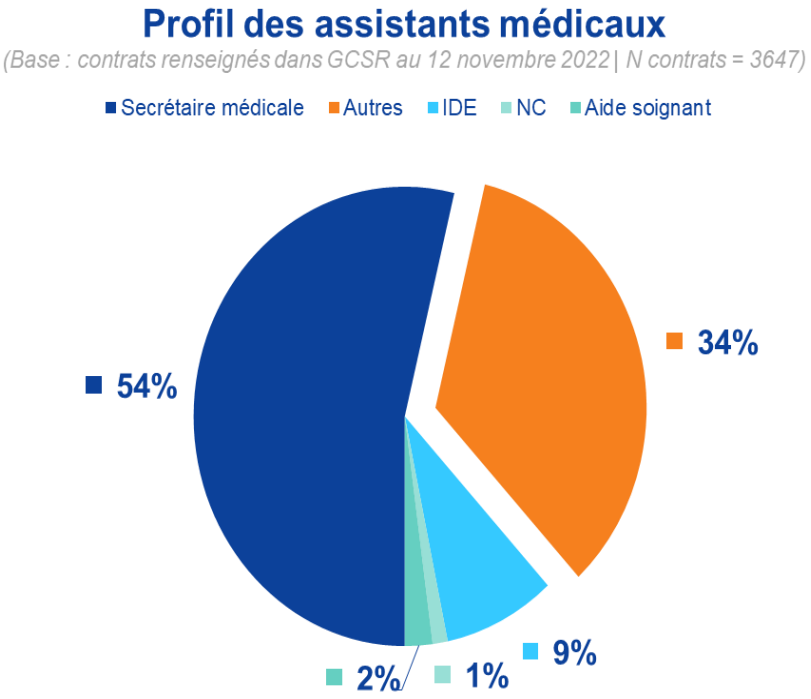



*Source : CNAM*

[38] Little is known about the professional background of medical assistants. According to CNAM data, collected during a survey conducted in October-November 2022, 54% of medical assistants are former medical secretaries, 9% are nurses, 2% are care assistants and 34% belong to a very poorly understood "other" category, which includes both administrative secretary-type profiles and profiles such as nursery nurses or psychologists.

[8] Half (47%) of the contracts signed with employing physicians are for part-time work, 30% for one-third time, and only 23% for full-time work.

Graphique 3 : Professional background of medical assistants




*Source : CNAM*

[39] An analysis of the trainees' professional background reveals a much higher proportion of medical secretaries, at 80%.

[40] According to the CNAM survey, 15% of medical assistants have worked for the same doctor as a medical secretary. CNAM acknowledges, however, that this figure is underestimated by employers in order to derogate from the contractual obligation to re-employ another medical secretary if the former medical secretary is promoted to the position of medical assistant. The estimate given by the mission's contacts is (much) higher than half.

[41] The remuneration of medical assistants is governed by the classification grid of the medical staff branch. They are positioned between levels 5 and 9 like healthcare assistants, while medical secretaries are positioned between levels 4 and 8, and in practice are concentrated at levels 6 and 7, and caregivers are between levels 8 and 13. In 2019, their gross monthly salary ranged from €1,642 to €1,953.

**The number of medical assistant vacancies registered with Pôle Emploi and job applications advertised by Pôle Emploi in 2022**

According to Pôle Emploi, 586 medical assistant vacancies were advertised by the national agency in 2022. However, these offers very often correspond to jobs other than medical assistant as defined by the collective agreement for medical practices. A visit to the Pôle Emploi website demonstrates this: on April 25, 2023, of the first six medical assistant job offers on the Pôle Emploi website, only one concerned a multi-professional health center. The others were for an orthopedic sports surgery center, a medical equipment installation technician, an imaging center, an aesthetic center and a cancer center.

The number of jobseekers looking for a position as a medical assistant at the end of January 2023 was 301 in category A and 455 in categories A, B and C. It is not possible to know what proportion were looking for a position in a private practice.

*Source : Pôle Emploi*

## 2.2 Other medical assistants

[42] In fact, a number of professionals perform functions close to or similar to those of medical assistants whose employment is subsidized by the health insurance scheme. These may be medical assistants employed by medical practices who hold the CQP or are in training, but who are not subsidized by the health insurance scheme because their employers are not eligible for aid. They may also be medical assistants employed in branches other than medical practices, who may or may not hold the CQP. This is also the case for medical secretaries or professionals with similar functions who carry out tasks that go beyond those required of medical secretaries.

### 2.2.1 Medical assistants in certain specialties (ophthalmologists, cardiologists, dermatologists, plastic surgeons, etc.) and "acting" medical secretaries.

[43] Several specialties have been employing assistants for a number of years, and have played a leading role in the process of formalizing the function.

[44] This is the case for liberal ophthalmologists, who have been resolutely committed to multi-professionalism and assisted teamwork for nearly twenty years, under the impetus in particular of their union, the SNOF[9] . According to the SNOF's latest survey for 2021, 71% of independent ophthalmologists were on assisted work contracts, including 90% of doctors under the age of 40. ¾ of assisted work takes place in sector 2, which itself represents around 64% of ophthalmologists, including 49% non-OPTAM. In their multi-professional teams, ophthalmologists mainly use orthoptists (53% of independent ophthalmologists use them in their practices), as well as, to a lesser extent, nurses, opticians and, increasingly, "ophthalmology medical assistants".

[45] Thus, in 2021, the SNOF estimated that ophthalmologists employed 665 medical assistants in ophthalmology, i.e. 15% of the total number of practice assistants. It is impossible to put a figure on the number of medical assistants employed by ophthalmologists, as some of them are not included in the number of medical assistants whose recruitment is subsidized by the health

[9] On this subject, see a report by IGAS and IGESR: *La filière visuelle: modes d'exercice, pratiques professionnelles et formation*, 2019.

insurance scheme, due to the ineligible nature of their employers (sector 2). Nevertheless, there has been a sharp increase in the number of "ophthalmology medical assistants" since 2019-20, from 282 to 665 between 2020 and 2021, and the creation of the medical assistant CQP is seen by ophthalmologists themselves as a key factor in this growth.

[46] In 9% of cases in 2021 (18% in 2020), ophthalmic medical assistants were the only support provided by ophthalmologists, and 87% of them worked with orthoptists. In 56% of cases, there was more than one medical assistant per practice in 2021 (versus 2% in 2020). Geographically, the regions with the highest proportion of medical assistants in ophthalmology are two overseas regions (Indian Ocean and Pacific), as well as Hauts-de-France and Pays de la Loire.

[47] Cardiologists are specialists, most of them in sector 1 and therefore eligible for health insurance support, who often work as part of a team as part of their private practice. They employ a significant, albeit unquantified, number of medical assistants, some of whom have been with the company for a long time (15 years), and whose tasks sometimes go beyond the scope of the official definition (fitting and removing equipment, performing ECGs, taking vital signs, looking for orthostatic hypotension and late potentials ).[10]

[48] Dermatologists are another specialty that uses assistants in their practices. About ten years ago, they set up an ad hoc training program for dermatologist assistants (lasting around 100 hours) in conjunction with training organizations, which was validated by the dermatologists' union. Aesthetic surgeons have followed suit.

[49] In addition, a significant number of medical secretaries, though impossible to specify, carry out de facto tasks that fall within the scope of the medical assistant function as formalized in 2019. For some of the trainees, including some interviewed by the mission, the CQP training consists mainly in formalizing the learning of tasks they already perform.

### 2.2.2 Medical assistants in health centers and other establishments in the private health sector

[50] In 2020, the health insurance scheme transposed the existing support scheme for doctors' practices to health centers. Thus, the national agreement for health centers, signed on July 8, 2015 with the representative organizations of health center managers and the CNAM contains a new article 19.10 entitled "supporting the deployment of medical assistants". It states that "the signatory parties agree to encourage and support the deployment of medical assistants in medical and multi-purpose health centers by means of lump-sum conventional financial aid" and that "this assistance function for the benefit of medical activity in the health center and the patient must enable salaried doctors in the health center to optimize their medical time and be supported on a daily basis". It specifies that the medical assistant "must have an ad hoc professional qualification, which will be obtained following specific training, including a possible VAE", without however specifying which training, or the conditions of eligibility for health centers.

[10] On this subject, see a comprehensive document written in 2022 by the Syndicat national des cardiologues: Innov'Cardio, *Les assistants médicaux, n° 4, April 2022.*

[51] To date, we have no information on whether or not health centers have hired such medical assistants[11] .

[52] Other types of healthcare establishments, belonging to branches other than private practice, employ staff known as "medical assistants". This is the case, for example, in establishments run by the Mutualité[12] , social security establishments and private clinics. However, we have no precise information on this subject.

### 2.2.3 Occupational health service assistants

[53] Occupational health service assistants (ASST) work in inter-company occupational health services. Since 2011, these services have been moving towards greater multidisciplinarity. Thus, since 2016, certain missions, in particular the performance of medical check-ups can be delegated within the framework of a written protocol and in compliance with the competences of the professionals concerned by the occupational physician and the law of August 2, 2021 has strengthened the possibilities, under the responsibility of each occupational physician, of delegating missions to members of the multidisciplinary team, primarily to nurses but also to ASSTs (examinations such as ECG or an audiogram), with a certain deliberate vagueness in what may or may not be delegated.

[54] In 2021, the DGT reported 6,180 ASSTs for 2,494 occupational health nurses and 3,700 occupational physicians, a much higher proportion than in private practices. Among them, the national collective agreement for inter-company occupational health services (June 2013 agreement) distinguishes three categories of assistants: assistant medical secretaries (3,782), multidisciplinary team assistants (1,243) and occupational health assistants (1,155).

[55] According to article R. 4623-40 of the French Labor Code, the ASST "provides administrative assistance to the occupational physician and other members of the multidisciplinary team in their activities. They also help to identify hazards and occupational health needs, particularly in companies with fewer than twenty employees. He/she is involved in the organization and administration of prevention projects, and in promoting occupational health and the department's actions in these same companies." Pursuant to article R. 4624-2, he or she takes part in workplace initiatives under the guidance of the occupational physician, and within the framework of the objectives set out in the multi-year project. In compliance with these various provisions, the ASST acts as a secretariat for consultations, and manages day-to-day relations with companies and employees (contact with members, invitations to attend, preparation of medical check-ups, reception of employees, management of complementary examinations, organization of inter-company SST interventions in the workplace). The ASST supports the multidisciplinary team. In close collaboration with other members of the multidisciplinary team, he or she also helps to identify hazards and occupational health needs, with priority given to companies with fewer than twenty employees. He/she is involved in the organization and administration of prevention projects, and in promoting occupational health and the department's actions in these

[11] The mission was able to meet with a former nursery assistant working in a municipal health center, and therefore covered by the local civil service.

[12] A recent study by the Observatoire de l'emploi et des métiers en mutualité on *"Jobs in mutual healthcare and support services up to 2025"* includes a fact sheet on medical assistants.

same companies. The department's role is to act as a relay for occupational risk prevention policies.

[56] The training framework for ASSTs is not defined by legislation or regulations, and there is no title, diploma or CQP. Nevertheless, training organizations specialized in the field of occupational medicine offer training courses of around 200 hours.

# 3 Employers of medical assistants in the medical practice sector

## 3.1 Medical practices and their branch

[57] According to the OMPL, the medical practice sector comprised 31,044 employing companies in 2020, i.e. medical practices with at least one employee. This number has been declining significantly over the past ten years (the estimated number of employing practices was around 30,200 in 2022), due to a slow but steady trend towards concentration.

[58] In 2014, the OMPL estimated that 2/3 of self-employed doctors relied on salaried staff to carry out tasks related to their medical activities: mainly secretarial work, but also maintenance, management and for some paramedical activities (handling radiology equipment, ophthalmology examinations...). In 2019, specialist doctors accounted for 22% of employer practices, but nearly a third of employees. Structures with 10 or more employees are on the rise, representing 3% of practices but almost 30% of the branch's employees in 2019, half of which are from radiodiagnostic and radiotherapy activities alone. These practices are by far the largest, with an average of 12.8 employees, compared with 1.8 to 2.3 in other sectors. Half of all facilities with 20 or more employees are radiology practices, and the other half are mainly GP practices.

[59] The most common business form is the sole proprietorship (16,050 practices in 2019, or 49.4% of the total), but this form is declining in favor of groupings (10,470 sociétés civiles de moyens or 32.2% of the total, 1,460 sociétés de personnes or 4,5% of the total, and 190 associations, or 0.6% of the total), which accounted for 37% of medical practices in 2019, and joint-stock companies or, to a much lesser extent, SISA (sociétés interprofessionnelles de soins ambulatoires), which accounted for 13% in the same year[13] .

**The organization of private practice: an increase in group practice**

In France, liberal medicine is governed by a number of historic principles: independence, freedom of installation and fee-for-service remuneration. These principles mean that each doctor is free to organize his or her medical activity in accordance with current regulations. Private practitioners set up highly personalized structures that reflect the relationship they wish to maintain with their patients, and the balance they aim to strike between time worked and income.

[13] SISAs were created in 2011 to enable multi-professional coordinated practice structures to collectively receive subsidies to remunerate activities carried out jointly by the healthcare professionals practicing there. There were 205 such structures in 2019, representing just 0.6% of medical practices.

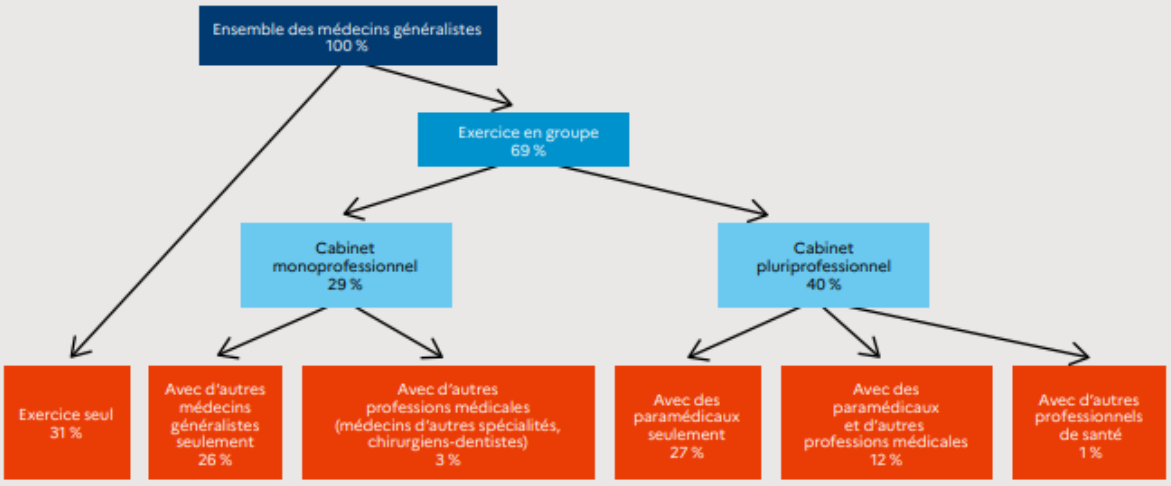
Regulations applicable to independent medical practice mainly concern premises and patient files. Premises must comply with regulations applicable to any establishment open to the public. The practice must also ensure continuity of care. This means that the doctor must allow access to his files by a colleague in his absence. The doctor is also required to keep medical records for ten years. And file management requires special computer equipment.

The practice of self-employed medicine is not limited to patient care: it also includes administrative and management time, either inherent to any business (accounting, etc.), or in part specific to the self-employed healthcare professional (reception and processing of requests, confidentiality and archiving of medical records, relations with other healthcare professionals and social security organizations).

To take on these activities, the doctor may join forces with colleagues to share premises or pool expenses and upkeep, and/or delegate some of the tasks to non-medical staff, either employees of the practice, service providers or spouses.

The French healthcare system offers a wide variety of forms of grouped local healthcare organization. Leaving aside organizations based on salaried doctors, such as municipal health centers, community health centers and mutualist centers, there are group practices, multi-professional health centers and CPTSs.

**Schéma 1** Répartition des médecins généralistes libéraux en 2022, selon les professionnels de santé avec lesquels ils partagent leur cabinet principal




**Lecture >** 29 % des médecins généralistes exercent dans un cabinet monoprofessionnel. 27 % des médecins généralistes exercent dans un cabinet pluriprofessionnel avec des paramédicaux uniquement.
**Champ >** Médecins généralistes libéraux, installés au 1er janvier 2018 sans mode d'exercice particulier exclusif, France entière, hors Mayotte.
**Sources >** DREES, Observatoires régionaux de la santé (ORS) et Unions régionales des professions de santé (URPS) de Provence-Alpes-Côte d'Azur et des Pays de la Loire, quatrième Panel d'observation des pratiques et des conditions d'exercice en médecine générale de ville, janvier à avril 2022.
> *Études et Résultats* n° 1244 © DREES

In practice, by 2022, only 31% of GPs were still practicing alone, while 69% were practicing in a group, in a single-profession practice in 29% of cases, and in a multi-profession practice in 40% of cases. This represents an increase of 15 points since 2010 and 8 points since 2019. We also note that among doctors working alone in 2019, one in five was practicing in a group three years later.

Group practice is mainly chosen by younger doctors (87% of doctors under 50 versus 53% of those aged 60 and over in 2019) and, to a lesser extent, by women (80% versus 62% for men)[14] . Group practice is practiced by 62% of GPs in the Sud region, compared with 82% in Pays de la Loire. It is slightly less common in under-dense areas. In 2019, GP groups averaged three full-time equivalent (FTE) GPs. In 40% of cases, the group comprised up to 2 FTEs, and in 53% of cases, more than 2 FTEs and up to 5 FTEs. The size of the groups varied from region to region.

Coordinated practice, encouraged by the public authorities, is developing in several forms, including for private practitioners.

This is the case of the maisons de santé pluriprofessionnelles (multi-professional health centers), created in 2007, which aim to enable independent professionals to work in groups, based on a health project that attests to their coordinated practice. Today, one GP in 6 (17%) works in one of the 2,000 maisons de santé pluriprofessionnelles (MSPs), most of which are located on one or more sites in medically disadvantaged areas. MSPs employ an average of 19 professionals.

Private practitioners also participate in the "communautés professionnelles territoriales de santé" (CPTS), created in 2016. These are a flexible mechanism for professionals who want to work together to meet the specific healthcare needs of a population catchment area. CPTSs can benefit from ARS support to enhance the value of their work. Their development appears to be relatively slow, due to the complexity of implementation.

Where appropriate, private practitioners also participate in primary care teams or specialized care teams. Formed around primary care general practitioners, primary care teams help to structure patients' healthcare pathways in coordination with primary care providers, with a view to meeting unscheduled care needs and coordinating chronic care in particular. Specialized doctors can participate in a specialized care team, which is a group of healthcare professionals made up of doctors specializing in one or more fields other than general medicine, who choose to coordinate their care activities with all the players in a given area, including primary care teams, on the basis of a healthcare project they draw up together.

Despite these developments, private practitioners are still mainly at the stage of practicing medicine individually within a collective framework, rather than practicing collectively.

*Source : HCAAM*

[60] According to the OMPL, the total number of employees in the branch was 89,445 in 2020, an average of 2.9 per practice, with 85% of employers having either one or two employees[15] . While the number of medical practices is declining, the number of employees has risen sharply, by over 20% since 2010. These figures reflect the development of group practices, encouraged by the public authorities.

[61] The national collective agreement for medical practice personnel of October 14, 1981, extended and amended by dozens of successive endorsements, applies[16] . In 2013, DREES estimated that 30,000 salaried jobs outside the medical practice sector, but employed in healthcare establishments with commercial status, including 11,200 nursing jobs and 19,300

[14] According to a CNOM survey published in April 2019, only 3% of young interns surveyed plan to work as sole practitioners, compared with 72% who plan to work as part of a group or in an MSP, and 19% as salaried employees.

[15] The OMPL estimate for 2021 was 90,760 employees. The DGT, for its part, considers that there will be 115,000 employees in the sector in 2020, based on the DSN.

[16] Cf. Home | Convention collective nationale (ccn-cabinets-medicaux.fr) and Convention collective nationale du personnel des cabinets médicaux du 14 octobre 1981 - Légifrance (legifrance.gouv.fr).

administrative jobs, had their employment directly linked to the activity of self-employed doctors. According to DREES, this was the case for 11,800 salaried employees working with surgeons.

[62] Among the branch's employees, white-collar workers make up the vast majority (73.1%, including 58.7% medical secretaries according to the OMPL, see below), followed by intermediate professions (technicians, supervisors, nurses, etc.) for 20.1% and managers for just 2.8% (a sharply declining proportion which contrasts with the 14% in the healthcare sector).

[63] In 2018, the OMPL estimated that the main salaried employees of medical practices were broken down as shown in the following table.

Tableau 2 : Table - Breakdown of the main salaried employees in the medical practices branch

| Type of trade | Business | Workforce | Share |
|---|---|---|---|
| Partial exercise of the trade | Specialist nurses | 1 446 | 1,6 % |
| | General care nurses | 2 168 | 2,5 % |
| | Other rehabilitation specialists | 1 806 | 2,0 % |
| | Medical technicians | 9 094 | 10,3 % |
| Business support | Executive secretaries, executive assistants (non-executive) | 1 171 | 1,3 % |
| | Dental, medical and veterinary assistants, medical technician assistants | 4 750 | 5,4 % |
| Business support | Qualified receptionists and information hostesses | 930 | 1,1 % |
| | Switchboard operators, telephone operators | 2 439 | 2,8 % |
| | Secretaries | 51 756 | 58,7 % |
| | Miscellaneous service employees | 1 284 | 1,5 % |
| | Cleaners | 2 856 | 3,2 % |

*Source : OMPL, INSEE, DADS 2016-2018*

[64] According to the OMPL, human resources management in medical practices remains largely empirical. The tendency is to recruit for administrative functions to the detriment of paramedical or maintenance functions, as reforms have led to an increase in the administrative obligations of medical practices.

[65] The proportion of women and open-ended contracts is very high, at over 90%. The sector is one of the most feminized in the country. However, the proportion of men has risen slightly in recent years, no doubt due to two factors: a slight increase in gender diversity in existing professions, and the entry into the sector of new, more masculine professions (such as

information technology). The proportion of part-time employees is around 43%, a figure that has remained stable in recent years and is well above the average for other sectors. Employees in the sector are relatively old on average: only 25.9% are under 35, while 37.9% are aged 50 and over, a proportion that has risen significantly over the last ten years. Ageing is particularly marked among women.

[66] Overall, careers in this sector are long. The employee turnover rate, of which medical secretaries make up the vast majority, is a not inconsiderable 14%. Not surprisingly, this rate is higher in the Paris region than elsewhere.

[67] The median net annual income for the sector is €21,830, including €20,260 for employees.

[68] The average level of qualification in the sector is low. In 2014, the OMPL estimated that almost two-thirds of employees had a diploma below the baccalaureate level. According to the OMPL, the branch is also characterized by a relative weakness in access to professional training: it accounts for 25.9% of employees in the healthcare sector, and is responsible for only 8.7% of training initiatives (in 2020). Only 6.9% of employees took part in at least one training course in 2020, including 5.8% via the skills development plan (compared with 15.3% in the healthcare sector). The ratio of training companies to total companies was 5.3%, compared with 25.6% in the healthcare sector. Employees under the age of 35 are proportionally more numerous among trainees and, conversely, employees of very small businesses (the bulk of medical practices) are under-represented among trainees. The rate of access to training was 3% in 2019 for companies with fewer than five employees. Radiology practices in particular send the most employees to training, with an access rate of 21% in 2019, compared with 6% in general medicine and 4% in surgery.

[69] 86% of training departures are financed by the training plan. In 2019, accredited titles or diplomas accounted for 3.5% of training courses, and CQPs only 1%. Training areas are primarily related to the company's core business (38% of training courses). IT and digital training accounted for 18%. Overall, training courses are of short duration: less than 14 hours for almost two-thirds of courses (40% of which last 7 hours or less). The average duration of training courses, however, is 56 hours, due to the 10% of courses ranging from a hundred hours to a maximum of 2,200 hours.

## 3.2 Employers of medical assistants receiving health insurance assistance

[70] This is the only population of employers for which we have relatively accurate data, thanks in particular to a health insurance survey carried out in October-November 2022 among the 108 CPAM and CGSS.

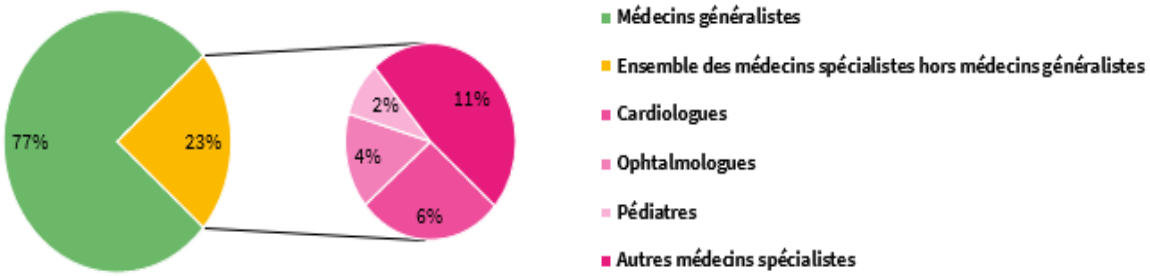
[71] At the end of 2022, according to the most recent statistics provided by the branch, there were 4,069 doctors with an assistance contract, representing 3.63% of all practising doctors[17] .

[72] The vast majority of doctors employing medical assistants are general practitioners (between 75% and 80%), with only 20% to 25% of contracts signed by specialists. The most frequently represented specialties signing contracts are cardiologists (11%), ophthalmologists

[17] CNAM does not have the number of doctors eligible for assistance, but only the number of practicing doctors, which is higher. The penetration rate is therefore understated.

(6%), pediatricians (4%), neuropsychiatrists and psychiatrists and dermatologists, which is roughly consistent with the frequency of assisted work.

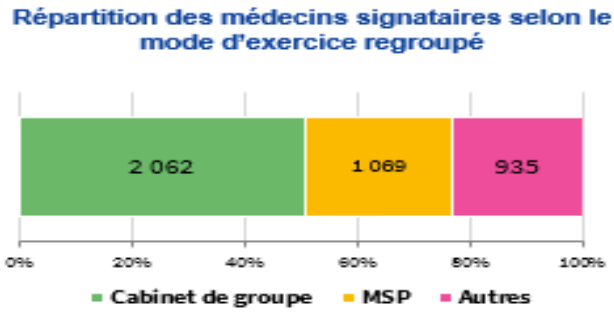
Graphique 4 : Proportion of GPs and specialists signing assistance contracts (February 2023)




*Source : CNAM*

[73] 92% of signatory doctors are sole practitioners and 8% are mixed practitioners. 55% of signatory doctors are involved in some form of coordinated practice, including 18% in a multi-professional health center.

Graphique 5 : Distribution of signatory physicians by practice mode




*Source : CNAM*

[74] In 16% of cases, the employer of medical assistants is an employer group.

**Medical assistants and employer groups**

Employers' groups (GE) were created in 1985. Article L1253-1 of the French Labor Code states: "Groups of persons falling within the scope of a single collective agreement may be formed for the purpose of making available to their members employees bound to these groups by an employment contract. The purpose of such secondment may be to replace employees following a training course covered by the present code. They may also provide their members with assistance or advice on employment or human resources management.

An employers' group is based on the initiative of economic players to meet their skills needs. Jobs are created by the grouping of member companies, which mobilize manpower by making GE employees available, sharing their working time between these structures. In particular, employer groups can help small and medium-sized businesses cope with fluctuations in activity, seasonal fluctuations, recruitment difficulties and the need to mobilize specific skills in certain areas or for certain professions. In addition to providing employees and coordinating employment between companies in the group, GEs can offer a range of services dedicated to securing recruitment and managing human resources.

Employer groups are most widespread in the agricultural sector, where they employ around 30,000 workers. According to a recent study (December 2022) by the Direction de l'animation de la recherche, des études et des statistiques (Dares), there are only 900 such groups outside the agricultural sector, and they employ just 25,000 people, mostly blue-collar workers.

It is not known how many groups of self-employed doctors there are, or how many medical assistants they employ to date. Nevertheless, the mission met with the heads of two such groups. "Le Groupement", in Occitanie, employs 60 medical assistants for every 100 general practitioners who are members. Their medical assistants are paid between the minimum wage and €2,200 gross per month. It began operations in April 2020. Its managers recognize that the employers' group is one "tool among others" for achieving the goal of 10,000 medical assistants. They see the value of employer groups in supporting GPs' teamwork.

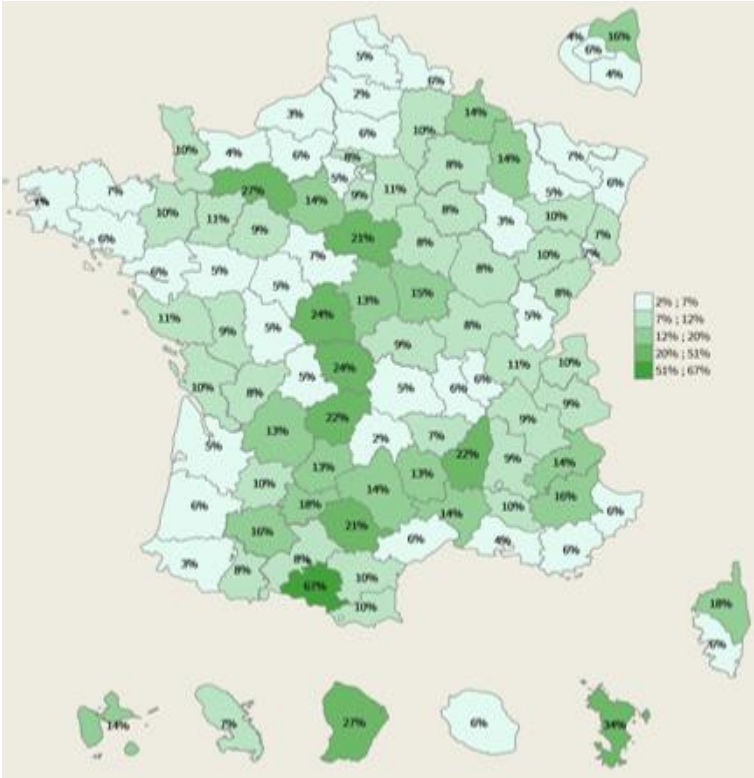
*Source : Mission*

[75] The five départements with the highest number of self-employed doctors who have signed a contract with the health insurance scheme to recruit a medical assistant are: Manche (165), Nord (164), Seine-Saint-Denis (163), Haute-Garonne (127) and Ille-et-Vilaine (105).

[76] The proportion of self-employed doctors employing medical assistants also varies widely from one département to another, for reasons that are not yet fully explained. Departments in which the proportion of self-employed doctors employing medical assistants exceeds 10% (as at December 31, 2022) are mainly rural or overseas: Ariège (29.8%), Corrèze (10.6%), Creuse (14.2%), Indre (15.4%), Manche (30.2%), Nièvre (15.1%), Guyane (17%) and Mayotte (29.7%). This is undoubtedly due to the size of the active files of doctors practicing in these departments, and the mobilization of professionals to resolve a relative shortage of doctors, as well as that of the health insurance system.

[77] Conversely, departments in which the proportion of doctors employing assistants is very low, below 2%, are either urban departments (the reason given is the high cost of land) or also very rural departments: Bouches du Rhône (1.1%), Calvados (1.7%), Cantal (0.5%), Haute-Marne (1.7%), Pyrénées-Atlantiques (1.6%), Rhône (1.8%), Paris (1.1%), Seine-Maritime (1.7%), Somme (1%), Territoire de Belfort (1.3%), Hauts-de-Seine (1.3%) and Val de Marne (1.6%).

Carte 1 : Proportion of signatory physicians compared to total physicians - as of February 25, 2023




*Source : CNAM*

# 4 Recruitment pools for medical assistants

[78] There are many recruitment pools for assistants. The main pool is that of the tens of thousands of medical secretaries, mainly from private practice. However, there is also a large potential pool of nursing assistants and nurses.

[79] It goes without saying that many other people, particularly jobseekers, as well as young people in initial training, should be able to become medical assistants if the medical assistant training program evolves.

## 4.1 The main pool: medical secretaries

[80] Medical secretaries already working in doctor's surgeries are the main, or natural, pool for medical assistants. The medical assistant CQP was designed as a priority by the branch for them, to ensure their professional development and give them greater autonomy in their career development, and some of the functions of medical secretaries overlap with those of medical assistants.

### 4.1.1 The job of medical secretary

[81] The job of medical secretary is not well known. It corresponds to ROME sheet M1609 entitled "secretarial and medical or medico-social assistance"[18] and to sheet 3344 of the International Standard Classification of Occupations (ISCO-08 nomenclature within the "administrative secretaries and specialized secretaries" category).

[82] The medical secretary's role is one of reception, information and administrative assistant. Their role and missions may vary according to the context in which the profession is practiced, as may the job title (medical secretary in the medical field, medico-social secretary in the social and medico-social field).

[83] According to the RNCP data sheet for the medical and medico-social secretary title, the medical secretary is responsible for the reception and overall administrative management of the structure's users. They are also responsible for the administrative management of the secretariat in a multidisciplinary, computerized environment. In particular, the medical secretary is the interface between all those involved in the care network, whether internal or external to the facility. He/she is central to the proper transmission of information.

[84] The job requires mastery of basic secretarial skills, notably office automation and the ability to organize one's time around several tasks (physical and telephone reception, administrative work...). It also requires the ability to manage the pressure of patient demand, which is often urgent and unscheduled (in 2008, DREES estimated that 12% of GP activity was unscheduled). Problems of aggression and violence are probably not uncommon.

[85] The OMPL pointed out in 2014 that private practices still suffer from very empirical operations, with secretarial staff often having to operate in the absence of clear guidelines for sorting patient requests and organizing appointments, the degree of priority of requests generally being determined on an ad hoc basis by either the doctor or the secretary, which places a certain amount of responsibility on her[19] .

[86] As the OMPL pointed out in 2014, medical secretaries in private practices may also have to intervene in the preparation of consultations, to undress or re-dress a patient, perform weighing or toasting, clean equipment, or even perform simple technical acts and act as coordinators (this would be more the case in maisons de santé than elsewhere). Medical secretaries in healthcare facilities other than private practices do not seem to have such responsibilities.

[87] For these reasons, in 2014, the OMPL considered that conditions for the medical secretarial profession were difficult, as it constituted a pivotal but poorly supported player between the demand and supply of care from liberal practitioners. The situation has probably not changed since then.

[88] Medical secretaries can work in a wide variety of settings beyond private medical practices, and therefore fall outside the scope of this branch's collective bargaining agreement. This is

[18] The job description in sheet M1609 does not, however, correspond to the new medical assistant job that is the subject of this report.

[19] See an article by MACSF on the civil and criminal liability of medical secretaries: www.macsf.fr/responsabilite-professionnelle/cadre-juridique/responsabilite-secretaire-medicale

particularly the case in health centers, private for-profit and non-profit hospitals and clinics, and local government agencies.... This is also the case in the medico-social sector, where we speak of medico-social secretaries.

[89] In the hospital civil service, medical secretaries are known as "medico-administrative assistants" (AMA), whereas before 2014 they were called "medical secretaries". They are now category B agents, numbering around 27,600 (average annual ETPR in public health establishments, according to the SAE survey[20] 2021). A number of administrative assistants, who are category C agents, also act as medical secretaries in public health establishments.

[90] In the local civil service, you'll need to pass the "health and social sector" specialization competitive examination to become a medical secretary and work alongside local doctors.

### 4.1.2 Little is known about the number and characteristics of medical secretaries

[91] Unfortunately, there is no precise census of the number of medical secretaries in the various healthcare structures[21] , as the profession is not clearly identified in the various nomenclatures and surveys (DSN, FAP-2021 nomenclature used in the Employment survey).

[92] The range of estimates is therefore very wide, from 66,500 to 136,000 employees:

- According to ACOSS, which processed the DSN in response to a request from the mission, there will be 66,478 separate secretaries in the healthcare sector by the end of 2022. This figure is in the minority when compared with the estimated number of medical secretaries in the scope of the collective agreement for private practice alone (see below).
- According to DARES, which also carried out an employment survey at the request of the mission, there will be an average of 108,000 "medical secretaries and medical or medico-social assistants" (108,000) in 2021 and 2022, to which we can add 28,000 "medical or medico-social executive secretaries". This is certainly an overestimate, given the inclusion of the medico-social sector in particular.

[20] Annual statistics on establishments.

[21] Given the importance of the role of medical secretaries, and their role as the main breeding ground for medical assistants, it would be worthwhile to carry out a census.

**Key data on medical secretaries and medical or medico-social assistants from the Employment survey**

The employment survey carried out for the mission by DARES provides the following picture of the 108,256 medical or medico-social assistants it records:

99% are women. There are only 1,100 men;

Their median age is 45 and their average age is 43.9, 3 and 1.9 years respectively more than those of the salaried population;

Their median length of service is 13 years and their average length of service 16.3 years, close to that of the salaried population as a whole (12.6 and 15.9 years respectively);

Nearly 31% work part-time, with over 17% between half-time and three-quarters time, a significantly higher proportion than in the salaried population (18.4%). Nearly 10% of medical secretaries and assistants consider themselves underemployed, compared to 5.6% of the employed population;

Their median net monthly salary is €1,500 and their average monthly salary is €1,493, significantly lower than that of the salaried population (€1,800 and €2,048 respectively);

Employers are mainly private companies or associations (82.1%), but also hospitals or medical-social establishments (10%), followed by the State or a public administrative establishment (EPA) (2.8%), a public company (2.7%), a local authority (1.2%), a social security organization (0.6%) or even an individual (0.5%);

Nearly 9 out of 10 medical secretaries and assistants (86.4% to be exact) have permanent contracts or are civil servants. 8.9% are on fixed-term contracts, and INSEE counts almost 2,000 who are self-employed;

Nearly half (48.7% vs. 21% of the employed population) have a baccalaureate or equivalent, and 20.6% a short higher diploma (vs. 15.8% of the employed population), but only 7.9% a long higher diploma (vs. 29.9% of the employed population). Only 7.4% have no diploma at all, or the CEP or brevet des collèges.

*Source : DARES*

[93] We know a little more about the population of medical secretaries working in doctors' surgeries, but our knowledge is still too imperfect.

[94] According to the OMPL, 60% of the branch's employees in 2016 were "medical assistants" in the sense of "medical secretaries", representing between 48,500 and 50,500 employees[22] . This number would be around 51,800 in 2018.

[95] DREES has also published some interesting data on the use of medical secretaries by GPs. At the start of 2022, 51.2% of self-employed GPs in France since January 1, 2018 (excluding Mayotte) had a medical secretary in their practice.

[96] Doctors practicing in groups are more likely to have a physical secretariat (65% for GPs practicing in more pluriprofessional groups versus 24% for GPs practicing alone). This can be explained by the economies of scale achieved by group practice. The presence of a physical secretariat in the doctor's office is also linked to the volume of activity: 56% of practitioners with a high volume of activity say they have a physical secretariat, compared with 54% of those with a moderate volume of activity, and 40% of those with a lower volume of activity.

[22] Figures vary according to OMPL publications. After medical secretaries, medical electroradiology manipulators would appear to be the branch's most numerous group of employees.

**The combination of secretarial channels used by GPs in 2022**

Around half of GPs combine several secretarial channels. A third of GPs with a secretariat have only an on-site physical secretariat, 17% a remote telephone secretariat only[23] and 5% an online appointment booking tool only. But 9% of GPs use all three secretarial channels, 5% an on-site and telephone secretariat, and 14% a telephone secretariat and an online appointment booking tool. According to Doctolib, the majority of online medical appointments are booked by secretaries.

*Source : DREES, Doctolib*

### 4.1.3 Likely to grow in the coming years as tasks evolve

[97] It is likely that the number of medical secretaries will continue to rise in the coming years. This trend contrasts with the trend for secretaries in general, whose numbers, which were 380,000 in 2019 according to INSEE, are set to fall by 55,000 between 2019 and 2030 according to DARES estimates, for two reasons: the digitization of the economy and the rationalization of work organization[24] .

[98] The growth in the number of medical secretaries is due to several factors:

- The rapid increase in demand for independent care: according to Doctolib, there will be a shortfall of 100 to 150 million consultations per year by 2030, i.e. a quarter of the current supply;
- Steady growth in the size of private and group practices;
- The rejuvenation of the age pyramid of self-employed doctors ;
- The need to free up medical time and increase productivity in private practices.

[99] Demand for medical secretarial services is already strong, as demonstrated by some of the training organizations met by the mission. It is likely to remain so in the years ahead, despite the parallel growth of telephone secretarial services and online appointment scheduling tools.

[100] Overall, almost one in three GPs who did not have a secretarial service in 2019 will have one in 2022. DREES points out that the rate of use of a physical secretariat in the practice has risen by one point over this period (from 50% to 51%). In its prospective study published in 2021, the OMPL estimated that the number of new medical secretarial jobs would be between 300 and 400 per year.

[101] At the same time, the role of the medical secretary is undergoing significant change. According to the OMPL, the management of appointments is in part declining (this point is qualified by Doctolib, which points out that a majority of online appointments are booked

[23] This solution is developing rapidly: according to DREES, the use of remote telephone secretarial services is expected to increase by 8 points, from 30% to 38% of GPs, between 2019 and 2022. Pricing is generally per call (ranging from €0.5 to over €1 per call), and many operators are competing in this market, which merits a specific study.

[24] Cf. France Stratégie and DARES, *Les métiers en 2030. Report by the Prospective des métiers et qualifications group*. March 2022.

through a secretary), while tasks linked to computerized file management, data monitoring and control are becoming central.

### 4.1.4 Initial and continuing training for medical secretaries

[102] In terms of training, the ROME datasheet specifies that this job is accessible with a diploma at Bac level (Bac ST2S, bac professionnel gestion-administration devenu AGOrA ...) to Bac + 2 (BTS SP3S or DUT for example). It can also be accessed with a BEP in the tertiary sector, supplemented by professional experience in the medical sector. Access to the 1er grade of AMA in the hospital civil service is open to candidates holding a secondary school baccalauréat or a level IV diploma, or a qualification recognized as equivalent.

[103] There are several CQPs or qualifications for medical secretaries or equivalents, including a "technical secretary" CQP set up by UNAPL in the 2000s for secretarial work in liberal businesses and a Ministry of Labor title for "medical-social assistant secretary". In 2014, the OMPL estimated that around 1,200 people obtained medical secretarial certification each year. AFPA estimated that by 2021 there had been 6,300 certified medical-social assistant secretaries, including 820 at AFPA.

[104] In practice, according to figures from DARES and the Employment survey on the population of secretaries in the health and medico-social sector as a whole[25] , almost half (48.7% vs. 21% of the salaried population) have the baccalauréat or equivalent and 20.6% a short higher diploma (vs. 15.8% of the salaried population), but only 7.9% a long higher diploma (vs. 29.9% of the salaried population). Only 7.4% have no diploma at all, or the CEP or brevet des collèges. The initial qualification level of medical secretaries, traditionally low on average, is likely to rise, given the skill requirements of larger practices.

[105] The OMPL, for its part, highlights the difficulties of training and qualifying existing medical secretaries, in a more general context of insufficient training for branch employees in view of the changes underway. In 2019, 71% of employees trained in the branch were employed as medical secretaries (40%) or radio manipulators (31%), which is roughly in line with their share within the branch (76%). 3% of medical secretaries prepared for the medical secretary CQP, the only one in existence in 2019, 10% prepared for a diploma and 16% were on a professionalization contract. The average duration of training courses for medical secretaries was 88 hours. Support for VAE was almost non-existent (0.1% of training courses), despite the branch's efforts.

## 4.2 The pool of healthcare professions

[106] A second major component of the medical assistant pool is made up of healthcare professions. On the one hand, there are three types of healthcare professionals (nurses, orderlies and nursery assistants) authorized to work as medical assistants by the Order of November 7, 2019, issued in application of the last paragraph of Article L. 4161-1 of the French Public Health Code, after completing a 112-hour job adaptation training course (FAE) covering block 2 of the

[25] With all the limitations associated with this overly broad scope.

CQP (reception and administrative management of patients). These are also other healthcare professions, some of whose functions are similar to those of medical assistants.

### 4.2.1 The healthcare professionals listed in the Order of November 7, 2019.

#### 4.2.1.1 The nurses

[107] Nurses provide preventive, curative and palliative care to promote, maintain and restore patients' health. It's a highly responsible profession that demands rigor, vigilance and technical skills, and is essential to the smooth running of the healthcare system.

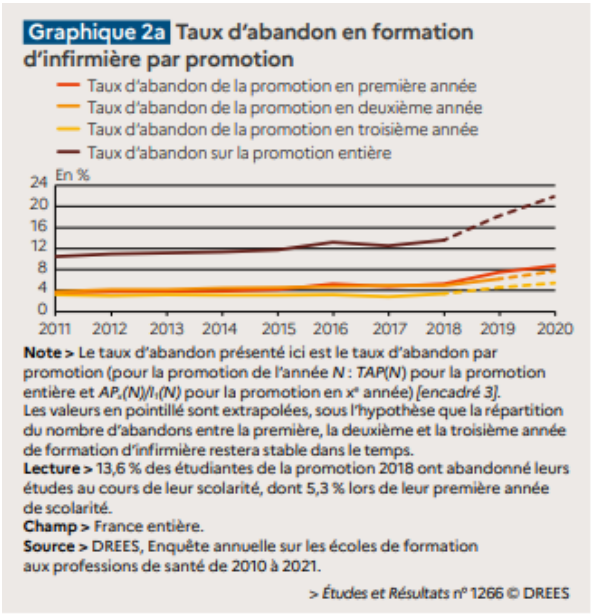
[108] Training for the State Diploma in Nursing, a level 6 diploma that leads to a bachelor's degree, lasts three years and is based on alternating theory and practice. It is divided into six semesters of twenty weeks each, equivalent to 4,200 hours, with 2,100 hours of theoretical training, in the form of lectures (750 hours), tutorials (1,050 hours) and guided personal work (300 hours), and 2,100 hours of clinical training (internships).

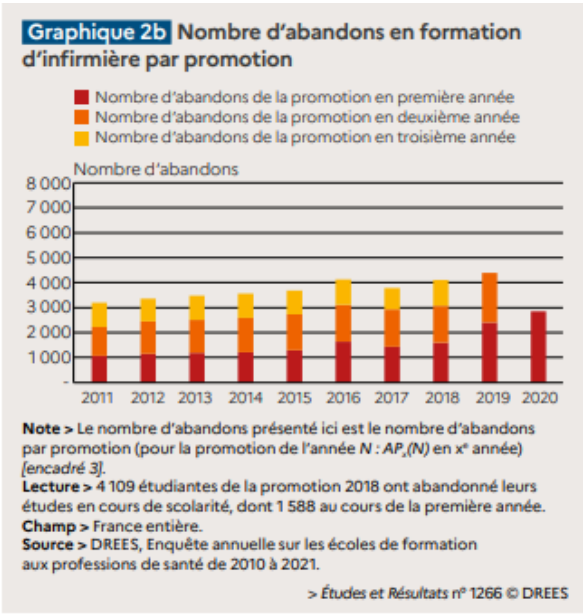
[109] Students who have passed their 1ère year (PASS or LAS 1) may also be admitted to the first or second year of a nursing course. Admission procedures are set by each training establishment. Professionals with three years' contribution to a social security scheme, in particular practising nursing auxiliary diploma holders, are recruited under the continuing professional training scheme, and are subject to specific admission procedures.

[110] Nursing training is provided by the Instituts de formation en soins infirmiers (IFSI) and access is for baccalaureate holders via Parcoursup.

**A high and rising drop-out rate among nursing students and other healthcare professionals during their studies**

By 2021, 10% of female students had dropped out in their first year of training. This figure was three times lower in 2011 (3%). Over the entire schooling of the class of 2018, 14% of female students dropped out, 3 points more than the class of 2011. These dropouts are more frequent in Normandy and Pays de la Loire, as well as among men. One in ten female students in the first year of training to become a nursing auxiliary or medical electroradiology manipulator will also have dropped out by 2021. For most health training courses, the first-year dropout rate is significantly higher than in the early 2010s. Among three- and four-year courses, the dropout rate for the entire course doubled in the 2010s for medical electroradiology manipulators and chiropodists.




*Source : DREES, 2023.*

[111] There are five core nursing skills:

- Assessing a clinical situation and making a diagnosis in the field of nursing ;
- Designing and implementing a nursing care project ;
- Accompanying a person in the performance of their daily care ;
- Implement diagnostic and therapeutic actions;
- Initiate and implement educational and preventive care.

[112] Five transversal skills are common to certain paramedical professions:

- Communicating and conducting a relationship in a care context;
- Analyze the quality of care and improve professional practice;
- Research and process professional and scientific data;
- Organize and coordinate care interventions;
- Inform and train professionals and trainees.

[113] Nurses are the first category of professionals, for several reasons:

- The benefits for some doctors of employing a paramedical professional who is perfectly familiar with the vocabulary and realities of health, care, care pathways and patients, and could even help them perform technical acts if this were now authorized for nurses becoming medical assistants;

- Hundreds of thousands of working nurses: estimated at 637,600 on January 1, 2021 by DREES and 663,100 by DARES (including 409,000 salaried employees for ACOSS, compared with 514,000 for DREES)[26] ;
- The large number of nurses who have already retired or wish to retire for reasons linked to working conditions;
- The benefits for doctors of having a qualified healthcare professional to assist them in their practices;
- The relative ease with which nurses can obtain a job adaptation training certificate (112 hours) to become a medical assistant.

[114] There are, however, a significant number of obstacles to the conversion of nurses to medical assistants, a conversion which is not encouraged by the health authorities:

- The very high demand for nurses in public and private healthcare establishments and in private practice, which is creating a shortage;
- The overqualification of nurses to work as medical assistants, which risks diverting scarce healthcare resources;
- The loss of the nurse's ability to perform nursing acts during the term of his or her medical assistant contract, even if he or she can perform them in addition if he or she continues to work as a nurse;
- The risk of medical assistants' tasks being shifted if many nurses were to take on this role, a risk to which some nursing unions are very attentive;
- The difference in remuneration is very significant, especially for nurses with a certain level of experience.

[115] In fact, according to health insurance figures, only 9% of contracts signed with employers of medical assistants involve nurses. It would appear that these are mainly professionals wishing to improve their difficult working conditions, even at the cost of lower remuneration.

[116] It can also involve professionals on disability, etc.

[117] There is no estimate of the number of nurses who might be tempted by such a retraining or career change. There are probably several thousand. We might also consider the number of student nurses who abandon their studies and would like to work as medical assistants instead.

[118] These pools should be clearly identified and their members provided with clear information. The ban on performing nursing acts as a medical assistant could also be lifted.

[26] DREES has significantly revised downwards the number of nurses in 2022. The differences between the figures put forward successively by DREES, DARES and, even more so, ACOSS raise questions for a profession as important and numerous as that of nurses, which is also considered to be in short supply.

#### 4.2.1.2 Orderlies

[119] Nurses' aides are another important potential pool for medical assistants, despite the fact that so far very few of them have chosen this career path: they account for just 2% of contracts signed.

[120] As a healthcare professional, the nursing auxiliary is empowered to provide care of daily living or acute care to preserve and restore the continuity of life, well-being and autonomy of the individual, within the framework of the nurse's own role, in collaboration with the nurse and as part of a shared responsibility. Care assistants have a three-fold mission: to support patients in their activities of daily and social living, in accordance with their life project; to collaborate on personalized care projects within their field of competence; and to contribute to risk prevention and inter-professional clinical reasoning.

[121] The role of the caregiver is part of a global approach to the person, and takes into account the relational dimension of care, as well as communication with other professionals, learners and caregivers. The caregiver works as part of a multidisciplinary team in the care departments or care networks of health, medico-social or social facilities, particularly in the context of hospitalization or continuous or discontinuous accommodation in a facility or at home.

[122] Training to become a Level 4 nursing assistant lasts one year. It lasts 1,540 hours, divided equally between theoretical teaching, delivered in particular using healthcare simulation tools, and clinical teaching via internships. Three five-week internships and one seven-week internship are included in the curriculum. The seven-week internship enables students to explore or consolidate their career plans, and may also help with recruitment.

[123] The training framework comprises five blocks, corresponding to ten training modules (see table below).

## Tableau 3 : Skills blocks and training modules for nurses' aides

| Blocs de compétences | Compétences | Modules de formation | Modalités d'évaluation du bloc de compétences |
|---|---|---|---|
| **Bloc 1 - Accompagnement et soins de la personne dans les activités de sa vie quotidienne et de sa vie sociale** | 1 - Accompagner les personnes dans les actes essentiels de la vie quotidienne et de la vie sociale, personnaliser cet accompagnement à partir de l'évaluation de leur situation personnelle et contextuelle et apporter les réajustements nécessaires | **Module 1. - Accompagnement d'une personne dans les activités de sa vie quotidienne et de sa vie sociale** *Module spécifique AS* | **Etude de situation Evaluation des compétences en milieu professionnel** |
| | 2 – Identifier les situations à risque lors de l'accompagnement de la personne, mettre en œuvre les actions de prévention adéquates et les évaluer | **Module 2. Repérage et prévention des situations à risque** *Module spécifique AS* | |
| **Bloc 2 - Evaluation de l'état clinique et mise en œuvre de soins adaptés en collaboration** | 3- Evaluer l'état clinique d'une personne à tout âge de la vie pour adapter sa prise en soins | **Module 3. - Evaluation de l'état clinique d'une personne** *Module spécifique AS* | **Etude de situation en lien avec les modules 3 et 4 Evaluation comportant une pratique simulée en lien avec le module 5 Evaluation des compétences en milieu professionnel Attestation de formation aux gestes et soins d'urgence de niveau 2** |
| | 4- Mettre en œuvre des soins adaptés à l'état clinique de la personne | **Module 4. - Mise en œuvre des soins adaptés, évaluation et réajustement** *Module spécifique AS* | |
| | 5 – Accompagner la personne dans son installation et ses déplacements en mobilisant ses ressources et en utilisant les techniques préventives de mobilisation | **Module 5. - Accompagnement de la mobilité de la personne aidée** | |
| **Bloc 3 - Information et accompagnement des personnes et de leur entourage, des professionnels et des apprenants** | 6- Etablir une communication adaptée pour informer et accompagner la personne et son entourage | **Module 6. - Relation et communication avec les personnes et leur entourage** | **Etude de situations relationnelles pouvant comporter une pratique simulée Evaluation des compétences en milieu professionnel** |
| | 7 – Informer et former les pairs, les personnes en formation et les autres professionnels | **Module 7. – Accompagnement des personnes en formation et communication avec les pairs** | |
| **Bloc 4 - Entretien de l'environnement immédiat de la personne et des matériels liés aux activités en tenant compte du lieu et des situations d'intervention** | 8- Utiliser des techniques d'entretien des locaux et du matériel adaptées en prenant en compte la prévention des risques associés | **Module 8. – Entretien des locaux et des matériels et prévention des risques associés** | **Evaluation à partir d'une situation d'hygiène identifiée en milieu professionnel Evaluation des compétences en milieu professionnel** |
| | 9 - Repérer et traiter les anomalies et dysfonctionnements en lien avec l'entretien des locaux et des matériels liés aux activités de soins | | |
| **Bloc 5 - Travail en équipe pluri-professionnelle et traitement des informations liées aux activités de soins, à la qualité/gestion des risques** | 10 - Rechercher, traiter et transmettre, quels que soient l'outil et les modalités de communication, les données pertinentes pour assurer la continuité et la traçabilité des soins et des activités | **Module 9. – Traitement des informations** | **Etude de situation pouvant comporter une pratique simulée Evaluation des compétences en milieu professionnel** |
| | 11- Organiser son activité, coopérer au sein d'une équipe pluri-professionnelle et améliorer sa pratique dans le cadre d'une démarche qualité / gestion des risques | **Module 10. – Travail en équipe pluri professionnelle, qualité et gestion des risques** | |

*Source : training standards for nurses' aides*

[124] Training is provided by nearly 500 nursing aid training institutes throughout France, and is accessible via initial training, continuing education, validation of acquired experience and apprenticeships. Training is open to all, with no diploma requirements. Holders of certain diplomas (nursery assistants, ambulance drivers, family life assistants, educational and social support workers, medical-psychological assistants, medical regulation assistants, holders of professional ASSP or SAPAT baccalaureates) benefit from exemptions to become a nursing auxiliary.

[125] There are more factors in favour of retraining nurses as medical assistants than there are for nurses:

- A practical knowledge of the medical environment, patients and certain technical procedures;
- They possess many of the skills needed to work as medical assistants, and even similar skills for orderlies working in hospital outpatient clinics;
- This is a significant number, estimated at 418,600 by ACOSS, 455,700 by DARES and 480,000 by the CNP des aides-soignants (DREES does not have a recent estimate), an unquantified but significant proportion of whom would like to retrain;
- The absence of obvious professional development at present (except for becoming a home-based social worker or nurse, but by training in a school);
- The pay differential between orderlies and medical assistants is smaller than that of nurses.

[126] However, there are still a number of obstacles to the conversion of nurses' aides to medical assistants, which are reflected in the current situation:

- The demand for care assistants is very high, creating a shortage, as is the case for nurses;
- Nurses' training in administrative matters is limited overall;
- Pay gaps remain for experienced care assistants, although employers can close some of them if they wish.

#### 4.2.1.3 Nursery assistants

[127] Nursery assistants work with young children in health facilities (maternity wards, pediatrics or neonatology departments), medical and social services (day-care centers, PMI centers, medical-educational institutes, nurseries).

[128] Working in maternity wards or hospital wards, nursery assistants provide routine care for newborns and infants. She weighs, measures and changes babies, grooms them and prepares their bottles. She also advises mothers on routine care and maintains the child's room and equipment. In the PMI (maternal and child protection centers), the childcare assistant attends consultations given by the doctor. She welcomes children, weighs and measures them. She keeps files up to date and advises parents. She also ensures the cleanliness of equipment and premises. In crèches or day-care centers, the nursery assistant is responsible for a group of 5 to 8 healthy children, aged between 3 months and 3 years. Her activities follow the children's rhythms: she changes them, feeds them or teaches older children to eat on their own, to walk and to become potty-trained. She constantly monitors the child's development. She also organizes games and early-learning activities.

[129] The nursery assistant is a member of a team under the supervision of a manager: nursery nurse, early childhood educator, nurse...

[130] Since the start of the new academic year in September 2021, training to become a nursery auxiliary has been registered at level 4 of the Répertoire national des certifications professionnelles, enabling nursery auxiliaries to be positioned in category B of the hospital civil service.

[131] The updated training program is structured around new activity areas and skill blocks. The five areas of activity are

- Support and care for the child in activities of daily living and social life, identifying any weaknesses;
- Assessment of the person's clinical condition and implementation of appropriate care in collaboration with the nurse, integrating quality and risk prevention;
- Information and support for people and their families, professionals and learners;
- Maintenance of the person's immediate environment and materials related to care activities, the place and situations of intervention;
- Transmission of observations, whatever the tool and communication method.

[132] The five skill blocks are :

- Support and care for the child in activities of daily and social living;
- Assessment of clinical condition and implementation of appropriate care in collaboration ;
- Information and support for people and their families, professionals and learners;
- Maintenance of the person's immediate environment and of materials related to activities, taking into account the place and situations of intervention;
- Multi-professional teamwork and processing of information relating to care activities and quality/risk management.

Tableau 4 : Skills blocks and training modules for nursery assistants

| Blocs de compétences | Compétences | Modules de formation | Modalités d'évaluation du bloc de compétences |
|---|---|---|---|
| Bloc 1 - Accompagnement et soins de l'enfant dans les activités de sa vie quotidienne et de sa vie sociale | 1 - Accompagner l'enfant dans les actes essentiels de la vie quotidienne et de la vie sociale, personnaliser cet accompagnement à partir de l'évaluation de sa situation personnelle et contextuelle et apporter les réajustements nécessaires | Module 1. - Accompagnement de l'enfant dans les activités de sa vie quotidienne et de sa vie sociale<br>*Module spécifique AP* | Etude de situation<br>Evaluation des compétences en milieu professionnel |
| | 1bis - Elaborer et mettre en œuvre des activités d'éveil, de loisirs, d'éducation et d'accompagnement à la vie sociale adaptées à l'enfant ou au groupe | Module 1bis. Activités d'éveil, de loisirs, d'éducation et d'accompagnement à la vie sociale<br>*Module spécifique AP* | |
| | 2 – Identifier les situations à risque lors de l'accompagnement de l'enfant et de son entourage, mettre en œuvre les actions de prévention adéquates et les évaluer | Module 2. Repérage et prévention des situations à risque<br>*Module spécifique AP* | |
| Bloc 2 - Evaluation de l'état clinique et mise en œuvre de soins adaptés en collaboration | 3- Evaluer l'état clinique d'une personne à tout âge de la vie pour adapter sa prise en soins | Module 3. - Evaluation de l'état clinique d'une personne<br>*Module spécifique AP* | Etude de situation en lien avec les modules 3 et 4<br>Evaluation comportant une pratique simulée en lien avec le module 5<br>Evaluation des compétences en milieu professionnel<br>Attestation de formation aux gestes et soins d'urgence de niveau 2 |
| | 4- Mettre en œuvre des soins adaptés à l'état clinique de l'enfant | Module 4. - Mise en œuvre des soins adaptés, évaluation et réajustement<br>*Module spécifique AP* | |
| | 5 – Accompagner la personne dans son installation et ses déplacements en mobilisant ses ressources et en utilisant les techniques préventives de mobilisation | Module 5. - Accompagnement de la mobilité de la personne aidée | |
| Bloc 3 - Information et accompagnement des personnes et de leur entourage, des professionnels et des apprenants | 6- Etablir une communication adaptée pour informer et accompagner la personne et son entourage | Module 6. - Relation et communication avec les personnes et leur entourage | Etude de situations relationnelles pouvant comporter une pratique simulée<br>Evaluation des compétences en milieu professionnel |
| | 7 – Informer et former les pairs, les personnes en formation et les autres professionnels | Module 7. – Accompagnement des personnes en formation et communication avec les pairs | |
| Bloc 4 - Entretien de l'environnement immédiat de la personne et des matériels liés aux activités en tenant compte du lieu et des situations d'intervention | 8- Utiliser des techniques d'entretien des locaux et du matériel adaptées en prenant en compte la prévention des risques associés | Module 8. – Entretien des locaux et des matériels et prévention des risques associés | Evaluation à partir d'une situation d'hygiène identifiée en milieu professionnel<br>Evaluation des compétences en milieu professionnel |
| | 9 - Repérer et traiter les anomalies et dysfonctionnements en lien avec l'entretien des locaux et des matériels liés aux activités de soins | | |
| Bloc 5 - Travail en équipe pluri-professionnelle et traitement des informations liées aux activités de soins, à la qualité/gestion des risques | 10 - Rechercher, traiter et transmettre, quels que soient l'outil et les modalités de communication, les données pertinentes pour assurer la continuité et la traçabilité des soins et des activités | Module 9. – Traitement des informations | Etude de situation pouvant comporter une pratique simulée<br>Evaluation des compétences en milieu professionnel |
| | 11- Organiser son activité, coopérer au sein d'une équipe pluri-professionnelle et améliorer sa pratique dans le cadre d'une démarche qualité / gestion des risques | Module 10. – Travail en équipe pluri professionnelle, qualité et gestion des risques | |

*Source : Training standards for nursery assistants*

[133] The training, which leads to a state diploma, lasts 1,540 hours over eleven months, divided equally between theoretical and practical training in internships or healthcare simulation tools. It is open to all, regardless of qualifications, and is delivered by 141 training institutes.

[134] The exact number of childcare assistants is difficult to estimate: ACOSS identifies 72,570, while DARES counts 108,365. According to DREES, there were 6,600 students enrolled in childcare assistant training in 2021.

Tableau 5 : Comparison of diplomas and training courses for nurses' aides, childcare assistants and nurses

| Diplôme préparé | Durée de la formation | Conditions de diplôme et d'expérience pour accéder aux épreuves d'admission | Niveau du diplôme délivré | Titre de diplôme |
|---|---|---|---|---|
| Diplôme d'état d'aide-soignant | 10 mois (18 mois max pour les apprentis) | - | 4* | CAP ou équivalent |
| Diplôme d'état d'auxiliaire de puériculture | 10 mois (18 mois max pour les apprentis) | - | 4* | CAP ou équivalent |
| Diplôme d'état d'infirmier | 36 mois | Bac ou équivalent | 6 | Bac+3 |

*Source : Mission*

[135] It is difficult to estimate the number of childcare assistants who might want to retrain. A specific analysis should be carried out.

### 4.2.2 Other healthcare professions

[136] Other healthcare professionals could also provide a breeding ground for the medical assistant function, as some of their functions are already closely related. This is particularly true of the following professionals.

#### 4.2.2.1 Medical-technical assistants

[137] The ROME nomenclature combines medical assistants with dental assistants and audioprosthesist assistants under the name "medico-technical assistant". ROME J1303 specifies that the job of medico-technical assistant prepares the medico-technical elements for the practitioner to carry out the procedures and carries out the medico-administrative follow-up of patient/client files, may provide technical support to the practitioner in carrying out care, may install medical equipment in private homes (respirator, nutrition pump, etc.) and may carry out the administrative management of the structure.

[138] This category also includes medical regulation assistants.

- Dental assistants and dental aides

[139] The tasks of dental assistants, who are the main collaborators of dental surgeons, overlap considerably with those of medical assistants, except that they are not placed under the authority of a doctor but of a dental surgeon[27] . Dental assistants are in charge of welcoming and seating patients in the dental chair, and preparing medical devices for cleaning. They are also responsible for packaging surgical and sterilization tools. The dental assistant also organizes the practitioner's

[27] According to France Compétences, the profession of dental assistant has even inspired that of medical assistant. The ROME nomenclature combines medical assistants, dental assistants and audioprosthesist assistants under the name "medico-technical assistant".

appointments: answering the phone, managing the calendar. They provide patients with information and simple oral hygiene advice, and may be required to identify and classify X-ray images. They manage stocks of dental materials and products. Dental assistants can work in hospitals, clinics or private practices.

[140] The versatility inherent in the very nature of the dental assistant profession means that these professionals are playing an increasingly important role in dental practices. The advantages of "four-handed work" are widely emphasized in terms of ergonomics, stress reduction for the practitioner and improved quality of care.

[141] The dental assistant training program, which leads to a level 4 qualification, lasts 18 months and lasts 1,878 hours, including 343 hours of theoretical training and 1,535 hours of practical training. Training is provided on a sandwich basis, usually under a professionalization contract, with employment in a dental practice. A VAE pathway is also available.

[142] The training reference framework has been reduced from ten to eight learning areas requiring validation: general knowledge of the dental assistant's activity; relationship-communication, education and health promotion; management of infectious risks and equipment maintenance; management, transmission and follow-up of patient records; assistance to the practitioner; complementary examinations - emergency procedures and care; traceability and professional risks; work organization, multi-professionalism and support for trainees and new recruits.

[143] Level 2 dental assistants who can "contribute to diagnostic imaging procedures, prophylactic procedures, orthodontic procedures and post-surgical care" will also be introduced in the near future.

[144] There are also dental assistants[28] , who are much less numerous than dental assistants, and tend to be found in larger practices. They hold a CQP acquired over a 12-month period as part of a professionalization contract or promotion through work-study schemes. The training of dental assistants is based on mastery of some of the learning areas required to obtain the title of dental assistant. Dental assistants must be trained in the following areas: general knowledge of the dental assistant's activity; patient relations and communication; management of infectious risks; management, transmission and follow-up of patient records; emergency procedures and care; traceability and professional risks.

[145] In practice, dental assistants are entrusted with tasks similar to those of dental assistants, to the legal exclusion of tasks requiring their presence in the treatment room at the time of the operative sequence. In other words, dental assistants' duties are restricted to activities that exclude any direct participation in treatment, as is the case for medical assistants.

[146] The number of dental assistants was estimated by OMPL at 29,300 in the private practice sector, to which must be added an unknown number of dental assistants in other sectors. The OMPL estimates the number of dental assistants at only around 1,000.

- Hearing aid assistants

[28] The course is listed as "inactive" in the RNCP.

[147] The audioprosthesist's assistant, or audioprosthesis technical assistant, is the audioprosthesist's right-hand man. There are several thousand of them, and in practice at least one per hearing aid center.

[148] The profession is not yet regulated, and the tasks of hearing aid assistants - administrative (reception, invoicing) and technical (minor maintenance, excluding audiometry and hearing aid adjustment in principle) - are not precisely defined. The profession requires no compulsory training. There is, however, a certificate of professional qualification (certificat de qualification professionnel d'assistant technique en audioprothèse) (level 4 training), which takes around 100 hours to complete.

[149] The most obvious career path for hearing aid assistants is, of course, to become hearing aid practitioners themselves.

- Medical regulation assistants

[150] They are category B hospital civil servants who work in SAMU/centres-15 and SAS, providing medical support 24 hours a day, 7 days a week. The ARM is the first point of contact for any caller in the event of a medical emergency or need for unscheduled care. The medical regulation assistant helps to ensure that people in emergency situations are properly guided. Reporting to the medical regulator, the ARM is responsible for receiving, listening to and analyzing emergency calls, managing callers' stress and emergency situations, prioritizing calls by questioning callers precisely, activating the appropriate means of action under the responsibility of a doctor, and mastering computer and telephone tools. Their training lasts one year and is divided into 1,470 hours of training, equally divided between theoretical instruction and internships.

#### 4.2.2.2 Other professions

[151] A series of healthcare professions, further removed from the medical assistant, and with a bac+2 or bac+3 level, can be pointed out, even if a reconversion is not necessarily obvious. These include :

- Opticians, who are numerous (over 40,000), with a Bac+2 diploma, half of whom are aged between 20 and 35;
- Medical laboratory technicians, of whom there are around 45,000, with a Bac+3 state diploma, and x-ray manipulators, of whom there are around 28,000 to 29,000, also with a Bac+3 degree[29] . Their missions are mainly technical.

[152] Last but not least, we should mention the profession of veterinary auxiliary technician, in the field of animal health rather than human health. There are an estimated 15,000 of them. The veterinary auxiliary assists and supports the veterinarian, mainly in the city. They are responsible for secretarial duties, hygiene and safety, and care assistance - in other words, missions very similar to those of a medical assistant. Training leads to a level 4 CQP, the only qualification recognized by the profession, and lasts 24 months, including 805 hours at the training center.

[29] Cf. the recent IGAS report: Charlotte Carsin and Alain Meunier, *Manipulateurs en électroradiologie médicale : un métier en tension, une attractivité à renforcer*, February 2020.

## 4.3 Other possible breeding grounds

[153] Two healthcare and medical-social professions were frequently mentioned to the mission.

[154] Medical-psychological assistants, who work with dependent people of all ages, whether their impairment is sensory, physical, mental or psychological. Their scope of action is twofold. Their knowledge of "nursing" care enables them to help people with everyday tasks (getting up, going to bed, washing, dressing, eating, getting around) by establishing a relationship of trust with them. At the same time, their training in social and interpersonal skills enables them to stimulate communication and memory, notably through cultural, sporting and creative activities. They are trained to a level 3 diploma (Diplôme d'Etat d'accompagnant éducatif et social).

[155] Auxiliaires de vie sociale help people who are ill, disabled, frail, elderly or very dependent to carry out the acts of ordinary life. As part of their personal assistance activities, they are present for the essential acts of life: getting up, going to bed, washing, hygiene care (excluding nursing care). They also provide support during the fitting of orthopaedic devices for people with disabilities. The AVS prepares and takes care of meals and household chores. They take care of administrative tasks, outings, shopping, etc. They also have level 3 training.

# 5 Opportunities for medical assistants

[156] The branch has not yet given any specific thought to possible career paths for medical assistants. The novelty of the profession means that there is still some time to build appropriate career paths. Nevertheless, this is an important point to clarify in order to ensure that the medical assistant function is attractive from the moment they enter training. The OMPL thus points out that "the construction of an individualized pathway for medical assistants to enhance their skills, enabling them to validate what they have learned and supplement it with specific training modules, should be given priority."

[157] We can already imagine a number of possible outlets for medical assistants:

- Health coordinators, who lead teams in the maisons de santé, manage the health project drawn up by the multi-professional team, implement public health initiatives and manage administrative tasks, while communicating internally and externally;
- Dental assistants or hearing aid assistants ;
- Nurses.

[158] It would be very useful to provide for certain exemptions or possible equivalences for medical assistants wishing to retrain in these professions.

[159] Some of the mission's interviewees also raised the possibility of developing, in a few years' time, a Level 2 medical assistant profession along the same lines as the dental assistant profession, with the medical assistants concerned playing a greater role in technical or care procedures. This solution should be studied in the light of the experience of level 2 dental assistants and the evaluation of the impact of medical assistants abroad.

# ANNEXE 2 : Certificate of professional qualification and job adaptation training

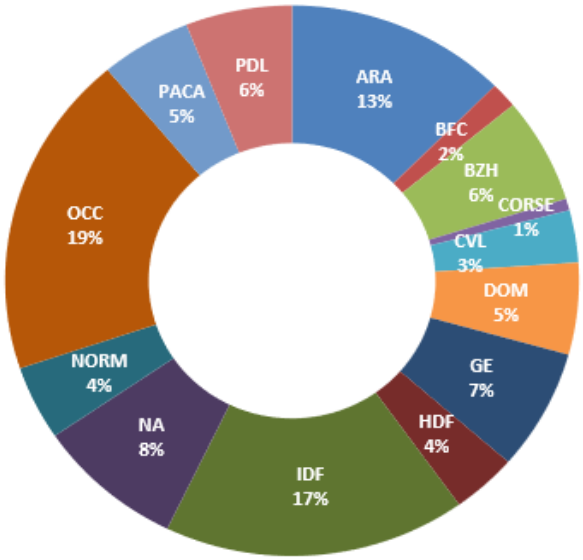
# CONTENTS

[160] This appendix outlines the history of medical assistant training (1) and explains why it is atypical (2). It provides an analysis of the RAC (3), describes the exemption mechanism and reveals the limits imposed by its sandwich course format (5).

[161] There are two ways to become a medical assistant: a 112h job adaptation training course (FAE) for healthcare professionals (IDE, ASDE and APDE) or a 384h professional qualification certificate (CQP) for all other profiles.

***Who are the AM trainees?***

95% women
41.6 years average age
80% of medical secretaries
80% in general practices
The specialties that make most use of AM are ophthalmologists and cardiologists, who account for only 4.6% and 3% respectively.
90% had a permanent contract when they started training
5.5% ASDE, 4.4% IDE, 0.7% APDE and 0.3% dental assistants
5% RQTH




Geographical origin of trainees

65% without exemption (i.e. complete the full 384 h - does not apply to FAE)
84% under a skills development plan
9.4% in job adaptation training (i.e. IDE, ASDE and APDE)
6.4% on professionalization contracts
0.2% personal training account

*Source : The CPNEFP database mission*

# 1 Medical assistant training is the fruit of long-standing work and a compromise by the branch

[162] The Medical Assistant CQP was registered with the RNCP under number 36358 on April 25, 2022, for a 3-year period. As a result, the CPNEFP (commission paritaire nationale emploi et formation professionnelle - national joint committee for employment and vocational training) for medical practices (the branch), which holds this certificate, has no plans to modify it in the short term, putting forward two main arguments: stakeholder satisfaction and the difficulty of the registration exercise.

[163] The certifier is the CNPEFP, an association of medical practice CQPs (ACQPCM), which holds the intellectual property rights to the branch's CQP titles.

[164] The medical assistant CQP is the fruit of long-standing work and negotiations between the various parties involved: general practitioner employers, specialist doctor employers, medical practice employees and public authorities.

[165] Indeed, the medical practice branch began working on the subject of medical assistants in 2014, initiating work on a reference framework with Actalians (which has since become Opco EP), bringing together general practitioners and specialists. The development of this function aroused reluctance on the part of the DGOS, which was not in favor of creating a new profession (and does not want medical assistants to become healthcare professionals), and employee unions, which identified a risk of task creep that could constitute a risk for future medical assistants.

[166] Work resumed in 2018, when the "Ma santé 2022" plan was announced, in conjunction with Opco EP's training engineering R&D department and the DGOS, which then championed the project that had become a government priority. In 2020, the branch launched the call for applications to select training organizations (see Appendix 4), and the first training courses began in March 2021. The registration file was submitted for the first time to France compétences in June 2021 and examined under the emerging professions procedure[30] .

[167] At the same time, medical specialists, who are more involved in technical procedures than general practitioners, and therefore more familiar with assisted work, have also carried out work that has fed into the development of the medical assistant CQP. In 2011, the Syndicat National des Ophtalmologistes de France (SNOF) continued work begun in the 2000s on the profession of Technicien Assistant en Soins Ophtalmologistes (TASO), which ultimately failed to see the light of day due to opposition from orthoptists. Subsequently, in 2014-15, on the basis of a survey carried out by the Observatoire des métiers dans les professions libérales (OMPL)[31] , the professional organizations for medical specialties worked on a reference framework for medico-technical assistants (AMT). It comprised a core curriculum of 441h + 21h AFGSU 2[32] and specialization

[30] The medical assistant profession was added to the list of emerging professions in January 2021. This listing enables the profession to benefit from a simplified registration procedure: see appendix on vocational training institutions and arrangements in force for the training of medical assistants.

[31] Cabinets médicaux, de l'état des lieux à la prospective - 2014.

[32] **Mastery of the medical environment**: 1. basic biology, anatomy and physiology (28 h), 2. main diseases and their effects (28 h), 3. medical vocabulary (14 h), 4. physics (14 h) // **Care assistance**: 1. delegated protocol for

modules of 175h each in ophthalmology, dental and maxillofacial surgery, ENT, aesthetics and dermatology. The core curriculum is similar to that of the CQP, but there is a major difference in that there is virtually no administrative content.

[168] The SNOF told the mission that it was working with one of the OFs on a new ophthalmology training course due to open in September 2023, aimed in particular at medical secretaries. Level 1 will involve 7 hours of e-learning, 7 hours of telepresence (visio) with an ophthalmologist and 14 hours of in-office training.

[169] France has therefore opted for a hybrid profession that is more administrative than medico-technical, in contrast to the choices made by other countries (see appendix on medical assistants abroad).

[170] However, the profession has also been opened up to healthcare professionals such as IDEs, ASDEs and APDEs. This decision was presented to the mission by the DGOS as belated, and also the result of a compromise (especially in the case of IDEs).

## 2 Medical assistant training has a number of atypical features

[171] Medical assistant training is characterized by a number of particularities in terms of prerequisite entry levels, access routes and format.

[172] In fact, the mission analyzed professions that are an identified breeding ground (medical secretary and dental assistant) and a profession with similarities (medical regulation assistant). All are level 4. The table below provides a detailed comparison.

care assistance (28 h), 2. instrumentation and safety instructions (14 h), 3. delegated intervention protocol (21 h), 4. interrogation (14 h) // **Health education**: 1. communication (21 h), 2. Public health policies (35 h), 3. patient psychology (28 h), 4. support and educational attitudes (42 h) // **Risk management**: 1. prophylaxis and prevention of contamination risk (42 h), 2. quality tools (21 h), 3. Continuous improvement (21 h), traceability (7 h) // Occupational **health and safety**: 1. occupational risk management, contaminant risk, radiation, blood exposure, chemical and biological risks (49 h), 2. gestures and postures (14 h), 3. AFGSU2

## Tableau 1 : Comparison of training for medical secretaries, medical assistants, dental assistants and medical regulators

| | Medical assistant | Medical secretary | Dental assistant | Medical regulation assistant |
|---|---|---|---|---|
| **Type of qualification** | CQP | 3 CQP and 9 professional titles | Professional title | Professional title |
| **RNCP NO.** | 36358 | 36632/36520/36495/36080/36491/36714/36897/36219/5497/36734 + 19175 secrétaire technique option entreprise de santé + 36085 secrétaire assistant médico-social du ministère du travail, du plein emploi et de l'insertion | 15745 | 34679 |
| **RNCP registration expiry date** | April 25, 2025 | 1er July 2024/1er June 2025/1er June 2025/15 December 2026/1er June 2027, July 2027, September 29, 2025, February 25, 2024, August 7, 2023, July 20, 2027, August 7, 2023 and 1er September 2025 | April 17, 2023 | 1er January 2024 |
| **Active certification** | Yes | Yes | Yes | Yes |
| **Certification body** | Association holding the intellectual property rights to CQP titles for the medical practice branch (branch) | See RNCP | Association pour le paritarisme dans les cabinets dentaires libéraux (branch) | Ministry of Health |
| **Healthcare professional** | No | No | Yes | Yes |
| **Access roads** | - Professionalization contract<br>- Continuing professional development<br>- VAE<br>- | - Initial training<br>- Apprenticeship (9/12)<br>- Continuing professional development<br>- Professionalization contract<br>- VAE<br>Depending on the course | - Initial training<br>- Learning<br>- Continuing professional development<br>- Professionalization contract<br>- VAE | - Initial training<br>- Learning<br>- Continuing professional development<br>- VAE |
| **Level of diploma required on entry** | - IDE<br>- ASDE<br>- EDPA<br>- Level 4<br><br>Level 3 with 3 years' experience as a medical secretary | Level 3 | Level 3 | - Baccalauréat or equivalent<br>- Level 4 qualification<br>- 3 years' full-time professional experience |
| **Graduation level** | Level 4 | Level 4 | Level 4 | Level 4 |

| | | | | |
|---|---|---|---|---|
| **Diplomas with which there are bridges (to become)** | - State-qualified nurse<br>- State-certified care assistant<br>- State-qualified nursery assistant<br>- Dental assistant<br>- Dental help<br><br>Medical secretary | | - Diplomas mentioned in Titles I to VII and IX of Book III of Part 4 of the CSP (French Public Health Code)33<br>- Hospital Pharmacy Preparer<br>- Dental help<br>- Qualified veterinary auxiliary | - Diplomas mentioned in Book III of Part 4 of the CSP<br>- Diplomas mentioned in articles D. 451-8834 and D. 451-9235 of the French Code de l'Action Sociale et des Familles (Social Action and Family Code)<br>- Medico-administrative assistants in the medical secretarial branch and hospital executive assistants in the hospital civil service, who have undergone job adaptation training in accordance with the conditions laid down by regulation.<br><br>Permanenciers auxiliaires de régulation médicale governed by decree no. 2016-1704 of December 12, 2016 |
| **Regulatory text governing training** | | Order of October 27, 2017 relating to the professional title of medico-social assistant secretary. | Order of June 8, 2018 | Decree no. 2019-747 of July 19, 2019 and Order of July 19, 2019 |
| **Total training duration** | 10 to 12 months for the CQP<br><br>2 to 3 months for FAE | Highly variable, depending on the type of diploma (TP or CQP), OF and access route | 18 months | 12 months |
| **Number of hours of theoretical training (without exemptions)** | 384h for the CQP<br><br>112h for FAE | Highly variable, depending on the type of diploma (TP or CQP), OF and access route | 343h | 735h |
| **Number of hours of practical training** | No mention | Highly variable, depending on the type of diploma (TP or CQP), OF and access route | 1535h (but variable according to OF brochures) | 735h (statutory) |

[33]Nurses, physiotherapists and chiropodists, occupational therapists and psychomotor therapists, speech therapists and orthoptists, medical electroradiology manipulators, audioprosthetists and opticians, dieticians.
[34]Accompagnant éducatif social diplômé d'Etat, which replaces the former qualifications of auxiliaire de vie sociale and aide médicopsychologique (references which still appear on the Ministry of Health's web page on medical regulation assistants.
[35] Repealed.

| | | | | |
|---|---|---|---|---|
| **Existence of exemptions**<br><br>**(+14h if AFGSU) - does not include assessment hours** | - IDE, ASDE and APDE: 252h<br>- Medical secretary: 49h<br>- Medical secretary + 1 year: 98h<br>- Dental assistant or dental helper: 49h<br>- Dental assistant or dental auxiliary + 1 year: 70h<br><br>+14h for all if AFGSU 1 valid | | - Diplomas mentioned in titles I[er] to VII and IX of book III of part 4 of the CSP[36] : 28h for all and 70h (including 21h AFGSU 2) for medical electroradiology manipulators<br>- Hospital pharmacy assistant: 28h<br>- Dental assistant: 161h<br>- Dental assistant + 1 year: 168h<br>- Qualified veterinary auxiliary: 21h<br><br>+ 21h for all (except medical electroradiology manipulators, see above) if AFGSU2 is valid | - Diplomas mentioned in Book III of Part 4 of the CSP<br>- Diplomas mentioned in articles D. 451-88[37] and D. 451-92[38] of the French Code de l'Action Sociale et des Familles (Social Action and Family Code)<br>- Medico-administrative assistants in the medical secretarial branch and hospital executive assistants in the hospital civil service, who have undergone job adaptation training in accordance with the conditions laid down by regulation.<br>- Permanenciers auxiliaires de régulation médicale governed by decree no. 2016-1704 of December 12, 2016<br><br>The terms and conditions for granting exemptions are defined by a decree issued by the Minister of Health, which has not yet been published. |
| **Number of approved training organizations** | 12 | 12 | 10 | 13 |

*Source : Mission*

[36]I: nurses, II: physiotherapists and chiropodists, III: occupational therapists and psychomotor therapists, IV: speech therapists and orthoptists, V: medical electroradiology manipulators and medical laboratory technicians, VI: audioprosthetists and opticians, VII: dieticians, IX: orderlies, nursery nurses, ambulance drivers and dental assistants.

[37]Accompagnant éducatif social diplômé d'Etat, which replaces the former qualifications of auxiliaire de vie sociale and aide médicopsychologique (references which still appear on the Ministry of Health's web page on medical regulation assistants.

[38] Repealed.

[173] In terms of entry level, medical assistant training stands out for its wide range of requirements. Via the CQP, this training is open to level 4 (baccalaureate) and level 3 (CAP and BEP) with experience for medical secretaries without diplomas, but also, via the FAE, to level 6 professionals (bac + 3) for nurses.

[174] The RNCP sheet sets out the prerequisites for access to the CQP :

- *"Level 4 or baccalaureate ;*
- *Jobseekers with no experience in the healthcare sector;*
- *Medical secretary (if certification not validated, 3 years' professional experience as a medical secretary) ;*
- *Dental assistant*".

[175] The wording used in the placement procedure drafted by the ACQPCM is different and more explicit, particularly for jobseekers: "*level 4 for young people who have completed their initial training; level 4 for jobseekers with no experience in the healthcare sector; validated level 4 certification in medical secretarial work, or non-validated on condition of 3 years' professional experience as a medical secretary*".

[176] Dental assistants are not mentioned. Logically, dental assistants, whose training has not been active since July 2020, are not mentioned in either of the two documents published subsequently, but they remain eligible for certain exemptions and therefore authorized to take the CQP.

[177] The table below summarizes the different levels of qualification required for medical assistant training, either through the CQP or the FAE.

Tableau 2 : Diploma level of the various professions/situations allowing access to medical assistant training (CQP or FAE)

| Profession | Diploma level | Training |
|---|---|---|
| IDE | Level 6 | FAE |
| ASDE | Level 4 | FAE |
| EDPA | Level 4 | FAE |
| SM certified | Level 4 | CQP |
| Dental assistant | Level 4 | CQP |
| Job seeker | Level 4 | CQP |
| Non-certified SM with 3 years' experience | Level 3 | CQP |

*Source : Mission*

[178] This positioning at level 4 on entry (with the exception of medical secretaries) is the result of a branch decision dated March 17, 2022.

A la suite des recommandations de la DGOS et des propositions de l'OPCO; en cohérence avec le travail de refonte de la classification des emplois de la branche des cabinets médicaux qui a intégré le métier d'assistant médical dans sa liste des métiers et sa grille de salaires ; enfin, en vertu de la décision de France Compétences en décembre 2020 d'inscrire le métier d'assistant médical sur la liste des nouveaux métiers.

La CPNEFP réunie en plénière ce jeudi 17 mars 2022 à la majorité de ses membres acte que le CQP assistant médical correspond à un niveau 4, et acte la nécessité de procéder à la demande d'une inscription du CQP à ce niveau.

*Source : CPNEFP*

[179] Prior to this date, some trainees were able to enter training without fulfilling the *above-mentioned* diploma requirements. According to the database provided by the branch, 14 certified trainees hold a "brevet", 12 a diploma below level 4, and 23 no diploma at all.

[180] An analysis of the database enables us to determine the educational background of trainees other than IDEs, ASDEs, APDEs and dental assistants. It reveals that half the trainees have a baccalaureate and 25% have a 2-year higher education qualification.

Tableau 3 : Diplomas held by trainees before starting CQP training

| Diploma level | Number of trainees | % |
|---|---|---|
| Bin | 649 | 49,6 % |
| Bac + 2 | 316 | 24,2 % |
| Experience 3 years SM | 128 | 9,8 % |
| Bac level | 121 | 9,3 % |
| Bac + 1 | 45 | 3,4 % |
| No diploma | 23 | 1,8 % |
| Patent | 14 | 1,1 % |
| Lower level 4 | 12 | 0,9 % |
| Grand total | 1308 | 100,0 % |

*Source : Mission based on restated CPNEFP data*

[181] In view of the massive recruitment desired by the public authorities, the mission recommends that level 3 should no longer be conditional on 3 years' experience as a medical secretary. It should be noted that no particular diploma is required for access to training as a

nursing assistant, whose reference framework is very similar to that of the CQP[39] . This opening should not lead to a reduction in the level of certified medical assistants, as the CQP provides for an assessment[40] and, in a deliberation dated July 7, 2022, the branch authorized total or partial repetition, enabling trainees who have not reached the required level to try their luck again.

> La branche des personnels des cabinets médicaux, organisme certificateur du CQP Assistant Médical, est tenue de délivrer le CQP AM.
>
> Pour les stagiaires ayant échoué à un ou plusieurs blocs de compétences du CQP AM il est nécessaire de mettre en place un dispositif leur permettant de terminer leur cursus et de pouvoir obtenir le CQP.
>
> La CPNEFP réunie en plénière le 7 juillet a acté l'inscription aux barèmes 2022 de prise en charge financière par l'OPCO des frais pédagogiques et annexes de sessions de rattrapage / redoublement pour les candidats au CQP AM qui se trouveront dans ce cas de figure.
>
> La CPNEFP du 7 juillet 2022 à l'unanimité de membres présents de demande à la SPP de l'OPCO EP l'inscription au barème 2022 pour le plan de développement des compétences une ligne nommée "Un ou plusieurs blocs du CQP AM" sur les fonds conventionnels, avec la prise en charge des frais suivants:
>
> - frais pédagogiques 20€ de l'heure (pour info idem CQP AM)
> - frais annexes pris en charge pour les entreprises quelque soit l'effectif (pour info idem CQP AM)
> - frais de salaire : 12 € de l'heure (pour info idem CQP AM)
>
> pour un nombre maximum de 112H par bloc limité à 2 fois le même bloc

*Source : CPNEFP*

[182] The 2019 decree specifies the three state diplomas required to work as a medical assistant: nurse (DEI), nursing auxiliary (DEAS) and childcare auxiliary (DEAP).

[183] In fact, as mentioned in the box *above*, IDEs, ASDEs and APDEs represent only a small proportion of the medical assistants recruited and trained.

[184] There are a number of reasons for this situation: the still fairly confidential nature of the medical assistant function, the potential loss of remuneration, the loss of civil servant status, strong opposition from the nursing order and certain nursing unions, and the prohibition on performing nursing acts for an IDE who becomes a medical assistant.

[185] The current situation therefore seems to rule out the risk, mentioned in the mission statement, of drawing on the already very limited pool of healthcare professionals. The mission even considers that the function of medical assistant may appear to be a possible development for professionals who no longer wish to or can no longer (physically or psychologically) pursue their activity in the hospital or private practice environment, and in particular for IDEs or ASDEs

[39] Entrance to the program is by examination, with no diploma required, and a minimum age of 17. The baccalaureate and certain vocational diplomas can be used to waive eligibility tests (e.g. CAP in early childhood educational support). Source ONISEP.

[40] To date, according to the information provided to the mission, failures have been very exceptional.

on disability. In this respect, we recommend that the professionals concerned be made more aware of this possible development.

[186] When it comes to access routes, as illustrated in the occupational comparison table, medical assistant training offers the fewest, excluding initial training and apprenticeship (which requires a professional qualification or diploma).

[187] Lastly, with regard to **the training model**, it is worth highlighting the condition set by the order of November 7, 2019[41] of a possible entry into training up to two years after hiring (and therefore certification three years later). While this condition is justified by the flexibility that the public authorities wished to grant at the time the CQP was created, to enable the scheme to ramp up immediately, it is neither relevant nor justified from a pedagogical point of view. In fact, it has the dual consequence of minimizing the relevance of the reference framework, which appears *de facto* too detailed in the eyes of employers and employees, and of allowing practices to take root that are far removed from the educational content subsequently taught.

[188] It's worth emphasizing the highly atypical nature of this post-hiring training period. Indeed, the mission compared this provision to those laid down for dental assistants or medical regulation assistants, for whom obtaining a professional qualification is a prerequisite for recruitment.

# 3 The reference framework is consistent with the medical assistant profession, but could be adapted to achieve the desired objective.

[189] The CQP model was designed by the branch, with the help of Opco EP and the DGOS, for medical secretaries, with a view to working alongside general practitioners. The content of the current CQP appears to be consistent with the target through the blocks and modules it comprises. Its aim is to enhance the skills of medical secretaries by adding a "health" dimension to the administrative skills they have already acquired.

[190] Additional skills cover aspects of individual health (patient pathways and examinations), public health (prevention and vaccination), care (material assistance to the practitioner) and health safety (hygiene rules within the practice). To take account of their administrative know-how, medical secretaries are exempt from a large part of the "reception and administrative handling of patients" block.

[191] The training and assessment of trainees is governed by a reference framework of activities, skills and assessment (RAC) in attachment no. 1. It comprises fifteen modules grouped into four blocks of a total duration of 384 hours (including 13 hours of assessment), details of which are given in the table below. The blocks can be taken in any order, and block 2 corresponds to the content recommended by the branch for the professionals concerned by the FAE.

[41] Relating to the exercise of the activity of medical assistant.

## Tableau 4 : Medical assistant CQP model and hourly volume

| Blocks | Modules | Current durations | Of which valuation[42] |
|---|---|---|---|
| Patient follow-up | Routine examinations and care | 21h | 1h30 |
| | Health care pathways and coordination | 35h | 1h30 |
| | Vaccination and screening | 14h | 1h |
| | Public health policies | 35h | 45min |
| Patient reception and administration | Patient file creation and follow-up | 35h | 2h |
| | Medical vocabulary | 14h | |
| | Medical software | 28h | Tutor evaluation |
| | Patient communication | 21h | 30min |
| | Telemedicine | 14h | 30min |
| Hygiene and quality | Contaminant risk management | 42h | 1h15 |
| | Indentitovigilance, pharmacovigilance | 35h | 2h30 |
| Operational assistance to the practitioner | AFGSU 1 | 14h | |
| | Constants and measurements | 14h | 30min |
| | Inventory management | 7h | 1h |
| | Technical assistance to the practitioner | 42h | Tutor evaluation |
| TOTAL | | 384h | 13h |

*Source : Mission*

[42] Source: specifications for the call for candidates for the development and implementation of the medical assistant CQP training program.

[192] In the opinion of those involved in vocational training with whom the mission met, the 384h duration is typical for this type of qualification. A comparison carried out by the mission with training for dental assistants and medical regulation assistants leads to the conclusion that the hourly volume of the medical assistant CQP is not particularly long: the theoretical training duration of 384h (which can be reduced to 269h30 for medical secretaries with one year's experience and a valid AFGSU 1 (see below)) is comparable to that of dental assistants (343h), and much lower than that of medical regulation assistants (735h). Furthermore, medical assistant training does not require any practical training, whereas dental assistants and medical regulation assistants take 1535h and 735h respectively. These elements are summarized in the table below.

Tableau 5 : Comparative training times for medical assistants, dental assistants and medical regulation assistants

| | Medical assistant | Dental assistant | Medical regulation assistant |
|---|---|---|---|
| Total training duration | 10 to 12 months | 18 months | 12 months |
| Duration of theoretical training[43] | 384h | 343h | 735h |
| Duration of practical training | Unframed | 1535h | 735h |

*Source : Mission*

[193] Generally speaking, the standard is considered satisfactory by most stakeholders. Nevertheless, the various parties met by the mission expressed the following comments:

- It is designed for people with little or no experience, and is therefore more a case of initial training, whereas the most important pool at present is that of medical secretaries. This observation needs to be qualified by the high proportion of exemptions available to medical secretaries (see *below*);
- There is little focus on medical specialties, but in practice training organizations take advantage of the excessive number of hours in certain modules to insert content relating to pediatrics and geriatrics, which are the shortcomings that have been systematically cited. What's more, the representatives of medical specialists interviewed by the mission agree that specific knowledge and know-how can be acquired in the practice;
- The list of authorized procedures is not sufficiently explicit. This finding must be interpreted differently: the authorized procedures are extremely limited (taking vital signs with automatic devices), which reduces the help that a medical assistant can provide.

[43] No dispensation.

[194] In more detail, the mission has listed in a table *below* the main comments made by training organizations and the expression of their common position established at a meeting organized by the branch on June 28, 2022.

[195] The modules (which are unanimously agreed on in terms of length) that the mission considers could be the subject of a reduction in their hourly volume are as follows:

- Public health policies (35h) ;
- Medical software (28h) ;
- Telemedicine (2pm) ;
- Identitovigilance and pharmacovigilance (35h) ;
- Evaluation (13h).

[196] For the others, the mission recommends studying the relevance of a reduction with stakeholders.

[197] On the other hand, the mission does not accept the suggestions made by the OFs for lengthening the duration of the contract.

[198] Finally, the mission is not in favor of requiring level 2 of the AFGSU (which would add 7 hours of additional training). The AFGSU 1, which lasts 14 hours, is sufficient for professionals who must work alongside a doctor who could intervene immediately if the patient's situation so required.

| Blocks | Modules | OF findings during interviews with the mission and adaptations made | OF recommendations June 28, 2022 meeting |
|---|---|---|---|
| **Patient follow-up (105h)** | Routine examinations and care (21h no exemption) | - Not enough content on pathologies and anatomy<br>- Lack of content on geriatrics and pediatrics (this comment applies to several modules)<br>- Too short | - Systematically begin training with notions of anatomy and medical vocabulary => **+7h** |
| | Health care pathways and coordination (35h no exemption) | | - Reduce duration from 35h to 28h => **- 7h** |
| | Vaccination and screening (14h without exemption) | | - Add an introduction to immunology => **+ 7h** |
| | Public health policies (35h no exemption) | - Too long | - Add notions of therapeutic education |
| **Patient reception and administration (112h)** | Creation and follow-up of patient files (35h - full exemption for SM) | - Block 2 too long for the content<br>- Too short | - Merge the module with that on "medical software" and reduce the total number of hours to 35h => **- 28h**<br>- For FAE trainees, add content relating to the health pathway, vaccination and prevention, and reduce the module on medical vocabulary. |
| | Medical vocabulary (14h - full exemption for SM) | - This module should be waived for IDEs and ASDEs<br>- Too short | |
| | Medical software (28h - full exemption for SM with one year's experience) | - Not suitable for the FAE public<br>- Too long and not adapted to the large number of existing software programs and the scarcity of trainers | - Merge the module with the one on "creating and monitoring patient records" and reduce the total number of hours to 35h => **- 28h** |
| | Patient communication (21h - full exemption for SMs with one year's experience and dental assistants and dental aids with one year's experience) | - Too short | |
| | Telemedicine (14h no exemption) | - Not suitable for the FAE public | |

| | | | |
|---|---|---|---|
| | | - Too long and often not adapted to employers' practices | |
| Hygiene and quality | Contaminant risk management (42h - full exemption for dental assistants and dental auxiliaries) | | - Create three 14-hour sub-modules on infectiology, hygiene and Covid |
| | Indentitovigilance and pharmacovigilance (35h - no exemption) | - Too time-consuming, especially since the AM will probably not have to carry out reports | - Integrate basic pharmacology and therapeutics without changing the hourly volume |
| Operational assistance to the practitioner | AFGSU 1 (14h - full exemption for AFGSU1 holders) | SO | - Plan for level 2 on the recommendation of emergency care teaching centers) => **+ 7h** |
| | Constants and measurements (14h - no exemption) | | |
| | Inventory management (7h) - full exemption for dental assistants and dental auxiliaries | | |
| | Technical assistance to the practitioner (42h - no exemption) | - Too long<br>- Too short | - Add content on pediatrics and geriatrics |
| Evaluation | Trainees exempted from courses are exempted from assessments, but cannot be counted. | - Too long | |

## 4 The exemptions provided are generally consistent with the expertise of the professionals concerned, but are insufficiently applied in the case of medical secretaries.

[199] With the exception of the first, the blocks can be waived according to the trainee's experience and qualifications. These are specified in the positioning procedure and are listed below.

Tableau 6 : Table of exemptions

| ACTIVITES / BLOCS DE COMPETENCES | MODULES DE FORMATION | DISPENSES |
|---|---|---|
| SUIVI DU PARCOURS DU PATIENT | Examens et soins courants en cabinet médical | Aucune dispense |
| | Parcours de santé et coordination | Aucune dispense |
| | Vaccination et dépistages | Aucune dispense |
| | Politiques de santé publique | Aucune dispense |
| ACCUEIL ET PRISE EN CHARGE ADMINISTRATIVE DES PATIENTS | Création et suivi d'un dossier patient | Dispense pour les personnes titulaires d'une certification en secrétariat médical (dont le titre de Secrétaire technique option entreprise de santé de l'UNAPL). |
| | Vocabulaire médical | Dispense pour les personnes titulaires d'une certification en secrétariat médical (dont le titre de Secrétaire technique option entreprise de santé de l'UNAPL). |
| | Logiciel médical | Dispense pour les secrétaires médicales possédant 1 an expérience |
| | Communication avec les patients | Dispense pour les titulaires :<br>- d'une certification de secrétariat médical (dont le titre de Secrétaire technique option entreprise de santé de l'UNAPL) + 1 an d'expérience dans le métier<br>- du titre Assistant·e dentaire et du CQP Aide dentaire + 1 an d'expérience dans le métier |
| | Télémédecine | Aucune dispense |

| | | |
|---|---|---|
| **HYGIENE ET QUALITE** | **Gestion du risque contaminant** | Dispense pour les titulaires du titre d'Assistant·e dentaire et du CQP Aide dentaire |
| | **Identito-vigilance et pharmacovigilance** | Aucune dispense |
| **ASSISTANCE OPERATIONNELLE AU PRATICIEN** | **AFGSU niveau 1** | Dispense sur présentation de l'attestation AFGSU |
| | **Constantes et mesures** | Aucune dispense |
| | **Gestion des stocks** | Dispense pour les titulaires du titre d'Assistant·e dentaire et du CQP Aide dentaire |
| | **Assistance technique au praticien** | Aucune dispense |

*Source : CPNEFP*

[200] This positioning procedure specifies that "*this list is not exhaustive, and may be supplemented by other certifications listed in the RNCP. New requests for exemptions are to be submitted to the ACQPCM for examination and validation*". The branch confirmed to the mission that exemptions were not listed in the RNCP and could therefore be easily reviewed.

[201] These exemptions make it possible to specify actual training times according to trainee profiles and experience. They are summarized in the table below:

Tableau 7 : Length of medical assistant training depending on exemptions granted

| Profiles | Medical secretary<br>1 year experience | Medical secretary | Dental assistant or helper<br>1 year experience | Dental assistant or helper | Other profiles |
|---|---|---|---|---|---|
| Total duration | **384h** | | | | |
| Course waivers | 98h | 49h | 70h | 49h | 0 |
| Evaluation waivers | 2h30 | 2h | 2h45 | 2h15 | 0 |
| Remaining hours | 283h30 | 333 h | 311h15 | 332h45 | 384h |
| If AFGSU validated | 269h30 | 319 h | 297h15 | 318h45 | 370h |

*Source : Mission*

[202] These exemptions are granted during the positioning process, which is carried out using the platform developed by the branch and accessed by training organizations. The process must be carried out by the training organization's pedagogical manager or CQP referent, and is ultimately validated by the ACQPCM. The exemption applies to the module and corresponding assessment[44].

[203] The exemptions provided for medical secretaries (98 hours of courses, 2 hours or 2.5 hours of assessment +/- 14 hours of AFGSU1), which also apply to hospital medical secretaries, seem relevant to the mission.

[204] On the other hand, the mission considers that there should be more training for dental assistants. With regard to the "creation and follow-up of a patient file" and "medical software" modules, for which 35 hours and 28 hours respectively are planned, only medical secretaries are exempt, whereas dental assistants benefit from 77 hours of training (35 hours of lectures, 21 hours of practical work and 21 hours of practical work) on the same subjects. Similarly, dental assistants are not exempt from the 42-hour "technical assistance to the practitioner" module, even though their training includes an 84-hour module (35 hours of lectures, 21 hours of supervised work and 28 hours of practical work). Ultimately, however, since dental assistants represent only 0.3% of medical assistants currently in training, this new dispensation would only have a significant impact on the average length of training if a greater number of dental assistants were to apply.

[205] After reprocessing the data in the database provided by the branch, the mission was able to ascertain that 53% of trainees with a medical secretary profile did not benefit from exemptions.

[206] As we did not have access to the individual files, we remain cautious as to the conclusions to be drawn. It does, however, draw the branch attention to this point, and in particular to the possible lack of knowledge of the system on the part of training organizations, at least one of which[45] told the mission that assessments were to be carried out on modules covered by exemptions.

[207] All in all, it would appear that medical assistant training is tailored to each individual's profile, and that exemptions make it modular.

# 5 Employers are critical of the training format, but there is room for improvement.

[208] Theoretically, the routes to certification are continuing training, professionalization contracts and validation of acquired experience (VAE). In practice, the vast majority (84%) of medical assistants are trained on a sandwich course, with funding from the skills development plan.

[44] In practice, some OFs told the mission that assessments were still compulsory for modules covered by the exemption, leading some trainees to end up taking the modules to ensure success at the time of assessment.
[45] This question was not explicitly included in the interview grid, and the practice was mentioned spontaneously by one of the training organizations. Given the figures for exemptions, the mission cannot rule out the possibility that this practice is more widespread.

[209] Employers agree that the current format, set by the branch itself, of alternating training over ten months[46] with two days a week, is an impediment to hiring a medical assistant, particularly when the latter is part-time. Indeed, this is tantamount to hiring a professional who is absent from the practice for the entire duration of his or her training, except in part during school vacations.

[210] It's important to remember, however, that the very principle of professional training is to allow employees to take time off to improve their skills, to the dual benefit of the employee and the employer.

[211] It should also be remembered that Opco EP provides for the reimbursement of salary costs when the medical assistant is in training, which in theory enables the employer to recruit a replacement medical secretary, but in practice is not very effective, as employers are reluctant to use a professional they do not know for a few days a week.

[212] It is against this backdrop that the branch has decided to set a minimum contract duration of 21h to be able to enter training, which prevents assistants hired on a one-third time basis from entering training. As mentioned in the excerpt from the record of decision of the branch meeting of October 6, 2022, the arbitration settlement of May 2023 effectively abolished one-third-time hiring, which constitutes an obstacle to training (otherwise compulsory) for a significant proportion of medical assistants.

| | |
|---|---|
| **durée alternance** | La CPNEFP n'a pas décidé la durée minimale des contrats de travail pour pouvoir faire de l'alternance. Une réflexion et un débat sont nécessaires. Il y a beaucoup de questions à ce sujet, et le flou laisse la porte ouverte à une hétérogénéité du déroulement des formations mais aussi des refus d'envoi en formation de la part de certains employeurs ou des refus prise en charge de certains stagiaires par des OF.<br><br>Il est proposé de fixer une durée de 21h minimum. Cela pourrait permettre aux employeurs qui ont des contrats de 16 ou 18h de pouvoir faire un avenant de 3 ou 5h pour être en conformité avec la règle établie par la branche et ce le temps de la formation en alternance. de plus la CPAM semble envisager de supprimer les ⅓ temps des conventions conclues avec les praticiens. Par ailleurs, il faut rappeler que les salariés déjà en poste peuvent bénéficier de dispenses qui de facto réduisent le temps de formation.<br><br>**DÉCISION de la CPNEFP : il est décidé à l'unanimité des membres présents que la durée de l'alternance sera de 21 heures à compter du 1er janvier 2023. les contrats pour entrer en formation devront être de 21H minimum. Les personnes qui ont plusieurs temps partiel et dont le cumul est supérieur ou égal à 21H peuvent entrer en formation.** |

*Source : CPNEFP*

[213] Various ideas have been put forward to respond to this criticism (of a too long absence from the office) but few are effective in the short term in achieving the objective set:

- Spreading training over more than one year: OFs are not in favor of this, as it would generate a risk of trainee fatigue and drop-out, an analysis that the mission shares. Indeed, the vast majority of trainees are adults who already have family commitments and may be reluctant to be away from home for 2 days a week;
- Offer more modular training: as mentioned *above*, the mission concludes that training is modular because of the exemptions it provides for both the CQP and the FAE.

[46] Training organizations generally follow the school vacation calendar in their area.

[214] On the other hand, the mission would like to highlight more interesting and longer-term solutions such as :

- Increase the proportion of distance learning, which will provide a solution to the two obstacles expressed by training organizations (insufficient premises and difficulties in recruiting trainers);
- Offer trainees the opportunity to follow all 384 hours of the CQP on a continuous basis;
- In addition to the CQP, create a medical assistant qualification or, where appropriate, a broader health assistant qualification for all healthcare structures, not just doctors' surgeries. This would open up the possibility of recruiting medical assistants as apprentices and benefiting from apprenticeship funding. It would also be a sign of the value of the function and the beginnings of the construction of a profession. The training required to obtain this qualification could, if necessary, be grouped together over a few months (three or four), interspersed with a period on the job.

# ANNEXE 3 : Institutions, professional training schemes and certifications for training medical assistants

# CONTENTS

[215] This appendix provides an overview of the institutions and professional training schemes in force for medical assistants, with details of their specific situation.

# 1 The medical practice staff branch, the CPNEFP and Opco-EP

## 1.1 The branch

[216] The professional branches play an important role in several areas of vocational training: forward-looking management of jobs and skills (GPEC) at sectoral and territorial level, the development of professional certifications, the management of work-study schemes and the financing of apprenticeships.

[217] In practice, the professional branch concerned by medical assistants is the medical practice staff branch. According to the 2021 collective bargaining report published by the DGT, it had 115,000 employees on December 31, 2020, which is an average position within the healthcare and social sector[47] .

[218] The medical practice personnel branch is closely linked to other branches of the healthcare sector, such as dental practices, veterinary clinics and practices, medical biology laboratories and dispensing pharmacies, all of which fall within the scope of the liberal professions. Other sectors include non-profit hospitalization, private hospitalization, establishments for the disabled, social and family services, education, culture, leisure and entertainment (ECLAT), and homecare and support services.

[219] The branch is fairly competitive in terms of representativeness. No single professional organization is dominant:

- Fédération des médecins de France (FMF): 35.99% ;
- Syndicat des médecins spécialistes (AVENIR Spé): 25.02% ;
- Syndicat des médecins libéraux (SML) 15.57% ;
- French Federation of General Practitioners (MG France): 12.67% ;
- Confédération des syndicats médicaux français (CSMF): 10.76%.

[220] The same is true of the trade unions:

- Confédération française démocratique du travail (CFDT): 37.74% ;
- Confédération générale du travail (CGT): 23.41% ;
- Union nationale des syndicats autonomes (UNSA): 20.43% ;
- Confédération générale du travail-Force ouvrière (CGT-FO): 18.42%.

[47] The figure given by OMPL is lower.

[221] According to the DGT, social dialogue poses no particular problem in the branch. It is not a joint committee, as permitted by article L2261-20 of the French Labor Code, and probably never has been.

[222] Among the major agreements reached within the branch, the DGT highlights those relating to the conventional contribution (annual until 2022), the overhaul of the classification (rider no. 76 in 2019), and the designation of the Opco EP (rider no. 74 of 2018). The DGT points out that in 2022, rider no. 86 of February 17, 2022 concerning the extension of the branch's perimeter (extended on July 1er 2022) and rider no. 87 of May 5, 2022 concerning wages (extended on August 24, 2022) were registered, and that in 2023, rider no. 88 of January 27, 2023 concerning provident benefits (in the process of being extended) was registered.

[223] It should also be pointed out that the branch will not be in compliance with the SMIC (minimum wage) from August 1er 2022, and that Mayotte is not covered by the OPCO, so an ad hoc funding mechanism had to be created.

## 1.2 The CPNEFP of the medical practice personnel branch

[224] Under the terms of the ANI of October 5, 2009, the CPNEFPs, established by the ANI of February 10, 1969, have a general remit to guide and promote vocational training in their field of competence, in line with employment trends. In particular, they are tasked with periodically examining quantitative and qualitative trends in jobs and qualifications in their professional field, in conjunction with the Observatoires Prospectifs des Métiers et des Qualifications (OPMQ), and defining training priorities.

[225] More specifically, the CPNEFP's mission in the field of vocational training is to:

- Participate in the study of existing training, further training and vocational rehabilitation resources for the various qualification levels;
- Work with public authorities and interested organizations to find ways of ensuring that these resources are fully utilized, adapted and developed;
- To this end, to formulate all useful observations and proposals, and in particular to specify the conditions for evaluating training initiatives;
- Monitor the application of agreements reached at the end of triennial branch negotiations on vocational training objectives, priorities and resources.

[226] The CPNEFP for medical practice personnel was first set up by the agreement of October 26, 1995, which was updated by branch amendment no. 85 of December 2, 2021. Its role covers all aspects of training for :

- Propose priorities and orientations for professional training;
- Promoting vocational training ;
- Helping to maintain jobs ;
- Set the policy direction for contract costs;

- Provide the SPP with branch policy decisions taken for effective and financial implementation (OPCO);
- Encourage the creation of CQPs ;
- Participate in the study of training, development and rehabilitation methods;
- Study the impact of changes in the sector on employment;
- Examine the procedures for implementing the guidelines defined by the branch;
- Periodically review the branch's diplomas and qualifications;
- Monitor the application of branch training agreements.

[227] The CPNEFP is a joint body. Its 18 to 20 members are drawn from trade unions and employers' organizations. Governance is also parity-based. It is chaired by Dr Jean-Claude Soulary, a member of the MG France medical union. Its vice-chairman is Stevan Jovanovic, a CFDT trade unionist.

## 1.3 The OPCO EP

[228] Eleven skills operators were created by the 2018 reform to manage contributions to vocational training and apprenticeships

[229] Each skills operator (Opco) is created by agreement between employee trade unions and employer professional organizations, and must obtain approval from the Ministry of Labor before it can manage company contributions. Approval is granted on the basis of several criteria, including the coherence and economic relevance of the Opco's field of intervention. Approval is granted only if the estimated amount of contributions managed (legal, conventional or voluntary contributions) exceeds 200 million euros, or if the Opco supports at least 200,000 companies.

[230] Each Opco provides a local service for small and medium-sized businesses, financing the skills development plan for companies with fewer than 50 employees, apprenticeship and professionalization contracts, as well as promotion or retraining through work-study programs (Pro-A). It also provides technical support to member branches for forward-looking management of employment and skills, and their certification mission.

[231] Since 2022, collection of the single contribution to vocational training and work-study schemes (Cufpa) has been transferred to Urssaf and Mutualité sociale agricole (MSA). In 2023, Opco will continue to collect additional contributions:

- contributions agreed by the professional branch for the purpose of implementing the branch's employment and training policy;
- voluntary contributions negotiated with companies for a service offering specific to each company.

[232] The Opco for local businesses (EP) was approved, as far as it is concerned, in March 2019. Its creation was based on the devolution of two former OPCAs[48] , Agefos PME and PEPSS[49] , which necessitated the merger of 18 different legal structures.

[233] Opco EP is the benchmark partner for local businesses and the Opco for the living environment: 54 professional branches are members, as are over 400,000 businesses with at least one employee (99% of which have fewer than 50 employees) and just under 3 million employees covered. Crafts and trades occupy a prominent place within Opco EP, but many other sectors are also represented: convenience stores, real estate, liberal professions, legal professions, personal services and janitors.

[234] Opco EP is jointly organized and governed by 5 employee organizations (CFTD, CGT, GCT-FO, CTFC, CFE-CGC) and 2 employer organizations (U2P and CPME). The Opco EP Board of Directors is supported by joint commissions, joint commissions set up in each region and 32 Sections paritaires professionnelles (SPP) as well as a Section paritaire interprofessionnelle (SPPI). There are a total of 2,000 joint administrators and representatives.

[235] The Opco has an extensive local network, with 95 sites and teams throughout France, including the French overseas departments and territories. In total, there are 1,100 employees serving some 2,000 directors.

[236] The Opco has a dual role as a financial operator (alternance and PDC-50) and skills developer (support for the 53 branches in terms of GPEC and professional certification of trades, observation, expert appraisals, investments with apprentice training centers - CFA, etc.). It accounts for one-fifth of the French apprenticeship system (20% of work-study students in France), 160,000 apprenticeship contracts and 300,000 to 400,000 work-study students, for a total commitment of €2.4 billion by 2022.

[237] 400 million has been committed by Opco EP for professional training in 2022.

## 2 Company financing of training

[238] Since the 1970s, companies have been at the heart of the continuing vocational training system. Their involvement is characterized by the obligation to train their employees and to contribute to the financing of continuing training.

[239] Employers are obliged to contribute to the financing of vocational training by providing training for their employees, without being required to spend a minimum amount. Employers are also required to pay several contributions each year.

[240] The contribution unique à la formation professionnelle et à l'alternance (cufpa) is made up of the taxe d'apprentissage and the contribution à la formation professionnelle, created by the Avenir professionnel law of September 5, 2018. The professional training contribution is equal to a percentage, variable according to the company's headcount, of the payroll. Each month, the employer must pay this contribution to the Urssaf or MSA, which transfer it to France

[48] Organismes paritaires collecteurs agréés.
[49] OPCA for local businesses and their employees.

Compétences. With the apprenticeship component of the single contribution, companies contribute to financing the training of young people on apprenticeship contracts and enrolled in technological and vocational training establishments. The apprenticeship tax is made up of two parts: 0.59% of payroll is earmarked for apprenticeships, and 0.09% finances technological and vocational training and in-kind subsidies to CFAs. In addition to the apprenticeship tax, there is a supplementary contribution, the Contribution supplémentaire à l'apprentissage (CSA).

[241] The legal contribution enables companies to receive funding from their Opco when they implement apprenticeship contracts, professionalization contracts or retraining or promotion through work-study schemes (Pro-A). Companies with fewer than 50 employees can also have their skills development plan (PDC) financed.

[242] Skills operators can also collect conventional contributions paid in application of a national agreement between representative employers' and employees' organizations. These sums are pooled as soon as they are received by the operator within the branches concerned.

[243] Organized into economic sectors, Opco provides services not only to companies, but also to the professional branches that created them. Since 2022, Urssaf and MSA have been collecting companies' vocational training contributions and transferring them to France Compétences, before redistributing them within the framework of dedicated Opco envelopes.

[244] Opco covers :

- Skills development initiatives for companies with fewer than 50 employees;
- apprenticeship and professionalization contracts, expenses relating to the training of tutors and apprenticeship supervisors and the performance of their duties, as well as retraining or promotion through work-study schemes;
- if a branch agreement so provides, for a maximum period of two years, training costs incurred in response to serious economic difficulties.

[245] They also cover the costs of informing their member companies about the challenges of sustainable development and supporting them in their plans to adapt to the ecological transition, in particular by analyzing and defining their skills needs. Skills operators help finance the remuneration of vocational training trainees. Traineeships are approved by the Opco Board of Directors.

[246] Under the financial section relating to skills development initiatives for companies with fewer than 50 employees, skills operators cover several types of costs, according to the procedures and priorities defined by their Board of Directors.

[247] Skills operators finance :

- the cost of training courses under the skills development plan and related expenses (transport, meals, accommodation and, where training takes place in whole or in part outside working hours, childcare or care for dependent relatives):
- topping up an employee's personal training account :
- training for jobseekers, including operational preparation for employment.

[248] In companies with fewer than 50 employees, Opco can finance training in health, safety and working conditions for members of the staff delegation on the social and economic committee, and for the reference person in the fight against sexual harassment and sexist abuse.

[249] Skills operators can cover the remuneration and statutory and contractual social charges of employees in companies with fewer than 50 employees, up to the hourly cost of the minimum wage (Smic) per hour of training, in accordance with the terms and conditions specified by the board of directors of each skills operator.

[250] Skills operators finance the costs of employee or volunteer participation in a jury for exams or validation of acquired experience.

[251] To date, Opco EP has committed €14.8 million to training medical assistants.

# 3 Training opportunities for company employees

[252] There are several ways for employees to take part in training during their employment contract, depending on whether the employer takes the initiative, the employees themselves or whether the training is co-constructed.

[253] Every two years, all employees are entitled to a professional interview to discuss their career development prospects. During this interview, professional training needs can be discussed. Capitalizing on the various interviews held within the company can contribute to the development of the PDC.

[254] Employees benefit from continuing professional training:

- or, at their employer's initiative, within the framework of the company's PDC. Employers who decide to train one or more of their employees exercise their managerial authority;
- or on their own initiative, within the framework of the personal training account (CPF) outside working hours, a professional transition project, leave to validate acquired experience and other forms of leave...

[255] In addition, in the event of difficulties in maintaining jobs, the employer must propose training schemes.

[256] Employees and employers can also take initiatives to co-construct a training program. Employees can approach their employer with a proposal to participate in financing a training course during their working hours, for which they agree to use their CPF. If the employer accepts the employee's request, he or she will be paid during the training period, and the remaining cost of the planned training may be covered in full or in part. The employer can also offer to contribute to the financing of training projects if employees agree to use their CPF.

## 3.1 The skills development plan

[257] The law lays down the principle that employees should have access to continuing vocational training, at the employer's initiative, if necessary within the framework of a PDC. At the same

time, it affirms the optional nature of the latter. The employer must, however, meet certain obligations in terms of vocational training (in particular, adapting to the position and maintaining employment).

[258] Employers who decide to train one of their employees are exercising their managerial authority. As such, the employee is carrying out a professional mission. Refusal to participate, or inappropriate behavior during training, may constitute misconduct that could justify dismissal.

[259] Compulsory training, as defined in the PDC, must be carried out during working hours, and entitles the employee to continued remuneration. The same applies to non-compulsory training, which is also carried out during working hours. On the other hand, if all or part of a non-compulsory training course is carried out outside working hours, the employee is entitled to compensation only if a collective agreement so provides.

[260] In agreement with the employee, the employer may contractually stipulate that the employee's training is to be taken into account in his or her career development. Before financing the employee's training, the employer may wish to ensure a return on his investment in the skills acquired by the latter should he leave the company. To this end, a training waiver clause can be signed with the employee.

[261] In practice, the PDC is the source of most of the branch's training courses, and of the medical assistant CQP in particular.

## 3.2 The personal training account

[262] The CPF enables any active person, from the moment he or she enters the job market until the date on which he or she asserts all his or her pension rights, to acquire training rights that can be used throughout his or her working life. The ambition of the CPF is to contribute, at the initiative of the individual, to maintaining employability and securing career paths. It is open to anyone aged 16 and over, and by way of exception, to 15-year-olds who have signed an apprenticeship contract.

[263] On the official website moncompteformation.gouv.fr, each person has a secure personal space where they can log in to their CPF. This site also enables them to:

- access information concerning him/her (e.g. the euro credit on his/her account);
- obtain information on eligible training courses;
- a first level of information on training financing;
- access to digital services related to career guidance, such as the free service of the Career Development Advisor (CEP).

[264] All working people are eligible for the CPF:

- a professional certification registered with the National Directory of Professional Certifications (RNCP);
- an attestation of validation of a block of skills forming part of a professional certification registered with the RNCP;

- a certification or accreditation registered in the specific repertoire (RS), including the CléA certification (socle de connaissances et de compétences professionnelles);
- actions enabling VAE as mentioned in 3° of article L.6313-1 ;
- skills assessment ;
- training courses for business start-ups or takeovers, aimed at realizing their business start-up or takeover project and ensuring its long-term viability;
- preparation for the theoretical test of the highway code and the practical test of the driving license for light vehicles (B license) and heavy vehicles.

[265] With regard to the CQP for medical assistants, according to information provided by Caisse des Dépôts in March 2023, only 2 training courses were offered on MonCompteFormation by a single training organization (Keyce Academy - Collège de Paris). There was no consumption in 2022 and only 2 files in January 2023 (at a cost of €2,240 per course).

## 3.3 Promotion or retraining through sandwich courses

[266] Promotion or retraining through work-study programs (Pro-A) is based on the principle of alternating theoretical and practical training on the job. It enables companies to support their employees' skills development through training or VAE programs.

[267] The Pro-A program is reserved for employees with at most a baccalaureate + 2 years of higher education, on permanent contracts (CDI) or permanent integration contracts (CUI-CDI), or on part-time contracts. No seniority is required.

[268] The training must enable the employee to obtain the knowledge and skills base ("CléA" or "CléA numérique" certificate) or a professional certification identified by his or her branch as responding to market developments (changes in customer relations, growth in teleworking, new organizations, new skills).

[269] Training takes place on a sandwich basis over a period of between 6 and 12 months. However, this period can be extended :

- Up to 24 months for certain beneficiaries and qualifications defined by branch agreement;
- Up to 36 months for young people aged 16 to 25 who have not completed upper secondary education and do not hold a technological or vocational diploma.

[270] In principle, the training is to last between 15% and 25% of the total duration of the Pro-A course, and a minimum of 150 hours. In practice, the professional branch for medical practice staff has decided to increase this percentage to 40% for the following employees:

- Employees with the first levels of qualification, whatever their age;
- Employees under the age of 30 ;
- Employees aged 45 and over or with at least 20 years' professional experience to maintain their employability;

- Disabled workers ;
- Employees returning to work after maternity or adoption leave, parental leave or long-term absence due to illness or accident.

[271] Training can take place at a training organization, or within the company if it has an in-house training department.

[272] Training can take place during working hours, with continued payment of salary. It may also take place outside working hours, subject to the employee's prior written agreement, up to a limit of 30 hours per year and per employee, or 2% of the package, where applicable (in the absence of a collective agreement setting other terms).

[273] A tutor must be appointed to support the employee throughout his or her training and liaise with the training organization. The tutor may be the company manager or a volunteer employee.

[274] Any Pro-A must be formalized by means of an amendment to the employee's employment contract, specifying the duration and purpose of the planned training program, as well as the training departure arrangements.

[275] Within the limits of the mutualized funds available, the Opco can cover all or part of the costs of the employee's training, including tuition fees, remuneration and ancillary expenses, according to the financing conditions defined by the branch. In practice, the medical assistant CQP is eligible for ProA funding from Opco EP. And the financing terms have been set as follows:

- Maximum reimbursement of training costs up to €7,680, including €9.15/hour from the legal budget, up to a maximum of €3,000, and €12.19/hour from the contractual budget, up to a maximum of €4,680.
- The following expenses are covered by the collective bargaining agreement: ancillary costs: in accordance with scales; salary costs: €12/hour.

[276] There are very few examples of ProA among CQP trainees.

## 3.4 The professional transition project.

[277] This scheme enables all employees to mobilize their CPF, in order to take part in a training program leading to a qualification, with a view to changing career or profession. It replaces individual training leave (CIF). The construction of a professional transition project can be supported by a professional development advisor. This involves informing, guiding and supporting the employee, as well as proposing financing. During the course of the professional transition project, the employee is asked to carry out a positioning test to adapt the duration of the training to his or her professional experience.

[278] During the professional transition project, the employee benefits from specific leave and his or her employment contract is suspended. The duration of the project is taken into account when calculating seniority. A minimum salary is paid by the employer. This is reimbursed by the regional interprofessional parity commission, known as Transitions Pro.

[279] Transitions Pro's mission is to ensure the financing of professional transition projects. They ensure the relevance of the preliminary positioning, the professional transition project and its financing. Jointly composed and accredited, they are coordinated by the Association nationale pour la certification paritaire interprofessionnelle, known as "Certif' Pro". In addition, France Compétences issues recommendations on the terms and conditions of funding allocated to the CPF transition, with a view to harmonizing them across the country.

[280] If you are unsuccessful in implementing your project, there are other ways of carrying out a retraining project or setting up or taking over a business, such as resigning with unemployment insurance compensation for training or setting up or taking over a business.

[281] Employers can also offer employees whose jobs are threatened a Transitions Collective scheme. If the employee accepts the offer, the company benefits from a subsidy from the regional Transitions Pro association.

[282] There don't seem to be any examples of career transition projects for medical secretaries in the sector.

## 3.5 Validation of acquired experience

[283] VAE has not worked well since its inception, particularly in the health sector. It has been the subject of a major reform which is gradually coming into force. For example, the law of December 21, 202[E] on urgent measures to improve the functioning of the labor market with a view to full employment aims to make VAE a simple, accessible tool for all working people wishing to develop their careers.

[284] It is regrettable to note that, while the medical assistant profession seems to lend itself well to VAE for medical secretaries, neither the branch nor the OPCO EP have so far wished to become involved in the experiment piloted by REVA[50] .

[285] Under these conditions, and in any event, it is unreasonable to expect many of the branch's employees to gain access to the CQP via VAE by the end of 2024 or 2025, especially as the conditions set by the branch are not very favorable (jury composition, duration and risk of failure).

# 4 Pre-employment training

[286] Jobseekers also have access to medical assistant training. In practice, however, very few of the trainees taking the CQP medical assistant course are job-seekers.

[287] To facilitate access to training, take stock of their professional situation and, where appropriate, initiate a professional development process, jobseekers can benefit from a Conseil en évolution professionnelle (professional development council). The aim is to enhance their skills, competencies and qualifications.

[50] REVA is the experiment set up to simplify the VAE process, and is destined to become a GIP to manage the single platform.

[288] To help them return to work, jobseekers can also decide to have their professional skills recognized with a view to obtaining a certification: professional title, CQP, VAE.

[289] As part of personalized social and/or professional support, jobseekers can benefit from a period of work experience (PMSMP) to discover a trade or sector of activity, confirm a professional project or initiate a recruitment process, or from a collective operational preparation for employment (POEC) which is a training action enabling several jobseekers to acquire the skills required to occupy jobs corresponding to needs identified by a professional branch.

## 4.1 POEC and POEI

[290] To date, there are no POEC or POEI beneficiaries for medical assistants. This situation is likely to change in the future, with a view to expanding the pool of candidates.

### 4.1.1 POEC

[291] Collective operational preparation for employment (POEC) is a training program enabling several jobseekers to acquire the skills required to fill jobs corresponding to needs identified by a professional branch or, failing that, by the board of directors of an Opco.

[292] The POEC aims to provide rapid access to sustainable employment (permanent contract, fixed-term contract, professionalization contract of at least 12 months, apprenticeship contract). With a relatively long duration - 400 hours maximum, which is longer than the duration of the medical assistant CQP - and including a period of immersion in the company, the POEC is recognized for its effectiveness in helping jobseekers find employment.

[293] In fact, as the scheme is initiated by Opco, professional branches and companies, it leads to trades with strong recruitment needs. What's more, the training offered and the immersion phase enable jobseekers to test their motivation against the reality of the job, and to train in the best possible conditions, so that they can then apply for the corresponding job with the companies behind the POEC project.

[294] For employers, the POEC program not only makes recruitment more secure by allowing jobseekers to gradually integrate into the company, but also enables them to receive the training they need.

[295] The POEC targets all jobseekers registered with Pôle emploi, whether or not they are receiving benefits, and all employers with skill requirements. Other participants are :

- the professional branches and Opco, which collect the recruitment and associated skills needs of their member companies and respond by setting up training initiatives within the framework of the POEC ;
- Pôle emploi, which is involved upstream of the training program. It refers jobseekers whose professional project has been validated to the training organization. These must be registered.
- For those under 26, training can be provided by an apprentice training center.

[296] To implement the POEC, a framework agreement must be signed between the Opco and Pôle emploi. It sets out the general framework of the partnership and the respective commitments:

- The Opco informs the relevant regional branch of Pôle emploi of its POEC project;
- The two parties define the implementation procedures and sign an operational protocol identifying the training initiatives and specifying the terms of collaboration at local level.
- The Opco provides Pôle emploi with the information it needs to refer jobseekers to the POEC training program.
- The Pôle emploi advisor prescribes training for the jobseeker.

[297] At the end of the training course, the Opco sends Pôle emploi a report on the training and a list of placements made at the end of the course and 3 months afterwards.

[298] Discussions have taken place between Opco EP and Pôle Emploi, but for reasons not fully understood by the mission, the POEC is not currently available for medical assistant training.

### 4.1.2 POEI

[299] POEI (préparation opérationnelle à l'emploi individuelle) is a financial aid scheme offered by Pôle emploi to employers, providing pre-employment training. Its aim is to enable the trainee to acquire the professional skills required to occupy the position corresponding to the job offer submitted by the future company to Pôle emploi.

[300] POEI is financed by Pôle emploi, and may also be co-financed by the Regional Council or Agefiph, for example. An Opco can initiate a POEI when it detects a need for training prior to recruitment by one of its member companies.

[301] POEI is open to anyone registered with Pôle emploi who has been offered a job with a minimum 12-month contract requiring in-house or external training to adapt their skills:

- Jobseekers, whether or not they are receiving benefits;
- Beneficiaries of a CRP/CTP (contract for professional reclassification/contract for professional transition) or contract for professional securitization ;
- And to private or public sector employers who have submitted a job offer to Pôle emploi.

[302] The POEI can cover up to 400 hours of training, except in exceptional circumstances. Training can be full-time or part-time, and must be carried out by a training organization within or outside the company recruiting you. The POEI can be set up for pre-qualifying training preceding a professionalization or apprenticeship contract of at least twelve months' duration. A period of direct training by the employer in the form of tutoring can also be included.

[303] During the training period, jobseekers are remunerated and continue to receive their benefit, up to the limit of their compensation entitlement. During the training period, the Allocation de Retour à l'Emploi (ARE) becomes the Allocation de Retour à l'Emploi Formation (AREF). Training courses approved by the State or the Region can provide paid training.

[304] Training rights acquired during employment are attached to the active person. As a result, they are portable, even when a person's status changes from that of an employee to that of a job seeker, whether or not they are registered with Pôle emploi. As a result, all jobseekers with a CPF retain the amount of euros previously capitalized.

# 5 Work-study contracts

[305] The two main types of work-study contracts are "contrats de professionnalisation" (also known as "contrats de pro") and "contrats d'apprentissage" (apprenticeship contracts). The Medical Assistant CQP is only accessible via a professionalization contract, and not an apprenticeship contract (in the absence of a professional title).

[306] The "contrat de professionnalisation" is an employment contract between an employer and an employee, enabling them to acquire - within the framework of continuing education - a professional qualification (diploma, title, CQP) recognized by the State and/or the professional sector. The aim is to help young people and adults enter or return to employment.

[307] Beneficiaries are young people aged between 16 and 25 to complete their initial training, jobseekers aged 26 and over, recipients of the revenu de solidarité active (RSA), the allocation de solidarité spécifique (ASS) or the allocation aux adultes handicapés (AAH), and people who have benefited from a subsidized contract (contrat unique d'insertion - CUI).

[308] The working hours of an employee on a professionalization contract are identical to those of the company's other employees. Training time is included in working hours. Employees benefit from a weekly rest period. All regulations concerning young workers under the age of 18 apply to minors on professionalization contracts, in particular regulations on working hours and the prohibition on working on public holidays, unless an exemption is granted.

[309] The contract may be signed on a part-time basis, provided that the organization of the part-time work does not hinder the acquisition of the qualification concerned, and that it complies with the conditions specific to the professionalization contract, particularly in terms of the duration of training in relation to the total duration of the contract.

[310] The "période de professionnalisation" (alternating periods of teaching and work on the job) takes place at the start of an open-ended contract. In the case of a fixed-term contract, it lasts for the entire duration of the contract. General, vocational and technological training is provided by a training organization, or by the company itself if it has an in-house training department with resources separate from those of the production departments.

[311] This training lasts between 15% and 25% of the total duration of the fixed-term professionalization contract, or of the professionalization action period under an open-ended contract, and may not be less than 150 hours. A branch agreement may, however, raise this duration above 25%, either for certain groups (RSA, ASS, AAH or CUI beneficiaries, jobseekers aged 26 and over who have been registered on the jobseekers' list for over a year, etc.), or for certain qualifications.

[312] Since the law of March 5, 2014, it has been compulsory for employers to appoint a tutor to support each employee on a professionalization contract. The tutor must be a qualified employee

of the company. He or she must be a volunteer with proven professional experience and have at least two years' professional experience relevant to the target qualification. Employee tutors may not simultaneously supervise more than 3 employees on professionalization or apprenticeship contracts, or on professionalization periods. Employers may act as tutors themselves, provided they meet the qualification and experience requirements. The employer may not simultaneously tutor more than 2 employees.

[313] According to the DGEFP, questioned by the mission, the number of professionalization contracts concerning medical assistants is excessively limited: 18 in 2021 and 19 in 2022, i.e. 37 in all (there were 119,000 new professionalization contracts in 2022 and 337 professionalization contracts concerning medical secretaries). The aim of these contracts is to obtain a CQP in 24 cases, but also, and without any details being available, a qualification recognized in the classifications of a CCN in 8 cases, and a certification registered with the RNCP excluding CQP in 5 cases. The average and median duration of professionalization contracts was 11 months.

# 6 Diplomas, titles and certificates of professional qualification and the RNCP

[314] There are different types of certification.

## 6.1 State diploma

[315] This is a certificate of aptitude that validates the recipient's level of education following training. It can range from bac+2 to bac+5. Holding a state diploma gives access to regulated professions. There are also national diplomas, which include baccalauréats, BTSs, licenses, masters and doctorates, etc., as well as university and institutional diplomas.

## 6.2 The professional designation

[316] It is a State certification issued by the Ministry of Labor, on behalf of the State. A vocational qualification is a professional certification that enables the acquisition of specific professional skills, and promotes access to employment or career development for its holder. It attests to the holder's mastery of the skills, aptitudes and knowledge required to exercise a profession.

[317] Professional titles are registered in the RNCP, managed by France Compétences. Titles are made up of blocks of skills known as Certificats de Compétences Professionnelles (CCP).

[318] The professional title covers all sectors (construction, personal services, transport, catering, commerce, branch, etc.) and different levels of qualification:

- level 3 (formerly level V), corresponding to CAP ;
- level 4 (formerly level IV), corresponding to the Baccalauréat ;
- level 5 (formerly level III), corresponding to BTS or DUT ;
- level 6 (formerly level II), corresponding to Bac+3 or 4.

[319] Examination sessions are organized by centers that have been approved for a specific period by the relevant regional directorate for the economy, employment, labor and solidarity (DREETS). These centers undertake to comply with the regulations defined for each examination.

[320] Professional designations can be obtained through vocational training, VAE and apprenticeships.

[321] State diplomas are more general than professional qualifications.

## 6.3 The CQP

[322] A CQP is a certification issued by a professional branch. It attests to the acquisition of professional skills in a particular trade. It is therefore a qualification signal recognized by the economic players in a branch.

[323] Legally, a CQP can exist with or without registration in the RNCP or the specific repertoire (RS). However, holders of a CQP can only benefit from a level of qualification if it is registered with the RNCP. It is therefore up to the CPNEFP to assess the appropriateness of proposing their registration according to a formal decision-making process.

[324] The CPNEFP, in its capacity as pilot for the deployment of the branch's certification policy, must ensure that the CQP or CQPs are implemented consistently by the organization that has received its mandate.

[325] There are two ways to prepare for a CQP:

- Through training, if the individual needs to follow a training path to progress to the CQP level. Training can be set up by the employer as part of the company's activities (PDC), or by the individual (notably via the CPF). The CQP can also be prepared as part of a professionalization contract.
- By VAE, if the CQP is registered with the RNCP, for employees or jobseekers with at least one year's experience relevant to the CQP.

[326] An apprenticeship can be used to prepare a qualification, but not, for the moment, a CQP.

## 6.4 RNCP and registration

[327] France Compétences maintains two national directories:

- the RNCP, which contains professional certifications targeting one or more professions; the associated training courses are mainly part of sandwich courses, continuing education and initial training under school or student status;
- the RS, which contains certifications for specialization or professionalization, or targeting cross-disciplinary skills (such as languages) or skills complementary to one or more professions.

[328] Only a certification registered with the RNCP can deliver a state-recognized level of qualification (with the sole historical exception of general and technological baccalaureates),

itself recognized within the European Qualifications Framework. Thus, the regulation of professional certifications, via the maintenance of the two national directories, is an essential lever for regulating the vocational training ecosystem.

[329] The RNCP is made up equally of certifications issued by government ministries and private bodies, including branches. 80% of RS certifications are issued by private initiative. When a certification is issued by an organization or a professional branch, France Compétences and its Certification Commission, almost half of which is made up of national cross-industry social partners, assess the application for registration according to criteria relating to : - the suitability of certifications for the skills requirements of the target professions (by examining the professional integration of holders for the RNCP); - the quality of the reference systems and the quality of the assessment process; - and, for the RNCP, the division into skill blocks and the implementation of VAE.

[330] The legislator has entrusted France Compétences, and more specifically its Professional Certification Commission, with the responsibility of examining registration applications according to registration criteria specified by the regulatory authority. While certain provisions are subject to strict interpretation, the majority of these provisions are framework concepts, the interpretation of which is the full responsibility of the professional certification commission, in compliance with the legislator's intention and under the control of the administrative judge, who ensures, in particular, that there are no manifest errors of assessment.

[331] Unlike automatic registration, which applies to state-issued professional certifications, registration on request applies to diplomas and professional qualifications not covered by automatic registration, and to CQPs. Applications are examined by a professional certification commission comprising a chairman, appointed by order of the minister responsible for professional training, and 18 full members and their alternates, appointed as follows:

- 8 full government representatives, appointed respectively by the Minister for Vocational Training, the Minister for National Education, the Minister for Higher Education, the Minister for Health, the Minister for Sport, the Minister for Agriculture, the Minister for Social Affairs and the Minister for Culture;
- 2 full representatives of regional councils or deliberative assemblies in the French overseas territories exercising powers devolved to regional councils in the field of vocational training, appointed by the Minister for Vocational Training, on the recommendation of the Association of French Regions;
- 5 full representatives of representative national and interprofessional employee trade unions (CFDT, CFE-CGC, CFTC, CGT, CGT-FO), with one representative per organization;
- 3 full representatives of national and inter-professional employers' organizations (CPME, MEDEF, U2P), one from each organization;
- 1 non-voting representative of the Conseil national consultatif des personnes handicapées (National Advisory Council on Disabled Persons)

[332] This commission advises the Director General of France Compétences on the registration of certifications on the RNCP, after review by France Compétences' Direction de la Certification

Professionnelle (it may submit a change of level or title, and proposes the duration of registration, which may not exceed five years).

[333] The main purpose of this opinion is to decide whether or not to register the certification project. In the event of a favorable decision, it also includes an accessory: the duration of the registration, the name of the certification, a classification according to the NSF nomenclature, and for certifications registered on the RNCP, the granting of a qualification level.

[334] The opinion is forwarded to the Director General of France Compétences, who, in principle, can only follow the commission's opinion in its entirety (the so-called "avis conforme" procedure).

[335] The application for registration of a vocational certification on the RNCP is examined on the basis of nine criteria set out in article R. 6113-9 of the French Labor Code, with the notion of "criteria" referring to a set of clues to guide the decision-making process:

1° the suitability of the jobs held in relation to the profession covered by the professional certification project, based on an analysis of at least two promotions of incumbents;

2° the impact of the professional certification project in terms of access to or return to employment, assessed for at least two promotions of holders and compared with the impact of professional certifications for similar or related professions;

3° the quality of the reference framework of activities, skills and assessment, as well as their overall coherence and the absence of literal reproduction of all or part of the content of an existing reference framework. When assessing the quality of the skills reference framework, account is taken, where appropriate, of skills linked to taking account of disability situations, accessibility and universal design as defined by Article 2 of the Convention on the Rights of Persons with Disabilities of March 30, 2007;

4° the introduction of procedures for monitoring all the methods used to organize the assessment tests;

5° taking into account the legal and regulatory constraints related to the practice of the profession covered by the professional certification project;

6° the possibility of accessing the professional certification project through VAE ;

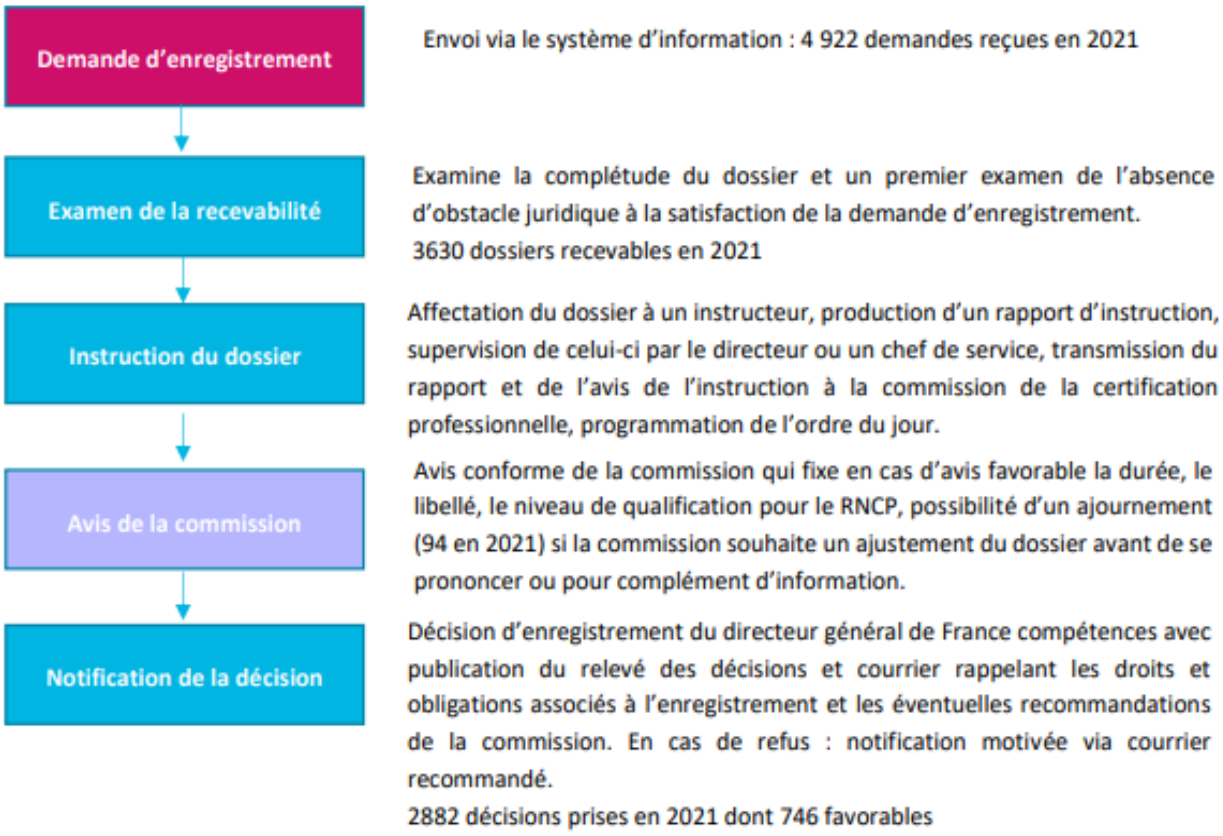
7° the coherence of the blocks of skills making up the professional certification project and their specific assessment procedures;

8° where appropriate, consistency :

- the total correspondence established by the applicant between the proposed professional certification and equivalent professional certifications at the same level of qualification;
- Partial correspondences set up by the applicant between one or more blocks of skills in this project and blocks of skills in other professional certifications;
- correspondences established by the applicant between one or more blocks of skills in this project and certifications or accreditations registered in the RS.

9° where applicable, the procedures for involving the national joint employment committees of professional branches in drawing up or validating the reference systems.

Graphique 6 : Registration procedure - overview




*Source : France Compétences*

[336] A simplified and derogatory RNCP registration procedure exists for professional certifications corresponding to so-called emerging or particularly evolving professions. A list of these trades is published each year by France Compétences, following a call for contributions from branches and professional unions: there are 23 for 2023.

[337] The registration of the medical assistant CQP benefited from this derogatory registration procedure, which dispensed with the first two of the 9 criteria mentioned above (reference to two promotions of holders), and therefore enabled us to move ahead more quickly.

# ANNEXE 4 : Approved training organizations

# CONTENTS

[338] The order of November 7, 2019[51] specifies the four professional qualifications required to work as a medical assistant:

- State Nursing Diploma (DEI);
- State diploma in nursing assistance (DEAS);
- State diploma for childcare assistants (DEAP) ;
- The certificate of professional qualification (CQP) for medical assistants.

[339] It also specifies that job adaptation training (FAE) is required for medical assistants who do not hold the medical assistant CQP, i.e. in practice for nurses, orderlies and nursery assistants.

[340] There are very few rules governing the delivery of the FAE. It can be offered by any training organization. A simple training certificate is issued. The branch recommends that candidates follow block 2 of the CQP's activities and skills repository, entitled "reception and administrative handling of patients", which lasts 112 hours.

[341] *On the other hand, the* branch has approved twelve training organizations to deliver the CQP, following a call for applications launched in 2020.

## 1 Twelve training organizations have been approved by the branch in 2021 to deliver the medical assistant vocational qualification certificate.

[342] A call for applications has been launched by the branch, based on a set of specifications which set out the context in which the medical assistant profession has been created, and all the information needed for training organizations to draw up a proposal: in particular, the target audience and prerequisites, the medical assistant's activities, and the assessment procedures, with reference to the activities and skills referential registered with the RNCP.

[343] With regard to the medical assistant's missions, which remain unclear or too restricted in the minds of employers in particular, the call for applications proposes in appendix[52] , block by block, an explanation of what is expected in terms of know-how, theoretical knowledge and procedural knowledge. The mission recommends that these elements be included in communication materials for stakeholders (CPNEFP, Opco EP, training organizations, CNAM, Ministry of Health, Ministry of Employment, Pôle Emploi, France Compétences, etc.).

[344] The call for applications also expresses the branch specific expectations:

[51] Relating to the exercise of the activity of medical assistant.
[52] Available online.

- The 2 days a week alternating format;
- Integration of trainees at any time of the year;
- A positioning process for a personalized career path;
- The criteria that trainers must meet: one year's experience in the CQP field, having completed a trainer training course, and 25% healthcare professionals;
- The preferred teaching methods (open distance learning (FOAD) without specifying the minimum or maximum proportion, face-to-face, on-the-job training (AFEST)).

[345] Lastly, the specifications state that the training will be paid for by Opco EP in accordance with the rules defined by its Board of Directors, and lists the documents making up the application file to be submitted by September 8, 2020. It lists the selection criteria:

- Compliance of the application ;
- The organization's experience in work-study programs ;
- Innovative nature of the proposal ;
- Compliance of the pedagogical project with the CQP ;
- Manage different learner profiles;
- Training organization.

[346] Forty applications were received and analyzed using an evaluation grid. The grid made it possible to qualify the proposals made by the candidates for approval according to the following criteria: profile (financial health and certifications held, in particular the QUALIOPI certification, which was not compulsory at the time) (out of two points), experience in the healthcare sector (by providing customer references) and in the activities covered by the CQP (out of two points), experience in work-study schemes (out of three points), logistical resources (out of two points) and human resources (out of three points) available for training, communication strategy aimed at future trainees and employers (out of 1 point), teaching methods (ODL, AFEST, practice-sharing groups, inverted pedagogy) (out of 2 points), handling of different profiles (with the implementation of a positioning process) (out of 1 point), teaching project (content, duration and methods in line with profiles) (out of 8 points) and understanding of the branch expectations (out of 1 point).

[347] Three criteria were eliminatory: an overall mark of less than 13/26; lack of experience in the field of work-study and health; and a mark of less than 4/8 for the pedagogical project.

[348] The branch told the mission that the choice was also made on the basis of territorial coverage, an item not explicitly mentioned in the analysis grid but included among the points to be included in the application file.

[349] This call for applications was the subject of a joint working group also involving Opco EP, and the contact point mentioned in the specifications was that of Opco EP.

[350] The table below summarizes the winning organizations. They began training in March 2021.

Tableau 1 : Training organizations accredited to deliver the CQP for medical assistants

| Training organizations |
|---|
| Association pour la formation de la biochimie et de la biologie - AFBB (does not offer VAE) |
| Association pour la formation médecins libéraux - AFML |
| CFA CCI Le Mans (does not offer VAE) |
| Collège des hautes études en médecine - CHEM |
| Conservatoire national des arts et métiers des Pays de la Loire - CNAM |
| CQFD |
| National Institute for Training and Research on Lifelong Learning - INFREP |
| Regional Institute of Social Work - IRTS |
| Institut supérieur de rééducation psychomotrice - ISRP |
| Keyce academy - collège de Paris |
| Pôle de formation Pasteur |
| Yschools |

*Source : CPNEFP for medical practices*

[351] After this approval stage, the branch set up fairly close monitoring of the twelve training organizations to ensure that quality was maintained over time. Meetings with training organizations also provide an opportunity to work on fundamental issues, such as the revision of the RAC (see appendix 2).

[352] In view of the number of trainees and the current timeframe for entering training (two years after hiring), all the accredited training organizations the mission met with affirm that the current supply is sufficient (no trainees are being turned away for reasons other than failure to meet the prerequisites), and that increasing the number of trained medical assistants will require better communication about this profession and even greater support for doctors in developing their skills as employers.

[353] On the other hand, and quite apart from any considerations relating to the pool of candidates and the obstacles to training deployment, achieving the target of 10,000 medical assistants recruited by the end of 2024 (and therefore entering training by the end of 2026 at the latest) presupposes changing the parameters of the training offer from both a quantitative and qualitative point of view. If we assume that around 1,500 people have been trained in 2 years, and that 8,500 remain to be trained in two and a half years, this means tripling the training offer.

[354] In addition, the mission is in favor of reducing the training start-up period from two years to one year, to make the kinetics of training needs even faster.

[355] This increase will be made possible by the increase in the number of approved training organizations already planned by the branch (see below), as well as by adapting the offering, notably by developing distance learning (which will also solve the problems of premises and availability of trainers mentioned by training organizations).

[356] The mission met with all twelve training organizations. Although it is not possible to give an exhaustive presentation of each of these organizations for reasons of business confidentiality, the mission was able to draw up a number of observations.

## 2 Training organizations are quite diverse and unevenly distributed across the country.

[357] Approved training organizations have different statuses: public, private or associative, and a training catalog more or less related to the healthcare field. Some of them have extended their catalogue to include the CQP, which represented a major investment in responding to the call for applications. For the record, as mentioned *above,* the absence of health-related training and experience in work-study schemes were eliminatory criteria in the call for applications. The branch told the mission that it had been obliged to seek "a balance" to convince training organizations to position themselves on a new qualification, without any visibility on the volume of trainees to be trained.

[358] Some offer training courses linked to the CQP, such as medical secretary (8), dental assistant (2) or veterinary assistant (3). The AFBB offers two similar - albeit shorter - training courses to that of medical assistant: medico-technical assistant in dermatology or aesthetics, which have been developed by the professional bodies of these two medical specialties, but are not registered with the RNCP.

[359] Details of the training courses offered by the twelve OFs are summarized in Table 2.

Tableau 2 : CQP-related training courses offered by the various OFs

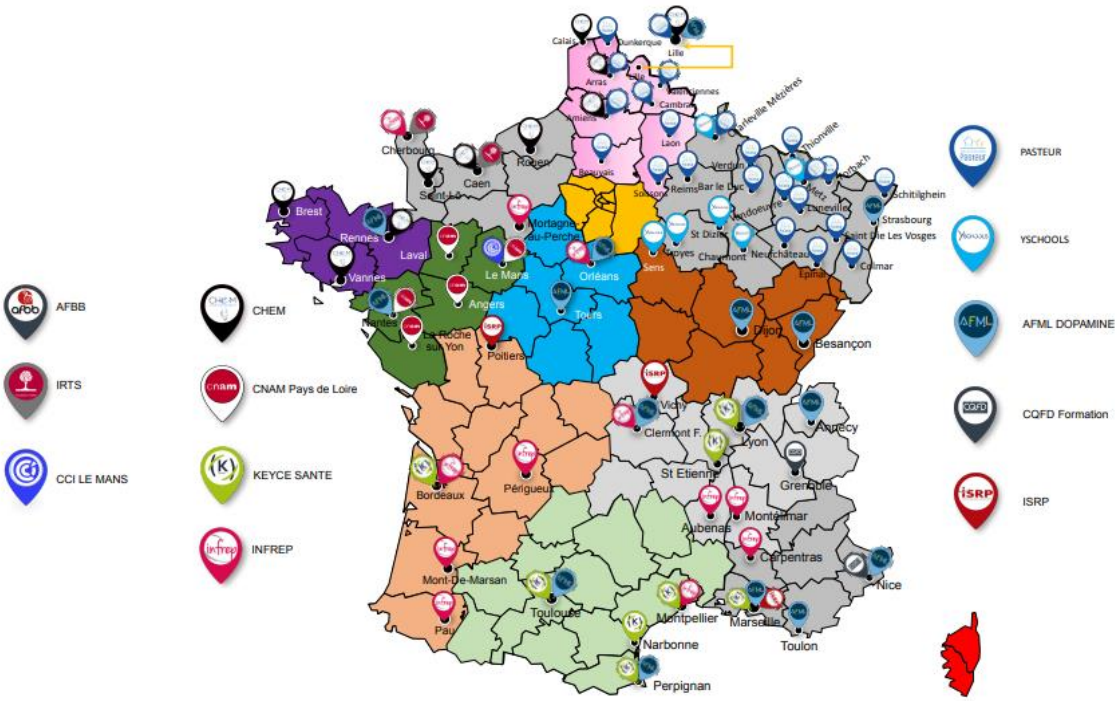
| Organizations | Medical secretary | Dental assistant | Veterinary assistant |
|---|---|---|---|
| AFBB | √ | × | × |
| AFML | √ | × | × |
| CFA CCI Le Mans | × | × | × |
| CHEM | × | × | × |
| CNAM PdL | × | × | × |
| CQFD | √ | √ | × |
| INFREP | √ | × | √ |
| IRTS | × | × | × |
| ISRP | × | × | × |
| Keyce academy | √ | × | √ |
| Pôle de formation Pasteur | √ | √ | √ |
| Yschools | √ | × | × |

*Source : Mission*

[360] In terms of their geographical location, there are three types of training organization: those with a local or even regional reach, those covering several regions, and those who have indicated to the mission that they can set up *ad hoc* training courses (at the branch's request) throughout France, particularly in regions not covered. The locations of the twelve training organizations are shown on the three maps below, and reveal deficits in the following areas: Northern New Aquitaine (essentially the former Poitou-Charentes region), Burgundy-France-Comté, Centre-Val-de-Loire, the former Auvergne region, Northern PACA, Northern Occitanie, Corsica and the French overseas departments.

[361] This situation is all the more noteworthy given that the use of distance learning is relatively underdeveloped (see *below*), and that the branch and Opco EP have imposed a rule of "geographical sectorization" of funding and trainees.

Carte 1 : Location of approved training organizations Entire France

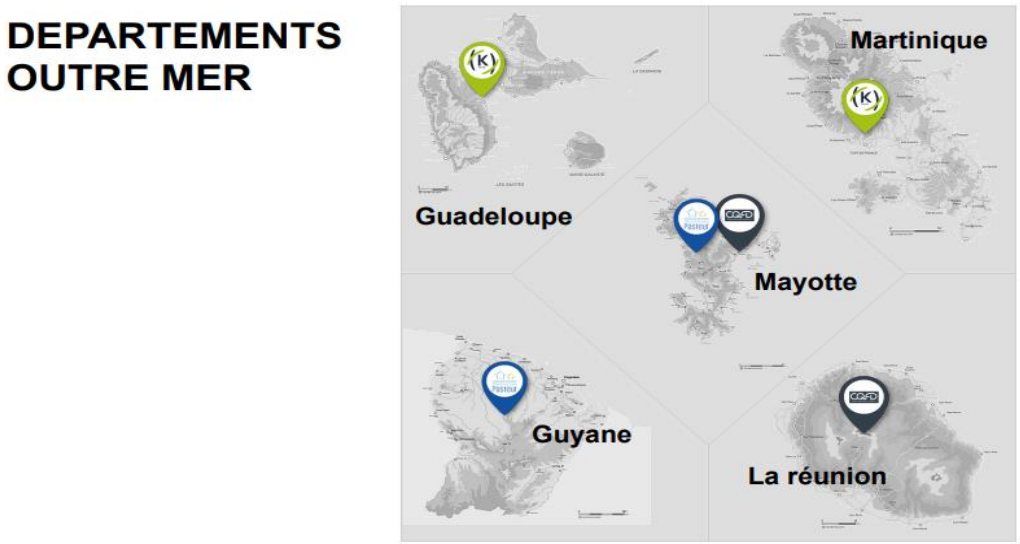



*Source : CPNEFP for medical practices*

Carte 2 : Location of approved training organizations in the Paris region


*Source : CPNEFP for medical practices*

Carte 3 : Locations of approved overseas training organizations




*Source : CPNEFP for medical practices*

[362] In order to complete the current offer and limit the number of areas without training facilities, the branch has decided to launch a new call for applications in the near future, with the aim of doubling the number of training organizations. Organizations that have already been approved have indicated that they are not opposed to this expansion, provided that it is effectively targeted at under-supplied areas, and that the geographical sectorization is

maintained. Indeed, in July 2021, the branch decided to suspend the reimbursement of certain ancillary expenses (accommodation and travel) to trainees who registered with a training organization far from their place of residence (see *below*). This provision is included in the Opco EP reference document[53] .

> Décision prise par la CPNEFP du 8 juillet 2021 qui seront soumises, conformément à la procédure habituelle à la SPP, au bureau et au CA de l'OPCO EP :
>
> *« Dans un souci de bonne gestion des fonds conventionnels qui représentent une partie conséquente des financements de la formation des assistants médicaux ; lorsque un stagiaire s'inscrira dans un organisme qui n'est pas le plus près de chez lui, les frais annexes afférents à la formation (restauration, déplacements et hôtellerie) ne seront pas pris en charge par l'OPCO. Il revient à chaque organisme de formation d'en informer le stagiaire. »*

[363] With regard to this regionalization, the mission notes that a certain vagueness is maintained by the branch and the Opco EP, which now deny its existence.

[53] The wording is slightly different in the reference document published by Opco EP entitled "Critères de financement 2023 - IDCC 1147 - Personnel des cabinets médicaux". On page 14, it states that "Travel and catering costs (it should probably read "accommodation") are only covered if the trainee attends training at an approved training organization (OF) located near his or her home or workplace. Catering costs are covered unconditionally".

**Opco EP's mechanism for reimbursing expenses to OFs and employers**

There are several ways to finance medical assistant training, mainly through Opco EP:

The skills development plan according to the following scales:

Training fees paid to training organizations: €20/hr excluding VAT
Ancillary expenses (accommodation, meals, travel) paid to employers for employee reimbursement: according to expenses
Wages paid to employers to replace their employees during training: €12/hour
It should be noted that the terms and conditions of Opco Santé, which intervenes very marginally, offer a less generous scale (€12/hr) for training costs.

Professionalization contract
Work-study retraining or promotion (pro-A)
Operational preparation for employment (POE)
Personal training account (CPF)

The average cost of training a medical assistant (CQP and FAE combined) is €12,600.

Reimbursement by the Opco EP is made on the basis of expenses actually incurred, within the limits of available funds and ceilings, and in proportion to the trainee's actual participation in the training.

In accordance with article R.6332-25 of the French Labor Code, payment of training costs is made once the services have been provided. It is therefore the responsibility of training organizations to provide Opco EP with the data required for payment of training costs (on a monthly basis, or at the frequency chosen by the training organization), which then triggers the calculation and payment of ancillary costs to the employer.

Two malfunctions were identified by the mission:

- A new, inflexible mechanism coupled with poor user information led to some initial malfunctions, but according to those involved, these now seem to have been gradually ironed out;
- Some trainees are obliged to advance the costs themselves (which can be high, see above), with employers waiting for the funds to be paid out by Opco EP before reimbursing their employees , which is not in line with employment law.

*Source : Mission*

[364] Training organizations also point to the need for a rational expansion of the offering, taking into account the economic viability of the ecosystem. Indeed, if the number of applicants for medical assistant training did not increase more rapidly than is currently the case, this expansion would mean opening training courses for classes too small to be commercially viable.

[365] The vast majority of training organizations reported small classes (15 to 25 trainees), but a capacity to scale up without always being able to put a figure on it. A few training organizations also told the mission that they maintain sessions for classes of less than ten trainees, which raises the question of profitability. At this stage, the difficulty lies not in increasing the number of training courses on offer, but in identifying the right candidates to take them.

[366] All the training organizations regretted that they were unable to carry out targeting for commercial canvassing, as they are accustomed to doing for other training courses. In fact, the French health insurance scheme says it is not authorized to provide them with the contact details of doctors who have signed a contract within the jurisdiction of each CPAM to subsidize the recruitment of a medical assistant. As a result, canvassing of employers by training organizations is limited; some have carried out e-mailings with the purchase of address files, or used advertising inserts in the specialist press, but to little effect.

[367] Some training organizations operating in several départements pointed out that the information provided by the health insurance could differ from one département to another, or even be erroneous. They also pointed out that this was particularly true in the first year of training deployment.

# 3 Teaching methods vary from one training organization to another, and the tools developed by the branch are unevenly appreciated.

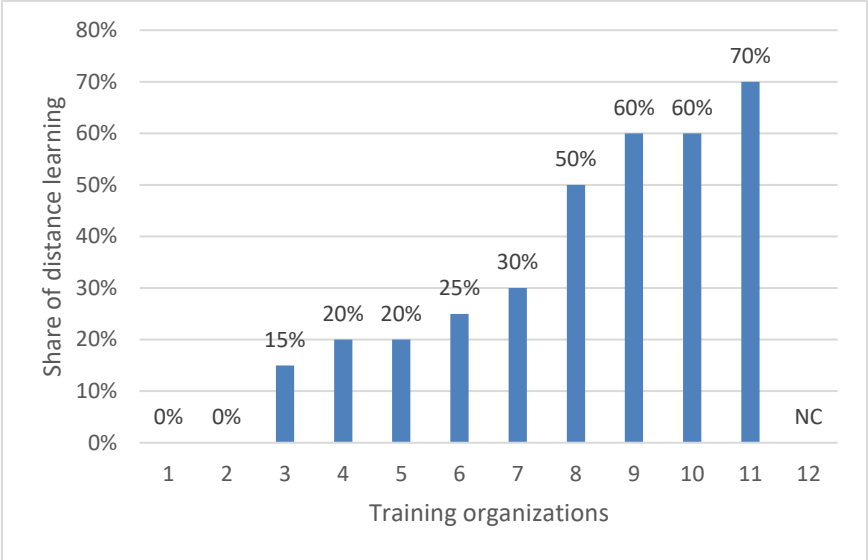
## 3.1 The proportion of distance learning is variable, but overall it is in the minority, and increasing it requires investments that not all training organizations will be able to make or wish to make.

[368] The branch call for applications provided for the possibility of using ODL without specifying its share. The majority of the training organizations we interviewed opted for face-to-face training, putting forward two arguments: the added value of peer-to-peer exchanges, and the practical nature of certain courses, particularly block 4 "operational assistance to the practitioner".

[369] Some of the training organizations also indicated that they were not in favor of distance learning, noting that trainees were attending courses from their place of work, and were therefore not available for learning. Training organizations operating in French overseas departments indicated that they preferred face-to-face training.

[370] The graph below gives an anonymized summary of the proportion of distance learning courses offered by training organizations.

Graphique 1 : Share of distance learning in training organizations' offerings




*Source : Mission*

[371] This graph shows that the majority of training organizations do not favor distance learning. Several have even indicated that they are opposed to it, and in practice three make little or no use of it. A number of lessons can be drawn from the organization of those who offer the most distance training:

- Before the introduction of geographical sectorization, some training organizations were keen from the outset to offer a range of products and services that would enable them to recruit trainees from as wide a geographical area as possible;
- Face-to-face meetings are preferred for the "operational assistance to the practitioner" block and for the "communication with patients" module;
- Some organizations offer distance learning for all four blocks but provide at least one face-to-face session per block, in particular to maintain a group dynamic;
- When the organization is present in several regions, distance learning courses are common to all locations.

[372] The mission's discussions with training organizations other than those accredited for the medical assistant CQP, which use distance learning exclusively, revealed that distance learning is suitable for all levels of trainee qualification (level 4 in this case), and is compatible with practical teaching, including in the healthcare field.

[373] On the other hand, setting up an exclusively distance learning course (synchronous or asynchronous) would require substantial investment, which smaller training organizations approved for the medical assistant CQP would probably not be able to support. As a result, such a development could only be envisaged in the medium term, and only after ensuring that practical training can actually be delivered to trainees.

## 3.2 The organization of the sessions combines promotions and entry into training over time, revealing a significant difference in levels.

[374] The branch call for applications stipulated that trainees could join the scheme at any time of the year, with the aim of enabling trainees to enter and leave on a permanent basis. In practice, some organizations operate on the principle of promotions that follow all the blocks in order over the school year. Others allow trainees to enter the course at the start of a new block, which means that they have to follow the blocks in a different order, but this does not seem to raise any particular pedagogical problems. In practice, training organizations follow school vacations.

[375] With regard to the integration of the EAF into the sessions, two options were described by the training organizations: sessions dedicated to the professionals concerned by the EAF several times a year, or joint sessions with trainees following the CQP and therefore once a year. Some training organizations have pointed out that healthcare professionals may be reluctant to accept this second option. They generally note a significant difference in level between FAE and CQP trainees, positively correlated with the initial qualification level.

## 3.3 The training support tools developed by the branch are useful, but their users are calling for improved ergonomics.

[376] The branch provides training organizations with two main tools for implementing training programs: the trainee positioning platform and the trainee's logbook.

[377] The platform is used by training organizations to register each trainee and position them: the branch analyzes on a case-by-case basis whether the prerequisites for training have been met, and validates any exemptions that may be granted.

[378] The trainee's booklet provides a reminder of the training framework and enables trainees to follow their apprenticeship in the practice under the supervision of the employing physician. It comprises 41 pages and includes the following sections:

- RGPD and personal data management to cover the use of personal data by the CPNEFP, the jury, training organizations and France compétences ;
- Contacts for the employee, tutor and training organization ;
- Presentation of the booklet, the CQP, the profession and the role of the trainee and tutor: the booklet emphasizes respect for patients' rights and the rules of confidentiality and professional secrecy to which they are subject. It indicates that the booklet is the vehicle for communication between the trainee, the tutor and the training organization;
- In-company" activity sheets describing the tasks carried out in each block and qualifying their completion;
- Tutor's opinion grids to determine whether each skill in the block has been "mastered", is "in the process of being acquired" or has "not been acquired". These sheets are dated and signed by the tutor;

**BLOC DE COMPÉTENCES 1**
**SUIVI DU PARCOURS DE SANTÉ DU PATIENT**

| Compétences | Maîtrisée | En cours d'acquisition | Non maîtrisée | Observations |
|---|---|---|---|---|
| Présenter aux patients les examens et les soins réalisés par le praticien, afin d'expliquer les étapes successives des examens et soins. | ☐ | ☐ | ☐ | |
| Présenter aux patients les précautions à prendre (avant et après un soin ou un examen), afin de prévenir les complications ou effets secondaires. | ☐ | ☐ | ☐ | |
| Vérifier le suivi par le patient de son protocole en recherchant les causes des écarts en matière de suivi. | ☐ | ☐ | ☐ | |
| Guider le patient dans son parcours de santé en vue d'améliorer sa prise en charge. | ☐ | ☐ | ☐ | |
| Vérifier la validité des vaccinations et la réalisation des examens périodiques prescrits en s'appuyant sur le carnet de santé et le dossier médical personnel du patient. | ☐ | ☐ | ☐ | |
| Relayer les campagnes nationales de prévention en expliquant au patient les recommandations de la campagne liée à son état de santé. | ☐ | ☐ | ☐ | |
| Informer les patients concernés, après indication du médecin, des campagnes de dépistage, de prévention et d'éducation, afin de les sensibiliser et les rendre acteurs de leur santé. | ☐ | ☐ | ☐ | |

- The training organization's evaluation grids for carrying out evaluations;

Épreuve 1
Épreuve en deux parties :
- Mise en situation orale : information d'un patient sur un examen ou un soin et les précautions à prendre avant et après.
- Questionnement à l'écrit portant sur un soin et un examen que le candidat devra décrire.

***Date de l'épreuve :***

| COMPÉTENCES ÉVALUÉES | CRITÈRES D'ÉVALUATION | Acquis* | Non acquis* |
|---|---|---|---|
| ▪ Présenter aux patients les examens et les soins réalisés par le praticien afin d'expliquer les étapes successives des examens et soins. | La description de la nature du soin ou de l'examen est exacte.<br><br>Les précautions à prendre pré ou post examen, avant et après un soin ou un examen, sont décrites dans des termes adaptés aux patients.<br><br>La description des précautions à prendre est conforme à la nature du soin ou de l'examen.<br><br>Les précisions apportées aux patients se limitent à la description des soins et des examens sans évocation de leur finalité. | | |
| ▪ Présenter aux patients les précautions à prendre (avant et après un soin ou un examen) afin de prévenir les complications ou effets secondaires. | | | |

**Évaluation : porter une croix suivant l'acquisition des compétences*

***Nom de l'évaluateur :*** ***Signature***

- CQP regulations: prerequisites, access criteria, assessment positioning, jury, conditions for obtaining the CQP, appeals by candidates, communication of results and control by the ACQPCM.

[379] A number of training organizations have pointed to the lack of ergonomics on the[54] platform, and to the cumbersome nature of the booklet, which tutors can consequently fill in very unevenly. It is through completed booklets that the branch has learned of task shifting.

[54] Given the time available, the mission did not investigate this aspect in depth.

[380] It should be noted that the trainee's booklet states that "*the tutor, if he feels the need, can follow a tutor training course financed by certain Opco*". According to Opco EP, no such requests have been made. In this respect, several training organizations have emphasized the lack of involvement that tutors have in monitoring their employees' training. This feeling may stem from the perception that employers and employees have of this training *("a prerequisite for receiving the CNAM subsidy*"), and from the time allowed to enter training (two years after hiring), which makes *the training* "*less interesting*".

## 3.4 The validation of acquired experience proposed by the vast majority of training organizations is not implemented by any of them, due to the inherent obstacles to this pathway.

[381] Since February 2023, the CQP has been accessible via VAE, a pathway which in theory seems particularly well-suited to medical secretaries, and which employers are keen to see. The conditions have been laid down by the branch and are summarized in the box below.

**VAE conditions set by the CPNEFP**

Proof of one year's full-time equivalent work, i.e. 1607 hours, in line with the requirements of the CQP reference framework as an employee, volunteer or volunteer.
Submit the admissibility file (and a cheque for €80 application fee) to one of the approved OFs for analysis.
Declaration of admissibility or non-admissibility of the application by the ACQPCM[55] within 2 months.
The admissibility decision is valid for 2 years.
Creation of a file based on the "livret 2" over a period of 9 to 12 months, with or without support from one of the approved training organizations (with possible financial support).
Sending the application and a cheque for €780 (payable by the candidate)
15-minute presentation and 30-minute discussion in front of the jury
Decision and dispatch of parchment if applicable

*Source : Mission*

[382] The branch website clearly highlights this possibility, even publishing possible dates for juries in 2023 (see *below*). Ten of the twelve training organizations are accredited for VAE, but no trainee has been certified in this way.

[55] The certifier is the CNPEFP, an ACQPCM association (association des CQP des cabinets médicaux) which holds the intellectual property rights to the branch's CQP titles.

Tableau 3 : VAE jury dates


*Source : CPNEFP website as of May 9, 2023*

[383] In practice, given the time required to prepare the application (9 to 12 months), the costs borne by the candidate, and the risk of not validating all skills and having to train for the part not validated, many of the people we spoke to believe that candidates tend to prefer the CQP, which takes no longer and offers a better chance of success.

[384] In addition, as is often the case, the composition of juries is a limiting factor. In this case, the RNCP-registered file stipulates that the jury must comprise two members of the CPNEFP, including one representative of the "employers" college, a practicing practitioner, and one representative of the "employees" college. It is generally difficult to mobilize self-employed professionals to sit on juries, given the loss of earnings this commitment entails. In fact, the last professional joint section (SPP) of Opco EP, held at the beginning of May, approved a budget to cover the costs of CQP AM juries: the amount per jury and per file is €20 (each file is studied by a pair, so the cost of studying a CQP AM trainee file is €40).

[385] All in all, the mission concludes that, in its current state, VAE will not deliver the scale-up expected.

## 4 Some organizations find it difficult to recruit trainers and cite premises constraints.

[386] The branch's call for applications stipulated that trainers had to have at least one year's experience in the CQP's training areas, and to have completed a trainer training course. And 25% had to be healthcare professionals. The mission was unable to collect all the data on trainer profiles from training organizations. Nevertheless, it appears that in the vast majority of cases, the trainers involved in the greatest number of hours are healthcare professionals (doctors and/or nurses). The presence of doctors is not systematic. In some cases, training organizations call on external speakers (ARS, psychologist, CPAM, IT specialist).

[387] The vast majority of training organizations have reported recruitment difficulties, which could potentially hinder the deployment of training if the proportion of distance learning remains limited. This difficulty concerns specialized profiles such as IT specialists, and healthcare

professionals for training organizations whose training catalog is not very developed in the healthcare field.

[388] Some training organizations have indicated that remuneration fees are not sufficiently attractive to motivate healthcare professionals, especially those working in private practice. Rates ranged from €50/hr net to €60/hr net for the most qualified trainers (including doctors and healthcare executives), and from €40/hr net to €60/hr net for others.

[389] For many training organizations, and even more so for those who make little use of distance learning, the physical limitations of available premises have been cited as a reason for increasing the number of courses on offer.

# ANNEXE 5 : Medical assistants abroad

# CONTENTS

[390] The profession of medical assistant has existed in many countries, including the USA, Germany, Switzerland and the Netherlands, often for a long time. In some of these countries, there are large numbers of medical assistants working alongside general practitioners. The skills of medical assistants vary from country to country, but their clinical skills are generally more extensive than in France. Lastly, medical assistants' training is, with a few exceptions, longer and more diversified than in France, in line with the scope of their prerogatives.

# 1 An increase in the number of primary care professionals[56] and teamwork to meet the challenges of health supply and demand.

## 1.1 Similar challenges in different countries, leading to changes in the organization of care and a broadening of the range of primary care skills

[391] Primary care systems in almost all countries are facing the same scissor effect between a current and future shortage of healthcare professionals, particularly GPs and nurses, and the rapid growth in demand for care.

[392] With regard to the shortage of professionals, this is due to the insufficient number of new students, the rapid ageing of the professional population and their new lifestyle requirements. As for the rapid growth in demand for healthcare, this is due to the rapid growth in the number of patients and the evolution of their demand, again due to the ageing of the population, which increases the prevalence of chronic illnesses and polypathologies, to growing medical consumerism and to the progression of health coverage in certain countries (cf. the United States with the Patient Protection and Affordable Care Act of 2010 or "Obamacare"). We must also take into account technical and medical progress, which is leading to increased - and sometimes excessive - specialization and fragmentation of care, the growing importance of outpatient care, and the rapid digitization of patient-physician relations and the management of procedures and data.

[393] In response to these changes, according to a recent study by the European Observatory on Health Policies and Systems[57] , the most frequently implemented orientations in Europe, in addition to the development of group practice and teamwork as isolated practice in town medicine becomes increasingly difficult, are of five kinds:

- relieve GPs' workload by sharing non-medical tasks and simple, routine medical tasks with a range of new professions, including medical assistants;

[56] This appendix focuses on primary care, but medical assistants also work abroad for specialist doctors, who also face demographic challenges.

[57] European Observatory on Health Systems and Policies, *Skill mix innovations in primary and chronic care, Mobilising patients, peers, professionals*. Edited by Matthias Wismar et alii.

- develop the role and presence of specialized nurses to avoid hospitalization and/or enable a quicker return home;
- create intervention teams for palliative care, psychiatric care and numerous chronic and polypathological situations;
- mobilize non-medical professions, such as social workers, police officers, firefighters, janitors etc... ;
- mobilize informal caregivers.

[394] The new healthcare professions that have emerged, with varying speed and intensity, in the United States and Europe, and have changed the skill mix of primary care teams, are[58] :

- physician assistants, who are healthcare professionals trained to provide general medical care within multi-professional teams under the supervision of general practitioners, particularly present in the United States;

Tableau 1 : Comparative situation of physician assistants in five countries

| Country | Germany | Netherlands | United Kingdom | Canada | United States |
|---|---|---|---|---|---|
| **Name** | Physician assistant or associate | Physician assistant or associate | Associate physician | Physician assistant | Physician assistant |
| **Creation date** | 2005 | 2000 | 2003 | 1991 in the army; 2003 Manitoba, Ontario, New Brunswick, Alberta | 1967, then in the 1970s at federal level |
| **Where they are in the care system** | Mainly in hospitals and nursing homes | In almost all care facilities | In almost all care facilities | In almost all care facilities | In all care facilities |
| **How many of them are there?** | 179 over the 2005-2015 period (225 in | 1 200 | 450 in 2017 (and 1,200 in training) | 500, including 300 in Ontario | 123 000 |

[58] Cf. Gemma Williams, *An overview of new and emerging roles in primary care*, presentation given at the CNAM - Observatoire européen des politiques et des systèmes de santé seminar in January 2019. Also involved, depending on the country, are midwives, speech therapists, physiotherapists, community health specialists, dentists, laboratory technicians... cf. Peter Groenewegen, Primary care practice composition in 34 countries, Health Policy, 2015.

| | | | | | |
|---|---|---|---|---|---|
| | training in 2015) | | | | |
| **Level and duration of training** | Bachelor's degree + 36 months | Master + 30 months | Master + 24 months | Master's or Bachelor's degree + 24 months | Master + 27 months |

*Source : Gemma Williams, op. cit.*

- advanced practice nurses (nurse practioners), who are masters-level nurses who provide care with an extended and advanced clinical role[59] ;
- nursing associates, who allow nurses to concentrate on more complex clinical activities;
- healthcare assistants, who work alongside nurses to carry out tasks previously performed by them;
- medical assistants, the subject of this report (see below);
- specialist paramedics, who are paramedical professionals such as physiotherapists who assist GPs in triaging patients, running the practice and managing minor pathologies to provide continuity of care for complex patients;
- pharmacists working in multi-professional practices, who take care of patients with chronic pathologies, their compliance and the promotion of their health.

[395] The impact of these new professionals, some of whom do not yet exist in France, is still imperfectly known.

Tableau 2 : Assessing the impact of new healthcare professionals in primary care

| Professionals | Physician assistants | Nurses | Pharmacists | Multidisciplinary team |
|---|---|---|---|---|
| Evaluation | Impact equivalent to that of physicians in terms of patient satisfaction and adequacy of care for non-complex needs<br>No clear evidence of cost-effectiveness<br>Improved productivity if | Care equivalent to or better than that provided by doctors<br>Improved physical and mental health | Improved physical health, but no evidence for mental health<br>Limited evidence of improved cost-effectiveness | No clear evidence of impact on health status<br>Possible improvement in end-of-life care<br>Improving mental health |

[59] It is estimated that these first two categories of staff are capable of carrying out at least 60% of the activities of a primary care facility.

| | | | | |
|---|---|---|---|---|
| | experienced physician assistants<br>Some evidence of reduced demand for primary care | Some indicators of reduced demand for care<br>No clear evidence of improved cost-effectiveness | Possible improvement in prescribing compliance<br>Some indications of reduced demand for care | Some indications of reduced demand for care |

*Source : European Observatory on Health Policies and Systems*

## 1.2 Primary care organization still varies enormously from country to country

[396] In practice, the organization of primary care varies greatly from country to country, depending on health policy and the history of the health system. There is no clear evidence that one organization is more efficient than another, and transposition from one country to another is not necessarily obvious.

[397] General practitioners obviously play a key role, but their position differs from country to country and according to whether or not patients are free to choose their doctor.

[398] In some countries, GPs still predominantly work in small practices, sometimes reduced to a single doctor, as is the case in Belgium. Germany is also a special case, with primary care organization still based mainly on solo practitioners, but these doctors are supported by one or two medical assistants in most cases (see below).

[399] In Austria, Italy, Luxembourg and Switzerland, doctor's surgeries include few professionals other than the physician.

[400] When there's only one other professional, it's usually either a nurse or a medical secretary. When there are two other professionals, it's usually a nurse and a medical secretary. On the contrary, British, Spanish, Finnish and Swedish medical practices include a fairly large number of professionals in addition to the doctor[60] .

[60] Cf. in particular Peter Groenewegen et alii, *Primary care practice composition in 34 countries*, Health Policy, 2015.

Graphique 1 :Median number of professionals present in primary care practices in addition to the doctor


*Source : Groenewegen, op. cit.*

[401] Analysis of the different configurations is complicated by the fact that the same professionals have different roles in different countries and healthcare systems. Nurses, for example, have a role quite similar to that of medical secretaries in former communist countries.

Tableau 3 : Segments of the care continuum (from the simplest to the most complex) and the role of professionals in different countries

| Types of care graded from 1 to 5 according to complexity | 1 - simple, well-defined tasks that can be performed with limited training | 2 - classic care | 3 - well-defined, protocolized clinical activities in specific fields (asthma, diabetes, etc.) | 4 - clinical diagnosis and treatment of less complex situations; some areas of chronic care | 5 - more complex treatments. Management and coordination of multi-professional teams (physician) |
|---|---|---|---|---|---|
| Germany | Medical assistant | No | No | No | General practitioner and internist |
| England | Care assistant | Nurse | Senior nurse or specialist | Advanced practice nurse | General practitioner |
| Australia | Medical assistant | Nurse | Nurse | Advanced practice nurse | General practitioner |
| Canada | Orderly | Nurse | No | Advanced practice nurse in primary care (PHCNP) | Family doctor |
| United States | Licensed practical nurse or medical assistant | Registered nurse | Clinical nurse specialist and midwives | Nurse practioner or assistant physician | Doctor |

# 2 Medical assistants, an important and often long-standing component of primary care organizations abroad

[402] Medical assistants, in the sense of professionals with both administrative and clinical responsibilities who work alongside doctors, have existed for several decades in a number of countries. This has been the case in the USA and Germany since the 1950s, and in the Netherlands since the 1960s[61] . In the UK, on the other hand, the function, or profession, has only recently come into existence (2017 on an experimental basis).

[61] Medical assistants were officially recognized in Germany in 1968, and more recently by an ordinance issued in April 2006.

**Medical assistants and ISCO (ILO)**

Medical assistants are listed in the International Standard Classification of Occupations (ISCO) managed by the International Labour Office (ILO) under code 3256, along with "other intermediate health professions", such as dental assistants, medical information officers, ambulance drivers, community health workers, opticians, physiotherapy technicians and assistants, environmental and occupational health inspectors and associates, ambulance drivers...

According to the ISCO classification, medical assistants "perform basic clinical and administrative tasks to assist in the care of patients under the direct supervision of a physician or other healthcare professional". The classification adds that "these tasks include :

- interview patients and their families to obtain information about their health and medical history;
- assist physicians and other healthcare professionals in examining and treating patients, including measuring and recording vitals, administering medications and performing routine clinical procedures such as administering injections and removing sutures ;
- prepare patients for examination and treatment, including explaining procedures and setting them up in the examination room;
- prepare and handle medical instruments and supplies, including sterilizing instruments and disposing of contaminated supplies in accordance with safety procedures;
- collect blood, tissue or other samples and prepare them for laboratory testing;
- provide information to patients and families on healthcare-related topics, including medications prescribed by a physician or other healthcare professional;
- provide pharmacies with information on prescriptions and refills;
- keep patient waiting and examination rooms clean;
- record information on patients' medical histories, diagnostic tests, treatment procedures and results, and other information in medical record-keeping systems;
- schedule patient appointments and prepare required documentation for billing, reporting and insurance purposes."

*Source : ILO*

[403] Medical assistants, whose function has officially existed since 1956, are extremely numerous in the United States (nearly 750,000, and 860,000 in 2031 according to the US Bureau of Labor Statistics[62] ) and Germany (over 400,000, including 370,000 in city practices), and to a lesser extent in the Netherlands (35,000).

[404] The profession is highly structured in the United States, around their professional organization, the AAMA[63] .

[405] It would appear that their presence in primary care has increased overall in recent years in those countries where they exist.

[62] This makes medicalassistants the largest occupational group in the healthcare sector, and one of the most job-creating professions in the USA.
[63] Cf. AAMA Official Site - American Association of Medical Assistants (aama-ntl.org).

[406] Most medical assistants work in practices or structures in town, but they are also qualified to work in other healthcare or medico-social establishments.

[407] The remit of medical assistants varies from country to country, but is generally more extensive than in France. They are both administrative and clinical. The administrative responsibilities of medical assistants are fairly similar from one country to another, while taking account of specific administrative features (e.g., the multiplicity of private insurers in the USA). Clinical responsibilities, on the other hand, are more varied, depending in particular on the scope of competence of the other professions working in the practice.

[408] The responsibilities of medical assistants also vary, within the same country, according to the type of care structure: large multi-professional practices, small structures, specialists... The regulatory framework governing the competencies of healthcare professions is also generally more flexible abroad than in France. This allows doctors to adapt the allocation and delegation of tasks to individual needs, even if it means developing the activities of professionals within a protocolized framework.

[409] In Germany, the skills of medical assistants (Medizinische Fachangestellte - MFA) are sometimes even more extensive than those of hospital nurses. In addition to billing the various insurers, they can renew prescriptions in conjunction with the doctor, carry out pharmaceutical check-ups in conjunction with pharmacists, carry out medical examinations such as ECGs, take biological samples (health checks, dispatch to analysis laboratories, receipt of results), carry out protocolized care with the doctor, notably for chronic wounds (care reserved for nurses in France). They can also take part in health promotion, prevention and therapeutic education. They can carry out certain tasks independently, and have a room and consultation hours for receiving patients.

[410] During their sandwich course, medical assistants are paid between €900 and €1,035 gross per month, depending on the year of training. Thereafter, according to their collective bargaining agreement, German medical assistants are paid between €2,150 and €4,000 per month, depending on seniority and specialization[64] . Additional training courses include oncology, outpatient surgery, gastroenterological endoscopy, pneumology, dialysis, ophthalmology outpatient surgery, radiation protection and occupational medicine.

[411] Many of Germany's medical assistants - level 2, as it were - provided they have three years' professional experience, become "non-medical practice assistants" (Nich Arztliche Praxisassistentin - NäPa). They carry out home visits in nursing homes on behalf of doctors. The delegation of certain clinical activities by doctors to medical assistants is regulated by an agreement between the doctor and the social insurance fund (GKS), listing examples of authorized activities and prerequisites. For example, anamnesis, diagnosis, prescription and surgical interventions may not be delegated.

[412] Germany, which seeks to attract 1.4 million foreign workers to the country each year, is actively promoting the medical assistant profession internationally[65] .

[64] According to old figures provided by Gemma Williams.

[65] https://en.life-in-germany.de/medical-assistant-in-germany/#:~:text=Medical %20assistant %20is %20the %20modern,accredited %20training %20profession %20in %20Germany

[413] In the Netherlands, the clinical duties of medical assistants are focused on the social and preventive aspects of patient care, and they manage the organization of the facility (stock procurement, equipment functionality, etc.). They can, however, triage patients, act on protocols for various types of care, and have their own role within the limits of their fields of action. All in all, the tasks of medical assistants depend very much on the internal organization of practices. As in Germany, Dutch medical assistants can carry out certain tasks independently. To this end, they have their own consulting room and hours for receiving patients.

[414] Salaries for Dutch medical assistants range from around €2,000 to €3,400.

**The clinical tasks of Dutch medical assistants according to their professional association**

Medical assistants :

- Determine the urgency of the request for care and the appropriate follow-up action (triage)
- Advise and inform patients
- Perform medico-technical operations
- Contribute to the organization of the firm or department
- Store patient data
- Collect samples for research
- Perform simple analyses (blood, fluoride, urine and stool tests)
- Care for wounds
- Make ECGs
- Treatment assistance
- Provide advice and information

*Source : Nvda.nl*

[415] In the USA, the clinical tasks of medical assistants are numerous. The AAMA lists the following in particular: taking medical histories, explaining treatment procedures to patients, preparing patients for examinations, assisting the physician during examinations, collecting and preparing laboratory specimens, performing basic laboratory tests, informing patients about medications, preparing and administering medications, including intramuscular, intradermal and subcutaneous injections, including vaccinations, as directed by a doctor or other licensed professional (nurse), transmitting prescription renewals as directed, performing phlebotomy and electrocardiograms, wound care and dressing changes. According to the CNAM, however, these services are less extensive than in Germany and the Netherlands. In many countries, it is clearly established that the "triage" function, which consists in determining the treatment priorities of patients according to the severity of their state of health, cannot be carried out by a medical assistant, whereas this triage is carried out by German and Dutch medical assistants (since 2016).

[416] The average annual remuneration for certified medical assistants is around US$40,000, or around €3,300 per month.

[417] England is the country where the skills and activities of medical assistants, a function created on an experimental basis in the mid-2010s, appear to be closest to those in France. It is

also the country where the professions practicing in primary care practices are the most diversified and among the most advanced. It should be noted that in England, nurses are already systematically present in doctors' surgeries, almost all of which are multi-professional group practices.

# 3 Longer and more varied training for medical assistants abroad than in France

[418] Training for medical assistants abroad is generally longer than in France, and the routes are more varied, as are the job opportunities.

[419] In Germany, training for medical assistants is a 3-year sandwich course, alternating between a vocational training center ("Berufsschule"), one or two days a week, and the practice of a general practitioner or specialist. An intermediate examination is held at the end of the second year, and a final examination (300 minutes written and 75 minutes practical) at the end of the third year. To enroll in the program, you need to have passed the baccalaureate.

[420] After three years' experience, medical assistants can become "non-medical practice assistants" by completing 271 hours of continuing education (201 hours of theoretical instruction, 20 hours of emergency management, 50 hours of practical instruction in the form of home visits).

[421] Specific further training courses enable medical assistants to specialize in a number of fields. Non-medical assistants can also become medical assistants through university training.

[422] In the USA, university or professional training is not always required to practice as a medical assistant, although this seems less common today. The AMAA has set up a certification program which it awards to baccalaureate-level medical assistants who complete accredited medical assistant training lasting between 9 and 24 months, and who pass an examination it organizes (200 multiple-choice questions in 4 times 40 minutes).

[423] In the Netherlands, three years of vocational training are required, with four possible levels of qualification for medical assistants.

[424] In Switzerland, training takes place over a three-year apprenticeship from the age of 16. Practical training lasts 3.5 days a week in a medical practice, while theoretical training at the vocational school lasts one and a half days a week, and there are also courses (38 days over 3 years). The training leads to a Federal Certificate of Competence (CFC) as a medical assistant.

[425] Medical assistants can consider the following specializations in particular:

- consultation assistance, radiology, first aid, laboratory, office administration, etc. ;
- clinical chemistry, haematology, pneumology, etc. ;
- Federal diploma as coordinator in outpatient medicine with clinical or management orientation, as respiratory disease consultant or as medical coding specialist (training in German);
- diploma of ambulance driver, nurse or operating room technician;

- Bachelor of science in medical radiology, nursing, nutrition and dietetics, physiotherapy, occupational therapy or osteopathy.

# ANNEXE 6 : Mission's methodology

[426] The "flash" mission was of short duration, and the methodology was adapted accordingly. It was based mainly on numerous interviews, document analysis and data analysis.

[427] **In terms of interviews,** the mission met with more than 130 people, mainly remotely, given the time constraints. It did, however, make a point of visiting two of the twelve training organizations. Where meetings could not be arranged, the team conducted telephone interviews. All the people met or called are listed in the report.

[428] With a few exceptions, all interviews were conducted on the basis of a grid drawn up by the mission and sent (with the mission letter) in advance to the interviewees. Given the format of the assignment (evaluation of public policy), no minutes were taken of these exchanges.

[429] As far as possible, the members of the mission tried to take part in all the interviews.

[430] Discussions were held with the commissioning firms and with all the central administrations in the healthcare sector (DGOS, DSS, DREES) and the employment and vocational training sector (DGEFP, DARES).

[431] The mission met with the main stakeholders: health insurance (at national and local level), the CPNEFP (or the branch), the Opco concerned, France compétences, AFPA, Pôle- emploi.

[432] She also met with representatives of associations and unions representing general practitioners and specialists, nurses, nursing aides, dental assistants, medical secretaries and patients.

[433] The mission met with the twelve training organizations approved by the branch, as well as with medical assistants who had been trained or were in the process of being trained. Given the time constraints, the mission had to divide up the interviews, which were held on the basis of a common grid. Prior to each interview, the team was informed of the confidential nature of the discussions, with a view to preserving business secrecy. In this respect, the mission did not draw up individual monographs.

[434] **In terms of document analysis,** the mission carried out in-depth bibliographical research, which led to a comparison of the functions of medical assistants abroad, and a summary of several theses submitted for the medical doctor's degree. She also benefited from the assistance of the IRDES documentation center.

[435] Of course, the mission analyzed existing regulations and collective bargaining agreements governing the function of medical assistant.

[436] It also collected extensive documentation through interviews. It carried out an in-depth analysis which fed into its findings and proposals. Data on the financing of the system were only partially obtained?

[437] **For the analysis of trainee data,** the mission had access to three different sources: CNAM data on contractualization, CPNEFP data on training, and Opco EP data on financing.

[438] The mission has drawn a number of conclusions, some of which should be treated with caution given the fragility of some of the data provided. In addition, the totals shown throughout the report should be related to each category: for CNAM, number of contracts, number of

physical medical assistants, number of FTEs; for the branch, number of trainees trained or in training; and for Opco EP, number of funding applications.

[439] For example, table 6 in the report compares contractualization data supplied by CNAM with funding application data (approximating the number of trainees trained) supplied by Opco EP.

[440] In addition, the mission has reprocessed the data contained in the CPNEFP database, in particular with regard to dates of birth, tutors' specialties (whose wording has been harmonized) and diploma level (whose wording has also been harmonized).

[441] The main change concerned the "occupation prior to training" data. In fact, trainees could be recorded under the names "medical secretary" or "medical assistant", which the mission considered as a single group: that of medical secretaries hired as medical assistants by the same employer, this adjustment being corroborated by the figures available elsewhere.

[442] For this same heading, 145 candidates were registered as pre-physicians. When these candidates were not IDE, ASDE or APDE and had a baccalaureate level, they were repositioned as "medical secretaries".

[443] In fine, the total number of medical secretaries and medical assistants appeared consistent with data available elsewhere.

[444] Finally, when analyzing this database, trainees eligible for the FAE were treated separately from those admitted to the CQP.

[445] The data relating to length of service could not be processed because it was too heterogeneous ("since", "year", "day/month/year", "between year and year", "between date and date", etc.).

[446] From this reworked database, the mission was able to carry out interesting extractions (simple or by constructing pivot tables) on the profile of trainees, their geographical origin, their average age, the proportion of exemptions granted, their level of education, their situation prior to hiring and the specialty practiced by their employer.

[447] The Opco EP database enabled us to identify the average cost of training, but not to go into more detail. The answers to the mission's questions did not explain the discrepancies between the CPNEFP and Opco databases, particularly as regards the mechanism used (skills development plan, ProA, professionalization contract, etc.). The mission has therefore retained the data provided by the branch.

[448] With regard to pools, data were collected from OMPL, ACOSS, DREES, DARES, DGFiP and Pôle Emploi. The mission found the data to be scattered and incomplete. For the most part, there are no precise data on medical secretaries, apart from those available from the OMPL and, to a lesser extent, DREES. Data on healthcare professionals (notably IDEs, ASDEs and APDEs) are also surprisingly variable, depending on the source.

[449] The mission made two interim presentations of its work in April and May. The second presentation was made in the presence of the Minister and the Director General of CNAM.