Physicians' Working Conditions in French Health Care System

SESSION 4:
Salary
Private practice
Continuous Medical Development
Staffing & Workload

Dr. Claude WETZEL

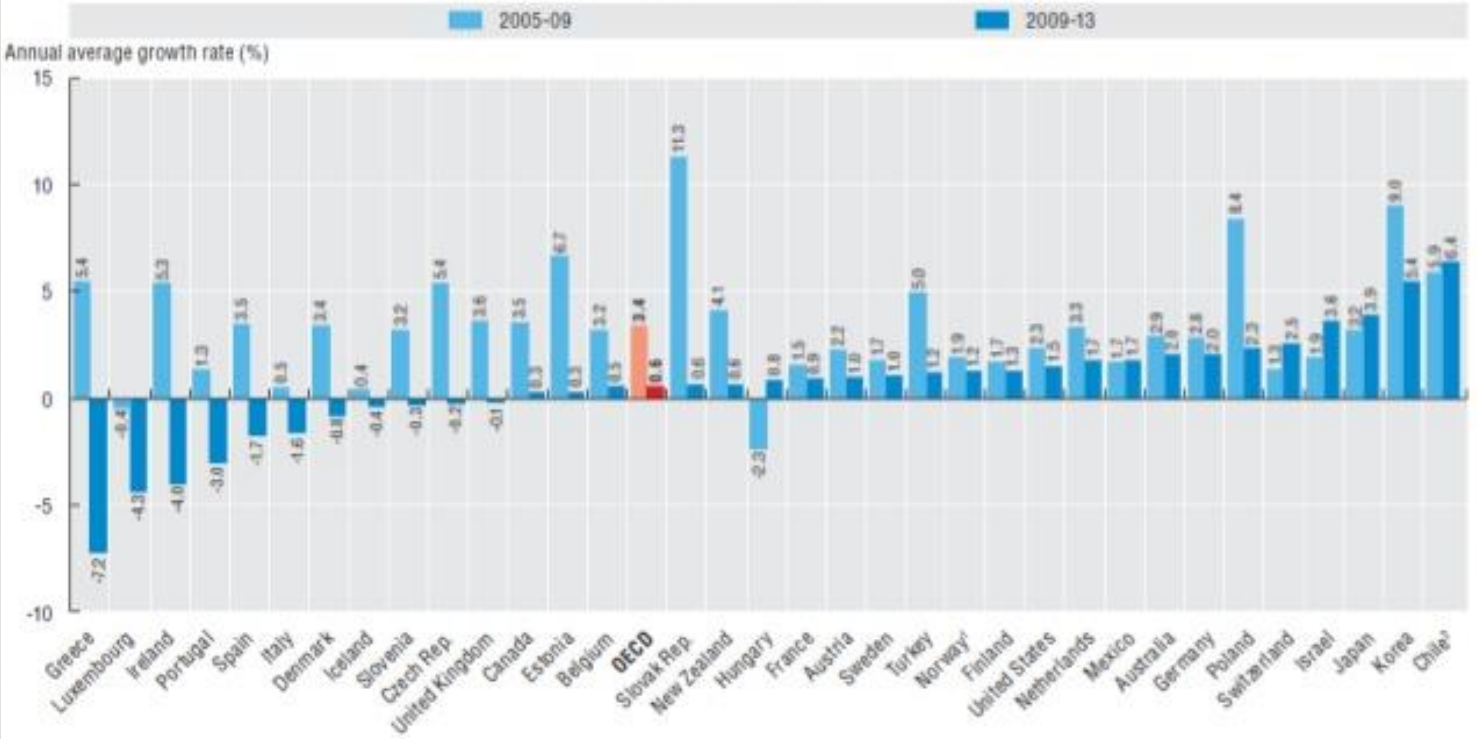
ANAAO/ASSOMED & SNR Fassid Conference

Genoa, April 8/9, 2016

ECONOMICAL ENVIRONMENT

Several European countries hard hit by the economic crisis have cut their health spending since 2009

Annual average growth rate in per capita health expenditure, real terms, 2005 to 2013 (or nearest years)

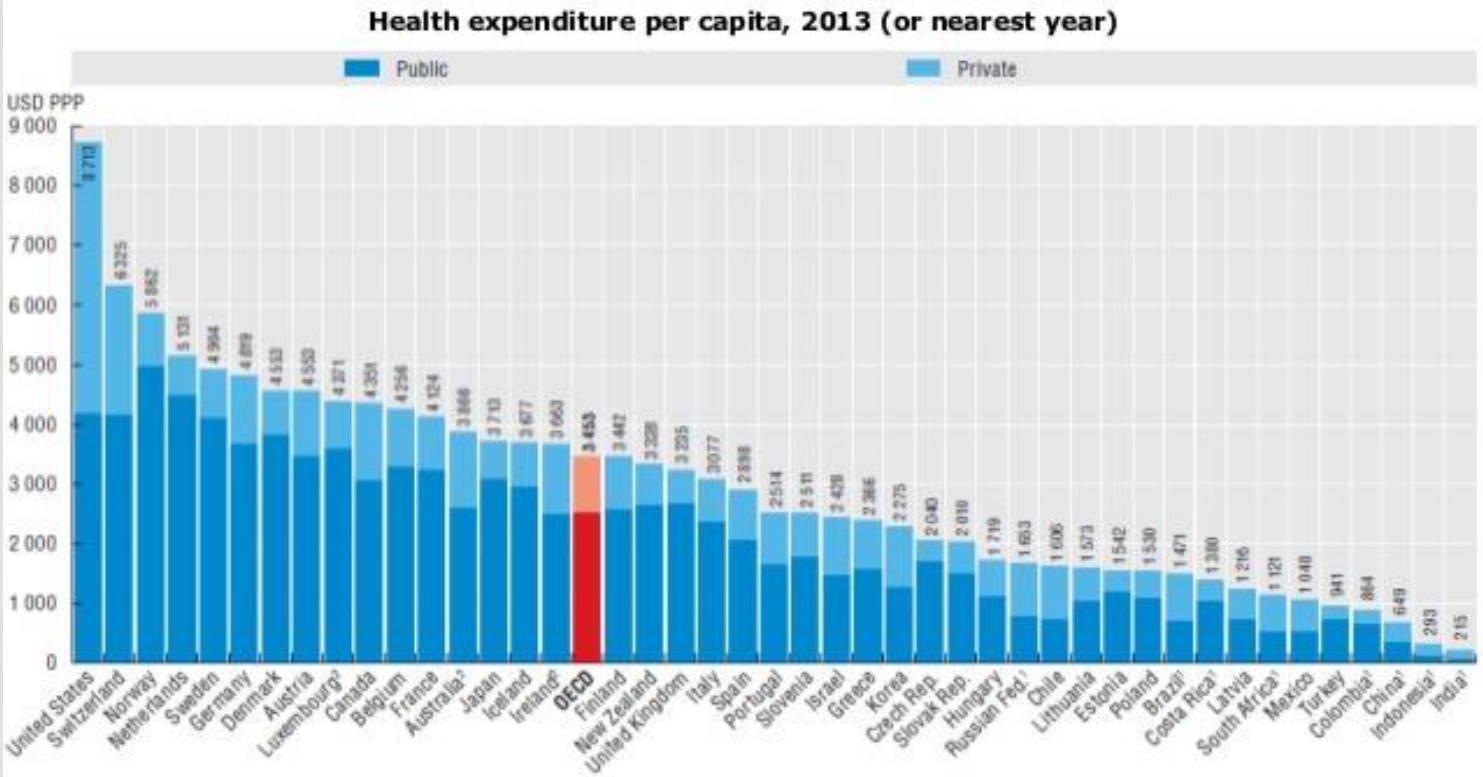


1. Mainland Norway GDP price index used as deflator. 2. CPI used as deflator.

***Source*: OECD Health Statistics 2015, OECD**

HEALTH EXPENDITURES

Health expenditure per capita varies widely across OECD countries. The United States spends two-and-a-half times the OECD average



Note: Expenditure excludes investments, unless otherwise stated.
1. Includes investments.
2. Data refers to 2012.

***Source*: OECD Health Statistics 2015, OECD; WHO Global Health Expenditure Database.**

MEDICAL SALARIES IN PUBLIC HOSPITALS

EMOLUMENTS BRUTS MENSUELS des PH au 01er juillet 2010

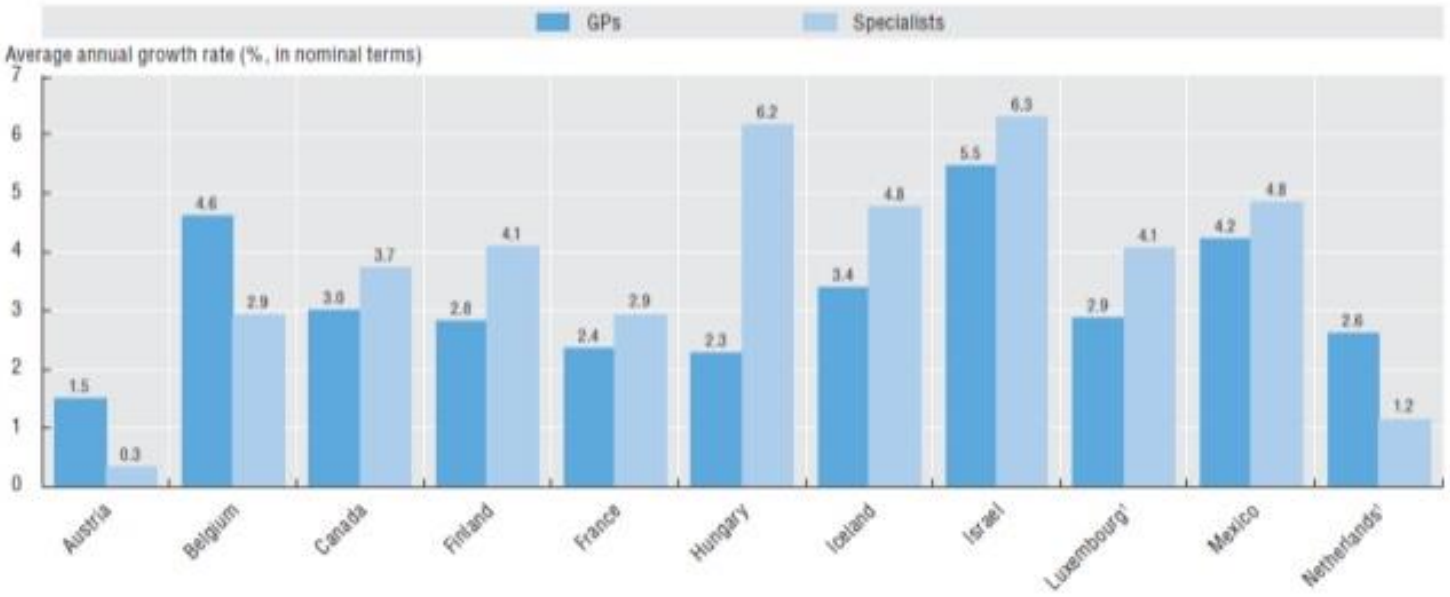
(arrêté du 12 juillet 2010 - J.O.R.F. du 21juillet 2010)

	PH Temps Plein		PH Temps Partiel pour 6 ½ j. hebdomadaires		PH Attaché pour 10 ½ j. hebdomadaires		PAC *(échelon = niveau)*	
1er échelon	*1 an*	4 081,55 €	*1 an*	2 448,93 €	*1 an*	2 507,05 €	*1an*	2 289,71 €
2° échelon	*1 an*	4 150,82 €	*1 an*	2 490,49 €	*2 ans*	2 637,02 €	*2 ans*	2 637,02 €
3° échelon	*2 ans*	4 247,82 €	*2 ans*	2 548,69 €	*2 ans*	2 870,76 €	*2ans*	2 870,76 €
4° échelon	*2 ans*	4 358,65 €	*2 ans*	2 615,19 €	*2 ans*	3 244,02 €	*2 ans*	3 244,02 €
5° échelon	*2 ans*	4 552,62 €	*2 ans*	2 731,57 €	*2 ans*	3 517,09 €	*3 ans*	3 517,09 €
6° échelon	*2 ans*	4 871,29 €	*2 ans*	2 922,77 €	*2 ans*	3 688,43 €	*4 ans*	3 688,43 €
7° échelon	*2 ans*	5 217,66 €	*2 ans*	3 130,60 €	*2 ans*	3 923,27 €	*retraite*	3 923,27 €
8° échelon	*2 ans*	5 383,92 €	*2 ans*	3 230,35 €	*2 ans*	4 081,55 €	**PC** *Art. R.6152-416 du CSP* pour 10 ½ j. hebdomadaires	
9° échelon	*2 ans*	5 577,89 €	*2 ans*	3 346,73 €	*2 ans*	4 150,82 €		
10° échelon	*2 ans*	5 993,54 €	*2 ans*	3 596,12 €	*3 ans*	4 247,82 €		
11° échelon	*2 ans*	6 242,93 €	*2 ans*	3 745,76 €	*4 ans*	4 358,65 €	*Sauf 3° et 6° art.R.6152-402* ≤ 4 794,51 €	
12° échelon	*4 ans*	7 097,42 €	*4ans*	4 258,45 €	*retraite*	4 552,62 €		
13 ° échelon	*retraite*	7 411,62 €	*retraite*	4 446,97 €			*3° art. R.36152-402* ≥ 2 637,02 € et < 2 870,76 €	
Indemnité d'engagement de service public exclusif	487,49 €						*6° art. R.6152-402* ≤4 794,51 € ou ≤7 411,62 €	
Indemnité pour activité exercée sur plusieurs établissements*	415,86 € *(les PC ne peuvent pas bénéficier de cette indemnité)* ***=***indemnité d'activité sectorielle et de liaison pour les psychiatres*							

REMUNERATION OF SPECIALISTS IN OECD

The remuneration of specialists has grown more rapidly than that of generalists in many countries, but not all

Growth in the remuneration of GPs and specialists, 2005-13 (or nearest year)



1. The growth rate for the Netherlands and for Luxembourg is for self-employed GPs and specialists.

***Source*: OECD Health Statistics 2015, OECD**

EMOS' SALARY GOALS

- **Increase hospital specialists wages**
  - **GDP per capita EU (in USD 2014)**
  - **(based on Purchasing Power Parity *Eurostat data)***

Germany 45,802 France 38,847 Italy 34,706 Portugal 28,392 Bulgaria 16,617

  - **French hospital doctors average gross income (35 years career)**

5,700 €/month (specialist)

48 h/week working time, according EWTD

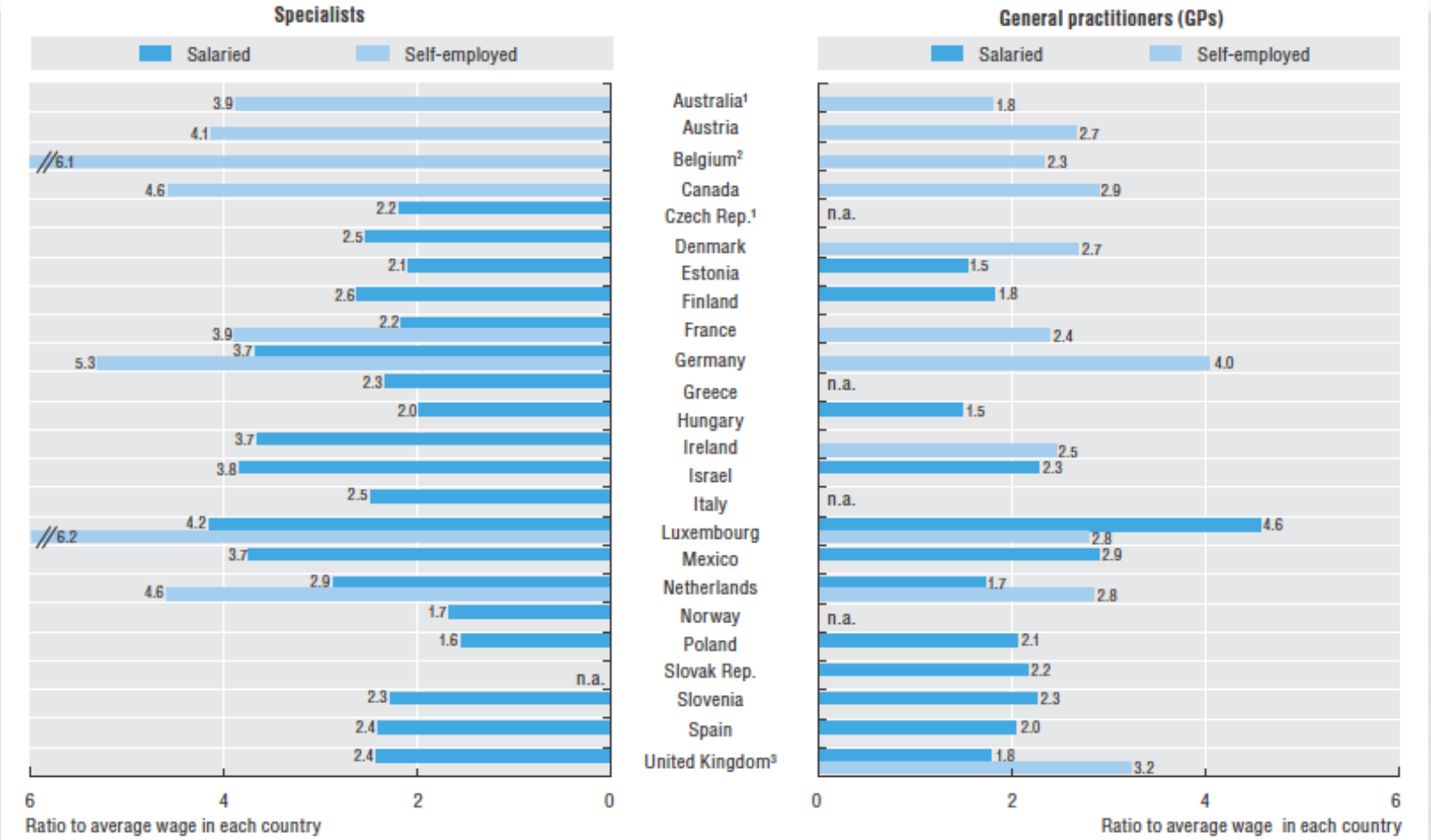
on-call duty payment not included

before taxes and social security contribution

salaried specialists average gross income in Europe

> target: 3 x average gross monthly salary

REMUNERATION OF DOCTORS RATIO TO AVERAGE WAGE, 2013 (OR NEAREST YEAR)



1. Physicians in training included (resulting in an underestimation).
2. Practice expenses included (resulting in an over-estimation).
3. Specialists in training included (resulting in an underestimation).

Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

ON-CALL & STANDBY DUTIES PAYMENT

INDEMNITÉS « continuité des soins et permanence pharmaceutique » au 1er juillet 2010 :

(arrêté du 12 juillet 2010 – J.O.R.F. du 21 juillet 2010)

Indemnité de sujétion correspondant au temps de travail effectué dans le cadre des obligations de service :	
- pour une nuit, un dimanche ou jour férié	**264,63 €**
- demi nuit ou samedi après-midi	**132,31 €**

Période de temps de travail additionnel accompli ***de jour*** du lundi matin au samedi après-midi inclus sur la base du volontariat et au-delà des obligations de service hebdomadaires :		**Période de temps de travail additionnel** accompli ***la nuit, le dimanche ou jour férié*** sur la base du volontariat et au-delà des obligations de service hebdomadaires :	
- pour une période	**317,55 €**	- pour une période	**473,94 €**
- pour une demi-période	**158,77 €**	- pour une demi-période	**236,98 €**

Astreinte opérationnelle (A.O.) :		**Astreinte de sécurité** (A.S.):	
- indemnité forfaitaire de base	**42,13 €**	- indemnité forfaitaire de base	**30,54 €**
- pour une demi-astreinte	**21,05 €**	- pour une demi-astreinte	**15,29 €**
		- cumul 4 semaines	**427,60 €**
- **FORFAITISATION**	**187,70 €**	- cumul 5 semaines	**549,78 €**

1er Déplacement (A.O., A.S.), et **déplacement Exceptionnel**	**65,41 €**
à partir du 2e déplacement (A.O., A.S.)	**73,73 €**
Déplacement(s) > 3H (au cours d'une ½ astreinte) + astreinte ð ½ période de temps de travail additionnel	
- de jour	**158,77 €**
- de nuit, dimanche ou jour férié	**236,98 €**
Maximum pour une A.O. ou une A.S. = PTTA de nuit ou réalisés au-delà des obligations de service hebdomadaires	**473,94 €**

(pour rappel : impossibilité de cumul entre indemnités de sujétion et indemnités de période de temps de travail additionnel)

PRIVATE PRACTICE IN PUBLIC HOSPITALS

- 20% of the working time maximum
- Royalty rates (to be refunded to the hospital budget)
  - Consultations: 16% for teaching hospitals, 15% for other hospitals
  - Acts other than imaging, radiotherapy, nuclear medicine, biology 25% for teaching hospitals, 16% for other hospitals
  - Acts of imaging, radiotherapy, nuclear medicine, biology: 60% for teaching hospitals and other hospitals
- A compensation for exclusive commitment to public service is paid for consultants who undertake, for a period of three years renewable, not to exercise a private professional activity = 487,49 €/month (since 2010)

WORKING CONDITIONS: WHEN THE WAGES TAKE PRECEDENCE OVER HEALTH

There are still allowances for risks, paid in compensation of harmful effects. And these recompenses remain an obstacle to reduce harmful effects, the company and the employee having found a financial compromise conditioned by their persistence. They also in the long term represent a genuine trap for the employee, who will have to choose between his level of wages and his health if this is degraded.

It becomes urgent to abandon this no-choice between health and remuneration. […] It would also be necessary to guarantee true wages for those who work. Because if health does not have a price, work has one.

Santé & Travail; 69; February 17, 2010

The contract is the trend

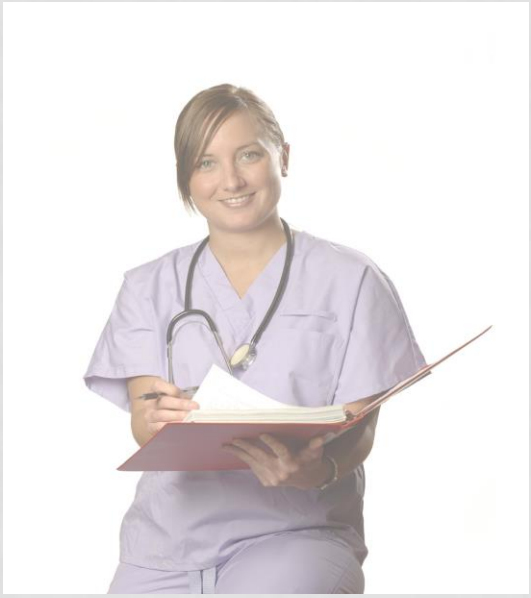
CONTINUING PROFESSIONAL DEVELOPMENT HEALTH ACTS JULY 2009 AND JANUARY 2016

- CPD aims to maintain and update knowledge and skills and improve practices. It is an obligation for health professionals.
- Every healthcare professional should justify over a period of three years, its commitment to CPD approach involving actions of training, analysis, evaluation and improvement of its practices and risk management. Engagement in an accreditation process is a commitment to continuing professional development approach.
- Deployment in 2013, under the responsibility of the French Medical Chamber and the Hospital Medical Councils
- Objectives:
  - Improving the quality and safety of care by:
    - Evaluation of professional practices
    - Acquiring or improving knowledge
  - Supporting the development of joint actions of medical personnel

Correct financing of CPD is not realised in France

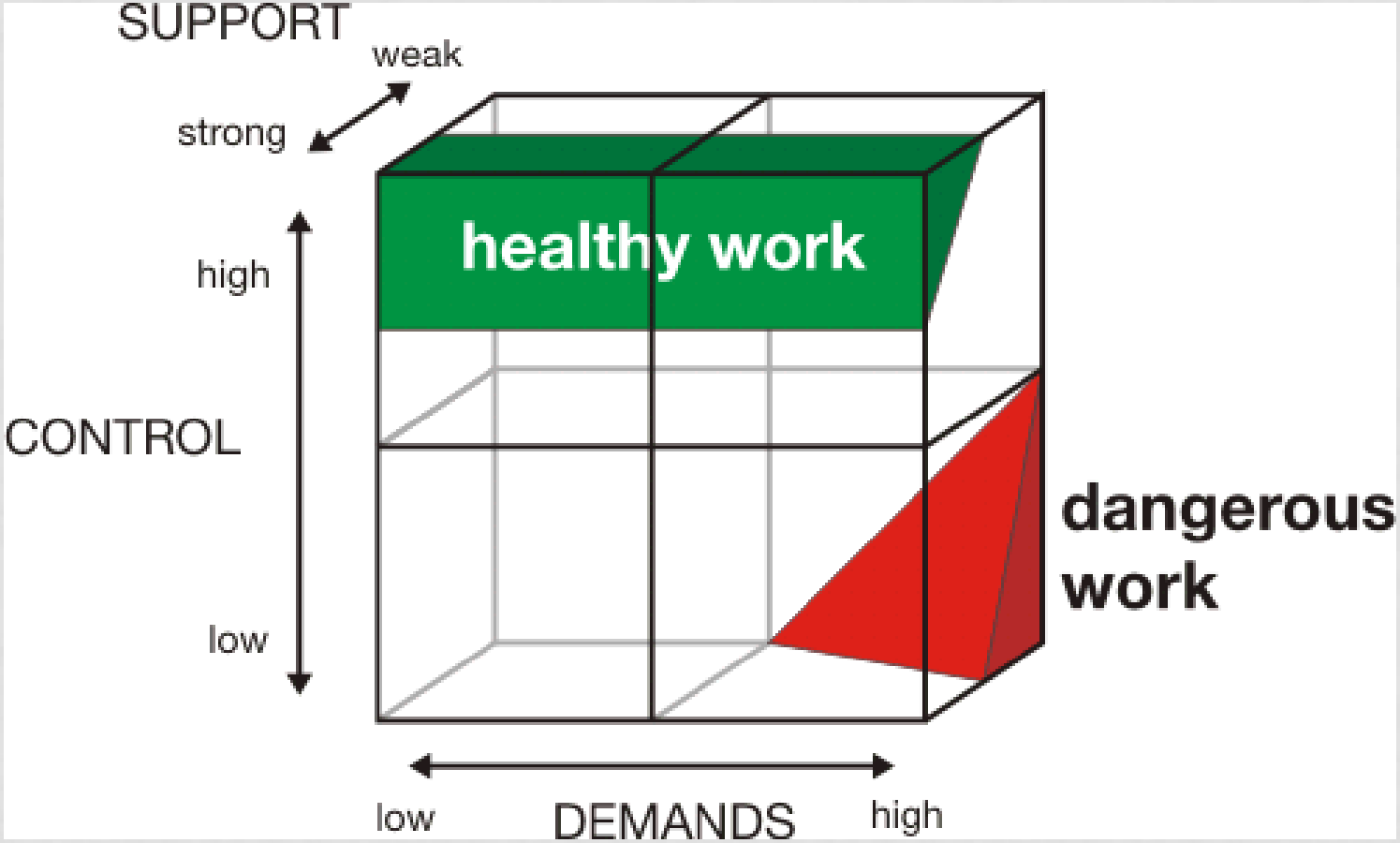
APPROPRIATE JOB AND PERSON MATCH

- Sustainable workload
- Choice and control
- Recognition and reward
- Supportive work community
- Fairness, respect and social justice
- Clear values and meaningful work



C Maslach & MP Leiter, The Truth About Burnout, 1997, Jossey-Bass Publishers

KARASEK & SIEGRIST MODELS



Siegrist J, Unfavourable health effects of high effort/low reward conditions Newspaper of Occupational Health Psychology, 1996

MODERNISATION OF WORKING CONDITIONS

Management and law-makers always try very hard, unsuccessfully, to

- import within the private sector the commitment and loyalty of civil servants
- whereas the very same undergo an offensive of these same values under the attacks of management logic

Linhart D.; Travailler sans les autres; Seuil Edit. 2010

Equity Compassion Solidarity Fraternity
Social justice Social cohesion

Healthcare and medicine are not commercial activities (ethical values)

NEW-TAYLORISM IN HEALTHCARE

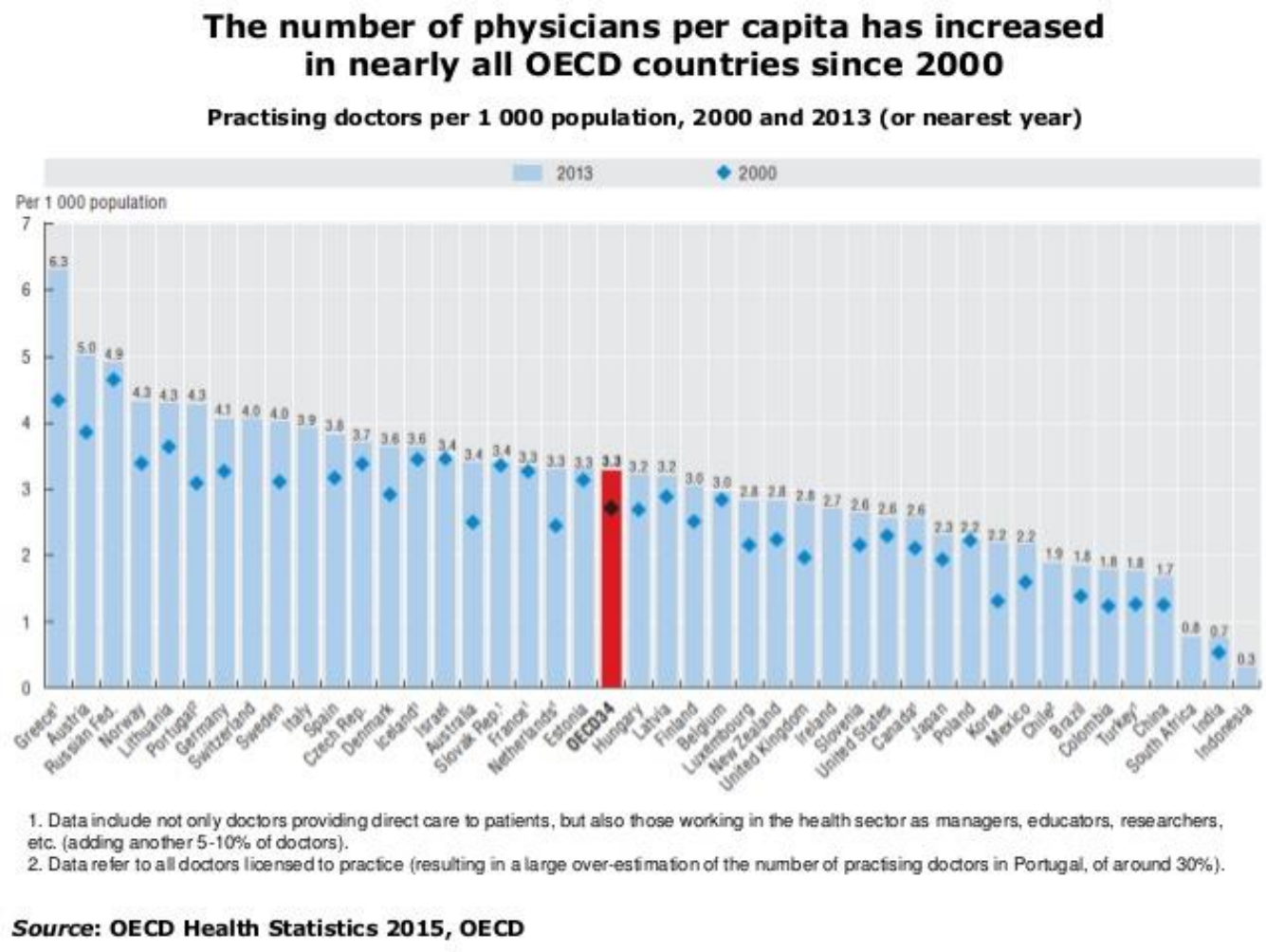
In the majority of private and public services we notice:

- Intensification of work with multiplication of constraints
- Suppression of "unproductive times "
- Organization of work in a defined time limit
- Regulation of standardized procedures

Mateen FJ, Dorji C; Mental Health-care worker burnout and the health imperative. Lancet. 2009 Aug 22;374(9690):595-7.

Cole TR, Carlin N; The suffering of physicians. Lancet. Oct. 2009 24;374(9699):1414-5.

MEDICAL DEMOGRAPHY

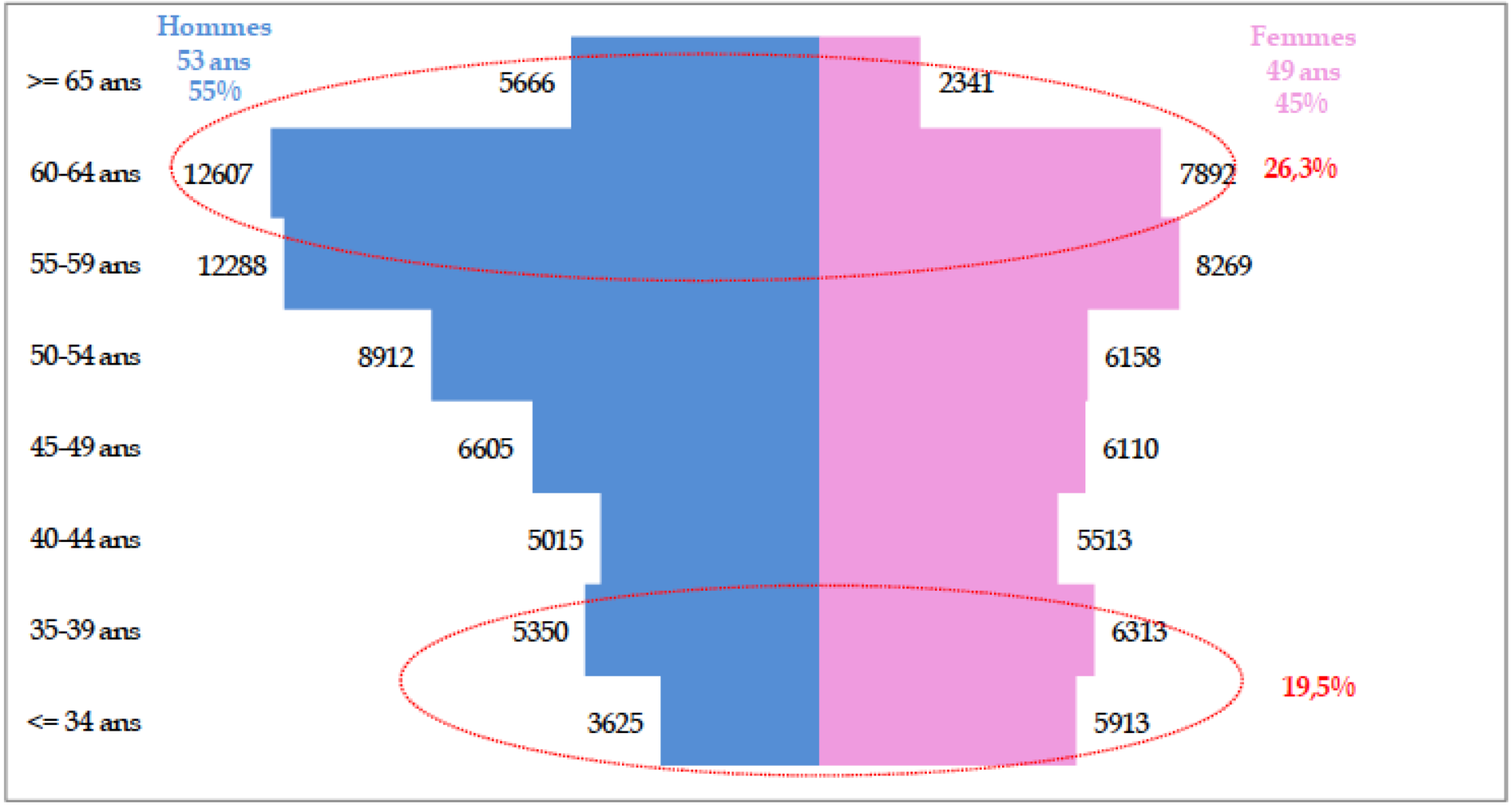


1. Data include not only doctors providing direct care to patients, but also those working in the health sector as managers, educators, researchers, etc. (adding another 5-10% of doctors).
2. Data refer to all doctors licensed to practice (resulting in a large over-estimation of the number of practising doctors in Portugal, of around 30%).

***Source*: OECD Health Statistics 2015, OECD**

AGE AND GENDER OF MEDICAL SPECIALISTS

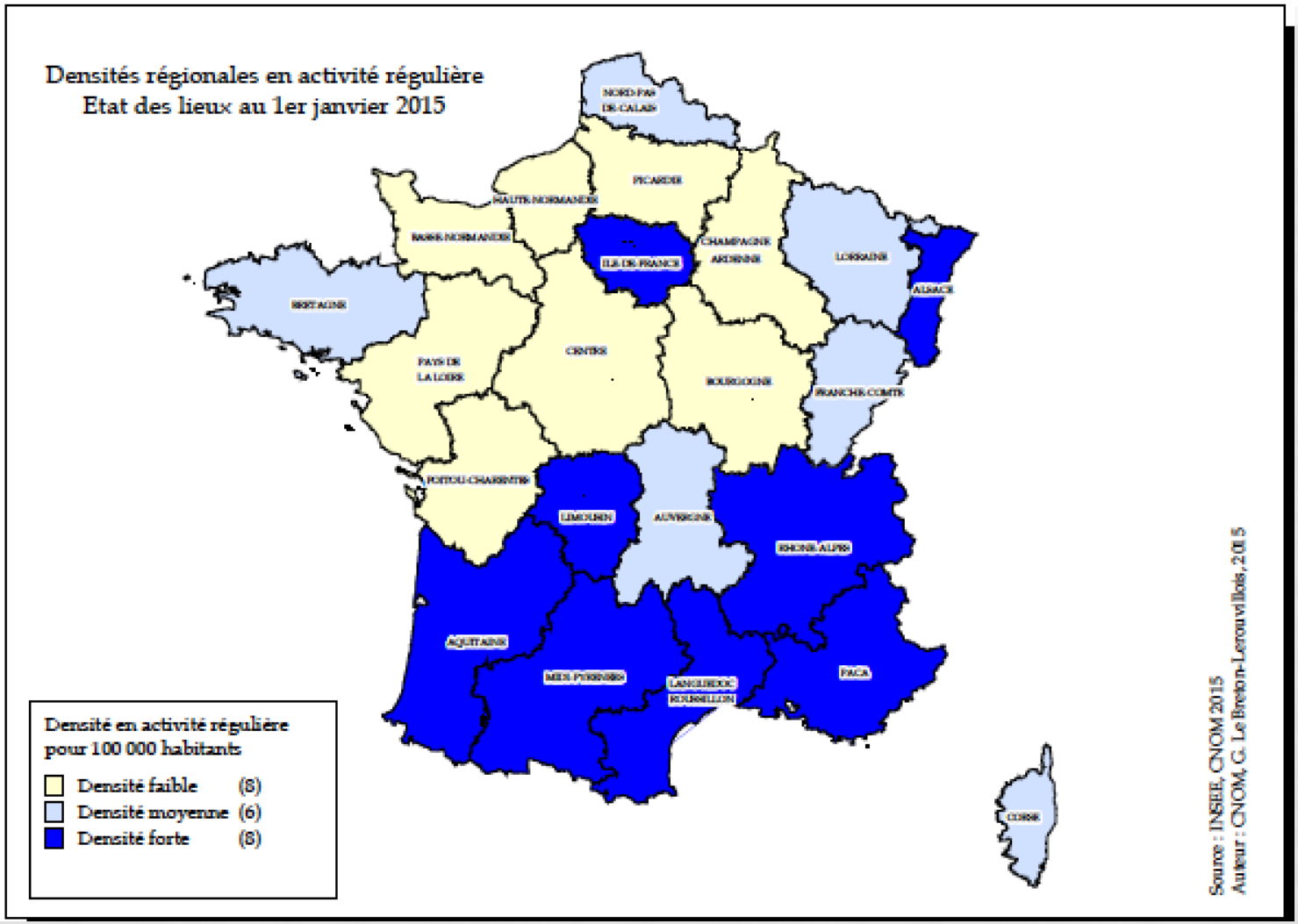
Graphique n°56: Pyramide des âges des médecins spécialistes médicaux et chirurgicaux en activité régulière - France



Atlas de la démographie médicale en France, CNOM, Janvier 2015

REGIONAL DEMOGRAPHY

Cartes n°3: Densités et variation régionales en activité régulière



Atlas de la démographie médicale en France, CNOM, Janvier 2015

STAFFING & WORKLOAD

Medical specialists greatly outnumber generalists in most countries: there are more than 2 specialists per every generalist on average

Generalists and specialists as a share of all doctors, 2013 (or nearest year)

1. Generalists include general practitioners/family doctors and other generalist (non-specialist) medical practitioners.
2. Specialists include paediatricians, obstetricians/gynaecologists, psychiatrists, medical, surgical and other specialists.
3. In Ireland and Portugal, most generalists are not GPs ("family doctors"), but rather non-specialist doctors working in hospitals or other settings. In Portugal, there is some double-counting of doctors with more than one specialty.

***Source*: OECD Health Statistics 2015, OECD**

TYPE OF PRACTICE

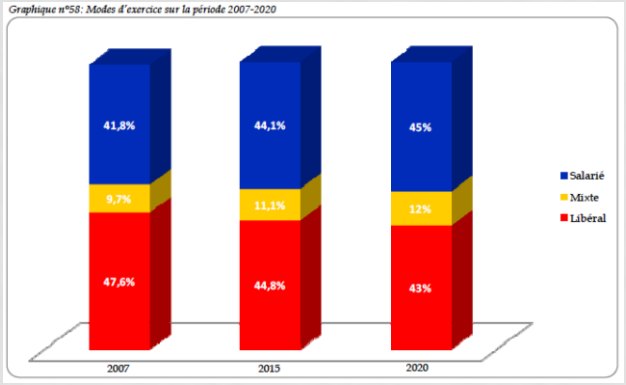


Tableau n°3: Répartition des médecins en activité selon le mode d'exercice

Mode d'exercice		Effectifs 2015		Pourcentage 2015	Variation n-8
Libéral			88750	44,7%	-6,3%
Mixte			22079	11,1%	+14,7%
	Libéral-Salarié	6240			
	Libéral-Hospitalier	14872			
	Libéral-Salarié-Hospitalier	967			
Salarié			87410	44,1%	+5,4%
	Salarié	27217			
	Hospitalier	57124			
	Salarié-Hospitalier	3069			
Divers			113	0,1%	
Sans exercice déclaré			13		
Total France entière			198365		

Atlas de la démographie médicale en France, CNOM, Janvier 2015

EUROPEAN WORKFORCE FOR HEALTH

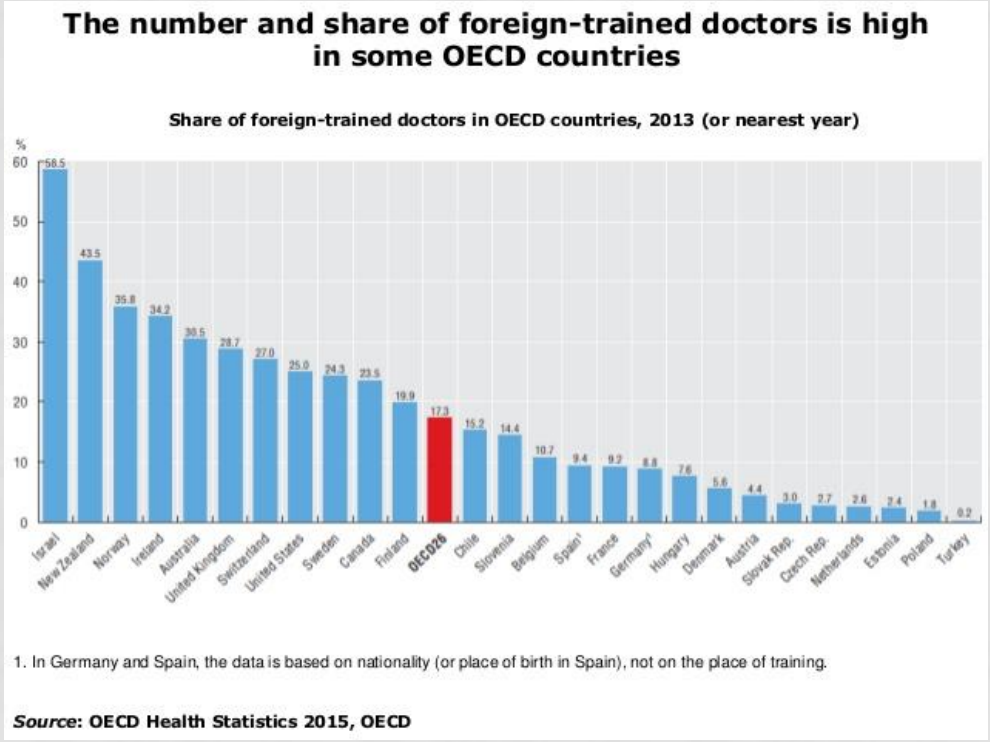
- **EU is facing alarming demography of physicians and nurses**
  - **Insufficient recruits coming through to replace people leaving (young doctors)**
  - **Feminization of the medical professionals (more part-time activity > increased *numerus clausus*)**
  - **Bad working conditions in a majority of Member states (need for improving Healthcare organisation, according to the EWTD, and funding)**
  - **Reconciliation of working time and family life**
- **Need of better medico-technical environment all-over EU**
- **Minimal guidelines for patient safety *(EMOs' European High Level experts Groups > UEMS, AEMH)***
- **Stop the brain-drain within the EU (E/W unbalance) *Bulgaria lost 50% of its nurses and 30% of physicians in 10 years …***
- **Stop the brain-drain in continental Europe, Africa and Asia for the benefit of UK, Ireland and North-America**

Currently we need doctors and not managers …

THE BRAIN-DRAIN

Thousands of European doctors are going abroad

The migration of the health professionals, trained in their country, towards Western Europe and Northern America poses a real problem of public health and equal opportunity of the populations in the Central and Eastern European Countries



European salaried doctors' difficulties

- To much hierarchy (managers)
- Increasing administrative tasks
- Priority of the economic strategies on the public health needs
- Constraints of public service missions and permanence of care (*on-call duty*)
- Insufficient incomes after long training period (*specialist 12 years*)
- Excessive working time (*opt-out*)
- More and more "burn-out" situations
- Difficult demography with ageing senior doctors > shortage of HC workforce, especially junior doctors

PERFORMANCE OF A FATIGUED DOCTOR

Literature includes several excellent series on both senior and junior doctors and students

All reach similar conclusions:

- we should work physiological normal duration (EWTD)
- we should work less at night (screening the life-threatening emergencies > "traffic lights")

O.A. Meretoja et al., Acta Anaesthesiol Scand 2009; 53:277-279 (F09-026)
Marianna Virtanen et al., Am J Epidemiol 2009; 169:596-605 (F09-030)

FRENCH SURVEY (GROUPE PASTEUR MUTUALITÉ 2008)

The burnout in medical and nursing staff is a syndrome which is defined by three dimensions:

- emotional exhaustion (individual stress),
- tendency to depersonalise their patients (cynism),
- decrease of the personal achievement (self-evaluation).

Three causes of burnout, often interdependent, are particularly proposed:

- difficult working conditions,
- an invading and harassing administration,
- a phenomenon of depreciation of the healthcare job.

www.souffrancedusoignant.fr

SUFFERING SYNDROME OF NURSING STAFF (MBI: MASLACH BURNOUT INVENTORY)

- 3 dimensions:

- an emotional *exhaustion* represented by *discouragement*, lower energy at work and feeling of overwhelming pressure which makes that *all seems difficult*, even *insurmountable*.
- a tendency to depersonalise their patients, considered as *objects*, without affect nor interest, even with *cynicism*.
- a decrease of the personal achievement: *devaluating themselves*, judging themselves *inefficient* and useless for their patients. *Without esteem for their work*, they neglect it and *let themselves go to exhaustion*.

LONELINESS: HEART OF THE SUFFERING

- Progressive isolation
- Suppression of the collective support
- Feeling:
  - permanently overburdened
  - no more able to do a work of quality
  - no more able to speak to his/her colleagues, themselves overburdened and in competition on the objectives

The concerns of managers and law-makers, interested only in short run economic and financial profitability, are in opposition to the concrete experiment of work lived by the employees.

To practice medicine, we need time.

Job has to be tailored to the individual and not vice versa

Strasbourg

European institutions

Many thanks!

University Hospitals