PRESS RELEASE

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REPORT TO THE SOCIAL AFFAIRS COMMITTEE

AID FOR THE RECRUITMENT OF PRIVATE PRACTICE DOCTORS - REFOCUSING AID ON THE HEALTH NEEDS OF THE POPULATION

At the request of the Senate's Social Affairs Committee, and following a suggestion from the Citizens' Participation Platform, the *Cour des comptes* has analysed the public aid available to private practice doctors for setting up practice in, or practicing in, areas identified as priorities by the public authorities. The *Cour* examined these aid schemes and sought to measure their effects in the light of the objectives they pursue. The period under review runs from 2016 to 2023, as some of these measures are multiannual and their effects are expected to last for some time.

A tangled web of costly aid, a large proportion of which is ineffective

There are many different types of aid available, depending on which authorities grant it, the conditions under which it is granted, the advantages they provide and the expected consequences for the population. Direct aid (subsidies) and indirect aid (tax exemptions) financed by the State coexist with other aid financed by the health insurance scheme, and still other aid granted by the various levels of local government.

Some grants are awarded exclusively if the doctor sets up practice in a health-related zoning area (priority intervention regions - ZIPs - or complementary action regions - ZACs), while others are awarded on the basis of so-called economic zoning areas, which are not specific to activities in the health sector (France-rural revitalisation regions, which are the successor to the former rural revitalisation regions, urban tax-free regions). Lastly, some aid is available to medical students who want to set up practice in an underserved area.

All in all, without even taking into account local aid, there are around fifteen different types of aid, from a variety of national sources. The corresponding expenditure amounted to €205m in 2023, benefiting 15,000 doctors and 2,000 students. The benefits are concentrated on a limited number of doctors: 3,000 of them received 60% of the aid from health insurance and tax benefits. The regions used to determine eligibility for certain types of aid are not consistent with each other. They may compete with each other and not ultimately favour the areas with the least medical resources. The precise extent of local authority aid is not known, but the cases examined show that it is significant, and some of it can further complicate the range of schemes available to doctors.

On the contrary, some financial aid schemes are proving their worth. This is the case for the aid allocated by the health insurance scheme, which has improved its configuration in the national agreement signed with the medical profession in 2024, which will apply from 1 January 2026. This is also the case for State-funded study grants, subject to a ceiling on their duration (10 years of study followed by 10 years of practice in an underserved area) and more rigorous monitoring of compliance with the commitments

made by the young doctor who has received them. The tax exemption for income received from participation in the "*permanence des soins ambulatoires*" (PDSA - nights, Saturday afternoons, Sundays and public holidays) is relevant in areas where there is a shortage of doctors.
On the other hand, the tax incentives for the France rural revitalisation regions (ZFRR, formerly ZRR) and the urban tax-free regions are costly and have no tangible effect in combating medical deserts. Lastly, some of the measures proposed by the government have not been mobilised to any great extent, such as the start of practice contract and the social exemption for those setting up practice in priority health regions (ZIP or ZAC). The *Cour* therefore recommends abolishing all tax subsidies, with the exception of those applicable to PDSA income, and the aid that is rarely used. This recommendation concerns measures currently being examined by Parliament, in Article 12 of the Finance Bill for 2026, and Article 21 of the Social Security Financing Bill.

Aid should be better targeted at factors that encourage the recruitment of doctors, to be coordinated closer to needs on the ground

Overall, the effectiveness of the financial measures put in place over the years to mitigate territorial inequalities in terms of the presence of private practice doctors, by encouraging them to set up practice as a priority in the most underserved regions, is proving limited. These do not cover the main factors that influence a doctor's choice of location and then stable practice.
Much more than the strictly financial advantages granted to individual doctors, the long-term establishment of doctors in underserved areas now often depends on the possibility of group practice in multidisciplinary health centres (or health centres for salaried doctors).
In the medium term, medical students and interns in training should be offered placements in underserved areas, as those who discover them in this way are more likely to settle there. In the longer term, spotting talent and encouraging people to study medicine at secondary schools in rural areas will help doctors to settle in the regions of their origin. Welcoming doctors born and qualified abroad and directing them towards underserved areas is another area that needs to be developed.
Generally speaking, the national system for steering aid to private practice doctors is too far removed from the actual situations encountered in the regions, from changes in needs and the supply of care, and from the pragmatic responses that local stakeholders can devise. It is no longer appropriate to deal separately with private practice and salaried practice - in health centres and health institutions - where the needs in terms of care pathways are least met. Similarly, access to primary care must be designed on a multi-professional basis (pharmacists, midwives, private nurses, etc.). Faced with these pressing responsibilities in terms of the population's needs, the public authorities can no longer continue to to organise their financial aid in a compartmentalised way. The *Cour* recommends that they organise themselves by defining a departmental plan for concerted initiatives (SDIC) that would bring together the funding bodies (the State - regional health agency and prefects), the three levels of local authorities (region, departments, municipalities and inter-municipalities), the health insurance scheme (primary health insurance funds), professional representatives and user representatives.
Compliance with the priorities defined by this plan would be a condition for the legality of public subsidies awarded to private individuals. This aid could be triggered in a coordinated manner in the form of calls for expressions of interest from the medical community, for areas defined as priorities, thus giving potentially interested practitioners a real vision of the various types of support that will be put together to welcome them and encourage them to set up in the long term.

Read the communication to the assemblies

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