How to ensure the care offer in the underprovided zones? The French experiences and tries.

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Statement of a double crisis: underprovided areas treated by soon-to-retire physicians

The shrinking and unequal medical demography is an urging issue in France. The country is facing two phenomena, which combination is accelerating the demographic problem. The first issue is the massive retirement of all the doctors from the baby boom generation within ten years: the density of physician will fall from 322 physicians for 100 000 inhabitants in 2008 to 276 in 2019. The second issue is the unequal repartition of primary care physicians over the territory, leaving some rural areas without physician: their density spreads from 260 in Picardie to 419 in the Riviera. The combination of the two phenomena makes that the soon-to-retire physician in a rural area, unlikely to be replaced, urges the risk of no care coverage in the area.

The public debate, involving the State, the Parliament, the National Health Insurance, the physicians unions and the local elected representatives as well, has been tackling the issue by various means: the training, the care provision organization with medical care centres, both incentive and coercive policies for the physicians' installation, cooperative care provision forms.

A project of law handling with the demographic issue is just being examined by the Parliament and displays the opportunity of a vigorous debate. Every member of the Parliament has had to face such a situation. The debate focuses on the coercive means to handle the physician demography.

Indeed, for the last five years, the government has managed the medical demography by the conventional way with incentive means to attract physicians in the underprovided areas: fiscal deduction, grants, income supplement. But the effect has remained marginal and makes the whole plan unlikely to solve the demographic crisis. The failure of the incentive way has led the members of the Parliament to ask for coercive means, against the will of the unions.

Nonetheless, the other means to handle the demographic issue, training, care provision organizations, cooperative care provision forms, have been quite poorly explored in comparison with the other member States.

The care provision in rural region: the difficulty to combine the freedom of setting up and the care duty constraints

A liberal care offer characterized by the freedom of setting up

The French system is strongly shaped by the liberal statute of the physicians. It has two main consequences: the freedom of the setting up choice and the consultation payment by the patient, refunded by the National Health Insurance on the base of a conventional price.

The freedom of setting up, to which the professionals are very attached, is a major issue because it prevents from any control by the State of the repartition of the health professionals on the territory. The second feature, which means that the physicians have a high income thanks to the National Health Insurance, which is financed by every citizen through the obligatory professional tax, entitles the National Health Insurance to regulate the setting up of these liberal health professions. It boils down to the debate incentive policy versus coercive policy.

Physicians exercising alone in their private cabinet

Besides, the primary care provision organization is essentially dealt by physicians exercising alone in their private cabinet: 39% of physicians are working in group in France, in comparison with 97% in Sweden and Finland, 92% in the United Kingdom, 57% in the Netherlands and 30% in Belgium.

The few physicians exercising in group practise with colleagues from the same speciality, and are an average of three physicians in a cabinet.

This type of exercise is certainly a matter of generation: while the old generation has been used to work isolated, the coming generation looks forward to exercising in a pluridisciplinary group. This change is partially explained by the feminisation of the medical profession, but also by a cultural evolution of the expectations of a generation willing to work in close relations with the other specialities and within a schedule compatible with family life.

An ageing population with chronic diseases

On the side of the demand, the population of rural areas is ageing, but not necessarily declining due to the setting strategy of the retired persons. Like any other member State, the chronic diseases, which characterize this aged population, need a specific approach of the care: pluridisciplinarity with physicians, specialists, and medical auxiliaries as well, prevention and health education.

A matter of regional development

The local municipalities have a major interest to attract new physicians in their underprovided area. First, the zone is threatening to empty further if the young population is not easily covered by the care offer. Second, the lack of care offer is translated by medical disfunctionings: delay to get a date with a specialist, bad orientation, lack of coordination, *etc.*

Forms of care provision for the underprovided areas: the development of pluridisciplinary care houses

The concentration of the hospital offer: to the end of the local hospitals

France has to face with another reform in the health field. The hospital organization is concentrating its offer on the main hospitals. Indeed, the small local hospitals with a weak activity are considered as unlikely to ensure the quality of care and as inefficient. The hospital care offer is thus concentrated on the hospitals equipped with important technical board. The demographic equation is all the more difficult and emergent.

The alternative of hospitalization: the development of the home care provision

The government is trying to develop the alternative to hospitalisation, or to enhance the care provision organization at home: home nurse care services, health networks, hospitalization at home if the medical care is not too heavy. Delivering the care at home for the aged persons has an important role for the quality of their life, and is likely to be cheaper even if it is not proved yet.

The pluridisciplinary care houses

The government has been developing for five years the pluridisciplinary care houses, aimed at developing the exercise in group with physicians, medical auxiliaries and specialists. The main features are the following ones:

- setting up in an underprovided area, rural or suburb;
- pluridisciplinarity of the professionals;
- care continuity thanks to the organization of the professionals;
- close collaboration with the other care structures, including hospitals.

The expectations are also different from a simple care centre:

- the care is provided to a population rather than clients; prevention, health education and a social-sanitary approach are thus developed;
- the cooperation care provision forms between physician and nurse are likely to be enhanced;
- the organization enables the professionals to have a schedule compatible with family life while providing care duty to the population.

Although this type of structure is expected by both the local elected representatives and the professionals, they are only 158 pluridisciplinary care houses in France today. The local municipalities usually pay for the facilities and a dedicated State fund pay for the supplies and administrative costs. Money is available but it seems few physicians are not ready to involve in the elaboration of such a project, in spite of the help of the local health insurance organisms.

Strategies to solve the medical offer demography: incentive policy versus coercive policy

The French debate is strongly opposing the incentive policy to the coercive policy. The Government, especially for the last five years, has implemented a determined incentive policy. Nonetheless, this one proved to be inefficient to solve the demographic crisis. Therefore, the Parliament has introduced some coercive measures.

A regulation at a national level based on incentives measures

The whole territory has been classified, at the level of the canton, according to the physician density evaluated by their activity and the care need of the population. Underprovided zones have been defined. The conventional negotiation decided some grants for the physicians set up in the underprovided zones:

- allowances for students in the underprovided zones;
- individual help for all the administrative forms;
- grants for setting up in the underprovided zones;
- increase of 20% of the income for a group exercise in the underprovided zones for three years;
- grant for the physician set up in the mountains;
- supplement of income for the care duty in rural areas;
- fiscal exemption from the tax on the income for the care duty in the underprovided zones;
- fiscal exemption from the income tax in the rural underprovided zones;
- fiscal exemption from the professional tax in the underprovided zones and the small municipalities;
- fiscal exemption from the employer tax for any employee in the rural underprovided zones;

All the information is gathered in only one website of the National Health Insurance. This site also provides the professionals with an interactive map, with the density of every district, the average activity for every type of health profession.

Nonetheless, the effect has remained marginal: only 1000 physicians have taken advantage of these incentives. It has proven that the incentive policy can not solve the medical demographic crisis.

A first coercive measure: the health solidarity contract

On the basis of the statement of failure of the incentive policy to solve the lack of care offer in the underprovided zones, the Parliament has introduced in the project of law being examined at present some coercive measures.

They thus introduced a measure proposing the physicians of the overprovided zone to sign a health solidarity contract according to which they agree to provide care also in underprovided areas or in humanitarian centres. If they refuse to sign his health solidarity contract, they have to pay an annual penalty of almost 3000€. This measure is to begin three years after the implementation of the new regional care organization schema foreseen by the project of law and only if this schema is evaluated as inefficient to provide care in the underprovided zones.

A regulation including both incentives and coercive measures: the case of the nurses

The model of a demographic regulation in France is the one implemented for the nurses. In 2009, the whole territory was classified, at the level of the canton, according to the nurse density evaluated by the nurse activity and the care need of the population. Underprovided zones and overprovided zones have been thus defined. The conventional negotiation decided some grants in the underprovided zones and forbids the setting up in the overprovided zones. Such a model may be applied for the physiotherapists and, eventually, the physicians.

A regional and transversal tool to diagnose the care offer demography

Recently, on the basis of a strong division between the hospitals and the liberal physicians, on the one hand, and, on the other hand, between the State and the National Health Insurance, the government, by its project of law, will create regional health agencies gathering the State and the Health Insurance competences, and managing the health organization for both the hospitals and the liberal medical offer. The key of this reform will be a regional care organization schema, mapping the whole care offer for all the care structures, including hospitals, liberal physicians, medical auxiliaries, *etc.* Having a tool displaying the whole offer should help the regional health agencies to coordinate properly the care provision organization.

To get the fidelity of the medicine students

It seems that the decisive point in the choice of the exercise area in which the physicians set up is the place in which they end their medicine studies. Therefore, the local municipalities, in order to get the students' fidelity, have proposed study grants against the agreement to set up in the area. The government decided to generalize this initiative and will propose to the medicine students at a national level, from next year, a study grant against the agreement to set up in any underprovided area for the same length of time he got the grant.

Along with this measure, the distribution of the students for their last cycle of medicine studies has been reformed and will provide the regions with medicine students according to their need of physicians, which was not the case before because they were provided only according to their training capacity.