Equal access to healthcare: a mirage for millions of French people

Since the great scientific and medical advances, which are one of the great conquests of the 20th century, our country - and this is its greatness - has always made the health of its people one of its main concerns. Firstly, by establishing free medical assistance, and secondly, by providing assistance to the elderly, infirm and incurable deprived of resources. This concern is therefore at the foundation of our social covenant, which has justified its being confirmed in law until it has been consecrated full constitutional value. If it is a relative right (in the sense that it can only be a right to care and not an absolute right to perfect health), it cannot be a non-effective right.

However, more and more of our fellow citizens are encountering great difficulties in accessing local care. This divide, which has long been known in rural areas, is worsening and spreading to many peri-urban communities, as well as to working-class neighborhoods in the heart of metropolitan areas.

Today, access to healthcare for all French people, in all territories, is more than ever a priority. Proof of this is that the term "medical deserts" has now imposed itself in the public debate and on the political agenda. The health crisis that has been shaking our country for many months has made this necessity an emergency... vital.

These difficulties concern both access to the general practitioner/treating physician and to a specialist that sick, frail, elderly or handicapped people cannot do without. In some regions, they lead to waiting times that are far too long, eroding the fundamental right to health that each and every one of us has. A fundamental right that includes equal access to healthcare throughout the national territory. Today, in the best of cases, this right suffers from a variable-geometry application. Finally, it is more globally our model of social protection that is collapsing.

These difficulties in access to healthcare deepen already entrenched inequalities, be they economic, social or territorial. At a time when our health system and all health professionals have been on the front line for many months in the face of the Covid-19 epidemic, it is essential to rethink its organization and access to care.

I/ An alarming inventory of medical deserts in France

a) A massive phenomenon with well-known causes...

Over the last ten years and the so-called "Bachelot1" law, laws2 and "Health3" plans have multiplied in order to fight, among other things, against medical deserts. Repopulating territories without practitioners while respecting the principle of freedom of establishment for liberal professionals is a public health objective for all governments. So far without success. Difficulties and inequalities in access to care have been steadily increasing. This is a major concern of our fellow citizens.

[1] Hospital Reform, Patients, Health and Territories Act, enacted July 21, 2009
[2] "Fourcade" Act (2011), "Touraine" Act (2016), "Buzyn" Act (2016)
[3] Pacte Territoire-santé (2012), Plan Ma Santé 2022 (2018)

In some jurisdictions, getting a simple routine appointment with a general practitioner is a challenge. When it's not tens of kilometers that you have to swallow to get an appointment, it's months that you have to wait. This is the harsh reality for many French people. Difficulties of access are indeed multiple and of several orders. Whether they are spatial (travel time), temporal (waiting time), or socio-economic (cost, fatigue). Entire swathes of the national territory are in the process of desertification, as demonstrated by health geographer Emmanuel Vigneron.

Beyond the unbearable character that medical deserts represent in terms of access to healthcare, the scale of the phenomenon requires shock treatment from public authorities. Between 6 and 8 million French people live in a medical desert, i.e. between 9 and 12% of the French population. Although this is not a French specificity, the national situation is much more deteriorated than in other OECD countries. In fact, the latter countries have an average density of
2.8 doctors per 1,000 inhabitants in rural areas, compared to only 2.7 in France. Moreover, our country lags far behind northern European countries such as Sweden (3.8) and Finland (4.4). For a country that has put the principle of Equality at the frontispiece of its social and political order, this is too little.

Worse still, these difficulties seem to be increasing. Indeed, the DREES has shown that in 2018, 3.8 million French people lived in an area under-equipped in general practitioners. This is 1.3 million more than in 2014 (2.5 million)! This reflects a growing mismatch between the supply and demand for care. There are many explanations for this. Medical time is decreasing due to the overall decline in the number of active physicians due to the retirement of generations of physicians from the high numbers of doctors from the 1970s to 1980s. The suppression of the numerus clausus is still far too recent to be able to compensate for these difficulties in view of the time required to train future doctors. Today, one out of every two general practitioners is at least 60 years old. Retirements have been multiplied by a factor of 6 over the last decade alone. In 2024, nearly 7,000 general practitioners or specialists are expected to retire, only accentuating the difficulties already observed.

Source: Le Journal du dimanche, "Voici la carte des déserts médicaux", May 5, 2019, by Emmanuelle SOUFFI

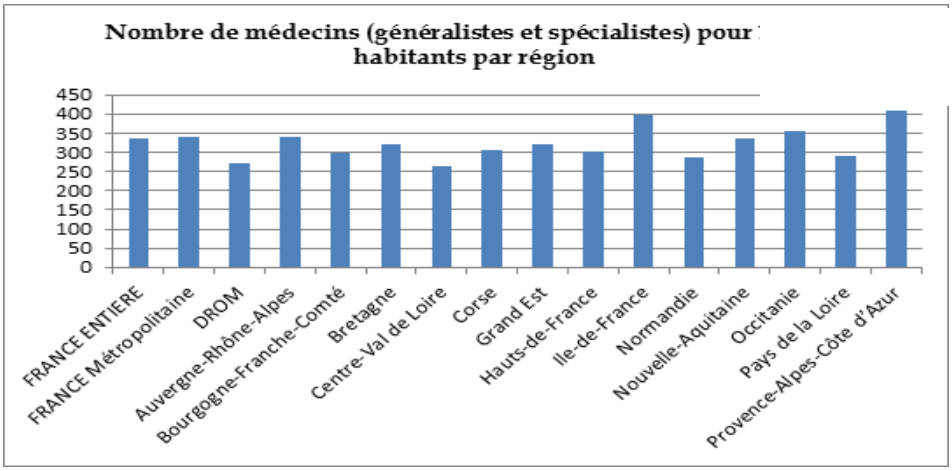
However, the total number of physicians, salaried and self-employed (all specialties combined) is still increasing. On the other hand, the number of general practitioners (practicing in cities or hospitals) has been stagnating for several years, leading to a rarefaction of their presence in many territories.

These difficulties are added to the increasing health care needs of the population and lead to the appearance of a "scissor effect". This increase is due in particular to the demographic vitality of our country as well as its aging.

Moreover, with regard precisely to the difficulties of access to a general practitioner, it seems that the growing disinterest of medical students in this profession only increases the difficulties observed. Indeed, they seem to want to specialize more and more, to continue their studies for a few years in order to obtain better remuneration.

Thus, between 2010 and 2017, the number of general practitioners decreased by an average of 12%, with strong territorial disparities. Thus, there is now a shortage of GPs in more than 11,000 municipalities, i.e. one city in three. Whereas our country used to train 13,000 doctors per year, it only trains 8,000 today.

b) ... and unevenly distributed over the entire territory (source DREES)



If medical desertification is a massive phenomenon that is tending to increase, it is marked by significant territorial disparities. Worse still, in terms of the distribution of private doctors, these disparities are widening from one territory to another. Thus, for example, the gaps between departments vary from 1 to 3 for general practitioners, as opposed to 1 to 8 for specialist doctors. For certain specialties, the gaps are even greater. This is notably the case concerning access to a pediatrician. In this case, the gaps vary from 1 to 24 from one department to another.

These inequalities in access to healthcare are all the more worrying and unjust because a growing proportion of the population lives in under-dense areas and the medical under-density is spreading from already under-dense areas.

Regions most affected by the shortage of general practitioners and specialists	Territories with the highest densities of general practitioners and specialists
West Indies-Guyana; Corsica; Centre-Val de Loire; Normandy; Auvergne Rhône- Alpes; Burgundy-Franche-Comté; Ile-de-France outside Paris	Southeastern France; Atlantic Arc; urban hospital-university departments, Eastern France

Rural areas and those on the outskirts of large cities are the most affected by medical desertification. Rural territories are home to a third of the population. Yet they are among the most under-endowed territories, even though their inhabitants are generally older than in the rest of the country and households are more likely to be made up of single people. In other words, where needs and dependency are greater than elsewhere, there is a significant shortage of doctors. This is an anomaly in our health care system. Peri-urban areas are also affected by medical desertification. For example, this is very prevalent in Seine-Saint-Denis. These difficulties of access to healthcare are therefore very strong in areas that are often the least endowed with public services and which experience the most injustice and inequality. The difficulty lies in attracting young doctors to these unattractive territories, while respecting the principle of freedom of establishment.

II/ Serious consequences for our social pact

a) Numerous closures of proximity structures

The consequences of medical desertification are multiple and numerous. Reducing the difficulties of access to urban medical care would not give a complete and accurate picture of the situation. With regard to access to hospital care, this may, for example, take the form of closures of local structures such as maternity wards. As Emmanuel Vigneron demonstrates, it should be noted that between 1997 and 2019, i.e. 22 years, 338 maternity hospitals out of 835 closed their doors.

b) Increasingly longer access times and more and more people are giving up care.

It can also result in an increasing amount of care being foregone, particularly due to longer appointment times and the geographical distance to practitioners. In 2018, the French will have access to an average of 3.93 consultations per year and per inhabitant, compared to 4.06 consultations in 2015 when, as we have said, the need for care is increasing.

Délai d'attente selon le professionnel contacté

En nombre de jours

	Moyenne	Premier décile	Premier quartile	Médiane	Troisième quartile	Dernier décile
Médecins généralistes	6	0	0	2	5	11
Médecins spécialistes						
Cardiologue	50	7	17	37	66	104
Dermatologue	61	6	20	50	92	126
Gynécologue	44	5	14	32	58	93
Ophtalmologiste	80	4	20	52	112	189
Pédiatre	22	0	0	8	34	64
Radiologue	21	1	4	11	27	48
Rhumatologue	45	3	13	31	59	96
Autre professionnel de santé						
Chirurgien-dentiste	28	2	7	17	37	67

Note • Les effectifs sont pondérés.
Lecture • En moyenne, chez les médecins généralistes, il s'écoule 6 jours entre la prise de contact et le rendez-vous. 25 % des prises de contact aboutissent à un rendez-vous dans la journée, 50 % en 2 jours ou moins et 50 % en plus de 2 jours ; 10 % des demandes se concluent par un rendez-vous dans un délai d'au moins 11 jours.
Champ • Personnes âgées de 20 à 71 ans en 2016, affiliées au régime général de la Sécurité sociale ou à une section locale mutualiste, France métropolitaine.
Source • DREES, enquête sur les délais d'attente en matière d'accès aux soins 2016-2017, résultats provisoires.

c) Increasing pressure on hospital services and SDISs

These difficulties also lead to increased pressure on the departmental fire and rescue services (SDIS) as well as on hospitals and emergency services. Particularly in the absence of general practitioners, they have become real adjustment variables. This is characterized in particular by an explosion in the number of emergency room visits, overloading departments and leading to overworked hospital staff. For nearly 20 years, the use of these services has been growing by an average of 3.5% per year. This is leading to restructuring and has a two-fold consequence: in areas where there are no hospitals nearby, private doctors are less inclined to settle because it makes their work more difficult. As far as the SDIS is concerned, this is manifested by an explosion in the number of interventions under the emergency personal assistance service (SUAP).

III/ Insufficient palliatives

For several years now, many leads have been launched in order to fight against this scourge of medical deserts. Firstly, with the creation of multi-professional health centers, which certainly make it possible to bring together professionals and facilitate their daily lives, but doctors still need to want to come and practice there, and in the long term. This is not the case everywhere, far from it.

Second, through various forms of incentives for physicians, particularly new graduates, to settle, at least for a time, in these under-endowed territories. It is clear that these incentives have no real overall effect, even if some local (e.g. the Pontgibaud multidisciplinary health center) or one-off successes may still exist. This has not even enabled us to cope with the retirement of a generation of

The aim is neither to reduce the progression of inequalities in access to health care, on the contrary.

The end of the numerus clausus, often put forward by advocates of immobility as the key to success in the fight against medical deserts, will not give any immediate results, as it concerns future doctors who will graduate in about ten years. And if the rules of free installation remain the same, it is a good bet that many of them will not choose to practice in under-endowed areas.

Through the proposals of our parliamentary groups, we have proposed since 2018, and unfortunately without success, to implement more coercive measures. For example, through a selective territorial convention. This would consist in limiting installations in overcrowded areas, on the principle of one departure for one arrival. To put it plainly, a private doctor (general practitioner or specialist) who wants to set up a practice could only be covered by an agreement in sector 1 if he or she settles in a deprived area.

This would indeed be a first step, although it is feared that many practitioners would still make the decision to move out of medical deserts.

For my part, I think that we must go further, by opening the reflection on the very principle of freedom of installation for new medical graduates. Many particularly essential professions do not benefit from this freedom and, through graduation or competitive examination rankings, are assigned an assignment for the first years of their careers. This is the case, for example, for teachers and police officers.

The situation is so urgent that we can no longer procrastinate. For the effectiveness of our responses to the challenge of territorial inequalities in access to healthcare must be fully involved in the implementation of balanced regional planning.

The principle of freedom of installation remains pre-eminent over the principle of equal access to care, whereas both should be put at the same level, in the general interest. While the Public Health Code states that "The fundamental right to health protection must be implemented by all available means", we have not yet tried everything.

Indeed, the inventive local initiatives carried out by the communities (health centres, use of salaried doctors, ambulant medicine, incentive schemes to attract young doctors such as housing assistance or financial support, do not entirely alleviate the difficulties observed. The French, like local elected officials, feel destitute and abandoned. In France, 87% of French people want to force doctors to settle in under-dense areas.

We must draw all the consequences of public health policies designed to combat medical desertification. We need more coercive measures, as the French are asking us to do. The survival of our social and republican pact is at stake, as well as the survival and the future of our health system.

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