Primary medical care in France

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With the upsurge of interest in primary medical care in the countries of the enlarged European Economic Community, I began comparing my own daily work and environment with that of our nearest neighbour, the general practitioner in France. I had read several general surveys of primary care in the countries of western Europe and decided to attempt[1] ' an understanding ' and a personal ' line of communication.'

In October 1974, I visited doctors in full-time practice to assess their attitudes to practice and the problems of their everyday work. My knowledge of French and of French medical terminology allows direct discussion, thus avoiding the artificiality of three-way conversation through an interpreter.

There are over 71,000 doctors in France[2] and the doctor/patient ratio is slightly better than our own. The French remain attached to the ethic of *Liberal Medicine*, receiving fees directly from the patient, preserving the reality of free choice of doctor by the patient and leaving the doctor less restricted by terms and conditions of service. Both general practitioners and specialists favour the system. Salaried doctors are employed in hospitals, health-centre clinics, in administration, and in industry. About 37 per cent of French doctors are in purely private practice, 28 per cent are salaried, and 35 per cent have part-time appointments in addition to their normal practice work.[2]

In France it is the solo general practitioner, working often from his own home, who is the primary physician. Group practices exist, but there are far fewer than in this country. In 1970, ten per cent of French doctors were working in groups. This percentage has risen considerably, encouraged by the work of the enthusiastic and vigorous Association Syndicale Nationale des Médecins Exercant en Groupe. Often groups are rather loosely knit, sharing the expenses of premises and secretarial staff, but retaining individual income and the doctor's personal clientele. Great stress is laid, I think rightly, on retaining a personalised style of practice.

The present Social Security Organisation was formed after the Liberation and is partly based on the ideas of the Beveridge Report of 1942. Most French doctors have accepted the agreement (*convention*) with the Social Security Offices, to respect a fixed scale of fees. A new agreement is due to be signed in 1975.

TABLE 1
EXAMPLES FROM CURRENT FEE SCALE

General-practitioner consultation	22 F. (* approx.	£2.15)
Specialist consultation	35 F. („	£3.40)
Psychiatric interview	55 F. („	£5.35)
Surgeon's fee (appendicectomy)	230 F. („	£22.45)
Removal of wax plug from ear	28 F. („	£2.75)

*Rate 22.1.75 falling from 10.25 F = £1

Since the Liberation in 1945, the Social Security Offices have been administered not by the State, but by a network of autonomous bodies on the principle that those

concerned should run their own schemes in the tradition of mutual aid.[3] The local offices record registrations and distribute benefits. Financial decisions are the responsibility of the national board which can decide to change contributions or alter benefit rates. For the present, the scheme is financed by earnings-related contributions from employers and employees and its independence is assured by the absence of financial participation by the state.

Under the general scheme, the patient is free to consult any doctor, not necessarily his own, as there is no formal system of lists. He may change his doctor during an illness, see several doctors, or consult a specialist directly, without referral. He consults a doctor who has accepted the standard fee scale, and is given a receipt. This can be taken directly to the Primary Social Security Office for cash reimbursement, or posted, in which case a draft is received in about two weeks. The same principle applies to prescription costs and to hospital and other expenses.

TABLE 2
PERCENTAGE OF REIMBURSEMENT OF TREATMENT EXPENSES
(General scheme)

Doctor's fees (consultations and visits)	75%
Tests, drug prescriptions, dental treatment	70%
Special or particularly expensive drugs	90%
Doctor's fees and cost of tests for hospital cases	80%
Hospital expenses (beyond 30 days: 100%)	80%
Long illness or costly treatment	100%

Over 98 per cent of the French population are covered by Social Security insurance. Self-employed and professional people have their own separate scheme. The poor do not pay for medical care or drugs and can also qualify for additional benefits from social aid offices.

In several special cases, there is no direct payment of medical expenses, the doctor's fees being paid by the social security body (*tiers payant* [4]). This system is also obligatory in all industrial accidents and diseases related to occupation.

Workload

The general practitioners I spoke to felt that on the whole they saw about the same number of patients per day as I do, but that about half were seen at home. Their working day seems more prolonged, but less intensive than mine. These impressions are supported by the figures given in a paper by Bertin.[5] His practice is in a Paris suburb and he lists all patients seen in the month of January 1969, which he considers fairly typical as there were no epidemics of influenza or other infectious disease. His statistics are compared in table 3 with a monthly average calculated from my own practice figures in the same year. There is also a marked similarity between the distribution of diagnoses he recorded and my experience.

TABLE 3

	Dr Bertin	*My practice*
Consultations	359	624
Visits	335	86
Total	694	710
Visits as percentage of total seen	*48%*	*12%*

Income and expenses of French doctors

It is difficult to make valid comparisons between net income and standard of living of practitioners in the two countries. To the differences in systems of payment and tax law, are added problems of varying exchange rates and varying rates of inflation. The spread of earnings seems much greater in France than in this country. Some doctors undoubtedly have very high earnings, but cannot be taken as representative of the profession as a whole.

A painstaking survey done by C.R.E.D.O.C.[6] (*Centre de Recherches et de Documentation sur la Consommation*) produced some interesting statistics. The survey was limited to earnings of non-salaried doctors, but includes fees and earnings from part-time appointments. The calculations were made from figures supplied by the tax office and the social security offices and took account of such factors as possible underestimation of receipts and overestimation of expenses and of the two different methods of fixing professional expenses for tax purposes (*Déclaration Controlée* and *Evaluation Administrative*).

The gross income of the average general practitioner rose from 99,297 F. in 1967 to 115,161 F. in 1969, i.e., an increase of about 16 per cent. Professional expenses during this period represented about 44·4 per cent of turnover.

In reading comparisons of incomes given in table 4, one should recall that these years saw a very substantial rise in the incomes of general practitioners in the United Kingdom after the Charter. With the high visiting ratio, car expenses of French general practitioner's were 14·5 per cent of total outgoings. There is no reimbursement of ancilliary staff salaries in France, so that doctors working in groups and having appointment systems are penalised in comparison with their less organised colleagues.

TABLE 4

COMPARISON OF INCOMES OF GENERAL PRACTITIONERS

	France 1967		*Great Britain* 1967/68	*France* 1969		*Great Britain* 1969/70
Gross	99,297 F[1]	£8,275[2]	—	115,161 F[1]	£9,600[2]	—
Expenses	44,087 F	£3,675	—	51,131 F	£4,260	—
Net income	55,210 F	£4,600	£3,943[3]	64,030 F	£5,335	£4,285[3]

[1] Recettes Professionelles des Médecins (C.R.E.D.O.C. 1973).

[2] Approximate sterling equivalent using exchange rate of 12 F to £1. (Rate 22 January 1975: 10.25 F = £1).

[3] Review Body Report (1972). (Halsbury). Average net income of unrestricted principals in general practice of all ages.

I was advised by the French Ministry of Health that earnings for 1973/74 had increased by at least 50 per cent of the 1969 figures. This was confirmed by the practitioners with whom I spoke. Averages of earnings in France are even less helpful than in the United Kingdom. City doctors perform more ' acts ' and have a different workload and higher income than rural practitioners.

The disparity in income between the two countries is worsened by the fall in value of sterling; 15 per cent down from the rate used in table 4. I estimate, therefore, that the average *gross* income of French general practitioners in 1973/74 was in the region of 173,000 francs (£16,000) a year.

Personal observations

My time was spent mainly in Paris, apart from a day trip to the residential suburb of Herblay to see a four-man general-practitioner group, and an enjoyable weekend at the village of Crécy-la-Chapelle, where I visited a single-handed country practitioner. In Paris I went to see a private group practice of specialists in the futuristic suburb of *La Défense*, and attended the fourteenth National Congress of French health-centre doctors. The latter provided many opportunities to discuss current medical topics with doctors from all over France and with representatives of patients' associations and administrators of the social security offices. Other visits were made to the Ministry of Health, a major French pharmaceutical company, and the flourishing Paris school of acupuncture.

Throughout my stay I was received with friendliness and courtesy and generous hospitality. I was aware of a strong interest, especially on the part of the group practitioners, to meet their British counterparts, and a disappointment that the British alone in Europe " do not come to our conferences, even those with simultaneous translation." In fairness, I must say that language barriers seem particularly formidable in France and I found an almost universal unwillingness to speak English.

Prescription charges

It may be useful to explain the system of prescription charges. Drug manufacturers are obliged by law to fix to each pack a label (*vignette* [4]), marked with a series of code numbers. When a prescription is dispensed, part of this label is removed from the pack and stuck to the prescription. Only prescriptions bearing cancelled ' *vignettes* ' qualify for reimbursement. The patient pays the full cost to the chemist and is normally reimbursed 70 per cent or, for special or particularly expensive drugs, 90 per cent.

Herblay group

It was with a group of general practitioners at Herblay that I felt most completely at home. I was invited to the weekly practice lunch at the group surgery and sat in on the discussion of day-to-day medical and management topics. Great interest was shown in the British system, particularly our very much higher ratio of secretarial staff and the part-reimbursement of staff salaries. The four doctors obviously envied our ability to benefit our practice from state subsidy, while avoiding being stifled by bureaucratic state control.

I found the group premises pleasant and bright, the consulting rooms having been furnished individually by the doctors in an almost luxurious style. The four partners spoke very frankly about their ideals, their income, and expenses. They were obviously happy with their choice, but were apparently making a substantial financial sacrifice to support the high running costs of this type of practice. As expected, an appointments system is used and a good system of record keeping maintained. The group employ a secretary and a receptionist and keep a well-equipped treatment and emergency room.

Conclusions

Many of the problems of primary care in France appear common to both countries. There is a shortage of doctors in general practice. A survey [7] of students' intentions showed only 21·5 per cent intended to become and remain general practitioners. Students tend to prefer specialist practice as fees are higher and there is more ' prestige '. The commission of the Health Ministry dealing with item-of-service fees, numbers only one family doctor among its 31 members. The proportion of specialists in France rose from 33 per cent [8] in 1966 to 42 per cent in 1969 and is still rising. I spoke to some trainee psychiatrists who did part-time locums in general practice. They had found the general-practitioner workload and working conditions unacceptable.

The medical faculties were least traumatised by the disturbances of May 1968 which shook the French university system. They did however benefit directly from the infusion of fresh money to finance reforms. The medical course now consists of three *cycles*:

(a) The first *cycle* lasts two years with a competitive examination at the end of the first year.

(b) The second *cycle* lasts four years, at the end of which there is a *stage interné* in a hospital, which lasts a year.

(c) The third *cycle* represents postgraduate training.

Regrettably, the great teaching potential of general practice remains relatively neglected. I was told of involvement by general practitioners in teaching at Nancy. In Paris (*Unité d'Enseignement et de Recherche de Bobigny*), part-time general practitioner tutors are involved in undergraduate and postgraduate teaching and there is a system of student attachments to practices. There is also a three-year postgraduate diploma course.[9]

Postgraduate refresher courses are organised for general practitioners. The Paris Faculty of Medicine runs evening classes and films and there are late-night television broadcasts for doctors. The famous clinical meetings, the (28) *Entretiens de Bichat*, were in progress when I was in Paris and thousands of doctors attend from all over France and from abroad. Despite these facts, I am left with the impression that among working general practitioners these courses are less relevant to general practice, less regarded, and less used than in this country.

As in this country the major problems in the field of medical care are economic and political. The present social security system, which appears to have been on the whole satisfactory, is creaking ominously. The Government is seeking a unified system and, to aid acceptance, has offered a subsidy of one year's revenue from taxes on alcohol (about 4,000 million francs)! The idea of subsidy represents a major reversal of the health and social security policy of the last 30 years. The proposals have met with suspicion on many sides, not least from the Communist C.G.T., and other large unions.

Changes are also taking place, especially in group practice, in the attitude of practitioners to the direct payment of fees. Some [10] feel that the progression towards state responsibility for personal health care is ineluctable, as is the state control of expenditure on personal medical care. The doctor cannot be free to fix his fee while the patient's reimbursement is fixed centrally. Fees can be discussed only with the paymaster—the state.

The attitude of the patient to medical care in France seems more individualistic and ' demanding ' than in this country. While it is possible to consult several different doctors, in fact this is rarely done and patients show a high degree of loyalty to their ' own ' doctor. Patients are more likely to see a specialist at his home or clinic than in a hospital. They tend to associate outpatient departments and public hospitals with low income or with serious or terminal disease.

The comments of French people living in the United Kingdom, who have known both systems of care, are salutary. They are, of necessity, the comments of a cultured, vocal, and relatively affluent group. The attitude of the British doctor is thought to be rather ' off-hand ' though I heard no complaints of the clinical standards. British doctors are not thought to over-prescribe as is felt to be the case in France. Hospital inpatient care in this country is highly thought of, especially as it does not involve the patient in expense.

What is the likelihood of integration of foreign doctors, including British, into the French system? Formerly, to practise medicine in France a doctor had to have a French medical diploma, be a French citizen, and be enrolled at the *Conseil de l'Ordre*

des Médecins. It is now possible (Décret de 21 mai 1974) for doctors, dentists, and midwives holding a recognised foreign diploma to sit an examination which will qualify them to practise in France. In any case, reciprocity and the free movement of doctors within the EEC may soon be a reality.

Language difficulties will probably continue to be the main bar to immigration, at least for a time, though we must not forget that there is a substantial number of general practitioners in this country whose native language is not English. The earliest changes will probably be the entry of German speaking doctors to Alsace-Lorraine and Italians to the South of France where there is a significant Italian population. British doctors moving to France would be most at ease among the protagonists of group practice. It seems to me unlikely that there will be much movement of French doctors to the United Kingdom.

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NITRAZEPAM (MOGADON) DEPENDENCE

The patient developed an intense dependence on nitrazepam after its use in treating insomnia. She finds herself unable to live a normal life without this drug. This case shows clearly that nitrazepam dependence occurs. Symptoms of depression, anxiety and agitation occurred immediately after the drug was discontinued and on two occasions were relieved by its reinstatement; they were probably withdrawal symptoms. It seems advisable, therefore, when prescribing nitrazepam to keep in mind the vulnerable personality of the patient.

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PATIENTS' ATTITUDES TO HEALTH CENTRES

Nine surveys of patients' attitudes to health-centre practice (eight in England, one in Northern Ireland) have been reviewed, with one survey covering attitudes to all types of practice.

There was general approval of health centres, which increased with familiarity with the system. The disapproving minority included a higher than expected proportion of the socially disadvantaged. Areas meriting particular attention from those providing services from a health centre include the appointment system, the reception procedure, and publicising the services available, particularly the out-of-hours arrangements.

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