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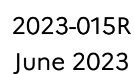
Inspection Générale
des Affaires Sociales

# Training of Medical Assistants

Report

**Frédérique SIMON-DELAVELLE** **Louis-Charles VIOSSAT**

**Members of the General Inspectorate of Social Affairs**



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# SUMMARY

[1] The creation of the medical assistant function is one of the measures of/from "Ma santé 2022" strategy presented in September 2018. It aims to "free up medical time" by relieving doctors of administrative tasks, and providing assistance with patient preparation and care when necessary.

[2] Quantitative objectives (increasing the number of consultations per doctor to meet unscheduled or urgent care needs, particularly in areas where there is a shortage of doctors and for specialties in short supply, improving access to a general practitioner, reducing waiting times for certain specialties) are combined with qualitative objectives (improving the quality of care, patient care and follow-up, by devoting more time to patients who need it, reinforcing continuity of care, strengthening coordination between the various stakeholders) 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).

[3] From an initial target of 4,000 medical assistants, the President of the Republic decided to increase their number to 10,000 by the end of 2024. This target presupposes attracting new vocations and diversifying the current pool, which is essentially made up of medical secretaries, expanding the existing training offer to accommodate more trainees, and finding the necessary funding, given that the average cost of training is €12,600 per trainee. It also means unlocking a system designed on a branch-by-branch basis, which limits the scope for rapid and substantial take-up. The adjustments made to the system will also have to guarantee a good level of training for these professionals, to whom the public authorities wish to entrust missions closely linked to the quality of care.

[4] According to the information we were able to gather in the time available, the medical assistant function satisfies both doctors as employers, who emphasize quality of life in the workplace, and employees, when their training path is effectively accompanied by a change in their tasks (the medical secretary usually stays in the same place) .

[5] Today, it is possible to become a medical assistant either after obtaining a Certificate of Professional Qualification (CQP), following a 384-hour sandwich course (two days a week during ten months), or after a 112-hour job adaptation course (FAE) for nurses, orderlies or state-qualified nursery auxiliaries. The wide range of profiles who can become medical assistants can make the job less transparent.

[6] Medical assistant training is atypical in several respects. It is open to candidates with qualifications ranging from level 3 (“certificat d'aptitude professionnelle” - CAP, “brevet d'études professionnelles” - BEP) for medical secretaries with some experience, to level 6 (bac + 2) for nurses, although in practice half the trainees have level 4 (baccalauréat). In addition, to facilitate the rapid take-up of the scheme when it was set up, the public authorities allowed for a two-year period between recruitment and the start of training, and thus a three-year period until certification. This flexibility has resulted in a time lag between the start of training and the completion of certification, as well as in employers and employees feeling that training is less useful when it takes place after two years in the job. The mission is in favor of deleting this

provision, but recommends a duration of one year to take account of the constraints weighing on the whole system.

[7] The CQP, which is the most common route into the profession, is based on a reference framework of activities and skills (RAC) broadly adapted to the function, which is predominantly carried out by GPs. Its duration is in line with training courses for comparable professions. What's more, it includes a large number of exemptions for medical secretaries, enabling the training volume to be reduced to 269h30. In this respect, the training can be considered as already modular and well adapted to the trainees' profile and experience. Nevertheless, and in response to criticism, the hourly volume of certain modules could be reduced.

[8] For the CQP, training can be provided by up to twelve organizations approved by the Commission paritaire nationale de l'emploi et de la formation professionnelle" (CPNEFP) for GP practices also called the branch. They vary in terms of status, size, organization and seniority in the healthcare field. Distance learning is used by a minority of them. They are currently in a position to train the candidates who apply, but not all of them are ready to double or triple their offer to meet the target. The branch plans to approve other organizations, taking into account the current uneven coverage of the country. If the demand for training is there, the increase in the number of distance learning courses (synchronous or asynchronous) will probably also be necessary.

[9] As far as the FAE is concerned, there are no constraints in terms of training organization or content, although the branch suggests taking the block of the CQP relating to administrative skills (from which medical secretaries are largely exempt). The mission recommends shortening the duration of this training to 35 hours (corresponding to the "creation and follow-up of patient files" module) instead of 112 hours.

[10] Today, canvassing operations by training organizations are made difficult, if not impossible, since they cannot obtain the list of doctors who have signed a contract with the health insurance scheme. The inclusion of a clause relating to the use of personal data in compliance with the General Data Protection Regulation (GDPR) in contract models should remove this obstacle and enable better mobilization of pools.

[11] The vast majority of people who have entered training since 2021 are medical secretaries working in GP practices, as this is how the scheme was conceived by the branch. Its genesis dates back to the 2000s. Several avenues had been explored, including a training program comprising a core curriculum and specialty modules, or a training program focusing more on medical-technical skills and less on administrative functions. This new function was created to offer career development prospects to the branch's employees, but was not intrinsically designed to accommodate other profiles, nor to mobilize the many possibilities offered by initial and vocational training.

[12] In fact, the medical assistant's field of intervention is subject to conflicting interpretations. Addendum no. 7 of June 2019 to the medical agreement specifies that the contours of the profession are set by the employer, and that the duties performed are specific missions that must be distinguished from those of other job categories (by which is meant healthcare professionals). In the way it has designed the CQP and issued the call for applications for the selection of training organizations, the branch has adopted a restrictive definition, under which medical assistants may not perform any medical-technical acts, apart from taking vital signs. In practice, medical

assistants may be entrusted with tasks that go beyond their remit, as is already the case for medical secretaries. In addition to compliance with the decrees governing the activities of healthcare professionals, this discrepancy can be explained, on the one hand, by the name given to these professionals (in French, the term "medical secretary" emphasizes the administrative aspect; "medical assistant" emphasizes the "medical" aspect) and, on the other hand, by the functions performed by medical assistants in foreign countries, which may be similar to those performed by doctors or paramedical staff in France. This ambiguity therefore leaves the function of the medical assistant unclear and may hinder recruitment. The mission is in favor of broadening the scope of medical-technical activities performed by medical assistants, as is the case in other countries, and of developing their skills in conjunction with representatives of the healthcare professions concerned. Nevertheless, the mission stresses the difficulty of positioning each of these professionals in relation to the others, and of determining their areas of competence within the French context of healthcare organization.

[13] In order to facilitate the development of this new function, a very generous aid scheme has been devised by the health insurance fund, the conditions of which are described in Addendum no. 7 to the national agreement organizing relations between self-employed doctors and the health insurance scheme, and now in the arbitration rules. The principle is to provide ongoing, scalable support for the recruitment of a medical assistant in return for taking on new patients. Between 2019 and 2022, a total of €119.2 million has been paid to doctors, mainly general practitioners. The arbitration settlement has eased the requirement to replace a medical secretary recruited as a medical assistant, by authorizing the use of a telephone secretariat, which is an appropriate adaptation.

[14] Nevertheless, the number of professionals entering training is progressing relatively slowly. In December 2022, according to data from the French national health insurance fund (CNAM), there were 4,069 assistance contracts, 3,100 medical assistants and 2,537 full-time equivalents (FTEs), of which only around 400 held the CQP or had completed a FAE.

[15] The system suffers from a lack of oversight. Indeed, medical assistants are not healthcare professionals, and as such, do not come under the responsibility of the General Directorate for Healthcare Provision (DGOS). The Departement of Health's other directions only deal with the subject to a very limited extent. In addition, there is little contact between the worlds of healthcare and vocational training, and the Délégation générale à l'emploi et à la formation professionnelle (DGEFP) has not been involved in the development of medical assistant training. In short, each stakeholder is playing its part, but without coordination. The mission recommends that the project be steered by the DGOS, which has recognized its value, and that a steering committee be set up to monitor the deployment of medical assistants.

[16] In addition, and still with a view to achieving the target set, the profession, training and financing arrangements will have to be the subject of concerted communication campaigns between the various stakeholders.

[17] There are also a number of obstacles to the development of this function, unrelated to training. An essential factor is whether or not doctors choose to recruit. Doctors have little appetite for the role of employer, and fear having to apply labor law. This obstacle could be overcome, in part, by the development of employers associations. Medical practices are not always able to accommodate a new professional, as prior to the new provisions set out in the May

2023 arbitration settlement, doctors had to replace their medical secretaries if the latter were recruited as medical assistants. Finally, the incentive for medical secretaries to join the scheme may not be sufficient, given the very small pay differential when they become medical assistants.

[18] At present, access to training is essentially centered around the Skills Development Plan (SDP), which restricts the pool of candidates and accentuates financing problems. In this respect, the mission proposes to develop pre-recruitment training by activating the individual or collective operational preparation for employment scheme, with greater involvement of Pôle Emploi (national public employment service). It also suggests that the branch, or the region, should contribute to personal training accounts, and that it should join in the new dynamic initiated by the public authorities for the validation of acquired experience (VAE) through experiments currently underway and the creation of the VAE public interest group.

[19] The decision to create a CQP restricts the pool of trainees and the funding of training courses. For the time being, medical assistants cannot be trained as apprentices (due to French regulation). The mission is therefore in favor of creating, in addition to the CQP, a healthcare assistant qualification that would apply to all healthcare structures. This would open up the possibility of recruiting medical assistants as apprentices, and benefit from new funding from France Compétences. 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).

[20] The mobilization of additional funding to train the thousands of new medical assistants over the coming quarters must finally be a priority for both the branch and the French government.

[21] An action plan incorporating the mission's recommendations could be drawn up and rapidly implemented by the DGOS.

# MISSION RECOMMENDATIONS

| N° | Recommendation | Priority | Responsible authority | Deadline |
|---|---|---|---|---|
| Transforming the function into a real business | | | | |
| 1 | Expand the scope of medical assistants as the nursing profession evolves | 1 | DGOS/CNAM | 2024 |
| 2 | Remind that nurses can perform nursing acts on an ad hoc basis as medical assistants | 2 | DGOS | 2024 |
| Guaranteeing control | | | | |
| 3 | Designate the DGOS as the interministerial lead for the "10,000 medical assistants" project and set up a steering committee | 1 | DGOS | T3 2023 |
| Developing training | | | | |
| 8 | Authorize level 3 candidates to register for the medical assistant CQP | 2 | CPNEFP | 2023 |
| 9 | Plan to start training as a medical assistant no more than one year after signing the assistance contract. | 1 | CNAM/DGOS | T4 2023 |
| 10 | Communicate with training organizations to ensure that exemptions for medical secretaries are systematically granted. | 2 | CPNEFP | T3 2023 |
| 11 | Reduce adaptation training to the "patient file creation and follow-up" module for caregivers who become medical assistants. | 1 | DGOS/CPNEFP | T3 2023 |
| 12 | Develop synchronous and asynchronous distance learning courses for medical assistants as quickly as possible. | 1 | CPNEFP/OF | T1 2024 |
| 13 | Create a health care assistant qualification to open up training to apprenticeships and train assistants to work in all types of facilities. | 1 | DGOS/DGEFP | 2024 |
| 15 | Develop pre-recruitment training via operational preparation for employment, whether individual or collective. | 1 | CPNEFP/Pôle Emploi | 2023 |

| N° | Recommendation | Priority | Responsible authority | Deadline |
|---|---|---|---|---|
| 16 | Involve the branch in the Validation of Acquired Experience (VAE) experiment piloted by REVA. | 1 | CPNEFP/REVA | T3 2023 |
| **Improving communication** | | | | |
| 4 | Design and implement communication and information campaigns targeting employers and breeding grounds | 1 | DGOS/CNAM/ CPNEFP/Opco EP/OF/Pôle Emploi | T3 2023 then 2024 |
| 5 | Attach the list and contact details of approved training organizations to the assistance contract and include an GDPR clause in the assistance contract allowing training organizations to canvass employers | 2 | CNAM | T3 2023 |
| **Taking financial aspects into account** | | | | |
| 6 | Provide financial and administrative support for medical assistant employer groups | 2 | CNAM/DGEFP | 2024 |
| 7 | Improve the classification of medical assistants and their remuneration ranges | 2 | CPNEFP | 2024 |
| 14 | Top up personal training accounts to finance medical assistant training | 2 | CPNEFP/Opco EP | 2023 |
| 17 | Rapidly release the additional funding needed to train new medical assistants | 1 | CPNEFP/Opco EP/CNAM | T3 2023 |

# SUMMARY

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# INTRODUCTION

[22] The creation of the function of medical assistant, who carries out "missions to assist doctors and help with patient pathways", is one of the flagship measures of the "Ma santé 2022" strategy presented in September 2018. For the public authorities, it meets the objective of freeing up medical time at a time when 6.7 million people do not have an attending physician. It also corresponds to a long-standing demand from doctors, specialists and then general practitioners, as well as employee unions to ensure professional advancement for medical secretaries.

[23] The ambition to deploy 4,000 medical assistant positions, corresponding to 2,000 FTEs, which was set out in the "Ma santé en 2022" strategy led to a series of texts (Addendum no. 7 to the medical agreement of June 2019, new job classification in the national collective agreement for medical practice staff, article 67 of the law of July 24, 2019 amending the public health code and the order of November 7, 2019) and the creation of a medical assistant CQP, which was registered in the "Répertoire national des certifications professionnelles" (RNCP) in April 2022, as well as the accreditation of twelve training organizations by the CPNEFP of the medical practice staff branch.

[24] The French President's announcement in early January 2023 that he would accelerate the recruitment of medical assistants, from a target of 4,000 by the end of 2022 to 10,000 by the end of 2024, in order to "free up medical time and enable care providers to concentrate on their core business", requires adjustments to the existing system, particularly in the area of training. This system has also been the subject of observations by doctors' unions during negotiations with the CNAM.

[25] It is against this backdrop that the Minister of Health and Prevention and the Minister Delegate for Territorial Organization and Health Professions entrusted the Inspectorate General of Social Affairs (IGAS), in a mission letter dated February 14, 2023, with a flash mission on the training of medical assistants. Mrs Frédérique Simon-Delavelle and Mr Louis-Charles Viossat, Inspectors General of Social Affairs, were entrusted with this mission.

[26] The mission has analyzed the issues raised by the training of medical assistants, placing them in the broader context of rapid, far-reaching changes in the organization of local care and the emergence of the medical assistant function and skills within primary care teams in France and abroad.

[27] His report presents the available information on the characteristics of medical assistants, their pools of talent - first and foremost medical secretaries - and their job opportunities. It also analyzes the scope and content of their missions, highlighting their lesser role than in other countries.

[28] The report looks in depth at the issues raised by the training arrangements for medical assistants, in particular their format, duration and adaptation to different profiles and employers, as well as their access and funding. It also assesses the adequacy of existing training provision for a rapid increase in the number of trainees.

[29] To carry out its investigations, the mission conducted a large number of face-to-face and videoconference interviews with the main stakeholders involved in the healthcare and health insurance sectors, as well as in the vocational training sector, two ecosystems that are generally unfamiliar with each other and not yet accustomed to working together.

[30] In addition to the relevant government departments, the team met with each of the twelve training organizations accredited by the medical practice staff branch, with three unions of self-employed doctors who have signed Addendum no. 7 to the medical agreement, with the branch's employers and employees, and with doctors, nurses, orderlies and medical assistants in post or in training.

[31] It has analyzed the data - still too sparse and of uneven quality - available on the population of medical assistants in post and in training, as well as that of medical secretaries and other pools. It also gathered comparative data on medical assistants and their training in North America and the European Union.

[32] This document comprises a summary report, six appendices devoted respectively to medical assistants, their employers, breeding grounds and outlets (appendix 1), the vocational qualification certificate and job adaptation training (appendix 2), current vocational training institutions and schemes (appendix 3), training provision (appendix 4), medical assistants abroad (appendix 5) and methodology (appendix 6), as well as two attachments.

[33] In its first part, the report highlights the fact that the role of medical assistant is limited in scope and not yet widespread, but is satisfactory to stakeholders (1). The second part shows that the training system is adapted to the branch current needs, but does not allow for rapid take-up (2). The report puts forward 17 recommendations for developing and adapting the system in line with the objective set by the French President.

# 1 A medical assistant function with a limited scope, still not widespread, but satisfying stakeholders

## 1.1 The role of medical assistant is well established abroad but was formalized in France only five years ago.

### 1.1.1 A profession that has become an important component of local healthcare organization in several foreign countries

[35] Medical assistants are "professionals with basic administrative and clinical duties to assist in the care of patients under the direct supervision of a physician [or other healthcare professional]"[1]. They have existed for several decades in the USA and Germany (since the 1950s), and in the Netherlands since the 1960s[2] . The function has only recently been introduced in the UK (2017 on an experimental basis).

[36] Medical assistants are extremely numerous in the USA: there are almost 750,000 of them today, and there will be 860,000 by 2031, according to the US Bureau of Labor Statistics. This makes them the largest occupational group in the healthcare sector, and one of the most job-creating professions in the country. This is also the case in Germany, where they number over 400,000, including 370,000 in city practices, and to a lesser extent in the Netherlands (35,000).

[1] This is the definition adopted by the ILO's International Standard Classification of Occupations (ISCO), which identifies medical assistants under code 3256 among the "other intermediate health professions" (dental assistants, medical information officers, ambulance drivers, community health workers, opticians, etc.).

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

Tableau 1 : The presence of medical assistants and healthcare professionals working in primary care with doctors abroad

| Country | France | Germany | Netherlands | United States |
|---|---|---|---|---|
| **Number of inhabitants (2021, OECD)** | 67,7M | 83,2M | 17,5M | 331,9M |
| **Number of doctors (OECD, 2019)** | 216 000 | 370 000 | 65 000 | 860 000 |
| **Number of doctors per 1,000 inhabitants (OECD, 2019)[3]** | 3,2 | 4,4 | 3,7 | 2,6 |
| **Number of medical assistants (last known figure)** | 3 100 | 400 000 | 35 000 | 750 000 |
| **Medical assistants per doctor** | 1,4 %[4] | 108 % | 53,8 % | 78,1 % |
| **Other healthcare professionals working with primary care physicians** | Very few nurses and other assistants | No | Nd | Nurses, nursing assistants, physician assistants |

*Source : OECD, mission*

[37] Faced with rapid growth in demand for care and severe pressure on the supply of doctors, medical assistants have become an important component of the new organization of primary care in these countries. They work, in ways that vary from one country to the next, with other professionals, most of whom do not yet exist in France or are not very widespread in city practices, such as physician assistants, advanced practice nurses (IPAs)[5] , nursing aides, health assistants, etc. Medical assistants are also increasingly managing digital communications between patients and doctors.

### 1.1.2 A recent creation in France based on previous work and a compromise

[38] The function of medical assistant was first mooted in our country by official reports and representatives of several medical specialties[6] . As early as the 2000s, ophthalmologists, cosmetic doctors, dermatologists, ENT specialists and dentists put forward various medical assistant projects, notably the "Techniciens assistants en soins ophtalmologiques" (TASO) project, to

[3] Neither the Organisation for Economic Co-operation and Development (OECD) nor the World Health Organization (WHO) appear to provide the number of doctors in primary care organizations by country. The only figures they do provide are for the number of doctors in all types of practice, including hospitals, per 1,000 inhabitants.

[4] The ratio of medical assistants to GPs is closer to 3%.

[5] Cf. for example Louise Luan and Cécile Fournier, *IPA en soins primaires : la construction difficile d'une profession à l'exercice fragile*, Institut de recherche et de documentation en économie de la santé (IRDES), Questions d'économie de la santé, n°277, April 2023, which counts 122 liberal IPAs in primary care against a target of 5,000.

[6] Briefly mentioned in Professor Yvon Berland's 2003 report on the transfer of tasks and skills, the medical assistant was also mentioned in the 2010 report by the President of the French Medical Order (CNOM), Dr. Michel Legmann. Much more recently, in June 2022, the report by Dr. François Braun of the "flash mission on emergencies and unscheduled care" referred to it as an element of the "toolbox".

develop assisted work and shorten appointment times with specialists. These were joined in the mid-2000s by GP organizations, in particular MG France.

[39] The medical practice branch began working on the subject of medical assistants in 2014[7] by initiating work on a reference framework with Opca Actalians, which has since become Opco EP, involving general practitioners and specialists. At the time, the development of the medical assistant function aroused reluctance on the part of both the DGOS, unfavorable to the creation of a new profession, and the employee unions, which feared a risk of task-shifting that could create difficulties for existing medical secretaries.

[40] It wasn't 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 medical assistant profession was officially created. This gave rise to Addendum no. 7 to the medical agreement in June 2019, Addendum 76 to the collective agreement for the personnel of liberal practices also in June 2019 and, in July 2019, an amendment to the public health code to protect medical assistants against the illegal practice of medicine[8] . The branch's work then resumed in conjunction with Opco EP's training engineering R&D department and DGOS, leading to the creation of a CQP that was registered under the simplified "emerging markets" procedure in April 2022, more than a year after the first trainees entered training (March 2021).

**Extract from the Ma Santé 2022 press kit summary on the new medical assistant function.**

## Libérer du temps médical pour répondre aux problèmes d'accès aux soins

Redonner du temps aux médecins, c'est leur permettre de se concentrer sur le cœur de leurs missions, à savoir soigner les patients et coordonner les parcours.

Dans ce but, une **nouvelle fonction d'assistant médical** est créée. Ce professionnel pourra notamment :

→ Accueillir les patients

→ Recueillir certaines données et constantes, ainsi que des informations relatives à l'état de santé

→ Vérifier l'état vaccinal et les dépistages

→ Mettre à jour les dossiers et gérer l'aval de la consultation (pré-remplissage de documents administratifs, prise de rendez-vous avec les spécialistes de recours, programmation des admissions en établissement hospitalier…)

### 3. CRÉATION DES ASSISTANTS MÉDICAUX

→ **Janvier 2019 :** début des négociations conventionnelles entre les professionnels de santé et l'Assurance maladie

→ **Été 2019 :** début de déploiement du dispositif

**OBJECTIF : 4 000 assistants médicaux en activité en 2022**

*Source : Ma santé 2022 press kit*

[41] In our country, the creation of the medical assistant function was a compromise between several different objectives. The public authorities, like GPs, were and still are particularly keen to

[7] Cf. for example the report by the Observatoire des métiers des professions libérales: Cabinets médicaux, de l'état des lieux à la prospective - 2014.

[8] Cf. article n°67 of the law of July 24, 2019, which amends article L.4161-1 of the public health code. 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 order, issued on November 7, 2019, specifies the required qualifications and training requirements.

free up medical time, so as to enable doctors, especially GPs, to increase the number of consultations they hold, and thus reduce the time it takes to treat patients, while improving access to care. The employee unions are very keen to ensure that medical secretaries receive training and have the skills they have acquired validated, so as to guarantee their professional development. Finally, medical specialists are particularly interested in the development of subsidized work for increasingly technical medical activities, carried out within the framework of genuine healthcare companies.

[42] The function of medical assistants combines quantitative objectives (to increase the number of consultations per doctor, in order to respond to unscheduled or urgent care needs, particularly in areas where there is 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), qualitative objectives (to improve 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).

## 1.2 The medical assistant function is very much supported by the health insurance system, and its scope of tasks is much more circumscribed than in other countries

### 1.2.1 A function largely subsidized by the health insurance scheme

[43] Aid for the recruitment, or rather employment, of medical assistants was created by Addendum 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 doctors unions (MG France, SML and CSMF), and approved by dispensation from the six-month rule as early as August 20, 2019 to enable rapid entry into force.

[44] The measures introduced by amendment no. 7 consist in supporting the hiring of medical assistants through the payment of a lump-sum financial aid package that is both permanent and scalable. Physicians are free to choose the tasks to be carried out by their medical assistants from the list of available tasks, as well as the length of time the medical assistants are employed[9] . 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.

[45] A five-year renewable recruitment assistance contract sets out the reciprocal commitments between the doctor and his or her primary health insurance fund. The hiring subsidy is paid individually by the doctor, who may pass it on to the group. If several doctors share the same medical assistant, each of them signs a contract with the primary health insurance fund (CPAM) to which they are attached, which is a source of complexity that should be eliminated[10] .

[9] Initially limited to one-third time, and now to one-half time, which creates a further obstacle: see below.
[10] For the time being, the limitations of the CNAM information system are delaying this development.

[46] In the initial text, eligibility was subject to strict conditions, notably in terms of practice sector (sector 1 or sector 2 adhering to Optam or Optam-Co), eligible specialties and zoning, minimum patient base, group practice and enrolment in a coordinated practice approach. The arbitration ruling, which came into force on May 1er 2023, has made these eligibility criteria more flexible. From now on, all medical specialties are eligible[11] and surgeons are eligible if their CCAM (common classification of medical acts) fees represent less than 20% of their total fees. There is no longer any requirement for coordinated or grouped practice.

[47] In addition, aid is conditional on an increase in the number of GP patients or active file, and doctors' commitments have been individualized and modulated according to the initial size of their patient base.

[48] The level of subsidy is very high, ranging from €21,000 per year for a one-third time employee (before the arbitration settlement) to €36,000 per year for a full-time employee. The amount decreases as the additional activity provided by the medical assistant increases the practice's income.

Tableau 2 : Provisions applicable to aid paid by the health insurance scheme to doctors who employ medical assistants

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: Option 1 (1/3 ETP) | Option 2 (1/2 ETP) | Option 3 spécifique ZIP/ZAC (1 ETP) | Versements de l'aide (acompte + solde) |
|---|---|---|---|---|
| 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)

*Source : CNAM. Provisions applicable prior to the arbitration rules*

[49] The aid is paid by the health insurance scheme in return for actual job creation: a medical secretary previously working for a doctor recruited as a medical assistant must be replaced to the extent of the secretarial time previously worked within six months of being recruited as a medical assistant. However, the arbitration rules (article 9.4.3) stipulate that the doctor may use a telephone secretariat rather than a physical one.

[50] The total amount of aid paid by the health insurance scheme is high: between 2019 and 2022 inclusive, it reached a cumulative €119.2M, including €106.8M for doctors in sector 1 and

[11] Except radiologists, radiotherapists, stomatologists, anesthetists, nuclear medicine physicians and anatomocytopathologists.

€12.3M for doctors in sector 2 Optam. For 2022 alone, payments totaled 55.4M€, including 49.4M€ for sector 1 doctors[12] .

### 1.2.2 A function whose scope of tasks varies according to configurations

[51] 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.

[52] However, the scope of authorized missions and tasks for medical assistants is set out in a number of texts, in particular amendment no. 7 to the medical convention and the CQP.

[53] In principle, the missions of medical assistants fall into three areas of intervention, according to Addendum no. 7, which makes it unclear that these are "specific missions distinct from those of other job categories":

- Administrative tasks. In practice, these 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 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 carried out by dental assistants in the dental chair;
- Tasks of organization and coordination, in particular with other players involved in patient care. These organizational and coordination tasks are similar to those of care or health coordinators in multi-professional health centers (MSP), or to those of nurses.

[54] Addendum n°7 makes no mention of patient triage, the interface between patients and doctors, or the population management of patients with chronic pathologies.

[55] In practice, as the mission was able to observe during its field interviews, the tasks entrusted to medical assistants by doctors vary greatly according to their profile (nursing[13] or non-healthcare) and work configurations: from one doctor to another, from one specialty to another (ophthalmologists make extensive use of medical assistants to carry out examinations prior to consultation, while other specialties employ few or none at all), from one type of local care organization to another (medical assistants seem to have broader clinical tasks when they are in a group practice than when they are part of a multi-professional team that includes nurses and care assistants, for example), from one ex-medical secretary to another (particularly in the case of long service or family proximity to the doctor). There are thus, in the words of one of the mission's contacts, "as many medical assistant profiles as there are doctor/assistant pairs".

[12] The amount of aid for the recruitment of medical assistants is significantly higher than that paid by the State for the recruitment of an apprentice (€6,000 once) or for the recruitment of a young person or job-seeker in a priority urban district (€5,000 per year for a full-time position, for three years). The effort per subsidized job is also higher than for the hiring of public health nurses under the Asalée scheme.

[13] With the proviso that, in principle, nurses who have become medical assistants can no longer perform nursing acts during their working hours. They can only do so outside their medical assistant employment contract, which represents a loss of skills for the organization of primary care.

[56] Ultimately, the mission's interviews with medical assistants in training revealed major differences in the tasks entrusted by doctors, on a spectrum ranging from medical secretarial work to the performance, even without direct medical supervision, of diagnostic procedures[14] .

### 1.2.3 A scope of clinical tasks which is much more circumscribed than in other countries, and is defined in contradictory terms.

#### 1.2.3.1 A much narrower scope of clinical tasks than in other countries

[57] The responsibilities of medical assistants, whether administrative or clinical, vary from country to country, but they are generally more extensive than in France, which chose to create this new function on a minimal basis. Some of the people we spoke to spoke of a "missed opportunity", underlining the benefits of funding medical assistants with real clinical and technical responsibilities. The term "medical assistant" may seem out of step with the missions actually assigned to them and could more appropriately be replaced by "medico-administrative assistant".

[58] The administrative responsibilities of medical assistants in France are quite similar to those in other countries, while taking account of institutional specificities (e.g. the multiplicity of private insurers in the United States).

[59] On the other hand, their clinical remit is much less extensive than in other countries. It's true that the regulatory framework governing the competencies of healthcare professions is more flexible in many foreign countries than it is in France, enabling doctors to adapt the allocation and delegation of tasks on a case-by-case basis, and that multi-professional teamwork is also more mature and developed.

[60] In France, medical assistants are not healthcare professionals, and the technical tasks they are authorized to perform are few in number, to the exclusion of all paramedical acts. According to the CPNEFP, they can only use automatic diagnostic equipment. Medical assistants cannot act autonomously, and have no consultation rooms or hours. Nor, as the CNAM reminds us, can they operate outside the doctor's office. Their remit is more limited than that of occupational health service assistants in France.

[61] By contrast, in Germany, where doctors still largely work alone or in pairs, 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, perform medical examinations such as ECGs, take biological samples (draw blood, send to analysis laboratories, receive results) or carry out protocolized treatments in conjunction with the doctor, notably for chronic wounds (care reserved for nurses in France). They can also provide health promotion, prevention and therapeutic education services.

[62] Germany's 400,000 medical assistants can also carry out certain tasks independently, and are provided with a room and consultation times for seeing patients. Some German medical

[14] This is clearly not in line with the provisions of the Public Health Code or the directives of the CPNEFP.

assistants, or Level 2s, with three years' professional experience, become "non-medical practice assistants" (Nich Arztliche Praxisassistentin - NäPa). They carry out home visits and visits to homes for the elderly (EHPAD) on behalf of doctors.

[63] 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 permitted activities and prerequisites. For example, anamnesis, diagnosis, prescription or surgical interventions may not be delegated to medical assistants.

[64] In the USA, too, the clinical duties of the 750,000 medical assistants are numerous and extensive. The professional association for medical assistants lists the following: taking medical histories, explaining treatment procedures to patients, preparing patients for examinations, assisting the physician during examinations, collecting and preparing laboratory samples, performing basic laboratory tests, informing patients about medications, preparing and administering medications, including intramuscular, intradermal and subcutaneous injections, including vaccinations, as directed by a physician or other licensed professional (nurse.), transmitting prescription renewals as directed, performing phlebotomies and electrocardiograms (ECGs), wound care and changing dressings.

[65] According to CNAM, however, their clinical skills are less extensive than in Germany and the Netherlands. In many American states, moreover, 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).

[66] In the Netherlands, the tasks of medical assistants are more 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 triage patients, act on protocols for different types of care, and have their own role within the limits of their field of action. As in Germany, Dutch medical assistants can perform certain tasks independently. To this end, they are provided with a room and consultation hours for receiving patients.

[67] In the medium term, as the nursing profession evolves and the number of IPAs rises, and in light of the experience of level 2 dental assistants, and in parallel with the rise in the number of medical assistants, it would be useful to work on the prefiguration of a level 2 medical assistant profession, whose clinical skills would be more extensive and who could work with a degree of autonomy. The creation of this level 2 would also offer greater career prospects. It would, however, run the risk of fuelling the issue of overlapping skills, a highly sensitive subject in France for the various professions concerned.

#### 1.2.3.2 A contradictorily defined perimeter

[68] There is a certain contradiction when it comes to the scope of medical assistants' missions. This is apparent from two points of view.

[69] On the one hand, Addendum no. 7 specifies that the "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, depending on 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 framework".

[70] On the other hand, the technical tasks authorized by the CPNEFP are very restrictive, whereas doctors in the field often interpret them (much) more extensively[15] .

[71] The narrow and imprecise nature of the scope of medical assistants' technical missions is a concern for trainers, who have to deal with trainees and employers with different expectations and practices.

[72] As the nursing profession evolves, it would seem advisable to broaden and clarify the scope of medical assistants' involvement, by consulting each national professional council (CNP) on the tasks that should be authorized and those that should be prohibited.

**Recommandation n°1** Expand the scope of medical assistants as the nursing profession evolves

[73] It would also be a good idea to authorize nurses who have become medical assistants to perform nursing acts during their work as medical assistants, which they are not allowed to do today.

**Recommandation n°2** Remind that nurses can perform nursing acts on an ad hoc basis as medical assistants

## 1.3 A function that is still not widely used in general practices, and in a heterogeneous manner

### 1.3.1 A position occupied by only a few thousand part-time employees, most of whom are former medical secretaries.

[74] According to the CNAM, on December 31, 2022, there were 3,100 distinct physical persons employed as medical assistants, corresponding to 2,537 full-time equivalent jobs and, according to the branch, 400 actual holders of the CQP[16] .

[75] This figure of 3,100 represents just over 3% of employees in the private practice branch[17] and a roughly equivalent proportion of exclusive and mixed private practice doctors. This is a smaller population than that of orthoptists or audioprosthetists, for example, who are among the least represented healthcare professions, and not comparable with nurses or orderlies.

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[15] The fact that many medical secretaries, though it's not clear how many, are already working as medical assistants also helps to blur the line between what is permitted and what is prohibited.

[16] At the same time, 4,069 assistant contracts were signed by employing physicians. The legal status of nurses, orderlies, medical secretaries and other professionals acting as medical assistants to doctors in medical practices without yet holding the CQP or FAE attestation needs to be clarified. The number of CQP holders comes from the CPNEFP.

[17] According to the OMPL, whose scope covers almost 100,000 companies, 480,000 employees and 11 branches, there were 90,800 employees in the medical practices branch in 2018, while the Direction générale du travail (DGT) estimates that there will be 115,000 in 2020.

[76] The vast majority of medical assistants (over 95%) are women, making it one of the most feminized professions. Their average or median age is not precisely known, but that of trainees is, on average, 41.6 years, which is high.

[77] The proportion of part-time workers among medical assistants is high but cannot be accurately quantified. According to the CNAM, it was 40% in October 2022. The vast majority of medical assistants (between 85% and 90%) are hired on open-ended contracts. 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, but the same medical assistant is frequently employed on several part-time contracts by several physicians in the same group practice or MSP.

[78] According to the CNAM, 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. The mission's analysis of trainees' professional backgrounds gives a rather different picture, with a very high proportion (80%) of medical secretaries among them[18] . Administrative profiles therefore outnumber nursing profiles, and medical secretaries are indeed the key source of medical assistants.

**The panel for observing practices and conditions of general practice and medical assistants**

The Direction de la recherche, des études, de l'évaluation et des statistiques (DREES) has just published the results of the fourth panel d'observation des pratiques et des conditions d'exercice en médecine générale on the use of a medical assistant. The survey, which excludes Mayotte, was carried out among 3,300 self-employed GPs in practice on January 1er 2018, with at least 200 patients for whom they are the attending physician, and with no particular exclusive mode of practice. The survey wave was conducted by internet and telephone between January 5 and April 22, 2022. Over 1,500 doctors responded to this survey wave.

91% of doctors surveyed had heard of the medical assistant profession. Older doctors and those practicing alone were slightly less numerous. GPs who had heard of the position had heard about it mainly through the professional press (52%) or a health insurance representative (44%), and to a lesser extent through professional associations (28%), by talking to colleagues (25%) or in some other way (10%).

More male GPs (6%) than female GPs (3%) worked with a medical assistant. Doctors belonging to a CPTS (professional community of health territory) in operation were also more likely to work with a medical assistant (12%).

Among GPs who did not work with a medical assistant, 11% wanted to, 59% did not and 30% had no opinion. Doctors with a high volume of activity were more likely to say they would like to work with a medical assistant. Four out of ten GPs (41%) felt that the medical assistant scheme could be a solution to better respond to patient requests. The opposite was true for 47%. GPs working in an MSP were more likely to be convinced (53%), as were doctors working with another non-physician healthcare professional (66%).

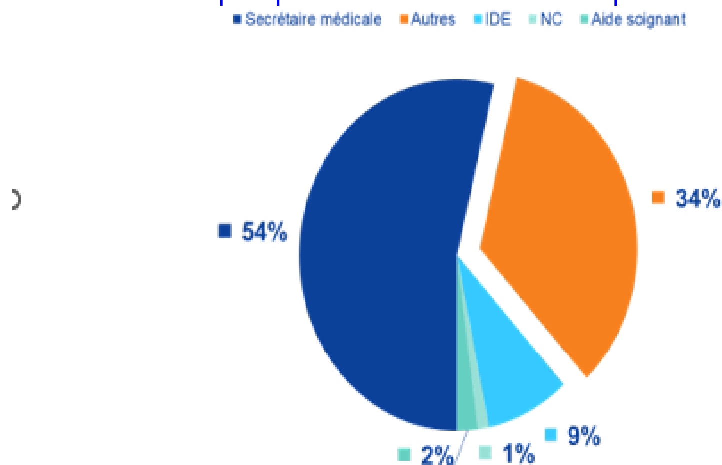
*Source : DREES, May 2023*

[79] According to the CNAM, 15% of medical assistants have worked for the same doctor as a medical secretary. However, this figure is undoubtedly underestimated by employers in order to

[18] Based on data from the trainee database provided by the CPNEFP.

derogate from the contractual obligation to rehire another medical secretary if the former medical secretary is promoted to the position of medical assistant, an obligation imposed by the CNAM, which does not wish to subsidize secretarial jobs. This percentage is likely to be (much) higher than 50%.

Graphique 1 : Medical assistant profile




*Source : CNAM*

[80] Medical secretaries already working in medical practices are the main, indeed the natural, pool for medical assistants. Indeed, the medical assistant CQP has been designed as a priority by the branch for them, to ensure their professional development and give them greater autonomy in their career development.

[81] The medical secretary profession is not well known, particularly in quantitative terms, and it would be useful to have studies on the subject. The medical secretary's role is one of reception, information and administrative assistant. Their role and missions can vary according to the context in which the profession is practiced, as can the job title (medical secretary in the medical field, medico-social secretary in the social and medico-social field). In particular, the medical secretary is the interface between all those involved in the care network, whether internal or external to the structure. He or she is central to the proper transmission of information. Medical secretaries can work in a wide variety of health and medico-social structures, outside private medical practices, and are therefore not covered by the collective agreement for this sector. This is notably the case in health centers, public hospitals (in which case they are medico-administrative assistants), private profit-making clinics and non-profit-making establishments, as well as in structures (health centers, etc.) belonging to the local civil service.... This is also the case in the medical-social field, where they are known as medical-social secretaries.

[82] 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[19] . This number was around 51,800 in 2018.

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

[83] At the beginning of 2022, according to DREES, 51.2% of self-employed GPs without a specific exclusive practice arrangement had a medical secretary physically installed in their practice. Doctors practicing in a group are more likely to have a physical secretariat (65% for GPs practicing in a more multi-professional group, 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.

[84] Given their sociological profile and the high demand from employers, it is not certain that the current pool of medical secretaries working in doctors' surgeries will be sufficient to cope with a rapid increase in the number of medical assistants, especially if current training arrangements are not made much more flexible.

[85] The medical staff branch classification grid positions medical assistants, in the medico-technical branch, between level 5 and level 9 like healthcare auxiliaries, while medical secretaries are positioned between level 4 and level 8, and in practice are concentrated at levels 6 and 7[20] . In 2019, when the new salary scale was signed, the gross monthly salary for medical assistants was between €1,642 and €1,953. This is very moderately higher than that of medical secretaries, at around 100€ per month, and therefore provides little incentive.

[86] In addition to the medical assistants whose employment is subsidized by the health insurance scheme, there is also a population of medical assistants who are not subsidized, either because their employers are not eligible, or because they have not applied for assistance, or because they belong to branches other than that of medical practices. In 2021, for example, ophthalmologists employed 665 ophthalmology medical assistants, i.e. 15% of all practice assistants, an unquantified but undoubtedly significant proportion of whom did not receive assistance from the health insurance scheme. In 2020, the French health insurance system transposed the existing aid scheme for doctors' practices to health centers, but it seems that it is not being applied for the time being. Lastly, other types of healthcare establishments, belonging to branches other than those of medical practices, employ some staff called "medical assistants", although the mission was unable to obtain many details: this is the case, for example, of establishments dependent on the Mutualité[21] or establishments dependent on the social security system, or private clinics. This is also the case for cancer treatment centers, even if the term "medical assistant" in this case corresponds to the function of medical secretary.

### 1.3.2 An heterogeneous coverage across the country and by specialty[22]

[87] The coverage of the territory by medical assistants is very heterogeneous, for reasons that are still not fully explained.

[88] The departments in which the proportion of self-employed doctors employing medical assistants exceeded 10% at December 31, 2022 are mainly rural or overseas: Ariège (29.8%),

[20] Caregivers are between level 8 and level 13.

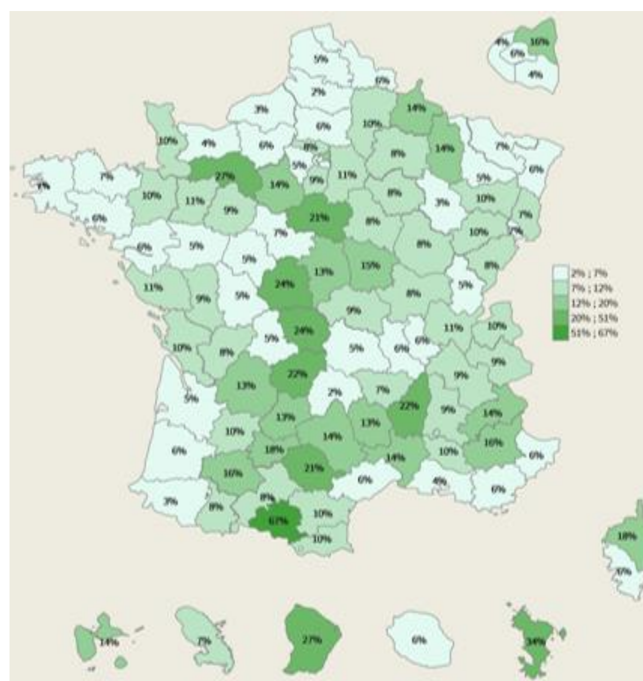
[21] A recent study by the Observatoire de l'emploi et des métiers en mutualité on *"Jobs in mutual healthcare and support services up to 2025"* includes a fact sheet on medical assistants.

[22] The figures we have are based on physician support contracts, not on the medical assistants themselves.

Corrèze (10.6%), Creuse (14.2%), Indre (15.4%), Manche (30.2%), Nièvre (15.1%), Guyane (17%) and Mayotte (29.7%)[23] . This is undoubtedly due to the size of the active files of doctors practicing in these departments, to the mobilization of these professionals to resolve a sometimes worrying shortage of doctors, and perhaps to the promotion of the system by the health insurance scheme.

[89] Departments where the proportion of doctors employing assistants is very low, below 2%, have a more varied profile: they are either urban departments (in which case the reason given is the high cost of land) or very rural departments[24] .

Carte 1 : Proportion of signatory doctors




*Source : CNAM*. As of February 25, 2023.

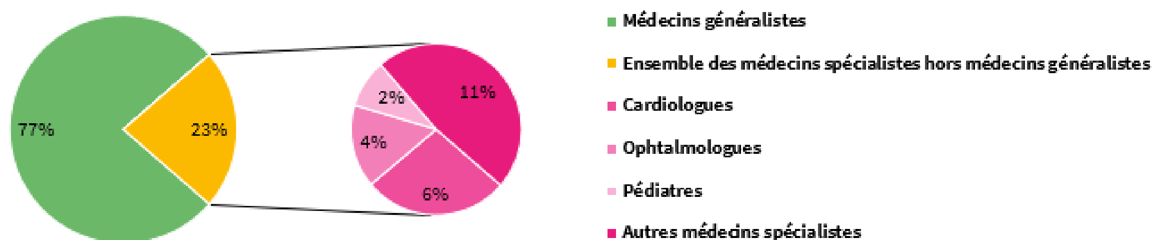
[90] There are also significant differences between specialties. Not surprisingly, three-quarters of employers of medical assistants are general practitioners (77%), given the way in which the CQP has been developed and the eligibility criteria for assistance.

[91] However, 23% of all assisted employment contracts were signed by medical specialists. The specialties that signed the most contracts are often those that use subsidized employment, in particular cardiologists (11%) and ophthalmologists (6%). Pediatricians (4%), psychiatrists and neuropsychiatrists are also among the most popular.

[23] The top five departments in terms of the 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).

[24] 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%).

Graphique 2 : Penetration rate of assistants in general practices




*Source : CNAM*

[92] 92% of signatory doctors are self-employed and 8% are in mixed practice. Around half of employers (2,060) are based in group practices, a quarter (just over 1,000) in MSPs and the remaining quarter in isolated practices. In 16% of cases, the employer of medical assistants is an employer group, such as "Le groupement", which was interviewed by the mission.

## 1.4 A function that satisfies stakeholders, but whose development remains constrained by a number of non-training obstacles

### 1.4.1 A function that gives overall satisfaction to employers, employees and CNAM

[93] Given the time available, the mission was unable to carry out a formal survey of employers, employees and patients. On the other hand, it was able to gauge the level of satisfaction of stakeholders through the many interviews it conducted and its analysis of the literature, particularly medical theses.

[94] The mission met with employers (mainly general practitioners, given the proportion they represent), medical assistants (trained or in training) and a federation of patient associations. Although they all highlighted a number of negative points, which are addressed in this report, they all agreed on the added value of the medical assistant profession when deployed in line with the skills included in the training reference framework.

[95] Employers report time savings, fewer administrative tasks and more fluid organization of their work. The amount of work is not necessarily reduced, but the material and psychological conditions are more favorable.

[96] For their part, when the training actually leads to a change in their duties, employees also report satisfaction with both the content of the training and its impact on the value of their work. In fact, training organizations report a very low drop-out rate. Some medical assistants reported that their training had led to changes in the organization of their practice and in their employer's way of working.

[97] In addition, the mission has identified seven theses on the medical assistant profession[25] , some of which are prospective, having been written before the reform, while others are based on analysis of the practices of doctors employing medical assistants. The following box summarizes the main conclusions.

[25] See bibliographical references at the end of the report.

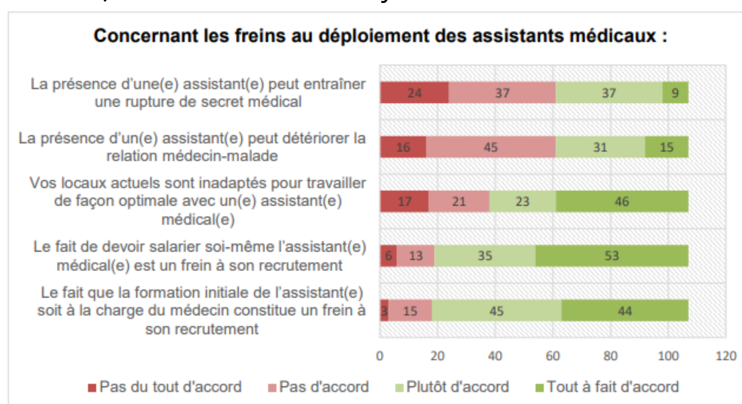
**Summary of lessons learned from medical theses**

The presence of a medical assistant in a practice can make it possible to:

- Time-saving for the doctor and therefore better patient care
- Reduced administrative workload
- Reduced mental workload (almost always a benefit)
- A better quality of life at work
- A pre-consultation service that saves time for some patients
- Increased interdisciplinarity for the benefit of patient care
- Safer care and, for patients, less "hierarchical" discussions about their health.
- An incentive to change medical practice, coupled with a fear of too much delegation (and the associated notion of responsibility).

The presence of a medical assistant can also have more negative aspects, notably the risk of altering the patient/doctor relationship and the reluctance of certain populations (particularly the elderly).

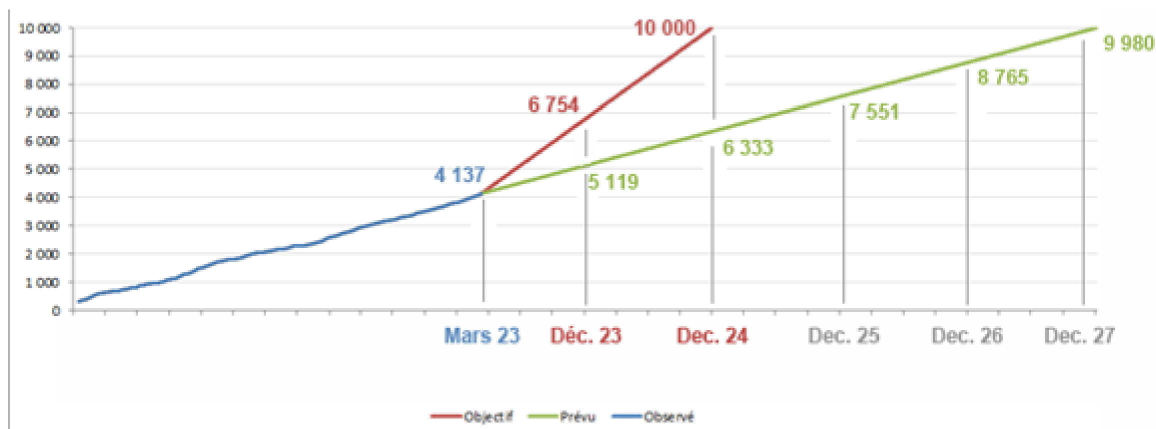
On the subject of conventional aid, the theses emphasize:
- freedom for doctors to organize their work with the medical assistant to be preserved, - a system better suited to specialist doctors and under-densified areas,
- a fear of having to work more,
- a fear that the aid will not be sustainable,
- difficulty being an employer,
- an obligation to replace the medical secretary if he or she becomes a medical assistant, which is a hindrance, and problems of accommodation for a medical assistant (whose practice presupposes the provision of a closed office) and a medical secretary




*Source : Mission based on the bibliography at the end of the report*

[98] CNAM is also generally satisfied with the progress of the scheme, which is in line with the objectives set. The number of contracts signed by doctors actually exceeded 4,000 by the end of 2022, and the activity of signatory doctors actually increased by almost 10%.

Graphique 3 : Growth in the number of medical assistant contracts since inception and projections for the future




*Source : CNAM*

[99] The CNAM considers that, given the limited number of doctors and the growing number of patients, medical assistants are an existing solution that works. It explains the relatively slow start-up of the scheme by its unfamiliarity with doctors and patients, and by three major obstacles: premises, reluctance to become an employer, and the fact that training makes the employee partly unavailable.

## 1.4.2 The development of the function continues to be hampered by a number of non-training obstacles

[100] The first, and perhaps most important, obstacle is the lack of a clear definition of the skills to be mobilized as a team in medical practices, and the consequent vagueness of the scope of technical tasks authorized for medical assistants. But a number of others can also be cited.

### 1.4.2.1 An insufficient management

[101] The many stakeholders are largely unaware of each other's prerogatives and constraints. This lack of understanding of the various components of the system leads to a siloed, uncoordinated approach.

[102] The Opco EP, which covers a very large number of branches and professions, has imperfect knowledge of the subsidies paid out by the CNAM, and the Ministry of Health does little or nothing to involve the ministry responsible for vocational training in discussions on the training of medical assistants, which itself has little knowledge of the healthcare sector. Finally, Pôle emploi is not very involved in promoting this profession, as jobseekers have very little access to it in practice.

[103] No central administrative department of the social ministries has really taken up this project, for lack of an obvious link: medical assistants working in private practices are not healthcare professionals and, as such, do not fall directly within the remit of the DGOS; the Social Security Department (DSS) is only familiar with them through the prism of conventional

negotiations and the funding provided by the health insurance scheme; DGEFP has not been involved in the development of training for medical assistants, and neither DREES nor DARES has carried out any specific work on this profession.

[104] All in all, the medical assistants project is not being piloted, which means that its deployment is less effective.

[105] To remedy this problem, it would be advisable to designate the DGOS as the interministerial pilot for the "10,000 medical assistants" project, and more generally for the medical assistants issue, even if they are not health professionals. Similarly, it would be useful to set up a tightly-knit project team involving a member of each key player (CPNEFP, Opco EP, CNAM, DGEFP, etc.), led by the DGOS, as well as a broad-based steering committee that would meet periodically.

**Recommandation n°3** Designate the DGOS as the interministerial lead for the "10,000 medical assistants" project and set up a steering committee.

#### 1.4.2.2 A communication to be amplified

[106] Although the origins of this function go back a long way, and were inspired by successful experiments in other countries, the medical assistant profession has remained confidential in France, both for employers and potential candidates. Yet there is a need for it, and the public authorities are very generous in their support.

[107] An information and communication campaign was launched by the Assurance Maladie when the conventional assistance scheme was introduced. Several sections were created on the ameli.fr website. A grassroots campaign among doctors was orchestrated, based on a circular and a network letter[26] , by health insurance delegates trained for this purpose in October 2019.

[108] A new CNAM campaign, less institutional than the first because it includes testimonials from doctors who practice with the help of a medical assistant, is also in preparation.

[109] Similarly, when the CNAM subsidy was introduced, a number of medical specialties publicized the profession and its added value in practices. The most comprehensive tool identified by the mission was an issue of the magazine Innov'cardio[27] which, in 66 pages, offers an extremely detailed presentation of the medical assistant profession, its training and added value, and features a series of employer/employee testimonials[28] . MG France has also issued a press release on the scheme.

[110] In addition, the subject appeared in the mainstream and professional media at the time of the launch of the "Ma santé 2022" strategy in 2018, at the time of the introduction of conventional aid and more recently with the announcements by the President of the Republic and the Minister in charge of health announcing a ramp-up of the scheme.

[26] Circulaire CIR-28/2020 and Lettre réseau LR-DDGOS-62/2019. The latter includes an appendix with a model contract for conventional aid and a communication kit for visits to physicians.
[27] Innov' cardio n°4, April 2022.
[28] A 12-page summary is available online: Innov' cardio - the summary.

[111] The Ministry of Health website has no section on this profession, nor does it appear in the directory of health professions. By way of comparison, the mission notes the section on medical regulation assistants. A comprehensive page describes the profession, training conditions and salary, and directs users to job offers at[29] . Another page, more focused on training, provides all the information you need, along with all the necessary documents (training guidelines, internship booklet, etc.) and practical tools such as sample internship agreements and diploma models[30] . Such communication is lacking for medical assistants.

[112] The CPNEFP medical practices website provides useful information, including a list of approved training organizations and details of how the Opco EP will cover the cost.

[113] In this respect, however, the mission notes a lack of clear communication on the subject of financing. While the above-mentioned document[31] describes in detail the reimbursement amounts for the various costs (teaching, salaries and ancillary costs) depending on the route taken to access the training, there is no suitable medium for employers, employees and training organizations to describe the operating procedure in a pedagogical way. This will have to be created.

[114] This lack of communication and the disparate nature of the system as a whole have led to a lack of understanding of the real added value of the medical assistant compared with the medical secretary, of how the different professions working alongside the doctor fit together, of the contractualization process with the health insurance scheme, of the sustainability of the aid, of the expected increase in activity, and of the impact on workloads and the risk of doctors incurring liability, particularly by delegating unauthorized tasks.

[115] The mission recommends that public authorities initiate broader, more concerted communication campaigns. An initial campaign could be one of the actions in an action plan dedicated to "medical assistants", defining:

- Targets: employers and their various representations; the various pools of potential candidates: medical secretaries wherever they work, nurses, care assistants and childcare assistants (also targeting professionals on disability[32] ), dental assistants, jobseekers and, more broadly, anyone who might be interested in the profession and who meets the prerequisites (the general public). For secretaries working in doctors' surgeries, who are inherently difficult to target, especially as they are not grouped together in professional associations or unions, the mission recommends that CNAM provide specific support to

[29] https://sante.gouv.fr/metiers-et-concours/les-metiers-de-la-sante/les-fiches-metiers/article/assistant-de-regulation-medicale-arm

[30] https://sante.gouv.fr/professionnels/se-former-s-installer-exercer/article/assistant-de-regulation-medicale-arm-le-point-sur-la-formation

[31] Critères de financement 2023 - IDCC 1147 - Personnel des cabinets médicaux du 4 avril 2023. On page 14, the document contains a typo stating that "travel and catering expenses" (at the place of accommodation) "are only covered if the trainee attends training at the approved training organization located near his or her home or workplace. Catering costs are covered unconditionally".

[32] For example, via professional representatives, particularly the CNP des aides-soignants, the association pour le développement des ressources humaines dans les établissements sanitaires et sociaux (ADRHESS) or the association nationale de médecine du travail et d'ergonomie du personnel des hôpitaux (ANMTEPH).

health insurance delegates. To target jobseekers, the DGEPF will draw up a precise list of the most relevant guidance providers and prescribers;

- Messages to be shared in order to raise awareness of: the profession among employers, the general public and identified breeding grounds[33] ; the conventional aid scheme, removing any ambiguity as to its permanence; training procedures; Opco EP funding procedures for employers, training organizations and trainees.

[116] These campaigns should also be lively and interactive, highlighting the experiences of doctors themselves in different possible primary care organizations (solo practices, group practices, MSPs, specialists) and the advantages - and limitations - of employing a medical assistant.

[117] Campaigns could be inspired by what has been done to support apprenticeships or, more recently, to promote the professions of medical regulation assistant (ARM) or early childhood. Medical assistants could also have found a place in the recent campaign to promote care and support professions, in which the medical assistant profession has a special place[34] . Links could also be made with the "one young person, one solution" scheme.

[118] As the role of medical assistant is a recent one, there is as yet no real structured representation. Nevertheless, the mission would like to draw attention to the existence of a Facebook page entitled "Assistant(e) médical(e) : un nouveau métier" (Medical assistant: a new profession), which has almost 3,000 members - not an insignificant number given the size of the profession - and which could be a relay to include in the communication plan.

[119] Finally, local players should be involved in these campaigns, whether they be CPAMs or the regional level of Opco EP, but also regional health agencies (ARS) and regional unions of health professionals (URPS).

**Recommandation n°4** Design and implement communication and information campaigns targeting employers and breeding grounds

[120] Similarly, it would be advisable in future to systematically append the list and contact details of approved training organizations to the CNAM assistance contract and, above all, to include in this contract a General Data Protection Regulation (GDPR) clause enabling employers (doctors) to be canvassed by approved training organizations.

**Recommandation n°5** Attach the list and contact details of approved training organizations to the assistance contract and include an RGPD clause in the assistance contract allowing training organizations to canvass employers.

[33] Stakeholders will be able to use the contents of the appendix to the call for applications for the selection of training organizations to produce this content.

[34] Profiles currently in the spotlight include nurses, midwives, care assistants, childcare assistants, medical regulation assistants, homecare assistants, medical electroradiology technicians, educational and social support staff and specialized educators.

#### 1.4.2.3 A reluctance to hire on the part of employer doctors linked to material and cultural factors

[121] The deployment of medical assistants is hampered by material factors on the one hand, and more cultural factors on the other, which concern doctors as employers.

[122] The most frequently cited obstacle is the lack of office space. Indeed, for older practices, located in apartments, the possibility of reserving an office for the medical assistant is often very limited, even though this space is necessary to carry out the tasks that most free up medical time (apart from administrative tasks): pre-consultations presuppose the preservation of medical secrecy and therefore their performance in a closed office.

[123] From the few exchanges between the mission and group practices (MSPs or health centers), the constraint also seems to exist in these structures which, although larger in size, were not necessarily designed with the new professions (IPA or medical assistant) in mind.

[124] The high cost of real estate in large conurbations makes it even more difficult to hire a medical assistant.

[125] The two cultural obstacles most frequently identified concern employers. On the one hand, they are not always willing to make room for a professional who would have a special relationship with their patients, and on the other, they have little appetite for recruitment and human resources management. Employing doctors, like most managers of very small businesses (VSEs), are wary of the rules and complexities of employment law, even though they may already employ a medical secretary.

[126] A significant number of doctors also seem to think that the aid paid by the health insurance scheme is not permanent, and that the economic model for hiring a medical assistant is therefore not sufficiently solid. They are afraid of tying their hands in the long term with an employee without being sure of having sufficient resources to finance him or her.

[127] On the subject of recruitment, several of the people we spoke to indicated that they were not in favor of hiring jobseekers with no experience in the healthcare field, considering that the current volume of hours worked would not be sufficient to guarantee the necessary upgrading of their skills.

[128] While the problem of premises is complex to resolve in the short term, recruitment could be partly facilitated by helping to develop employer groups. The aim of these structures is to provide their members with employees who are bound to the group by an employment contract. They can provide their members with assistance in employment and human resources management. MG France set up a grouping in April 2020, with 100 members. It concerns only general practitioners and the recruitment of medical assistants.

[129] Another experiment has been conducted in the Pays-de-la-Loire region, based on the URPS (see box below).

**The Pays-de-la-Loire employers' group**

This employers' group was created in July 2019 on the initiative of the region's regional unions of healthcare professions (URPS), with the initial aim of helping professional healthcare territory communities (CPTS) with recruitment and managing employment social management issues.
The employers' group also provides support to any structure linked to the liberal healthcare sector, by facilitating recruitment, and by securing and facilitating management between healthcare professionals, managers and employees:
- employee recruitment assistance at the member's request
- provision of the employee through an agreement
- social and financial management of jobs (pay slips, health insurance, provident scheme, annual interviews, company doctor, changes to employment contracts)
- provision of a time-tracking chart to employees and member organizations to help manage working hours
- sharing information and experience

*Source : Mission*

**Recommandation n°6** Provide financial and administrative support for medical assistant employer groups

[130] Employer groups are a useful adjuvant, but cannot be the priority solution for the hiring of medical assistants by doctors. It would also be advisable for the health insurance scheme, in conjunction with the branch and doctors' unions, to set up an online operational support system for the legal and administrative procedures involved in hiring employees (recruitment, dismissal, etc.) by employing doctors.

[131] The system also includes certain rules, such as the prohibition on hiring medical assistants for less than half-time, or the obligation for doctors to recruit a new medical secretary - now by telephone only if necessary - if they sign an aid contract. While these rules have legitimate explanations (notably to avoid misappropriation of aid), they are clearly disincentives. This point should be re-examined as part of the negotiations for the new post-arbitration medical convention.

#### 1.4.2.4 Insufficient incentives for employees to apply for jobs

[132] In addition, it is likely that the recruitment of large numbers of medical assistants will soon lead to a shortage of supply.

[133] At first glance, the pool of medical secretaries working in doctors' surgeries may seem sufficient for the recruitment of 10,000 assistants, since it amounts to around 50,000 people. In reality, however, the pool that could actually be mobilized is much smaller, as only a proportion of medical secretaries in doctors' practices - which we don't know how many, but which is probably in the minority - are undoubtedly open to changing their jobs and skills.

[134] At this stage, we should mention an obstacle to this development, already mentioned above: the small pay differential between medical secretaries and medical assistants, on the order of €100 per month. This is a point that should be taken into consideration rapidly by the branch and the health insurance company.

**Recommandation n°7** In the medium term, improve the classification of medical assistants and their remuneration ranges.

[135] To avoid encountering a shortage of candidates, and as mentioned above, the public authorities, Pôle Emploi and the sector would benefit from communicating widely, and in a concerted manner, directly with other recruitment pools: medical and medico-social secretaries in other sectors and types of establishment, other health assistants (hearing-aid technicians, occupational health, dental assistants), students who have stopped their medical or paramedical studies, employees affected by restructuring plans.

[136] This also means broadening access to training (see section 2 below).

# 2 A training system tailored to the branch current needs but unable to rapidly ramp up the number of trainees

[137] The training scheme for medical assistants revolves around a CQP designed primarily by the branch for medical secretaries in GP practices. This branch-level scheme, which is modest in comparison with a diploma or qualification, satisfies both employers' and employees' representatives, but is intrinsically hampered by the need to rapidly ramp up the number of trainees.

## 2.1 A vocational training scheme for existing medical secretaries, with its limitations

### 2.1.1 A vocational training scheme created by the medical practice branch primarily for its medical secretaries

[138] There are two types of training available to become a medical assistant. The main scheme is the CQP d'assistant médical, which lasts 384 hours over ten months and is aimed at non-healthcare professionals, in particular medical secretaries. The subsidiary scheme is a 112h FAE for healthcare professionals such as nurses, orderlies and nursery assistants.

[139] The medical assistant CQP was registered with the RNCP by the branch under number 36358, on April 25, 2022, for a period of three years, as part of the streamlined procedure for so-called "emerging" professions. The certifier is the CPNEFP, an association of medical practice CQPs (ACQPCM), which holds the intellectual property rights to the branch's titles.

[140] This CQP was designed for medical secretaries at a time when the branch was reflecting on the need to maintain an HR dynamic to avoid job losses, in line with announcements by the public authorities, who wanted to develop a new profession to free up medical time.

**Certificates of professional qualification**

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.

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 qualification level if it is registered with the RNCP. It is therefore up to the CPNEFP to assess the appropriateness of proposing its registration, in accordance with a formal decision-making process.

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.

There are two ways to prepare for a CQP:

- Through training, if the individual needs to follow a training path to progress to CQP level. Training can be set up by the employer as part of the company's activities (PDC), or by the individual (notably through the personal training account). The CQP can also be prepared as part of a professionalization contract.

- By validation of acquired experience, if the CQP is registered with the RNCP, for employees or job-seekers with at least one year's experience relevant to the CQP.

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

*Source : Centre-Inffo*

[141] The training was fundamentally designed to recognize the skills of existing medical secretaries, offer them the prospect of advancement (possibly accompanied by a small pay rise) and facilitate their professional mobility.

[142] The data available (see box below) confirm that the medical assistants trained today are indeed mainly former medical secretaries from GP practices, and more secondarily healthcare professionals.

**Who are the medical assistants in training?**

The characteristics of medical assistants in training are as follows:
- 95% women
- 41.6 years average age
- 80% of trainees in general practice
- the most represented specialties are ophthalmologists and cardiologists, who account for only 4.6% and 3% respectively
- the profiles are overwhelmingly administrative: 80% medical secretaries, 5.5% orderlies, 4.4% nurses, 0.7% childcare assistants and 0.3% dental assistants
- 5% of trainees are recognized as disabled workers
- 65% of trainees do not benefit from a waiver (i.e. they take the full 384 hours of training - this does not apply to the FAE).
- 90% of trainees have permanent contracts
- 84% of trainees are trained as part of the skills development plan
- 9.4% of trainees are in job adaptation training (i.e. state-qualified nurse (IDE), state-qualified nursing auxiliary (ASDE) and state-qualified childcare auxiliary (APDE)).
- 6.4% of trainees are on professionalization contracts
- 0.2% of trainees used their personal training account

*Source : Mission on the CPNEFP database*

[143] The medical assistant training program set up by the branch has a number of special features, in addition to the time allowed to initiate it (mentioned above), in terms of entry-level prerequisites and access routes.

[144] The mission analyzed professions that are either an identified breeding ground (medical secretary and dental assistant), or a profession with certain similarities (medical regulation assistant), all at level 4 (see table below).

## Tableau 3 : Comparison of training for medical secretaries, medical assistants, dental assistants and medical regulators

| | Medical assistant | Medical secretary | Dental assistant |
|---|---|---|---|
| **Type of qualification** | CQP | 3 CQP and 9 professional titles (TP) | 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 |
| **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 |
| **Active certification** | 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) |
| **Healthcare professional** | No | No | 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 |
| **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 |
| **Graduation level** | Level 4 | Level 4 | Level 4 |
| **Diplomas with which there are bridges (to become)** | - State-qualified nurse (IDE)<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)35<br>- Hospital Pharmacy Preparer<br>- Dental help<br>- Qualified veterinary auxiliary |
| **Regulatory text governing training** | | Order of October 27, 2017 relating to the medical-social assistant secretary vocational training certificate. | Order of June 8, 2018 |
| **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 |
| **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 |
| **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) |
| **Existence of exemptions**<br><br>**(+14h if AFGSU[36] ) - does not include assessment hours** | - IDE, ASDE and APDE: 252h<br>- Medical secretary: 49h<br>- Medical secretary + 1 year: 98h | | - Diplomas mentioned in titles I$^{er}$ to VII and IX of book III of part 4 of the CSP[37] : 28h for all and 70h (including 21h AFGSU 2) for medical |

[35]Nurses, physiotherapists and chiropodists, occupational therapists and psychomotor therapists, speech therapists and orthoptists, medical electroradiology manipulators, audioprosthetists and opticians, dieticians.

[36] Attestation de formation aux gestes et soins d'urgence (Certificate of training in emergency gestures and care)

[37]I: nurses, II: physiotherapists and chiropodists, III: occupational therapists and psychomotor therapists, IV: speech therapists and orthoptists, V: medical electroradiology manipulators and medical laboratory

| | - Dental assistant or dental helper: 49h<br>- Dental assistant or dental auxiliary + 1 year: 70h<br><br>+14h for all if AFGSU 1 valid | | 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 |
|---|---|---|---|
| **Number of approved training organizations** | 12 | 12 | 10 |

*Source : Mission*

[145] With regard to the entry level required, the table below summarizes the different diploma levels enabling access to medical assistant training, either through the CQP (level 4 overall) or through the FAE (from level 4 to level 6).

### Tableau 4 : Diploma level of the various professions/situations allowing access to medical assistant training (CQP or FAE)

| Professions | Diploma level | Training |
|---|---|---|
| IDE | Level 6 | FAE |
| ASDE | Level 4 | FAE |
| EDPA | Level 4 | FAE |
| Certified SM | 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*

[146] The positioning of the CQP at level 4, with the exception of medical secretaries with three years' experience, is the result of a branch decision dated March 17, 2022. Prior to this date, some fifty trainees were able to enter the training program without fulfilling the *above-mentioned* diploma requirements.

technicians, VI: audioprosthetists and opticians, VII: dieticians, IX: orderlies, nursery nurses, ambulance drivers and dental assistants.

[147] An analysis of the sector's database enables us to determine the actual qualifications held by trainees other than nurses, care assistants, nursery nurses and dental assistants. It reveals that half the trainees have a baccalaureate and 25% have a 2-year higher education qualification.

Tableau 5 : Diplomas held by trainees before entering CQP training (i.e. excluding FAE)

| 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 CPNEFP data*

[148] In view of the significant recruitment of trainees sought by the public authorities to reach the target of 10,000 medical assistants by the end of 2024, the mission recommends that the CQP be open to any level 3 employee, and no longer level 4 or level 3 for medical secretaries with three years' experience[38] . This opening should not lead to a reduction in the level of certified medical assistants, as the CQP provides for an assessment[39] and the branch has authorized, in a deliberation dated July 7, 2022, total or partial repetition, which would allow trainees who have not reached the required level to try their luck again.

**Recommandation n°8** Authorize level 3 candidates to register for the medical assistant CQP

### 2.1.2 A slow rise in the number of new trainees and trainees who have already graduated

[149] While the medical assistant CQP was only registered in April 2022, the first training entries took place as early as the first quarter of 2021.

[150] A total of 1,235 trainees are estimated to have entered training since 2021[40] . According to the figures provided by Opco EP resulting from the financial support commitment process, 236 started training in 2021, 721 in 2022 and 278 in the first half of 2023. There were no training entries in 2019 and 2020, while 1,877 assistance contracts were signed, and by December 31, 2022, less

38 No particular qualifications are required for training as a nursing auxiliary, whose qualifications are very similar to those of the CQP for medical assistants: entry is by examination, with no diploma requirements, and the minimum age is 17. The baccalaureate and certain vocational diplomas (CAP accompagnant éducatif petite enfance, for example) are exempt from eligibility tests. Source: Office national d'information sur les enseignements et les professions (ONISEP)

39 To date, according to the information provided to the mission, failures have been very exceptional.

40 See appendix 6.

than a quarter of medical assistants had entered training compared with the total number of assistance contracts signed between their employers and the health insurance scheme.

[151] Moreover, the number of trainees with the CQP is even more limited. By the end of 2022, it was estimated at around 400.

[152] The slow take-up of training is explained by the time it took to set up the training system, and by the two-year post-employment period during which employers are entitled to involve their employees in the training process.

Tableau 6 : Comparison of number of assistance contracts signed and number of trainees

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Number of new assistance contracts signed | 272 | 1 605 | 666 | 1 526 | ND |
| Cumulation of assistance contracts | 272 | 1 877 | 2 543 | 4 069 | ND |
| Number of new trainees | 0 | 0 | 236 | 721 | 278 |
| Cumulative number of trainees | 0 | 0 | 236 | 957 | 1 235 |
| Number of trainees / number of assistance contracts | 0 % | 0 % | 9,3 % | 23,5 % | ND |

*Source : CNAM, CPNEFP*

[153] Indeed, Addendum no. 7 to the medical agreement stipulates that "*for medical assistants recruited without holding the professional qualification certificate, the doctor undertakes that the person recruited will undergo this ad hoc training within two years of recruitment and obtain their professional qualification within a maximum of three years of recruitment*". This provision also applies to IDEs, ASDEs and APDEs, as stipulated in Article 2 of the Order of November 7, 2019[41] : "*job adaptation training in the field of organization and administrative management of a medical practice is required for medical assistants who do not hold the certificate of professional qualification for medical assistants, within three years of taking up their post*".

[154] Employers use this flexibility to delay their employees' departure for training. This behavior is probably accentuated when the employee is part-time, since his or her training time may then correspond to the time spent in the practice, thus depriving the employer of his or her employee for the duration of the training (around one year).

[155] In order to speed up the rate at which trainees enter training, but also to make it more interesting for them, it would be advisable for future medical assistants to enter training immediately after signing their medical assistant contract, and no later than one year after signing.

**Recommandation n°9** Plan to start training as a medical assistant no more than one year after signing the assistance contract.

[41] Order concerning the practice of medical assisting.

### 2.1.3 A reference framework of activities and skills that is adapted but could be marginally improved.

[156] 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, with its blocks and modules, would appear to be consistent with this target: it aims to enhance the skills of medical secretaries by adding a "health" valence to the administrative skills they have already acquired.

[157] The additional skills included in the modules cover aspects of individual health (patient pathways and examinations), public health (prevention and vaccination), care (material assistance to the practitioner) or 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[42] .

[158] Trainee training and assessment are governed by a RAC. It comprises fifteen modules grouped into four blocks for a total duration of 384 hours, including 13 hours of assessment. Details are given in the table below. The blocks can be taught in any order, and block 2 corresponds to the content recommended by the branch for professionals concerned by the FAE.

[42] See section on exemptions.

Tableau 7 : Medical assistant CQP model and hourly volume

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

*Source : Mission*

[159] In the opinion of those involved in vocational training with whom the mission met, the 384 h duration is typical for this type of qualification. What's more, a comparison with dental assistant and medical regulation assistant training courses[43] confirms that the hourly volume of the medical assistant CQP is not particularly high. The theoretical training time of 384 hours, which can be reduced to 269 hours 30 minutes for medical secretaries with one year's experience and a valid AFGSU 1, is comparable to that for dental assistants (343 hours), and much lower than that for medical regulation assistants (735 hours).

[43] See appendix 2.

[160] Furthermore, medical assistant training does not require any practical training time, whereas dental assistants and medical regulation assistants take 1535h and 735h respectively. These elements are summarized in the table below[44] .

### Tableau 8 : Comparative training times for medical assistants, dental assistants and medical regulation assistants (without exemptions)

| | Medical assistant | Dental assistant | Medical regulation assistant |
|---|---|---|---|
| Total training duration | 10 to 12 months | 18 months | 12 months |
| Duration of theoretical training | 384h | 343h | 735h |
| Duration of practical training | Unframed | 1535h | 735h |
| TOTAL | 384h | 1878h | 1470h |

*Source : Mission*

[161] Generally speaking, the stakeholders interviewed by the mission consider that the standards drawn up by the branch are satisfactory. A significant shortening of the training period, and a fortiori a halving of this period, as is sometimes suggested, does not seem feasible, even if it is true that it is designed for people with little or no experience, and therefore more in the context of initial training, whereas the largest pool of candidates at present is that of medical secretaries[45] .

[162] The referential has little to do with medical specialties, as it was designed primarily for general practices. In practice, however, training organizations are taking advantage of the excessive number of hours in certain modules to insert content relating to pediatrics and geriatrics, which are the needs most systematically cited. What's more, the representatives of medical specialists interviewed by the mission agreed that the knowledge and skills specific to their specialties can be acquired in the practice, or through ad hoc training modules developed in collaboration with training organizations.

[163] The mission has listed all the comments made during interviews with the twelve training organizations, as well as the expression of their common position established at a meeting organized by the branch on June 28, 2022 (see appendix no. 2). Some modules could be reduced in volume, such as those on: public health policies (35h), medical software (28h), telemedicine (14h), identity and pharmacovigilance (35h) or evaluation (13h). With regard to the module on medical software, the mission nevertheless draws the attention of the public authorities and the branch to the developments underway at the CNAM (notably in e-prescribing and billing), which require the training content to be adapted accordingly. For the other modules, the mission recommends considering the relevance of a reduction in the number of training modules with stakeholders and training engineering specialists.

[44] It is true, however, that occupational health assistant training lasts only 200 hours.
[45] This finding needs to be qualified by the fact that medical secretaries benefit from significant exemptions.

[164] The mission is not in favor of requiring level 2 of the AFGSU (7 hours of additional training), as is sometimes suggested. Indeed, the 14-hour AFGSU 1 is sufficient for professionals who work alongside and under the direct supervision of a doctor who can intervene without delay.

[165] With the exception of the first, the other blocks can be waived according to the trainees' experience and qualifications. These exemptions are specified in the positioning procedure managed by the[46] branch. These exemptions make it possible to reduce actual training times to suit trainee profiles and experience.

[166] In practice, as Table 7 shows, the duration of training for a medical secretary can be as low as 269h30 instead of 384h, which is not negligible.

Tableau 9 : 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 |
| Assessment 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*

[167] The nature of the exemptions provided for medical secretaries, which also apply to hospital medical secretaries, seems appropriate to the mission. However, the mission considers that these exemptions should be more extensive for dental assistants.

[168] Similarly, it is likely that too few medical secretaries (47% according to branch data reprocessed by the mission[47] ) benefit from the exemptions to which they are theoretically entitled. As the mission did not have access to individual files, it remains cautious. Nonetheless, it draws the branch attention to the fact that some training organizations may be unfamiliar with the system.

**Recommandation n°10** Communicate with training organizations to ensure that exemptions for medical secretaries are systematically granted.

[46] Cf. appendix no. 2. The branch confirmed to the mission that the exemptions were not registered with the RNCP and could therefore be easily reviewed, particularly before the April 2025 deadline.

[47] The mission has taken into account trainees in the "medical assistant" and "medical secretary" categories, which are the two categories entered in the database, but which, according to the mission's analysis, correspond to medical secretaries who have become medical assistants and are qualified differently at the time the positioning tool is filled in.

[169] Another way of significantly reducing the hourly volume of medical assistant training concerns care profiles. For nurses, orderlies, nursery assistants and other healthcare professionals, for example, it would be possible to abolish the requirement to take the 112-hour FAE, or at the very least limit it to the "creation and follow-up of patient records" module (35 hours), and possibly "medical software" once its content has been adapted (see above).

**Recommandation n°11** Reduce job adaptation training to the "creation and follow-up of patient records" module for caregivers who become medical assistants.

## 2.2 A training offer that meets current demand but is not adapted to rapid growth in the number of trainees.

[170] The training offer approved by the[48] branch has been dimensioned according to the same logic as that used to design the CQP (training existing medical secretaries), and taking into account a volume of 4,000 medical assistants, which was the first target set by the public authorities for the end of 2022.

[171] The government's new target of 10,000 medical assistants by the end of 2022 implies adapting the training offer, notably by slightly increasing the number of training organizations, as already planned by the[49] branch, and by developing the practices of training organizations, notably by increasing the proportion of distance learning.

### 2.2.1 A range based on twelve accredited training organizations with heterogeneous characteristics

[172] Twelve training organizations were selected and approved following a call for applications launched by the branch in 2020 (an agreement has been signed until December 2023). The mission met with all these organizations. While it is not possible to give an exhaustive presentation of each of these organizations in order to preserve business secrecy, a number of observations can nevertheless be made.

[173] As a result, the twelve training organizations have different statuses - public, private or associative - and their training catalogs are not always as specialized in the healthcare field as one might have thought. Some of them have extended this catalog to offer the CQP, which represented a major investment on their part to respond to the call for applications.

[174] As shown in the table below, some organizations offer training related to the CQP, such as medical secretary (7), dental assistant (2) or veterinary assistant (3). One organization also offers two related, albeit shorter, training courses: medico-technical assistant in dermatology or aesthetics, which have been developed by the professional organizations of these two medical specialties, but are not registered with the RNCP.

[48] See appendix 4 for a detailed presentation of this offer.

[49] A new call for applications was due to be launched in spring 2023 to select around twenty training organizations. This has been delayed due to the funding difficulties mentioned in this report.

Tableau 10 : CQP-related training courses offered by the various OFs

| Organizations | Medical secretary | Dental assistant | Veterinary assistant |
|---|---|---|---|
| AFBB - association for biochemistry and biology training | √ | × | × |
| AFML - association for the training of self-employed doctors | √ | × | × |
| CFA CCI Le Mans | × | × | × |
| CHEM - Collège des hautes études en médecine | × | × | × |
| CNAM PdL - conservatoire national des arts et métiers pays de la Loire | × | × | × |
| CQFD | √ | √ | × |
| INFREP - national institute for training and research in lifelong education | √ | × | √ |
| IRTS - regional institute for social work | × | × | × |
| ISRP - higher institute of psychomotor rehabilitation | × | × | × |
| Keyce academy | √ | × | √ |
| Pôle de formation Pasteur | √ | √ | √ |
| Yschools | √ | × | × |

*Source : Mission*

[175] In view of the number of trainees and the time currently allowed to enter training (two years after hiring), all approved training organizations affirm that the current supply is sufficient, 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. No organization reported to the mission that it had refused trainees for lack of space.

### 2.2.2 An imperfect national coverage and a limited use of distance learning

[176] In terms of geographical coverage, there are three types of training organization: those with a local or even regional reach, those that cover several regions, and those that 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.

[177] However, the location of organizations reveals 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.

[178] This situation is all the more notable 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. Thus, in July 2021, the branch decided to suspend the reimbursement of certain ancillary expenses (accommodation and travel) for trainees who registered with a training organization far from their home (see *below*). This provision is included in the Opco EP reference document[50] .

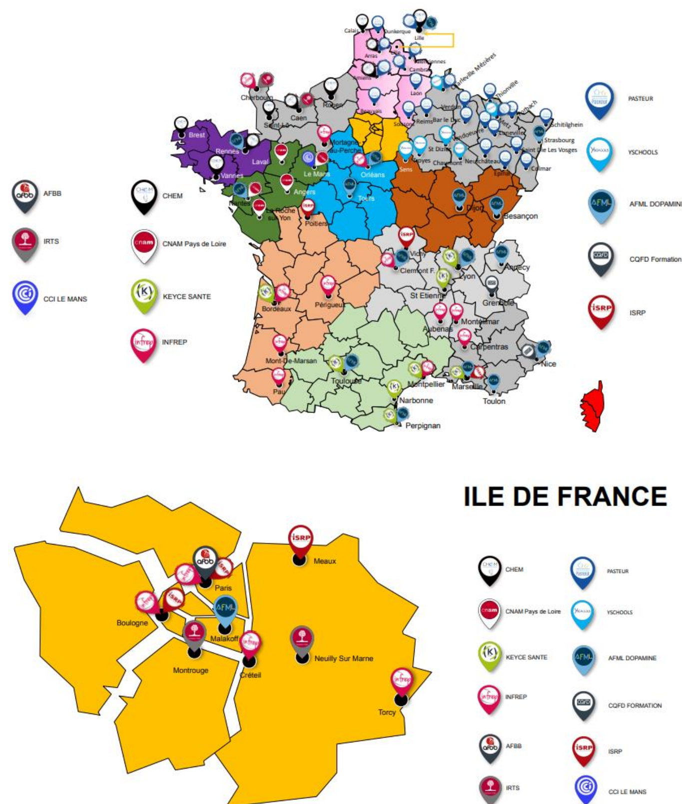
Décision prise par la CPNEFP du 8 juillet 2021 qui seront soumises, conformément à la procédure habituelle à la SPP, au bureau et au CA de l'OPCO EP :

*« 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. »*

[179] The branch and the Opco EP now maintain a certain vagueness about this geographical sectorization rule, the existence of which they now deny. Its legal validity should be examined by the DGEFP and the competition authorities.

[50] 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 the approved training organization located near his or her home or workplace. Catering costs are covered unconditionally".

Carte 2 : Location of approved training organizations (excluding DROM)

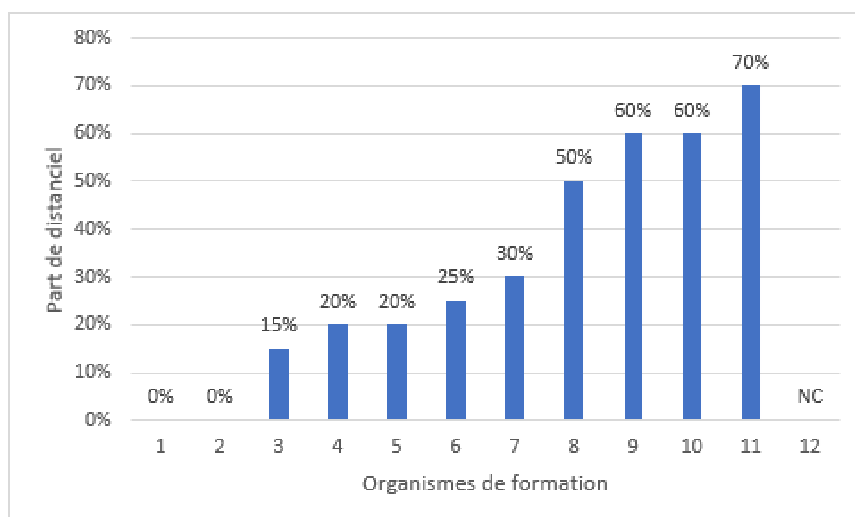



*Source : CPNEFP for medical practices*

[180] The branch call for applications provided for the possibility of using open distance learning (ODL), without specifying its share. The vast majority of training organizations we met chose to give priority to 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".

[181] Some of the training organizations also indicated that they were not in favor of distance learning, noting that trainees were following 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.

Graphique 4 : Percentage of distance learning offered by training organizations




*Source : Mission*

[182] The majority of training organizations do not favor distance learning. In fact, three of them 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 services that would enable them to recruit trainees from as wide a geographical area as possible, and they subsequently stuck with this organization despite the change in the rules;
- Face-to-face meetings are preferred for the "operational assistance to the practitioner" block and for the "communication with the patient" 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.

[183] 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.

[184] The development of distance learning would have the great advantage of solving the problem of availability of premises and trainers, with a view to a rapid increase in the number of trainees (cf. infra 223).

[185] On the other hand, setting up an exclusively distance learning course (synchronous or asynchronous) would require substantial investment, which the smallest accredited organizations would probably not be able to support. As a result, this development can only be envisaged in the medium term, and with the proviso that practical courses can be effectively delivered to trainees, unless specific funding is made available.

**Recommandation n°12** Develop synchronous and asynchronous distance learning courses for medical assistants as quickly as possible.

### 2.2.3 Difficulties for some training organizations to ramp up quickly

[186] Quite apart from any considerations relating to the pool of candidates and the obstacles to training deployment, achieving the objective set by the President of the Republic presupposes changing the parameters of the training offer, both quantitatively and qualitatively.

[187] Indeed, if we assume that around 1,500 people have been trained in two years and, following the CNAM's reasoning, that there are still 6,000 trainees to be trained in three and a half years[51] , this is equivalent to roughly tripling the need for trainee training.

[188] All training organizations have indicated that they can increase their existing training offerings. However, most of them will not be able to triple their offer in the short term, notably due to constraints on premises and trainer recruitment. These two obstacles militate in favor of increasing the number of accredited training organizations and making greater use of distance learning.

[189] As far as trainers are concerned, the branch's call for applications stipulated that they should have at least one year's experience in the CQP's training areas, and 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).

[190] The vast majority of training organizations reported recruitment difficulties, which could potentially hinder training deployment 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.

[191] 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 per hour net to €60 per hour net for the most qualified trainers (including doctors and healthcare executives), and from €40 per hour net to €60 per hour net for others.

[192] 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.

[51] 10,000 medical assistant contracts, the target set by CNAM, actually correspond to around 7,500 separate individuals. As 1,500 separate trainees have been trained to date, this means that reaching the target of 10,000 medical assistants actually represents the entry into training of 6,000 new trainees over the coming period. If we keep to the current rules, these new trainees will be able to enter training until the end of 2026, i.e. in three and a half years; if we follow the mission's recommendation, they will have to enter training before the end of 2025, i.e. in just two and a half years.

**Tutors' varying levels of investment**

As the training takes place on a sandwich course, the employer has a dual role to play with his employee: to enable him to put into practice the skills acquired during the theoretical and practical training provided by the training organization, and to certify the acquisition of these skills through the trainee's logbook.

This booklet sets out the training framework and enables you to follow your apprenticeship in the practice under the supervision of your employing physician. It comprises 41 pages and must be filled in as you go along. As mentioned *above*, it is an important tool in the CQP validation process. In fact, it is through completed booklets that the branch has learned of task shifts.

A number of training organizations have pointed out that the booklet is somewhat cumbersome, which means that tutors can fill it in very unevenly.

It should be noted that the trainee's booklet states that "*the tutor, if he or she feels the need, can follow a tutor training course financed by certain OPCOs*". According to Opco EP, no such requests have been made. In this respect, several training organizations have pointed out 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*".

*Source : Mission*

## 2.3 Access routes to training are too narrow and exacerbate existing financing problems.

### 2.3.1 Access mainly through the skills development plan and the FAE

[193] Today, for young people with no qualifications, for jobseekers and for people active on the job market, there are many possible ways of accessing training leading to qualifications, either on the initiative of the individual themselves, or on the initiative of their employer.

[194] In practice, the situation is very different when it comes to becoming a medical assistant: in fact, the training was designed primarily for medical secretaries already working for their physician employers, and secondarily for nursing staff. Other access routes, including those financed by Pôle Emploi or supported by the State, are de jure or de facto closed.

[195] Most professions can be accessed through initial training, including apprenticeships. This is the case, for example, for medical secretaries, via the medical or medico-social secretary qualification, for nursing assistants, via the nursing assistant diploma, or for nurses, via the nursing assistant diploma. This is not possible, on the other hand, for the medical assistant function, as it is based on obtaining a CQP which, as the law stands at present, is not open to initial training or apprenticeship, which require the existence of a title or diploma.

[196] This particularity distances doctors from a large potential pool of young medical assistant candidates whom they could hire under the financially favorable status of apprentice. It also prevents training establishments from investing in the development of initial medical assistant training courses.

**Recommandation n°13** Create a health care assistant qualification to open up training to apprenticeships and train assistants to work in all types of facilities.

[197] Against this backdrop, and with a view to training several thousand medical assistants (see below), it would be advisable to create, in addition to the CQP, a medical assistant qualification or, where appropriate, a broader health assistant qualification intended for all types of healthcare and medico-social structures, not just doctors' surgeries. This title 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 likely to interest more training organizations[52] . The training required to obtain this qualification could, if necessary, be spread over a few months (three or four), interspersed with a period on the job.

[198] It is also possible, in principle, for any active person, from the moment they enter the job market until retirement, to use their personal training account (CPF) via the Mon Compte Formation platform, and thus acquire training rights to help maintain employability and secure their career path. In principle, the CPF could be used by a current care worker (aide-soignant, nurse or nursery assistant) to finance his or her medical assistant training, which is organized into four distinct blocks, and whose cost remains relatively limited (around €2,000 to €2,500 for block 2, which these professionals must acquire). It could also be used by other employees more generally.

[199] In practice, this is not the case. For example, according to information provided by Caisse des Dépôts in March 2023, only two medical assistant training courses were offered on MonCompteFormation by a single training organization (Keyce Academy - Collège de Paris). There was no consumption in 2022, and only two files were open in January 2023.

[200] In addition, neither the branch nor the Opco EP has made any provision, as is often the case in many branches, to top up their employees' CPFs. This should now be the case, as it is for the regions.

**Recommandation n°14** Provision for branch or regional funding of personal training accounts

[201] Jobseekers, whose training is largely financed by Pôle Emploi, also have (very) limited access to medical assistant training. This is due to the characteristics of the sandwich course, which requires an employment contract, and to the tendency of employers, i.e. doctors, to give priority to hiring medical secretaries already working in their own practice or in another practice. The medical assistant profession is not one of the so-called "short-staffed" professions, and very few vacancies and applications - most of which must in fact correspond to the official definition - are registered by Pôle Emploi.

[202] The necessary discussions between the branch, the Opco EP and Pôle Emploi to enable jobseekers to access the operational preparation for employment (POE) have not been successful, for reasons that remain obscure to the mission. As a result, no jobseeker can benefit from access to the medical assistant function through either individual or collective POE.

[52] For example, the Association pour la Formation Professionnelle des Adultes (AFPA) contacted by the mission.

[203] It would be advisable for such discussions to take place very soon in order to allow access to the POE, whether individual or collective in priority, as well as access to company immersion courses.

**Recommandation n°15** Develop pre-recruitment training via operational preparation for employment, whether individual or collective.

[204] Like the apprenticeship contract, the professionalisation contract is a work-study contract. Its beneficiaries are young people aged 16 to 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).

[205] In practice, the number of professionalization contracts for medical assistants is excessively limited. The DGEFP database lists 18 in 2021 and 19 in 2022, for a total of 37, compared with 119,000 new professionalization contracts in 2022 and 337 professionalization contracts for medical secretaries.

[206] The aim of these contracts was to obtain a CQP in 24 cases, but also, and without being able to have details, a qualification recognized in the classifications of a CCN in 8 other cases, as well as a certification registered with the RNCP excluding CQP in 5 cases. The average and median duration of these professionalization contracts was 11 months. The Opco EP, for its part, recorded 27 professionalization contracts over the same period, and 35 if 2023 is included, i.e. just 2.8% of the total number of training cases handled since 2021.

[207] Promotion par l'alternance (ProA) is another scheme reserved for employees with at most a baccalaureate + 2 years of higher education, on permanent contracts (CDI), permanent integration contracts (CUI-CDI) or part-time work. There is no seniority requirement. Training can take place at a Qualiopi-certified training organization, or within the company if it has an in-house training department.

[208] The Medical Assistant CQP is eligible for ProA funding from Opco EP. In practice, Opco EP has identified only 8 applications for work-study promotion in 2022 and 2023.

[209] Finally, medical assistant training would, in theory, lend itself well to the VAE route for the thousands of existing medical secretaries looking to advance their careers. In practice, however, VAE is a complex system that has functioned poorly since its inception, particularly in the healthcare sector. In the case of the medical assistant qualification, the process is as long as or even longer than the CQP, and the chances of success are less guaranteed. It has been the subject of a major reform that will gradually come into force: the law of December 21, 2022 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.

[210] It is nevertheless regrettable to note that neither the medical practices branch nor Opco EP have so far wished to take part in the experiment led by REVA, the forerunner of the Groupement d'intérêt public (GIP) VAE.

**Recommandation n°16** Involve the branch in the Validation of Acquired Experience (VAE) experiment piloted by REVA.

[211] Under these conditions, and in any event, it is unreasonable to expect a large number of employees in the sector to gain access to the CQP via VAE by the end of 2024 or 2025.

[212] In practice, entry to training to become a medical assistant is therefore mainly via the PDC and, secondarily, via the FAE.

[213] Care profiles access the function of medical assistant by following an FAE which consists of block 2 "reception and care of the patient" for a duration of 112h. According to article 2 of the order dated November 7, 2019 issued by the French Ministry of Health and Solidarity, this training is "required for medical assistants who do not hold the CQP of medical assistant" (within three years of taking up the post).

[214] Training is offered by the twelve accredited training organizations, but may also be provided by other training organizations. It takes the form of a simple "attestation de formation d'adaptation à l'emploi" (training certificate for adaptation to the job) provided for in article 2 of the decree of November 7, 2019.

### 2.3.2 Major financing constraints

[215] The financing of medical assistant training by the branch and Opco EP poses serious problems, which have come to light in recent weeks, even though the number of trainees remains relatively low. It is clearly inadequate and unsuited to a rapid increase in the number of trainees.

**Opco EP financing conditions**

There are several ways of financing medical assistant training through Opco EP, mainly according to the following scales:

-Training fees paid to training organizations: €20/hr excluding VAT

- Additional costs (accommodation, meals, travel) paid to employers for employee reimbursement: depending on costs

- Wage costs 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.

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 enables 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 be gradually being sorted out;

Some trainees are obliged to pay the costs themselves (which can be high, see above), while employers wait for the funds to be paid out by Opco EP before reimbursing their employees, which does not comply with employment law.

[216] Considering that the average cost of training a medical assistant is 12.6 k€ including salaries, the gross funding requirement for training 6,000 trainees is around 75 M€[53] . These funding requirements cover the period between now and the end of 2026, i.e. 21.5 M€ per year for three and a half years, if we stay within the current rules, or even the end of 2025, i.e. 30 M€ per year for two and a half years, if the mission's recommendation to limit the period during which a medical assistant must enter training to one year after recruitment is implemented.

[217] It is clear that the industry will not be able to finance the training of the 6,000 new medical assistant trainees from legal and contractual sources, or from available reserves, although the mission was unable to establish the exact level of additional funding required, which nevertheless amounts to several tens of millions of euros[54] . The DGOS, the DGEFP and the CNAM should rapidly draw up a precise inventory with the branch and the Opco EP, and co-construct a financing plan, as has been done for other priority professions.

**Recommandation n°17** Rapidly release the additional funding needed to train new medical assistants

[218] Finally, the management of the training process relies heavily on the branch. The CPNEFP analyzes all applications submitted to the management tool made available to training

[53] For calculation of the number of new trainees to be trained, see footnote 50.

[54] It should be noted that the branch's conventional reserves total around €20 million.

organizations, in order to position candidates (i.e., check compliance with prerequisites and grant any exemptions). The branch also organizes the juries responsible for awarding the CQP on the basis of the results obtained. The branch could find itself in difficulty managing the system if the number of candidates rises sharply. It would therefore be advisable to help it strengthen its position in this respect.

**Other constraints on training**

Most CQP trainees are medical secretaries who have been working for their employers for several years. Some of them (a significant proportion, depending on the training organization) may be reluctant to take part in training.

This may be due to a lack of interest in going back to school, a relative lack of interest in training that increases with the time elapsed between recruitment and departure for training, or to the trainees' perception of training as an obligation for the payment of contractual aid ("*training imposed by the social security system*"), the possible increase in workload during the days when the trainee is present at the firm, if he or she is not replaced, and the not inconsiderable impact on private life due to their absence two days a week, as well as the advance payment of expenses that the trainee may have to make pending payment of the corresponding sums to his or her employer by the Opco EP.

Furthermore, some employers consider that their employees have already mastered the skills required by the CQP. The current format, set out by the industry, of alternating training over a period of ten months at a rate of two days a week, can be an impediment to hiring a medical assistant, especially when the latter is part-time. Indeed, this means hiring a professional who is absent from the practice for the entire duration of his or her training, except in part during school vacations. Training organizations report that trainees may be called upon to carry out their day-to-day tasks.

The tutor's role is seen as too time-consuming, especially filling in the trainee's logbook.

It can sometimes take a long time for expenses to be reimbursed. In fact, the payment of so-called "ancillary" expenses (accommodation, transport and catering) is conditional on the payment of tuition fees, which are only paid when the training organization requests them.

*Source : Mission interviews*

Frédérique SIMON-DELAVELLE Louis-Charles VIOSSAT

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# LIST OF PEOPLE MET

OFFICE OF THE MINISTER RESPONSIBLE FOR TERRITORIAL ORGANIZATION AND HEALTH PROFESSIONS

- Agnès FIRMIN-LE BODO, Minister
- Isabelle EPAILLARD, Office Manager
- Antoine-Mathieu NICOLI, Deputy Cabinet Director
- Dr Sophie AUGROS, medical advisor, in charge of organization and practice of healthcare professions
- Angèle MALÂTRE-LANSAC, Technical Advisor, in charge of Territorial Foresight and Innovation
- Guillaume CASSOURET, medical director trainee

OFFICE OF THE MINISTER FOR VOCATIONAL EDUCATION AND TRAINING

- Bruno CLEMENT-ZIZA, Chief of Staff

DIRECTORATE OF HEALTH SUPPLY - DGOS

- Marie DAUDE, General Manager
- Philippe CHARPENTIER, Deputy Director of Human Resources for the Healthcare System
- Julien MOLESIN, Head of the Health Professions Practice and Ethics Office

SOCIAL SECURITY DIRECTORATE - DSS

- Clélia DELPECH, Deputy Director of Healthcare System Financing
- Manon FLANDROIS, Project Manager

DIRECTORATE OF RESEARCH, STUDIES, EVALUATION AND STATISTICS - DREES

- Noémie VERGIER, Assistant to the Head of the Health Professions Office
- Maxime BERGEAT, Project Manager

HIGH COUNCIL FOR THE FUTURE OF HEALTH INSURANCE - HCAAM

- Natalie FOURCADE, General Secretary
- Marie-Camille LENORMAND, Deputy General Secretary
- Dominique POLTON, Scientific Advisor

GENERAL DELEGATION FOR EMPLOYMENT AND VOCATIONAL TRAINING - DGEFP

- Stéphane REMY, Deputy Director of Training Policy and Control
- Alexandra CHOL, Assistant to the Head of the Professional Certification Policies Mission - Training Policies and Control Sub-Directorate
- Christine MATRAGLIA, head of the work-study program and access to qualifications mission
- Marie LUET, Assistant to the Head of the Alternance and Access to Qualifications Mission
- Linda BEAUCE, in charge of developing validation of acquired experience and career development advice

NATIONAL HEALTH INSURANCE FUND - CNAM

- Thomas FATOME, General Manager
- Julie POUGHEON, Director of Healthcare Services
- Thierry ZACCHERINI, Head of Healthcare Professionals Department
- Philippe SOUBIELLE, Medical Director, Healthcare Professionals Department
- Yves-Marie LAGRON, Research Manager, Healthcare Professionals Department

CENTRAL FINANCING AGENCY FOR SOCIAL SECURITY - ACOSS

- Alain GUBIAN, Director of Statistics, Studies and Forecasting
- Anne-Laure ZENNOU, Head of Statistics and Network Coordination Department

POLE EMPLOI

- Cécile LIEURADE, Assistant to the Corporate Services Manager
- Chrystelle MIOT, Service Quality Manager
- Hervé JOUANNEAU, Acting Director, on training, work-study programs and VAE
- Cyril NOUVEAU, Director of Statistics, Studies and Evaluation
- Monika MISKOLCZY, Project Manager, Executive Office

NATIONAL JOINT COMMITTEE FOR EMPLOYMENT AND VOCATIONAL TRAINING (CPNEFP)

- Jean-Claude SOULARY, President, MG France
- Stevan JOVANOVIC, Vice-President, CFDT
- Florence MAURY, former President, French Confederation of Christian Workers (CFTC)
- Pascale SEBBAN, Administrative Secretary

OPCO EP

- Arnaud MURET, General Manager
- Fabien ROULLET, Operations Manager
- Emilie MARTINEZ, Project Manager reporting to General Management

OPCO-SANTE

- Jean-Pierre DELFINO, General Manager
- Catherine PAGEAUX, Branch Support Manager
- Sylviane LECLERCQ, Partnership Development and Work-Study Manager

UNIFORMATION OPCO

- Yann VAN ACKER, Director, Professional Branch Support
- Elisa BRALEY, Assistant to the Director of Resources and Head of the Projects and Studies Department

FRANCE COMPETENCES

- Andreea TOMA-PILOT, Head of the Specific Directory, Control and Transversal Projects Department, Professional Certification Division
- Sophie PARISOT, health and well-being instructor, Professional Certification Department

LES ACTEURS DE LA COMPETENCES, FORMERLY FEDERATION DE LA FORMATION PROFESSIONNELLE (FFP)

- Pierre COURBEBAISSE, Chairman
- Isabelle RIVIERE, Deputy Managing Director

- Emmanuel JORRY, Director, Association pour la formation de la biochimie et de la biologie -AFBB (Association for training in biochemistry and biology)
- Françoise SOUWEINE, AFBB General Secretary
- Anne-Valérie AUJAMES, General Manager of the Pasteur training center and President of the Grand-Est regional grouping

NATIONAL AGENCY FOR ADULT VOCATIONAL TRAINING - AFPA

- Christophe SADOK, Director of Engineering and Innovation
- Fabrice YEGHIAYAN, National Development Director
- Elisabeth GODDAERT, Business Services Sector Manager, Innovation Engineering and National Public Service Missions Division.

ASSOCIATION FOR TRAINING IN BIOCHEMISTRY AND BIOLOGY - AFBB

- Emmanuel JORRY, Director
- Françoise SOUWEINE, General Secretary
- Shantal FLOURET, Educational Manager
- Martyne VAILLANT, Senior Trainer
- Jenifer LOPES, former certified trainee
- Eva BEAUSSE, former certified trainee
- Lydie GIRAUD, former certified trainee

NATIONAL INSTITUTE FOR TRAINING AND RESEARCH ON CONTINUING EDUCATION - INFREP

- Pierre CURVALE, General Manager
- Benjamin BEUGNET, Training Project Manager

CONSERVATOIRE NATIONAL DES ARTS ET METIERS - CNAM PAYS-DE-LA LOIRE

- Thomas PROUVOST, CQP medical assistant referent, educational coordinator, public health unit

ASSOCIATION POUR LA FORMATION DES MEDECINS LIBERAUX - AFML

- Dr Audrey VIENNE, Educational Manager
- Karine BONET, Operations Manager

COLLEGE DES HAUTES ETUDES DE MEDECINE - CHEM

- Jean-Sébastien GUILLEREZ, General Manager
- Amélie MANCA, Deputy General Manager
- Mickaël DAVID, medical assistant in training

CQFD

- Elodie DEPIERRAZ, Educational Manager and VAE Accompanist

INSTITUT SUPERIEUR DE REEDUCATION PSYCHOMOTRICE - ISRP

- Dr Véronique VINSON - Educational Manager
- Léa NEGRI, administrative manager of the CQP and director of the Institut de formation aux métiers de la santé - IFAMS (healthcare training institute)

APPRENTICE TRAINING CENTER - CHAMBER OF COMMERCE AND INDUSTRY (CFA-CCI) LE MANS

- Christophe ALBERT, Director

- Rosa-Maria FRESLON, Health Sector Manager

REGIONAL INSTITUTE OF SOCIAL WORK - IRTS

- Julien LELOUP, Head of Professional Training, Development and Partnerships

YSCHOOLS

- Laetitia GILLOT, Health and Social Project Coordinator

KEYCE ACADEMY

- Alain DOLADILLE, Health Department Manager
- Stéphane LAFITE, Medical assistant sales manager

POLE DE FORMATION PASTEUR

- Anne-Valérie AUJAMES, General Manager

RICHERAND HEALTH COOPERATIVE

- Dr Alain BEAUPIN, Chairman

RICHERAND HEALTH CENTER

- Julie BOITARD, General Manager
- Dr Jeanne VILLENEUVE, Medical Director

ISSY-LES-MOULINEAUX HEALTH CENTER

- Laurence PARRAIN, Director of Health, Issy-les-Moulineaux Town Hall
- Karine GESLIN, medical assistant at both health centers

QUALIFIED PERSONS

- Dr. Pierre de HAAS, general practitioner in Pont d'Ain, former president of the French federation of health centers (FFMPF).
- Dr. Pascal GENDRY, general practitioner in Renazé, president of the AVECsanté movement
- Annick MOREL, Honorary General Inspector of Social Affairs, in charge of drafting the arbitration rules

CONSEIL NATIONAL DE L'ORDRE DES MEDECINS - CNOM

- Dr. René-Pierre LABARRIERE, Chairman of the Professional Practice Section
- Dr. Leïla OURACI, Deputy General Secretary
- Pauline CAILLEAUD, lawyer
- Caroline NICET-BLANC, lawyer

COMMISSION PARITAIRE PERMANENTE DE NEGOCIATION ET D'INTERPRETATION - CPPNI (PERMANENT JOINT COMMISSION FOR NEGOTIATION AND INTERPRETATION)

- Dr. Laurent VERZAUX, radiologist and committee chairman

CONSEIL NATIONAL PROFESSIONNEL DE GYNECOLOGIE ET OBSTETRIQUE ET GYNECOLOGIE MEDICALE (NATIONAL PROFESSIONAL COUNCIL FOR GYNECOLOGY AND OBSTETRICS AND MEDICAL GYNECOLOGY)

- Dr Michèle SCHEFFLER, President
- Pr Philippe DERUELLE, Secretary of the French National College of Gynecologists and Obstetricians

National Professional Council of Ophthalmology

- Prof. Béatrice COCHENER, Chairman
- Dr Pierre PEGOURIE, General Secretary
- Dr Thierry BOUR, President of the Syndicat National des Ophtalmologistes de France
- Dr Vincent DEDES, General Secretary of the Syndicat National des Ophtalmologistes de France

National Professional Council of Cardiology

- Dr Vincent PRADEAU, President of the National Union of Cardiologists and the CNP, cardiologist in Gironde
- Dr Marc VILLAECQUE, VP of the CNP, cardiologist in Nîmes

Conseil National Professionnel de radiologie

- Prof. Louis BOYER, Head of Department, Clermont-Ferrand University Hospital

Conseil National Professionnel des aides-soignants

- Carole CAUVRIT, President
- Arlette SCHUHLER, Assistant Secretary
- Caroline FERNAND, Treasurer

OPENCLASSROOMS

- Esther MAC NAMARA, Vice-President, Employers and Programs to Employment
- Louis-Simon BOILEAU, Public Sector Key Account Manager

National Council of the Order of Nurses

- Patrick CHAMBOREDON

Doctissimo

- Pierre-Yves BROSSARD, Strategy and Public Health Manager

Confederation of French Medical Syndicates - CSMF

- Dr Franck Devulder, Chairman
- Dr Luc DUQUESNE, President of Les Généralistes CSMF
- Dr Bruno PERROUTY, President of Les Spécialistes CSMF

MG France

- Dr Jean-Claude SOULARY, Treasurer
- Dr Gwenaëlle DERRIEN, President of MF FORM and Board member of MG 85

The Group

- Dr Margot BAYART
- Eric BAILLOT
- Cyrille de la CHESNAIS

Avenir Spe

- Dr Thierry BOUR, Vice President, Medical Technology

French Union of Dental Assistants - UFAD

- Mounia SANTOU, President
- Khadija BERROUNA, Vice-President and Treasurer

NATIONAL FEDERATION OF NURSES - FNI

- Daniel GUILLERM, Chairman

NATIONAL UNION OF NURSING PROFESSIONALS - SNPI

- Thierry AMOUROUX, spokesman
- Carmen BLASCO, General Secretary
- William PEREL, Assistant General Secretary
- Anne LARINIER, Treasurer
- Marie-Hélène FEUILLIN, Assistant Treasurer
- François MARTINEAU, Board member

ASSOCIATION OF MEDICAL AND SOCIAL SECRETARIES (ASMR)

- Catherine DEPLAIX, President
- Véronique VEILLON, Pedagogical Manager and member of the Board of Directors

PRIME MINISTER'S OFFICE - BETA.GOUV.FR

- Olivier GERARD, REVA project manager

MACSF

- Nicolas GOMBAULT, Assistant Manager

FRANCE ASSO SANTE

- Gérard Raymond, President
- Alexis VERVIALLE, health advisor

PAYS-DE-LA-LOIRE REGIONAL HEALTH AGENCY

- Claire GABORIEAU Direction de l'offre de santé et en faveur de l'autonomie, Head of Primary Care Access Department
- Béatrice BONNAVAL, Direction de l'offre de santé et en faveur de l'autonomie, Département accès aux soins primaires, in charge of access to care
- Stéphane GUERRAUD, Direction de l'appui à la transformation et de l'accompagnement, Head of the Healthcare Human Resources Department

LOIRE-ATLANTIQUE PRIMARY HEALTH INSURANCE FUND

- Pierre ROUSSEAU, Managing Director, Director of Risk Management Coordinator, Pays-de-la-Loire health insurance organizations
- Thomas BOUVIER,

UNION REGIONALE DES PROFESSIONNELS DE SANTE PAYS-DE-LA-LOIRE - URPS

- Dr Thomas HERAULT, Director
- Karine RETIERE, Physician Services Coordinator
- Géraldine L'HONNEN, Head of the Employers' Physicians Group

# CONTACTS

INSTITUTE FOR RESEARCH AND DOCUMENTATION IN HEALTH ECONOMICS - IRDES

- Denis RAYNAUD, Director
- Marie-Odile SAFON, Documentation Manager

PRISM'EMPLOI (PROFESSIONAL ORGANIZATION OF TEMPORARY EMPLOYMENT AND RECRUITMENT COMPANIES)

- Isabelle EYNAUD-CHEVALIER, Managing Director

CAISSE DES DEPOTS ET CONSIGNATION - CDC

- Michel YAHIEL, Director of Social Policies

OBSERVATORY OF PROFESSIONS IN THE LIBERAL PROFESSIONS - OMPL

- Noemia MARQUES, Delegate

# ACRONYMS

AAH: disabled adult allowance

ACOSS: central financing agency for social security funds

ACQPCM: association of professional qualification certificates for medical practices

AFBB: Association for training in biochemistry and biology

AFEST: on-the-job training action

AFGSU: certificate of training in emergency gestures and care

AFML: association for the training of self-employed doctors

AFPA: association for adult vocational training

AI: intermediary association

AM: medical assistant

AMA: medical administrative assistant

ANI: national interprofessional agreement

APDE: state-qualified nursery assistant

ARE: back-to-work allowance

AREF: back-to-work training allowance

ARM: medical regulation assistant

ARS: regional health agency

ASDE: state-qualified nursing assistant

ASS: specific solidarity allowance

ASSP: support, care and personal services

ASST: occupational health service assistant

AVS: social life assistant

BEP: vocational diploma

BIT: International Labour Office

CAP: vocational aptitude certificate

CCAM: common classification of medical acts

CCN: national collective bargaining agreement

CCP: Certificate of Professional Competence

CDI: open-ended contract

CEP: Conseil en évolution professionnelle

CFA-CCI: apprentice training center - chamber of commerce and industry

CFDT: French Democratic Labor Confederation

CGSS: Overseas General Social Security Fund

CGT: General Confederation of Labor

CGT-FO: General Confederation of Labor – Force ouvrière

CHEM: colleague for advanced medical studies

CNAM: National health insurance fund

CNAM: National conservatory of arts and crafts

CNOM: Medical Doctors National Order

CNP: National professional council

CPAM: primary health insurance fund

CPF: personal training account

CPNEFP: joint commission for employment and vocational training

CPTS: community of healthcare professionals

CQP: certificate of professional qualification

CRP: professional reclassification contract

CSA: supplementary contribution to apprenticeship

CSMF: Confederation of French Medical Unions

CTP: professional transition contract

CUFPA: one-off contribution to vocational training and work-study schemes

DARES: directorate for research, studies and statistics at the ministry of labor

DEAS: state diploma in nursing care

DEAP: state diploma in childcare assistants

DEI: state nursing diploma

DGEFP: General Delegation for Employment and Vocational Training

DGOS: General Directorate for Healthcare

DGT: General Directorate for Labor

DREES: Department of Research, Studies, Evaluation and Statistics

DREETS: Regional Department for the Economy, Employment, Labor and Solidarity

DROM: French overseas departments and regions

DSN: nominative social declaration

DSS: Social Security Department

DUT: university diploma in technology

EAJE: establishment for young children

ECG: electrocardiogram

EHPAD: establishment for dependent elderly people

EI: entreprise d'insertion

FTE: full-time equivalent

FTE: full-time equivalent

FAE: job adaptation training

FMF: French Doctors' Federation

ODL: open distance learning

GIP: public interest group

GPEC: forward-looking management of jobs and skills

HT: excluding tax

IDE: state-registered nurse

IFSI: nursing training institute

IGAS: Inspectorate General of Social Affairs

INFREP: national institute for training and research on lifelong education

INSEE: French National Institute for Statistics and Economic Studies

IPA: advanced practice nurse

IRDES: Institute for Research and Documentation in Health Economics

IRTS: regional social work institute

ISCO: International Standard Classification of Occupations

ISPR: higher institute for psychomotor rehabilitation

MSP: multi-professional health center

OF: training organization

OMPL: observatory of professions in the liberal professions

OMPQ: prospective observatory of trades and qualifications

ONISEP: National office for information on education and professions

Opco EP: skills operator for local businesses

OP: employers' organization

Optam: controlled pricing option

ENT: ear, nose and throat specialist

OSS: employee union organization

PASS: specific health access path

PDC: skills development plan

SME: small and medium-sized enterprise

PMI: mother and child protection

PMSMP: Period of work experience in a professional environment

POE: operational preparation for employment

POEC: collective operational preparation for employment

POEI: individual operational preparation for employment

ProA: promotion through work-study programmes

RAC: activities and skills repository

GDPR General Data Protection Regulation

RNCP: national registry of professional certifications

RS: specific directory

RSA: minimum income

SAPAT: personal and regional services

SAS: healthcare access service

SCP: professional partnership

SIAE: economic integration structure

SM: medical secretary

SMIC: minimum growth wage

SML: liberal doctors' union

SNOF: French national ophthalmologists' union

SPP: professional joint section

SPPI: interprofessional joint section

SST: occupational health service

TASO: ophthalmic care assistant technician

TP: professional title

UNAPL: national union of liberal professions

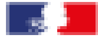
URPS: regional union of healthcare professionals)

VAE: validation of acquired experience

VSE: very small enterprise

WHO: World Health Organization

# LETTER OF INTENT



MINISTÈRE
DE LA SANTÉ
ET DE LA PRÉVENTION
*Liberté*
*Égalité*
*Fraternité*

Les Ministres                                        Paris, le 07 FEV. 2023

CAB FB/DGOS/RH2/ML/D23-002712

Monsieur le Chef de l'inspection générale des affaires sociales,

Dans le cadre de la stratégie de transformation de notre système de santé, le plan « Ma santé 2022 » a porté plusieurs évolutions pour renforcer l'accès à la santé de nos concitoyens, et notamment la création de postes d'assistants médicaux permettant de dégager du temps médical. A cette fin, les assistants médicaux réalisent des activités d'aide aux médecins libéraux en amont, pendant et après la consultation pour les libérer de tâches qui ne relèvent pas spécifiquement de compétences médicales. Cette mesure vise ainsi à augmenter le nombre de patients suivis par les médecins grâce, d'une part, à la préparation en amont des consultations par l'assistant et, d'autre part, à la réduction de la charge administrative pesant sur les épaules des médecins. Le développement des assistants médicaux est ainsi un levier essentiel pour libérer du temps médical, et contribuer à répondre aux difficultés d'accès aux soins. Actuellement, 52% des contrats concernent des médecins exerçant dans des territoires manquants particulièrement de professionnels (données CNAM) et 3 700 assistants médicaux sont en poste au sein des cabinets de médecins libéraux.

L'assistant médical est une nouvelle fonction, accessible aussi bien à des profils soignants (formation d'adaptation à l'emploi - FAE) qu'à des profils non soignants (certificat de qualification professionnelle -CQP), comme les secrétaires médicaux. La formation de l'assistant médical dépend ainsi de son métier d'origine. La durée et le contenu de la formation ont été négociés par la branche professionnelle des syndicats de médecins libéraux (CPNEFP) qui est aussi en charge du déploiement de la formation sur le territoire grâce aux organismes de formation autorisés. L'inscription au répertoire national des certifications professionnelles comme métier émergent a permis une reconnaissance par l'Etat de l'aspect certifiant de la formation et ainsi la mobilisation de financement par le compte professionnel de formation.

La fonction d'assistant médical a été prévue prioritairement pour les personnels actuellement en poste comme secrétaires médicaux et aux professionnels paramédicaux (infirmier, aide-soignant, auxiliaire de puériculture) souhaitant une reconversion. En outre, la formation est ouverte dès la sortie de formation initiale ainsi qu'aux demandeurs d'emploi.

.../...

Monsieur Thomas AUDIGE
Chef de l'Inspection générale des affaires sociales
Tour Mirabeau
39-43 quai André-Citroën
75015 Paris

Les annonces du Président de la République, le 6 janvier dernier, lors des vœux aux soignants, prévoient l'accélération du recrutement des assistants médicaux, de presque 4000 aujourd'hui, à 10 000 d'ici la fin de l'année 2024. Il s'agit là d'un enjeu majeur pour faire face à la raréfaction du temps médical, le temps que les effets des mesures structurelles engagées, telles que la fin du numérus clausus, se fassent pleinement sentir.

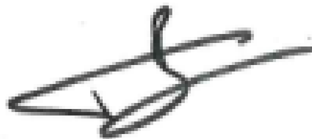
Ainsi, nous souhaitons qu'une mission IGAS soit lancée sur la formation des assistants médicaux afin d'évaluer sa pertinence et sa durée au vu des missions qui leur sont confiées par les médecins. La mission sera également chargée de dresser un bilan s'agissant de la mobilisation de financements diversifiés, du besoin en organismes agréés, de l'ouverture à d'autres acteurs chargés de la formation notamment dans le secteur public, des modalités d'accès à la formation et de validation des acquis de l'expérience. La mission évaluera à ce titre le besoin des différents secteurs sanitaires en veillant à ce qu'il ne se fasse pas au détriment de l'emploi des personnels de santé déjà formés. Au vu de ce bilan, la mission aura vocation à proposer des pistes d'évolution afin de répondre aux attentes des professionnels et de sécuriser l'atteinte de l'objectif de 10 000 assistants médicaux pour fin 2024. La mission portera notamment une attention particulière aux évolutions permettant de rendre plus cohérent ce parcours de formation dans l'organisation du travail de l'assistant médical auprès du médecin et de différencier davantage son contenu et sa durée selon le profil et les métiers exercés précédemment. Elle s'intéressera enfin aux parcours professionnels et aux possibilités d'évolution de carrière proposées aux assistants médicaux pour renforcer l'attractivité de ce métier.

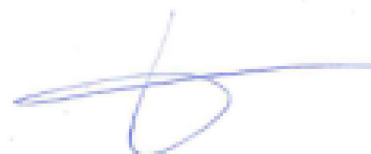
Afin d'élaborer les propositions soutenant la stratégie d'accélération que nous portons pour le recrutement des assistants médicaux, la mission veillera à consulter les syndicats de médecins libéraux, les représentants de la profession, la Commission Paritaire Nationale pour l'Emploi et la Formation Professionnelle (CPNEFP) de la Convention collective du personnel des cabinets médicaux, ainsi que toute personnalité qualifiée, expert ou service de l'administration qu'elle jugera pertinent d'auditionner dans le cadre de ses travaux. Ce travail pourra éventuellement comprendre une enquête auprès des assistants médicaux en exercice ou en formation.

Il est important que ces propositions puissent se traduire rapidement afin d'accompagner le déploiement d'assistants médicaux en ville. C'est pourquoi, le rapport issu des travaux devra être remis au plus tard fin mars 2023.

Vous veillerez en outre à la pleine cohérence de vos travaux avec ceux par ailleurs engagés par l'Assurance maladie dans le cadre des négociations conventionnelles avec les syndicats de médecins libéraux pour simplifier les modalités de mobilisation de ce dispositif.

Nous vous prions d'agréer, Monsieur le Chef de l'inspection générale des affaires sociales, l'expression de notre sincère considération.





**François BRAUN** **Agnès FIRMIN LE BODO**