ACADÉMIE NATIONALE DE MÉDECINE

Press release*

RECOMMENDATIONS
of the French National Academy of Medicine
on poorly medicalized areas,
known as "medical deserts", in France

This document is the synthesis of the proposals made by the Academy Working Group report

(Rapporteurs: Pr. Patrice Queneau and Pr. Rissane Ourabah)

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The Academy proposes the following recommendations to promote and facilitate medical practice in poorly medicalized areas:

A– HOW TO DEAL WITH EMERGENCY?

By urgently setting up a 1-year Citizen Medical Service for all newly graduated doctors, due to the extreme seriousness of the practitionner shortage. This Citizen Service will be maintained as long as the shortage situation requires it. It would be organized in each territory by its ARS (Regional Health Agency) in coordination with the "local medical school".
This will be done within the framework of a salaried workforce and using the infrastructures provided by the territories.

B- OTHER MEASURES

I – *Restore medical time*

1- Professional measure:

Optimize task delegations to other healthcare professionals, including nurses, advanced practice nurses (IPA), midwives, pharmacists, other caregivers and, in the future, probable new healthcare professions. A multi-professional training is essential.
These task delegations must be part of care pathways coordinated by the practitionner in charge, while respecting the competence of each individual.

2- Administrative measures:

2.1 Relieve physicians of administrative time and give them back "caregiver time":

– by simplifying the fee scale rules and reimbursement methods by third-party payers (patients benefiting from Complementary Health Solidarity or State Medical Aid),
– by recruiting more medical administrative assistants, secretaries and IT staff, thanks to a sustainable financial support.

2.2 F**acilitate early settlements** by setting up a one-stop shop for the various administrative and supervisory bodies and a precise mapping of territorial needs.

2.3 Remove the administrative obstacles allowing work and retirement to be combined with social fees generating additional rights.

2.4 A**llow multi-site exercise and off-site consultations, as well as a proper use of telemedicine**

2.5 S**trengthen the safety of doctors in sensitive areas** (surveillance equipment, direct connections with police stations).

2.6 Reevaluate financially **home visits**, taking into account additional costs, and facilitate parking.

II P***romote and facilitate practice in poorly medicalized areas***

1- Strengthen the network of health centers in the territories
– by facilitating the physician grouping and the constitution of care teams in more diverse and flexible forms: health centers, multidisciplinary health centers (MSPs), with integration into professional territorial health communities (CPTS),

–by promoting projects from caregivers themselves, more adapted to local needs.

–by facilitating the setting up of a necessary permanence of care.

2-P**romote multi-site practice** as indicated above.

3- P**romote and facilitate first-time installation in poorly medicalized areas**, through financial incentives, in particular increased and secure over time installation bonuses...

4-I**ncrease the fees of all doctors** by 20% **in poorly medicalized areas**; this supplement will be maintained 2 or 3 years after the end of the classification as a poorly medicalized area. The additional cost for the Health Insurance system must be assigned outside the medical procedures overall budget.

5-S**trengthen links and coordination with hospital:**
– by better involving local hospitals: “every doctor must be able to have a hospital gown”,
– by encouraging hospital practitioners from university hospitals to relocate certain outpatient consultations to non-university hospitals,
–by encouraging university hospitals to set up networks of hospitals, themselves in contact with private practice.

6-M**aintain in all salaried positions conditions of exercise that favor patient care and doctor independence faced with** the profitability priorities of some financial groups.

III –Act urgently on the “numerus apertus” and training

1 – by i**mmediately and significantly increasing the "numerus apertus" and** adapting it to the real needs of territories thanks to a precise and updated mapping, including the number of doctors practicing part-time, those practicing a non-medical profession and those practicing very little or not at all. One consequence is that it takes on average more than two doctors to replace one retiring doctor.

2- by d**eveloping, from the 2nd cycle onwards, compulsory internships in poorly medicalized areas, with:**

–an increase in the number of outpatient internships in all specialties, as well as in the number of university internship supervisors (MSU)

– the creation of **tutors** to help and supervise all students, these tutors benefiting from a real university status, like the MSUs, allowing them to be paid and not compensated.

3- by d**iversifying the territorial and social origin of students** and motivating them through an information and support policy **starting in high school** (positive French and foreign experiences).

4– **If the creation of a 4th year of specialized studies (DES) in general medicine diploma is decided upon, by professionalizing it through ambulatory internships**:

– organized by the university medicine departments, and supervised by MSUs and tutors

– without any territorial obligation,

– with training in medical practice, management and taxation.

That year cannot be a solution to compensate for deficits in under-resourced areas.

5- I**mprove public service commitment contracts (CESP) by:**

- a better information on the terms and conditions of the contracts

- the support of each student by a motivated *"referent"*, supervising him/her throughout his/her studies and helping him/her to refine his/her professional project.

IV –Decentralize decision-making processes in the field of health care

– by organizing this decentralization in a concerted way between the doctors of the territories, the local elected officials, the representatives of patients and the ARS,

– by adapting the preferred decision-making level to the institutional level.

V –R***aise public awareness on the proper use of medicine***

All these measures designed to improve the care and ultimately the health of patients reinforce their request to participate in medical decisions within the framework of better health democracy. That implies:

– to inform the population of the service provided by the French healthcare system, with its scientific requirements, its complexity, its limits, its cost, but also the quality of its caregivers who exercise difficult professions with a high level of responsibility,

– to educate patients in the proper use of care pathways, “which includes” plutôt que “including” respecting appointments with doctors and other caregivers,
– to strengthen the therapeutic education of patients to make them responsible for their health, especially during chronic diseases.

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