Cour des comptes

AID FOR THE RECRUITMENT OF PRIVATE PRACTICE DOCTORS

Refocusing aid on the health needs of the population

Communication to the Senate Social Affairs Committee

November 2025

Summary

For several years now, France, like many of its European partners, has been suffering from an unfavourable medical demography. At the same time, the ageing of the population, largely as a result of medical advances, has increased the pressure on demand in the face of shrinking supply. This context has led the public authorities (Ministry of Health, National Health Insurance Fund, local authorities) to take measures to ease this pressure in the geographical areas that have been most affected for a number of years. However, the situation is likely to persist, as it will be several years before medical density, adjusted for the effects of an ageing population, returns to its 2021 level. In the short term, therefore, the measures taken can only, at best, reduce inequalities in access to care between regions, without compensating for the overall shortfall.

A tangle of different types of aid that are insufficiently managed and come from various sources

This survey is based on an analysis between 2016 and 2023 of a large proportion of the aid provided by the State and the French National Health Insurance Fund (CNAM) for the recruitment of private practice doctors. Some of these schemes are due to be modified in 2026, such as CNAM aid, or are likely to be modified as part of the Finance Act for 2026, such as tax aid that is conditional on settling in certain areas.

There are at least fifteen different types of aid (in terms of design, management and the regions in which it applies), ranging from aid granted to young doctors (or medical students) to encourage them to settle and remain in areas where there is a shortage of doctors ("health regions") to tax exemptions covering both the non-commercial profits (BNC) of private practice doctors and local taxation, granted because they set up practice in areas with an economic purpose ("economic regions"). The regions eligible for this aid, such as tax-free urban zones (*zones franches urbaines* - ZFU) and France rural revitalisation zones (*zones France ruralités revitalisation* - FRR, formerly ZRR), do not necessarily coincide with the defined health regions.

The financial aid alone allocated to established doctors and students committing to settle in certain areas that are weak economically or in terms of access to health services amounted to around €205m in 2023, benefiting 15,000 doctors and 2,000 medical students. Half of this aid was allocated to health regions and the other half to economic regions.

The following conclusions can be drawn from this situation:

- the number of different aid schemes and their lack of coherence make them opaque and difficult to understand, which means that young doctors setting up in practice are unfamiliar with them, only a small number of beneficiaries use them (with the exception of aid granted by the CNAM) and the administration costs are high in relation to the amounts paid out;
- zoning schemes compete with each other, between those designed to encourage doctors to set up practice and those designed to provide general support for activity and employment, for which doctors can claim substantial tax exemptions and reductions, without any quid pro quo in terms of services rendered to patients;
- start-up aid is concentrated: 60% of all tax subsidies and CNAM aid benefits 1.2% of the total number of practising doctors, whether in private practice or salaried, i.e. 3,000 private practice doctors (including 2,280 GPs and 720 other specialists) out of 241,255 (including 102,065 GPs and 139,190 other specialists);

- the medical zonings that give rise to eligibility for aid are objective in their construction but do not take sufficient account of the origin of the health shortage, which may result from a shortage of several health professions, not just doctors, to meet the needs of the population concerned;
- compliance with the commitments made by doctors when they receive aid under the health zoning scheme is not effectively monitored.

In addition to the overlap between aid for health areas and tax subsidies for economic areas, there is also the financial support that each level of local authority can provide. Unlike national-level aid, the aid provided by these local authorities cannot be assessed at present, but there are many initiatives and the expenditure involved is considerable. This aid could even turn out to be higher than that paid by the State. This situation accentuates the confusion and leads to inappropriate competition between schemes and between regions.

Unproven effectiveness of aid, which only partially addresses the criteria used by doctors to choose their place of practice

The conclusions of a number of studies carried out by the Directorate for Research, Studies, Evaluation and Statistics (DREES), the National Institute for Statistics and Economic Studies (INSEE) and the National Council of the Order of Physicians (CNOM) all point to the marginal role played by financial assistance for doctors setting up practice in areas with a physician shortage, compared with other factors influencing choice. This is also the view of doctors' representatives, as well as students and interns, with the exception of study grants (public service commitment contracts). The quality of the professional environment weighs more heavily in decisions to set up a practice than the financial advantages: young GPs are particularly afraid of having to cope alone with a demand that may prove unsustainable for them if a local health ecosystem including colleagues from different specialities, pharmacists, laboratories and imaging centres is not able to complement their work.

Other factors, such as the presence of local public services (childcare, sports and cultural facilities, etc.) or the ability of the spouse to find a job nearby, are also taken into account. Research by lecturers at the École des hautes études en santé publique (EHESP) and the Institut de recherche et de documentation en économie de la santé (IRDES) has shown that financial aid only has a significant effect on medical density in underserved areas when it is used in a context of collective practice, in particular through multi-professional health centres (MSPs). Isolated, it has little impact.

The objectives and application procedures for aid for doctors to set up in practice therefore need to be reviewed. Firstly, it is advisable not to renew aid that is little used, such as the contract for the start of practice and the social exemption for setting up practice in a health region[1], which had been the subject of an experiment under Article 51 of the Social Security Financing Act for 2020. However, Article 21-II of the Social Security Financing Bill for 2026, examined by the Council of Ministers on 23 October 2025, proposes the creation of a new contract, known as the "territorial ambulatory medical practitioner" (PTMA) contract. Like its predecessors, such as the start-of-practice contract, there is a risk that it will meet with only modest enrolment.

Secondly, in the case of doctors, aid targeted at economic areas such as the FRR (formerly ZRR) and ZFU regions should be withdrawn, as this aid is costly and has no tangible effect in combating medical deserts. Part of the resulting budgetary gain could be reallocated to financial support for collective practice in multi-professional health centres (MSPs), the effectiveness of which has been demonstrated in French and international studies.

1 This exemption, which benefits other contracted healthcare professionals, is of little interest to doctors, given the significant exemption from health and family insurance contributions enjoyed by 80% of contracted private practice doctors.

However, Article 12 of the Finance Bill for 2026, tabled in the National Assembly on 14 October 2025, proposes to extend to private practice doctors setting up practice in priority urban neighbourhoods (QPV) an eight-year exemption on their non-commercial profits, comparable to that which applies, at least until the end of 2025, to doctors setting up practice in urban tax-free regions (ZFU). This measure would be costly because it would apply to a much larger number of municipalities and a much larger population living in QPVs than in ZFUs; it would also add to the confusion between the different territorial aid granted to doctors (health-related aid and aid targeting economic regions). Finally, in 2026, it would begin a new period of eight years of exemption for its beneficiaries.

Thirdly, research shows that the geographical origin of future doctors plays a major role in their subsequent place of establishment and the speciality they choose. Diversifying the geographical and social origin of medical students must therefore be an objective[2]. Students from rural areas are more likely to practise in rural areas and to do so as general practitioners than those from large cities. Allowing high school students to choose a "health" option before the baccalauréat, offering distance learning for the first year of medical studies, as some health training and research units (UFRs) already do, in areas where there is a shortage of doctors (Nevers, Pau, etc.), or encouraging postgraduate and internship placements in areas where there is a shortage of doctors would be more effective than relying on the financial assistance currently in place to help doctors set up in practice.

2 In its communication to the Senate on access to health studies of December 2024, the *Cour des comptes* had already recommended the creation of a regional range of training courses giving access to health studies and the development of guidance schemes for secondary school students in rural areas or from socially disadvantaged backgrounds to encourage them to take up medicine, midwifery, dentistry and pharmacy. *Cour des comptes*, Access to health studies, four years after the reform, an essential simplification, communication to the Senate Social Affairs Committee, December 2024.

Refocusing on the needs of the population and multi-professional coordination at a relevant local level

The delimitation of regions eligible for doctor recruitment aid is based on a measure of the match between the supply of and potential demand for healthcare in a given area. This statistical measure, although objective, is not sufficient to reorganise aid on the basis of the current health zoning alone. Health data relating to the territory's population should enable us to take better account of priority health needs.

This is illustrated, for example, by the tense local situations observed in the Centre-Val de Loire region, the situation of which was the subject of an in-depth analysis[3]. These priority needs can be analysed using existing health indicators, made available to stakeholders at the departmental level, to better target and coordinate their interventions: excess visits to emergency departments for needs that are partly covered by outpatient care, number of patients with long-term conditions (ALD) who do not have a general practitioner, patient leakage rate[4] when patients are obliged to travel far from their department or region to receive treatment, patients with supplementary health insurance who have difficulty consulting a doctor who is geographically distant, breast and colon cancer screening rates, etc.

Improving the criteria on which aid is based must be accompanied by better coordination between funders.

If interventions are insufficiently coordinated at national level, they are even less so with those of the local authorities. There are three ways of improving the effectiveness of government action in this area:

- promote group and multi-professional practice (for example, between gynaecologists and midwives, or with pharmacists and nurses) in relation to care needs that often require combined interventions or coherent care pathways;
- consider that the supply of doctors in underserved areas should also be assessed taking into account salaried practice, which has become the majority practice, all specialities included, in health establishments (outpatient procedures and consultations) and health centres;
- streamline and simplify the range of aid available from the State, the health insurance scheme and the local authorities, by organising consultation between these funders, so as to draw up concerted intervention plans for the recruitment of private practice doctors and then organise joint calls for expressions of interest with a view to allocating the aid.

Such coordination could be organised at the departmental level, taking into account the comparative merits and limitations of the different levels of consultation and action that could be envisaged.

3See Appendix 3.
4 The leakage rate expresses the proportion of patients who, in order to access care, are obliged to travel outside their department of residence.

Recommendations

1. Abolish, from 1 January 2026, the tax exemption on non-commercial profits for private practice doctors setting up a practice in the France rural revitalisation zones, urban tax-free regions and regional aid regions, in compliance with the non-retroactivity clause for multi-year tax measures, and not grant this exemption to private practice doctors setting up in priority urban policy areas *(Minister for the Economy, Finance and Industrial, Energy and Digital Sovereignty, Minister for Action and Public Accounts, Minister for Regional Planning and Decentralisation*).
2. Abolish, from 1 January 2026, the two measures resulting from Article 51 of the Social Security Funding Act for 2020: contracts for the start of practice and social security exemptions *(Minister for Health, Families, Autonomy and the Disabled*).
3. From 1 January 2026, limit to ten years the period during which the aid paid under the public service commitment contract (CESP) can be received, and monitor compliance with the commitment to practise and its duration in underserved areas by doctors who received this aid during their studies *(Minister for Health, Families, Autonomy and the Disabled*).
4. Identify, by the end of 2026, in the functional nomenclature of local authority expenditure, direct financial aid to healthcare professionals *(Minister for the Economy, Finance and Industrial, Energy and Digital Sovereignty, Minister for Action and Public Accounts, Minister for Regional Planning and Decentralisation*).
5. By the end of 2026, draw up a departmental plan for concerted initiatives to support the installation of doctors, in order to organise the coherence of financial interventions by the State, the health insurance scheme and all local authorities, according to the health needs of the local population *(Minister for Health, Families, Autonomy and the Disabled, Minister for Regional Planning and Decentralisation*).
6. From 2027, allocate financial aid to doctors as part of calls for expressions of interest to implement the departmental plan for concerted initiatives *(Minister for Health, Families, Autonomy and the Disabled, Minister for Regional Planning and Decentralisation, National Health Insurance Fund*).
7. By the end of 2026, to support local consultation in drawing up the departmental plan for concerted initiatives, make available to local partners a common database on primary care needs and supply, broken down by department, by health region, by public inter-municipal cooperation body, by territorial professional health community region and by municipality (*Minister for Health, Families, Autonomy and the Disabled, National Health Insurance Fund, National Medical Council, National Institute of Statistics and Economic Studies*).
8. Design, by the end of 2026, financial aid to reduce the cost of compulsory training time for doctors wishing to return to general practice, after having stopped this activity for more than three years, subject to recruitment in an underserved area *(Minister for Health, Families, Autonomy and the Disabled, National Health Insurance Fund*)..