Cour des comptes Chambres régionales & territoriales des comptes

TERRITORIAL ORGANISATION OF PRIMARY CARE

Thematic public report

Summary

May 2024

Summary

The French are finding it increasingly difficult to access primary care, to the extent that a large part of the country has been described as a "medical desert". Broadly defined by article L. 1411-11 of the French Public Health Code (CSP), primary care includes not only care provided by general practitioners and some specialists with direct access, but also advice from pharmacists, nursing care, physiotherapy, dental care and care provided by speech therapists and psychologists. The importance of this care - sometimes also referred to as primary or first- line care - has nevertheless been recognised and promoted for over forty years by the World Health Organization (WHO) and the Organisation for Economic Cooperation and Development (OECD)[1]. In France, it has been enshrined in a number of laws designed to improve the coverage of needs by teams of available and skilled primary care professionals, a factor recognised as decisive in the effectiveness of the healthcare system.

Increasingly limited access to primary care

In France, as in all developed countries, there is a growing imbalance between supply and demand for this type of care.

The supply of healthcare is the result of complex and contradictory changes in the number of healthcare professionals and changes in how these professionals work, in particular the reduction in the availability of evening and weekend medical attention slots.

Demand, meanwhile, is increasing due to the growing frequency of chronic pathologies, which are leading to an ever-increasing volume of so-called "scheduled" care (accounting for around 70 % of GP workload). Patients are also finding it increasingly difficult to find a response to their requests for so-called "unscheduled" care, due to overcrowded diaries and changing demands.

These tensions are reflected in a number of quantitative indicators: the average time taken to obtain an appointment with a doctor is getting longer, according to the data available (even when this is incomplete). The proportion of patients without a GP is increasing, as is the proportion of doctors no longer taking on new patients. Efforts to "reach out" to patients who live the furthest away from care facilities are coming up against the same difficulties, linked to the saturation of medical provision. Among patients without a GP, the proportion of the most disadvantaged (receiving C2S supplementary health insurance), which is higher, is also growing proportionately faster.

[1] With the Alma-Ata Declaration of 1978 on the place of primary care in health systems, these issues were identified almost 50 years ago by WHO. The OECD, for its part, has produced numerous reports drawing attention to the need to develop primary care.

Imbalance between care supply and demand: adverse consequences

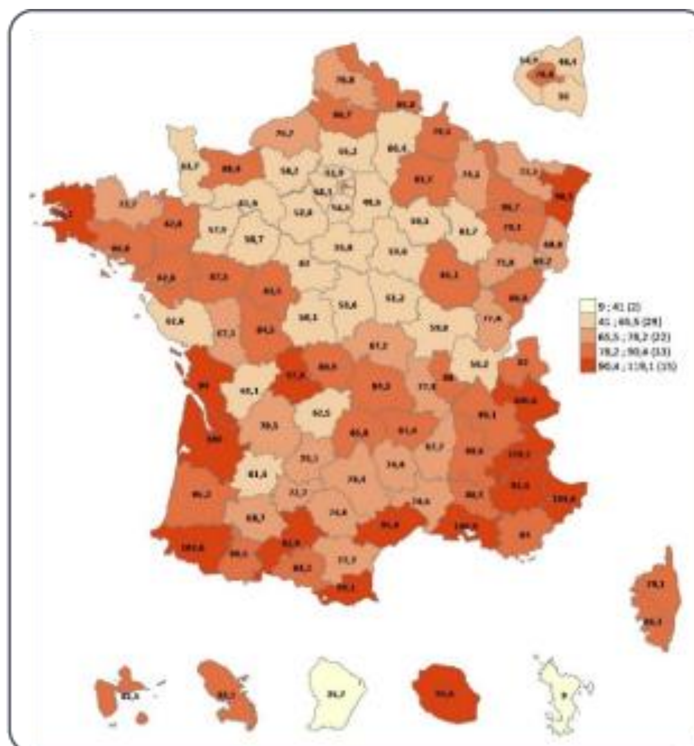
Source: Court of Accounts

More specific analyses relating to the Aveyron department, and even more so to the territory of New-Caledonia[2] show the extent of the shortcomings observed in certain territories, where primary care provision is very weak and the remoteness of these territories often makes travel to healthcare centres a lengthy process.

More generally, there are major inequalities in the geographical distribution of professionals, and these are worsening across the board: up to one-quarter of patients may not have a general practitioner (i.e. twice the average), and the rate of visits to A&E for non- serious incidents can be as high as 40 % in some areas such as the Ardennes, for example, according to the Grand Est region A&E observatory. Behind these data lies the risk of a deterioration in the relationship between healthcare professionals and patients, with the proliferation of appointments limited to a single "reason".

[2] Although healthcare is a territorial responsibility and therefore does not fall within the remit of the authorities in mainland France, an examination of the organisation of primary care in New Caledonia highlights pronounced differences in the situation between smaller provinces and territories, and the importance of an overall, coordinated strategy to meet the challenges associated with this first level of care.

Number of general practitioners, excluding specialist physicians, per 100,000 inhabitants in 2021



Source: CNAM

Successive, uncoordinated measures that are less and less focused on the areas that need them most

Since the end of the 1990s, various plans and measures have been deployed to improve the organisation and efficiency of primary care or to level out its geographical distribution.

The initial emphasis was placed on the "pivotal" role given to "referring" GPs and then "attending" GPs. “Care networks” have been set up to facilitate this referral and share the burden of patient follow-up. Various "pacts" or "plans" then sought to strengthen and better target the assistance given to healthcare professionals to encourage them to set up, or stay in, areas with a scarcity of doctors.

From 2010 onwards, the aim has focused more on developing so-called "coordinated" care structures: multi-professional health centres or multi-purpose medical health centres. More recently, priority has also been given to developing cooperation between healthcare professions and optimising (or 'saving') medical time. At the same time, a number of measures have been adopted, aimed at entrusting health establishments with tasks to support private practice primary care professionals.

These measures remained uneven. The July 2009 law on "hospitals, patients, health and territories (HPST)” had nevertheless established the principle of public responsibility for "organising primary care" and entrusted the regional health agencies with the task of implementing it, but they lacked sufficient legal or financial tools to build a common strategy.

The strategy outlined at national level, with the laws of January 2016 and July 2019, and then with the national health strategy for the years 2017-2022, has reaffirmed the essential nature of modernising and adapting primary care. However, this strategy has not been translated into measurable operational objectives. The reviews carried out count the number of schemes deployed and sometimes look at the amounts mobilised, but they provide little

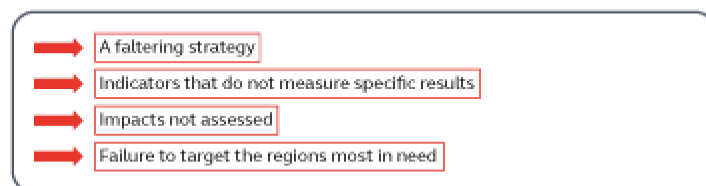
detail on the difficulties encountered and fail to compare the results obtained with the stated ambitions, or even the financial resources allocated, which are not consolidated. There is therefore a stark contrast between the ambition of the measures announced and the "feeling of abandonment" experienced by the inhabitants of the most vulnerable *regions*.

Whether we are talking about direct aid to healthcare professionals, designed to encourage them to set up or stay in vulnerable areas, or aid designed to develop coordinated practice between professionals or to save medical time, the sheer number of these schemes, some of which are still in the start-up phase, and their instability over time make it very difficult to consolidate the overall results. The appropriateness of these different tools is not guaranteed, particularly as the aid offered is not well targeted.

There are of course some positive developments, such as the introduction of the access- to-healthcare service. On the whole, however, from the dual point of view of access to care and reducing territorial and social inequalities in health, the aid provided, although more generous, is insufficient, judging by its low impact.

Furthermore, the possibility for professionals from different professions to organise structured cooperation is not sufficiently put into practice. A number of comparative studies show that the delegation of tasks from doctors to other healthcare professionals is lower in France than in other developed countries.

An insufficiently targeted policy



Source: Court of Accounts

A public policy to be "energised", with a clear statement of the results to be achieved

Based on the different tools and levers that are gradually being brought together, what method should be used to disseminate the most effective and efficient practices in the regions? The detailed analyses included in the regional reports help to make the avenues for change put forward in the national report more practicable. An analysis of the diverse public initiatives implemented within the scope of the *Châteaubriant* territorial professional health community (CPTS) in *Loire-Atlantique* shows, first and foremost, the value of hands-on initiatives adapted to local realities: in their multiplicity and diversity, the aid packages granted by local authorities to complement national schemes have contributed to a dynamic, albeit one that is still fragile or inadequate. Secondly, an analysis of the work carried out by the ARS (regional health agencies) and the CPAM (local sickness insurance fund) in the *Aveyron department* highlights some undeniable successes, particularly within the scope of the Aubrac CPTS, but also reveals that deficiencies persist or are even worsening in several catchment areas.

In order to consolidate the positive momentum already under way and make it sustainable, and above all to ensure that this momentum does not "overlook" entire regions, a comprehensive strategy is essential, designed to mobilise the available levers in an appropriate way, depending on the alerts identified in each region. As shown by the initial work undertaken in this area in the Aveyron department, the definition at department level of regional projects for primary care organisation, which are then broken down into CPTS (or, failing this, catchment areas), seems promising and is worth expanding. These projects, placed under the aegis of the departmental delegations of the ARS and the CPAM but open to partnerships,

should be clearly driven by a logic of results, based on a very selective set of "alert" indicators. National authorities, for their part, should adapt their tools to support and equip this approach by steering and regularly assessing its progress.

Existing subsidies would be adapted to support these regional projects, becoming more selective and targeting the most vulnerable areas or patients. More proactive measures are however essential in the most deprived areas, with the deployment where necessary of hospital health centres or secondary medical practices, supported by construction and development grants and - in the long term - by an obligation to practise part-time in underserved areas, in return for giving GPs and specialists the opportunity to set up practice in better equipped areas.

Recommendations

1. To include the reduction of social and territorial inequalities in health in the remit of territorial health plans *(ministry of health).*
2. To implement annual national monitoring of the policy for improving access to primary care, under the administrative supervision of the general secretariat of the ministries responsible for social affairs *(ministry of health).*
3. Within the framework of negotiations between the CNAM and private practice doctors, to provide for a proportion of the aid for the creation of jobs for medical assistants to be allocated separately, based on regional priority criteria (e.g. 50 %) *(ministry of health, CNAM).*
4. With a view to developing cooperation between healthcare professionals, to make aid to the different coordinated practice structures conditional on the signing of protocols *(ministry of health, CNAM)*.
5. To encourage doctors to come and work part-time in areas where there is a shortage of healthcare professionals: in the short term, by supplementing local authority aid for equipping secondary practices; and, in the longer term, by making any new set-up in areas with the best supply of doctors conditional on a commitment to work part-time in areas with the lowest supply *(ministry of health)*.
6. To offer hospital doctors working in hospital health centres the possibility of receiving remuneration partially indexed to their activity, under secure legal conditions *(ministry of health).*
7. In areas where there is a shortage of health professionals, to give hospitals a new task of general value, consisting of deploying multi-purpose health centres *(ministry of health).*