CONGRESS OF VILLEURBANNE

SAINT-POURÇAIN SECTION ON SIOULE THEMATIC

CONTRIBUTION

RESORB MEDICAL DESERTS
For access to healthcare for all citizens, everywhere.

Medical deserts are multiplying and getting worse. It is estimated that there are eight million French people living in these parts of the territory. As for the answer to be given by the public authorities, two schools are clashing.

Considering that incantations and incentives have so far failed to halt the process - even less to correct it - many are those who, overwhelmed, advocate "coercive" measures, the **most widespread being** the "selective conventionnement" of doctors at the time of their installation in private practice, according to the medical density observed on the territory concerned. Only those who settle outside the "overcrowded" areas could be covered by health insurance.

This measure is supposed to safeguard the principle of freedom of installation. But, considering that the system does not allow them, in certain cases, to practice other than in sector 2 (non conventionné), most doctors consider that this principle, to which they are particularly attached, is indeed eroded. In any case, the prospect of the implementation of this measure has always triggered particularly vigorous reactions until now. Governments have then retreated without it having been possible to respond calmly to the criticisms raised, particularly with regard to the supposed perverse effects or the ineffective or even counter-productive nature of the formula. No experimentation was even envisaged.

The public authorities therefore fall back on **so-called incentive measures** often presented in bulk, each of which is supposed to resolve the issue on its own, without, here again, serious evaluations of experiments conducted in one or another part of the territory having been carried out in a sufficient manner to allow for a generalization to be envisaged.

In fact, the minister in charge of health periodically launches one or more measures with an enthusiasm proportional to the relief he or she feels at having escaped the vindictiveness, or even the general strike, of the corporation. Which corporation is itself satisfied, as a matter of principle, to have made the government back down, even though it seemed determined, this time, to use great means to allow citizens to be simply cared for when they are ill.

The next step is generally as follows: the State and the CNAMTS agree to give their blessing to the desperate and often costly steps taken by certain local authorities whose means are inversely proportional to the inconveniences caused by medical desertification.

However, it is likely **that a more constant political will,** shared with professionals, combined with a real pooling of the corresponding expenses, as well as genuine monitoring and evaluations, would help to resolve this issue.

Incentives are very varied and can be grouped into a **few categories,** and can be appropriately **combined with each other**:

Medical studies.

The end of the numerus clausus has been decided. Considering the foreseeable and predicted decrease in the number of general practitioners over the last ten years in a country with a growing population, it may be difficult to understand why this decision was not taken earlier.
All the more so as the concrete effect will only be felt in about ten years.
The fact remains that while this contributes to answering the question of enrolment (provided that it is accompanied by an increase in the number of places offered at university) it does not address the distribution in the population or in the territories.

It is planned to **move away from the "hospital-centered" nature of** doctor training, to open it up to the human sciences, and even to "decompartmentalize" it in order to prepare practitioners for a less solitary exercise of their activity. This part, which is indispensable, will probably require a strong and constant political will to be effective.

Easier to implement within a reasonable time frame: increase the number of **internships** for residents in **under-resourced areas with** a general practitioner, encourage replacements in rural (or underserved urban) areas. If we want to make this type of medical practice attractive, we must start by making it known. If students only know about the CHU, why would they leave it?

Some recommend the creation of **a new training program in "local medicine" and its** specificities, in order to better ensure the quality of the transition from training to installation. After the first five or seven years of his career, carried out in this way, the young doctor could naturally change course.

The "**public service commitment contract" introduced** by the HPST law (2009), i.e., financial aid granted to the student in return for a commitment to work in an under-endowed territory, did not produce satisfactory results.

So it is sometimes proposed to put in place a formula whereby the student would be paid **during** his university course with the **obligation to work** for seven or ten years in a nursing home in an under-endowed sector. This arrangement worked very well for years for teachers (and continues for some civil servants).

Consideration of the current aspirations of young physicians.

Who wants to settle down in a desert?
First answer: in this "desert" there are inhabitants. That's why we need a doctor and that's why we need a doctor who is sure to be able to earn a decent living.

But this (young) doctor often has a spouse who wants to work there (or nearby), and children who go to school, college, high school. The whole family has hobbies.
This means **public services, comfortable housing, cultural and sports activities... It is** also true that public service workers also need a doctor. This is the whole issue of regional planning, organized by living areas, with the concern of attractiveness. It all makes sense.

The young doctor who settles in does **not want to practice in isolation and** fears the "overload" of work experienced by his predecessors, with consequences on family life, on the quality of the service provided and, sometimes, on the health of the practitioner.
He aspires to work **in multi-professional groups**, to be able to exchange with colleagues, to diversify his activities (prevention, care, training, interventions at the local hospital, at the EHPAD...).

Multi-professional care homes and health centers are an appropriate response, provided that they are carried out by professionals on the basis of a joint project, with the support of local authorities and, as often as possible, a privileged relationship with a local hospital.

The **territorial health professional communities** (CPTS), promoted by Minister Touraine, provide a framework conducive to these initiatives. They make it possible to develop preventive actions, to better ensure home care for the elderly, and to treat patients with chronic illnesses. They can also, **provided that they organize a permanent care service for patients from the very first call,** help to seriously relieve congestion in hospital emergency departments.

In order to be able to better organize their working hours and control their living conditions, whether in the city or in the country (there are needs everywhere), doctors are more and more attracted by **the status of salaried employee**, whether full-time or part-time. The **"mixed" remuneration** formula **(salaried** and fee-for-service) is often sought-after and makes it possible to practice in different locations in adapted forms, particularly to treat "medical deserts" in a flexible and diversified manner.

The experience of the department of Saône et Loire deserves interest: five health centers cover some fifteen loss-making territories with some forty salaried doctors (from a budget annexed to the department).
The State, for its part, is financing 400 salaried doctors in 2019, i.e. a fairly limited number, mainly to ensure the city-hospital link.

Improved efficiency of medical practice.

The use of **telemedicine makes it** possible, under certain conditions, **to optimize the use of medical time.** The equipment can be, for example, operated by a nurse or an assistant with a remote doctor, general practitioner or specialist.
But this implies a coverage of the territory by "very high speed broadband". However, medical deserts are most often also **digital deserts,** especially in the rural world.

Generally speaking, the **development of advanced practices (or** delegation of tasks), particularly for nurses, will greatly contribute to the efficiency of the system: regular patient monitoring, prescription of additional examinations, renewal or adaptation of certain medical prescriptions. It requires some regulatory measures, ongoing training actions and processes for validating acquired experience.
In addition, **pharmacists can dispense medicines without a compulsory medical prescription,** under certain conditions, or even give vaccinations by the same pharmacists, whose dispensaries are supposed to "cover" the entire territory and the entire population.

It is likely, even if their role does not always seem very clearly defined, that the recruitment of 4,000 **medical assistants,** including in under-resourced areas, will go in the same direction. They are in charge of supporting the doctors and saving them time... while waiting for the suppression of the numerus clausus to take effect.

Finally, after a great deal of trial and error and difficulties that were not only technical, the DMP (**shared medical record)** would be in the process of being implemented. It is still far from being truly operational, and it will take some time before it is generalized. It is, however, an indispensable tool for making the new patient treatment methods mentioned above a reality: less compartmentalized, more collective and more fluid.

The conditions for success.

Since situations differ from one territory to another and solutions require the mobilization or at least the good will of a large number of actors, it is not possible to rely solely on the RHA (regional health agency) and its "centralized" decision-making processes.
RHAs must play a role in providing impetus, guidance and support, with initiative and responsibility falling to local **health** committees **organized by catchment** area and bringing together elected officials, health professionals and user representatives.

Networked LRAs can also help committees build on successful local experiences.

Financing, which remains "the sinews of war", should not be an insurmountable difficulty. Until proof to the contrary, there is no reason why health care should not be covered by compulsory and complementary health insurance, which ensures fair remuneration for everyone in well-endowed (or even over-endowed) territories, and not in deficit areas.
In addition, RIF (Regional Intervention Fund) credits, for example, can be used to resolve specific difficulties. After all, it is a matter of ensuring equal access to health care for all citizens.

It will remain to address an issue so often neglected, that of the readability of the **organization of the system by** patients. **All** the actors are concerned by this question.

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