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1. Basic country information

1.1 Population

On January 1st, 2009, the French population was estimated to be close to 64 million (62.4 million in Metropolitan France). It has grown steadily between 1995 and 2007 (at a 0.67% annual average rate between 2000 and 2009). According to demographic projections, the population in Metropolitan France should reach 67.2 million by 2030.

The number of deaths declined steadily between 1995 and 2002 when it became more stable, with the exception of 2003. The latter was due to the scorching heat of August 2003 that resulted in a significant increase in the number of deaths (+ 3% between 2002 and 2003). This tragic event played a crucial role in the French public health policy. Since then the number of deaths is decreasing.

The number of births has increased by about 10% between 1995 and 2008.

Today, the most striking demographic feature of France is its high fertility rate. After more than a decade of increase, the fertility rate reached 2.02 children per woman in 2008 which is close to the generation renewal level (2.1 children per woman). The French fertility rate is one of the highest among European Union’s countries and among OECD countries as well.

The share of women of childbearing age decreased over the last 25 years. Indeed, the high fertility rate can be explained by a higher fertility among women between 30 and 40 years of age: in 2008, 21.5% of newborn children had a mother aged 35 years or more (against only 16.5% ten years ago).

Life expectancy at birth increases regularly, gaining about two months each year. In 2007, life expectancy at birth in Metropolitan France reached 80.9 years. A French woman is expected to live until 84.4 years old, and a French man until 77.4.

The gap between men and women as regards to life expectancy remains high. However, it is narrowing (8.18 years in 1995 against 7 years in 2007) due to the new tendency of women to adopt “risky behavior” (mainly related to tobacco addiction).

The major gains in life expectancy at birth are due to the decline of men’s mortality between 55 and 65 years of age, and to the decline of women’s mortality between 75 and 85 years of age. Life expectancy at 60 has increased by 3.5 years between 1986 and 2006.

The French age pyramid shows that the proportion of elderly people in the population has increased between 1995 and 2006. In 2006, close to one in six French person (16.44%) was over 65 years. In fact, the most striking evolution concerns people over 75 years: they represented 6% in 1995 and 8.10% in 2006. The population ageing is set to continue as the ‘baby boomers’ born after the Second World War are close to the retirement age. In Metropolitan France, from 2030 onwards, according to demographic projections, the population over 65 will outnumber the population under 20 (amounting to 23.2% and 22.8% of the total population respectively).

Although the share of the population under 20 has been declining slowly in the past, it remained stable over the last decade (25.1% in 2006). Young people amounted to 30% of the population in 1980 and 26.40% in 1995.

In 2007, 77% of the French population lived in an urban area. The share of the urban population has increased since 1995 (75%). Over the last years, this urban growth has mainly

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2 Idem.
taken place in outer suburbs and “rural” areas surrounding big towns, rather than in cities centres.

### 1.2 Geo-political data

The **French Transparency Corruption Perception Index** published by Transparency International decreased in 2008. With an index of 6.9 (on a scale ranging from 0 - corresponding to a high corruption level- to 10 - corresponding to a low corruption level-), France lost 0.4 points and is placed 4 ranks below. In 2008, France reached the 23rd position.

Recent events may have contributed to the worsening perception of corruption over the last years: the indictment of the former French President because of “fictitious jobs” at the Paris' office of Mayor, the indictment of the former Prime Minister (“Clearsteam”), or the use of official secret in order to stop investigations (frigates from Taiwan)...

However, positive changes were taken, particularly with the November 2007 Law on corruption.

The **Worldwide Governance Indicators** reveal a more optimistic picture. According to these indicators, in 2008, France ranked well as regards to good governance. Indeed, France performs better than 90% of the rest of the world in areas such as citizens’ participation in selecting their government, government effectiveness, rule of laws and control of corruption. The worst French indicator, that is the indicator with the highest progression margin, concerns political stability and the absence of violence, for which one third of the world's countries rank better than France.

**France’s economic freedom score** is 63.3 and France was the 64th freest economy in the world in 2009. Its overall score fell by 1.4 point due to decreases in six out of ten components of economic freedom. France ranks 28 out of 43 countries in the European region, and its overall score is higher than the world’s average.

France's scores are above the world’s average for six out of ten economic freedoms and are especially good in business freedom, property rights, and fight against corruption. However, its rank can be explained by the high tax level, the significant labour market regulation system and the high level of government expenditures (over 50% of GDP). Still, the limit on the number of working hours or the significant role played by the government and state-owned or state-controlled firms are part of the French history, culture and way of life and are still supported by most French people.

It is often thought that a high level quality of life is enjoyed in France. However the international indicators of quality of life don't reflect such a remarkable level.

According to the **Human Development Index**, based on life expectancy at birth, educational attainment and income, France is ranking well. It obtained in 2006 the 11th position (with a 0.955 score).

But France only reached the 25th position for the **Economist Intelligence Unit's quality of life index** in 2005, with a score of 7.084. Among the different indicators used to shape the aggregated score, France is performing poorly on gender equality, unemployment and divorce rate. Indeed, women are paid on average 19% less than men and the unemployment rate was 8.9% in 2005. In addition, 10% of wedding celebrated in 2000 had led to divorce in the following
five years\textsuperscript{3}. In fact, since the reform of divorce by mutual consent in 2005, the number of divorces is now increasing.

In sum, France succeeds in ensuring to its population the basis of human development but it has more difficulties as regards to favouring the social conditions needed to reach one of the world’s highest levels of quality of life.

**1.3 Economic indicators**

In 2008, France’s gross domestic product (GDP) amounted to over US$ 2,115 billion (€ 1,950 billion), which represents a 1.65% increase in value and a 0.4% increase in volume compared to 2007.

These figures place France slightly below the EU average for per capita GDP. Between 2000 and 2007, per capita GDP in volume has risen on average by 1.1% each year in France, against 1.4% for EU-15 and 1.8% for EU-27.

In 2008, the active population amounted to over 28.2 million. The activity rate among people between 15 and 64 years of age is equivalent to 70.4%. However, there are some differences between men (75%) and women (65.9%) and according to the age group. French active population between 15 and 24 years of age (39%) is almost equal to the one between 55 and 64 (40.2%). Still, these activity rates are below the EU average (respectively 44.5% and 50%), mainly because of longer studies and the 1990s government plan of early retirement.

The total employment rate has steadily increased between 1995 and 2007 (+ 4.9%) and reached 64% in 2007. During the same period, the total unemployment rate decreased (- 2.7%) from 11% to 8.3%.

The employment rate and the unemployment rate hide some disparities by gender.

In fact, the women employment rate (59.4%) is lower than the men employment rate (68.6%). In 1995, there was a 15.18% gap between the two rates. In 2007, this gap decreased to only 9.21%. The women employment rate (+ 7.9%) increased at a faster pace than that of men (+ 1.9%) between 1995 and 2007.

Similarly, the women unemployment rate (8.9%) is higher than that of men (7.8%) however the gap is decreasing from 3.7% in 1995 to 1.1% in 2007. Thus, the decrease in the women unemployment rate was more significant (- 4.1%) than that of rate (- 1.5%) between 1995 and 2007.

The employment rate and the unemployment rate present some differences by age group.

The employment rate for people between 25 and 54 years of age has steadily increased over time, from 77.1% in 1995 to 83.2% in 2008 that is over the EU average (79.6% in 2008).

The employment rate for people between 15 and 24 years of age has strongly increased (from 26.1% in 1995 to 32.2 % in 2008), but hasn’t reached the EU average level (37.6%) yet. Similarly, the unemployment rate for young people has decreased. The issue of unemployment for young people was addressed by global employment policies as well as by particular measures dedicated to young people and their employers. For instance, more than 30

measures were taken since 1975 in order to increase the employment rate of the youth. Yet many young people are on fixed-term contracts and don’t always get a job corresponding to their competences, thus creating a downgrading feeling.

The employment rate for people between 55 and 64 years of age has strongly increased as well (from 29.6% in 1995 to 38.3% in 2008). Despite this evolution, this senior employment rate in France in 2008 still remained below the EU average (45.6% in 2008).

Since 2003, some measures offer incentives to older workers to go on working. They include the progressive lengthening of the pension contribution period, an increased surcote (the additional pension given to those who contribute for more than the legal number of years), withdrawal of the waiver of job-search requirements, the possibility of combining employment income and pensions, a higher mandatory retirement age and reform of the special pension schemes.

Yet the increase in the employment rate for older workers will come up against the legal retirement age, which is set to 60 years old, still below the age set in many OECD and EU countries.

The employment rate and the unemployment rate present some differences by education level.

In fact, the more educated a French is, the less he or she is likely to be unemployed. For instance, in 2007, in the period running between one to four years after their graduation, there were 9% of unemployed people among those who had obtained a high level university degree against 37% among people who had not reached the high-school level. The proportion of unemployed people decreases as people are integrated in the labour market. Thus, only 9.4% of people who didn’t reach the high-school level are unemployed 11 years after the end of their initial training.

In 2005, there were about 2 million persons working in the French health system, accounting for approximately 7.2% of the working population – this proportion has been steady since 1995.

Among people working in the health system, about 65% are health care professionals: nurses, nursing aides and physicians form the three main categories (in number).

Those employed in the health care sector also include administrative and technical staff working in public or private hospitals, health insurance funds and the pharmaceutical industry.

The dependency rate has been steady between 1995 and 2008. In 2008, the share of people under 20 and of people over 65 represent 48.45% of the population between 15 and 65 years of age, who constitute not only the workforce but also the social protection system payers, especially the retirement system (49.15% in 1995).

As regards to the average cost of living, the household’s expenditure has slowly increased in 2008. This increase was the weakest since 1998 (+1.0% in volume).

For instance, households’ health related expenditures (including or not a complementary health insurance scheme) have increased since 2006 (+5.9% in volume, in 2008).

The average increase of the gross disposable income of households (+3.6%) has been steady between 1995 and 2008.

As prices increased significantly over the last years, households’ purchasing power has lowered. In 2008, the rise of purchasing power has been the weakest since 1996 with a 0.6% increase.
There are some disparities among the French regions concerning the economic indicators. Overall, the data for overseas department are worse than data concerning metropolitan France. For example, the gross domestic product per capita in overseas departments in 2007 amounted to only 56% of the gross domestic product per capita in metropolitan France.

Some French metropolitan regions are more dynamic and attractive than others.

In the Île-de-France region (the region of the French capital city), the gross domestic product per capita has been the highest between 1995 and 2007. In 2007, it represented 170% of the average GDP per capita for the other metropolitan regions.

In Alsace region, the unemployment rate has been below the French average between 1995 and 2008. On the other hand, in the former industrial Nord-pas-de-Calais region (North of France), the unemployment rate has been one of the highest over the period.

Similarly, the repartition of the youngest and the oldest in France is unequal. In some regions, the proportion of young people is particularly important, reflecting an attractive environment for young households (Alsace region, Centre region). Other regions are affected by a large share of old people, often in relation to a population ageing in rural areas.

In Limousin region, the share of under 20 and over 60 represents more than 95.1% of inhabitants between 20 and 60 years of age. This relation can be less worrying in some attractive regions like Île-de-France (74.4%) or Alsace (79.3%).

However disparities on the labour market according to gender and age are observed in all French regions.

2. Health Status and Health System

2.1 Health Indicators

The overall picture of the health of the French population shows mixed results. Life expectancy (whether it be measured at birth, at 65 years old, or free of deficiency) appears to be higher than in many other comparable countries. The infant mortality rate (3.8 per 1000 in 2006) has fallen dramatically over the last few decades and is now lower than the rate for the European Union as a whole. As far as cardiovascular diseases are concerned, France fares much more favourably than other countries with comparable standards of living.

And yet, there are some genuine weaknesses, particularly with regard to its premature death rate (before the age of 65) - which is still one of the highest in the European Union - and the notable differences in premature death between men and women, from region to region, across different population groups and among people from different social categories.

2.1.1 Mortality

The crude mortality rate fell regularly between 1995 (9.2 per 1000 inhabitants) and 2006 (8.4 per 1000 inhabitants).

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The infant mortality rate followed the same tendency, falling from 5.0 per 1000 in 1996 to 3.8 per 1000 in 2006, making it lower than the mean infant mortality rate for the European Union as a whole (4.8 per 1000 in 2006)\(^5\). The fall in the maternal mortality rate has been less regular. The maternal mortality rate stood at 7.4 per 100,000 live births in 2008\(^6\). Approximately 50% of all parturient deaths are considered avoidable, particularly through the appropriate managing of postpartum haemorrhaging. The increase in age of mothers giving birth, which increases the vital risk for mothers to above the age of 35, is probably responsible for slowing down the drop in the maternal mortality rate in France.

Tumours and respiratory diseases are the main causes of death in France. Since 2004, tumours have been the number one cause of death across the whole population. In 2006, nearly 30.1% of all deaths across France were in some way linked to tumours. As a general rule, an improvement in survival rates at 5 years old has been recorded. This can be attributed to advances in therapy, as well as improvements in diagnostic medicine. Systematic screening for certain types of cancer (breast cancer, cervical cancer, colorectal cancer) has been introduced for a number of population categories.

Conversely, circulatory diseases (ischaemic heart disease, cerebrovascular diseases, etc.) are now the second greatest cause of death in France. In 2006, they accounted for 28.2% of all deaths, but were the first cause of death among women.

As far as other causes of death are concerned, respiratory diseases accounted for 5.9% of all deaths in 2006, diseases of the nervous system accounted for 5.3%, diseases of the digestive system accounted for 4.5%, diseases of the endocrine system accounted for 3.6% and behavioural and mental disorders accounted for 3.2% of all deaths. The numbers of deaths attributable to external causes are relatively high: accidents accounted for 4.6% of all deaths and suicides accounted for 2% of all deaths in 2006. It should be noted that France is one of the countries in the European Union with a high suicide rate. Suicide is the second cause of death after car accidents for young people between the ages of 15 and 24 years old. The suicide rate is considerably higher among men and elderly people. The suicide rate varies significantly from region to region, and is highest in the north of France and Brittany.

Like the crude mortality rate, the premature death rate (i.e. deaths occurring before the age of 65) has also been decreasing over the last decade. In 2006, it stood at 209.65 per 100,000 people, as opposed to 237.73 per 100,000 people in 1995.\(^7\) Yet these figures are still higher than the average for the European Union's fifteen largest member states: France has one of the highest premature death rates of the European Union.

Nevertheless, there have been some improvements over the last decade. The premature death rate due to circulatory diseases (28.07 per 100,000 people in 2006) and infectious diseases (4.27 per 100,000 people in 2006, down from 11.98 per 100,000 people in 1995) has fallen. But it is still the case that the premature death rate due to the main cause of death in France - i.e. tumours - has been stable for the last 10 years or so (86.65 deaths per tumour per 100,000 people in 2006). Although, for example, the premature death rate due to breast cancer has been relatively stable, the premature death rate due to lung cancer, on the other hand, has increased (from 20.79 per 100,000 in 1995 to 23.47 per 100,000 in 2006). This can be attributed to the premature death rate due to lung cancer doubling for women: in 1995, there were 5.09 deaths for each instance of lung cancer among women under the age of 65; by 2006, this figure had risen to 10.45. This can be explained by the increase in smoking among women over the last 30 or so years. This increase is such that the premature death rate due to lung cancer looks set to carry on rising for women in the years to come.

\(^5\) Source EUROSTAT.
\(^6\) Source ECO-SANTE 2009.
\(^7\) Source ECO-SANTE 2009.
A very different picture between men and women

French men have a lower life expectancy than French women, despite the fact that the gap between the two has been narrowing in recent decades. These discrepancies between the sexes regarding mortality rates are highlighted by the various indicators in place for the premature death rate and the avoidable premature death rate (due to high-risk behaviour, such as alcoholism, smoking, dangerous activities). The age-standardised premature death rate for men is shown to be 2.2 times higher than for women. And as far as the main cause of death is concerned, circulatory diseases are still the first cause of mortality among women, with cancer being the main cause for men.

Social inequality continues to affect mortality rates. The difference in life expectancy at 35 years old between managerial staff and labourers is 7 years for men and 3 years for women. Social differences continue to affect life expectancy free of deficiency after 60 years old, evidence of the long-term effects of job type and living conditions.

Considerable differences in premature death rate are detected between different geographical regions. There is a definite North-South divide in France, which is particularly pronounced for men. Taking all causes of premature death together for the period 1997-1999, the death rate for men in the Nord-Pas-de-Calais region in the north of the country was 32.7% above the national average.8 The situation is more favourable in the southern parts of France.

This disparity seems to suggest that improvements in people's health are possible for certain categories of the population or with respect to certain diseases (behavioural disorders, diseases associated with people's day-to-day environment or work situation, or their socio-cultural environment) that can be targeted.

2.1.2 Morbidity

In France, morbidity is understood as referring to long-term illnesses. These are conditions which involve prolonged treatment and particularly costly therapy. An official list of these conditions has been drawn up by the Ministry of Health. There are currently 30 diseases on this list of long-term illnesses. For each one of them, the cost of the various treatments associated with it is completely reimbursed by the patient's health insurance scheme.

1,117,556 new cases of long-term illness were diagnosed in 2007,9 including 257,484 malignant tumours, the most common cause (23% of all new cases). The other diseases on the list were (in decreasing order): diabetes (117,720 - 15.9% of all new cases), severe hypertension (126,958 - 11.4% of all new cases), long-term psychiatric disorders (92,461 - 8.3% of all new cases), cardiac insufficiency and severe cardiopathy (84,789 - 7.5% of all new cases)

The average age was generally higher than 50 years old (the general average age was 62 years old). It was only lower than 20 years old for two long-term illnesses: cystic fibrosis and progressive scoliosis.

Taken right across the board, as of 31 December 2007, 8 million people with health insurance schemes10 were making claims for costs associated with the treatment of long-term illnesses.

Four groups of long-term illness account for 75% of all sufferers in France:
- cardiovascular diseases (2.6 million people)
- malignant tumours (1.6 million people)
- diabetes (1.5 million people)
- long-term psychiatric disorders (0.9 million people).

Using disability-adjusted life years (DALYs) for measuring overall disease burden helps determine the ten diseases or causes11 which lead to the greatest number of good health years

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8 Regional health monitoring body for the Nord-Pas-du-Calais region (2002), 2002 monitor for Regional Health Programmes in the Nord-Pas-de-Calais and PRASE regions.
9 Data from the CNAMTS, see: www.ameli.fr.
10 As of 31 December 2007, 56.5 million people were covered by a health insurance scheme - 88% of the French population.

11 The DALYs are included in the appendix, classified into types of illness.
2.2 Health System: General Information

**General expenditure on healthcare**, an aggregate used for the purposes of drawing comparisons at international level, increased over the last decade, accounting for 11% of per capita GDP in 2007.\(^{12}\) This was also the case in 2006 - 2% higher than the average for all OECD countries (8.9%). This puts France in the second highest position out of all OECD member countries - far behind the US (16%), but comparable to Switzerland (10.8%) and Germany (10.4%).

As far as **total health expenditure on healthcare per inhabitant** is concerned, France spends more than the average for all OECD countries, with an average of $3601 on health care per capita. (adjusted for purchasing power parity for various currencies)\(^{13}\). This is far behind the US ($7290) as well as Norway, Switzerland, Luxembourg, Canada and Austria.

**Public financing** is the main source of financing for health expenditure in France. 79% of health expenditure is financed by the state - more than the average for OECD member countries (72.8%)\(^{14}\).

Between 1995 and 2008, the way in which **health expenditure financing is structured** underwent a slight change: the financing provided by Social Security was reduced from 77.1% to 75.5%, with the shortfall being taken up by various complementary bodies, the contributions of which have increased from 12.2% to 13.7%. In 2008, the outstanding amount payable by households (see Focus section) stood at 9.4%, a little lower than in 1995 (9.6%).

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**FOCUS: THE PERCENTAGE OF HEALTH CARE COSTS WHICH ARE STILL PAYABLE BY HOUSEHOLDS - GETTING THE POPULATION TO ASSUME FINANCIAL RESPONSIBILITY FOR THEIR HEALTHCARE SERVICE**

The changing ways in which the financing of healthcare expenditure is structured reveal a very uneven picture, depending on the periods of time under scrutiny. Basically, the percentage of healthcare costs borne by households fell between 1995 and 2004.

This percentage started to increase in 2005, partly because of the growth of certain expenses that were not covered by Social Security, and partly because of various economic measures designed to reduce the deficit of the healthcare insurance branch of the Social Security system.

First of all, on 1 January 2005, a system was introduced whereby each person paid a fixed rate of €1. This sum was deducted from the total amount reimbursed for each consultation with a doctor, any procedure a doctor might carry out, or for any tests done; this fixed rate contribution generated approximately €400 million of savings for health insurance schemes, which were transferred to the outstanding amount payable by households.

In 2006, the rates for reimbursing patients for the cost of medical consultations were adjusted to reflect whether or not they respected the conventional healthcare delivery system. Given that complementary bodies get fiscal incentives for not taking up the slack for this reduction in reimbursement by the Social Security system, this measure had a bearing on the amount payable by households. Added to this is the fact that the French Social Security system is cutting back on the reimbursement of certain medicines, generating €400 million worth of savings for healthcare schemes in the process and further adding to the amount payable by households.

In 2007, the penalties levied on people who did not respect the conventional healthcare delivery system were increased: this resulted in the reimbursement rate falling from 70% to 50% for healthcare not provided within the context of the standard system. The fixed rate contribution which had initially been set at been €1 per day was increased to €4.

According to the findings of the Social Security’s accounts committee in June 2009, the introduction in 2008 of thresholds on medicines (€0.50 per box), on auxiliary medical procedures (€0.50 per intervention) and on healthcare transport (€2 per journey) - of which the total is fixed at an upper limit of €50 per patient per year - has most likely generated €890 million for the health insurance system.

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\(^{12}\) DREES (Department of research, analysis, assessment and statistics, part of the French ministry of health) (2009), *Comptes nationaux de la santé 2008* (National health accounts 2008).

\(^{13}\) ECO-HEALTH OECD 2009.

\(^{14}\) ECO-HEALTH OECD 2009.
As far as **hospital care** is concerned, this is the responsibility of French healthcare establishments and falls into three different categories, depending on their status. As of 31 December 2007, the most recent date for which figures are available, France counted:
- 1001 state-run hospitals;
- 782 private non-profit making hospitals;
- 1055 private profit making hospitals.

Across France as a whole, **numbers of hospital beds** have been falling steadily over the last decade. Between 1995 and 2006, the number of hospital beds per 100,000 people fell by nearly 18%. In 2006, there were 716.78 beds per 100,000 people. However, it is more useful to look beyond overall hospital bed capacity and instead consider the increase in hospital beds available for the various main types of medical treatment, as well as the distribution of these beds between total and partial hospitalisation needs.

As far as **short-stay hospitalisation** is concerned (**medicine, surgery, obstetrics**), the numbers of beds available for partial hospitalisation are tending to increase, while the numbers of beds available for total hospitalisation are stabilising. This can be attributed to changes in the state’s undertaking to reimburse expenses - changes that have come about as a result of developments in medical techniques and treatments. In 2007, the numbers of beds available for partial hospitalisation (8.7% of the total beds available for short-stay hospitalisation) increased by 5.9% on the previous year, whereas numbers remained more or less stable for total hospitalisation.

Similarly, the numbers of beds available for the partial hospitalisation of **psychiatric** patients increased by 1.5% in 2007. For a number of years now, partial hospitalisation has been strongly encouraged and accounted for 32.2% of facilities used by psychiatric patients in 2007.

As far as **follow-up and rehabilitation care** is concerned - where the number of beds was always traditionally too low for requirements - the number of beds has continued to grow across all hospitals: +0.8% in 2007 following a rise of 4% in 2006. This increase is partly due to the 2003-2007 Cancer plan, which made provision for an extra 15,000 beds to be phased in over 5 years as part of a bid to provide the most complete overall care. The numbers of beds available for partial hospitalisation increased considerably in 2007 (a 6.8% rise on 2006), with partial hospitalisation accounting for 6.3% of the overall numbers of beds available for follow-up and rehabilitation care.

2007 saw a slight drop in the numbers of beds available for the provision of **long-term care**. This was the case in state-run hospitals, and even more so in the private sector.

As far as the employment of healthcare professionals is concerned, there are no statistics available in France for gauging the **rate of unemployment** among them. That said, it is thought that it is extremely low - given that the public often associates these professions with staff shortages.

The nursing profession is particularly affected by recruitment difficulties. This was illustrated by the annual CRÉDOC-UNEDIC survey in 2003 about human resources, which placed it at the very top of the list of professions experiencing recruitment difficulties. 80% of all nursing recruitment operations were considered difficult\(^{15}\). The job market therefore clearly favours professionals who are in a position to choose from a broad range of job offers, thus placing employers in competition with each other. This state of affairs invites employers to try and outdo one another. Those who come out best are the hospitals able to offer the most attractive working conditions - particularly large state-run hospitals - whereas other hospitals or

departments (medical social centres, geriatric departments, etc.) have the greatest difficulties filling their vacancies. Certain regions in France also have difficulties in recruiting physiotherapist, doctors and midwives.

Looking ahead to 2015, recruitment difficulties are considered inevitable, although they will be more or less so depending on the type of medical care involved, and will vary from hospital to hospital. Recruiting auxiliary nurses, for example, may also become difficult - particularly in retirement homes.

There is not a great deal of data available about vacant posts in France's various healthcare professions. Fragmented data is available regarding specific categories of profession in the healthcare sector ("hospital doctors" in state-run hospitals). Data is also available for certain specific regions that have opted to use this indicator.

The data relating to vacancies for doctors in state-run hospitals should be looked at very carefully. On the one hand, this data only relates to "hospital doctors" who enjoy the standardised status of doctors in state-run hospitals; details of vacancies for these posts are published in the Official Journal. If the post still has not been filled even after it has been advertised in the Official Journal, many hospitals will then seek to recruit doctors on a per-contract basis; if the post is then filled by somebody working on a per-contract basis, it will still be considered vacant for the purposes of gathering statistics. On the other hand, the concept of 'vacancy' with respect to posts for doctors in hospitals is based on theoretical staff numbers which are determined by hospitals for each care department and then communicated to the regulatory authorities. But changes in the ways that hospitals are financed and the introduction of a casemix-based financing system means that this concept of theoretical staff numbers is no longer relevant. Hospitals are no longer to be bound by the approval or otherwise of the regulatory bodies. Instead, they pay the doctors that they are able to pay, taking into account income generated by the various types of medical care provided. This is completely changing the previously established concept of theoretical staff numbers.

After these methodological precautions, it is noteworthy that there is a significant disparity in vacancy rates depending on specialist field and region. Some specialist medical fields are more affected than others by high vacancy rates. In 2005, psychiatry (20.20%), anaesthetics (15.53%), emergency medicine (9.58%) and radiology (7.54%) were among the most affected. Areas such as biology (1.93%) and orthopaedic surgery (2.15%), on the other hand, appeared unaffected.

Medical staff vacancy rates also vary from region to region. As a general rule, there is a higher number of vacancies for medical staff in France’s overseas territories: in 2005, 40.9% of all full-time hospital doctor posts were vacant in Guiana, 34.5% in Mayotte and 34% in Guadeloupe. In mainland France, a number of regions which are less appealing because of their geographical location (often in the north of France) have significantly high vacancy rates: 25.2% in Basse-Normandie, 22.6% in Champagne-Ardenne, 21.9% in Franche-Comté, 20.4% in Limousin and 20.1% in Lorraine. Regions in southern France, on the other hand, such as Aquitaine or Provence-Alpes-Côte d’Azur have 50% fewer vacancies (10.4% in Aquitaine, 10.7% in PACA). The Paris region (12.2%), southern areas (the Midi-Pyrénées region with 13.9% unfilled posts and the Languedoc-Roussillon region with 13.4% unfilled posts), as well as Alsace - which is particularly dynamic (13.4%) - are the areas in France which are least affected by medical recruitment difficulties. However, there can still be dramatic variation in the numbers of hospital vacancies between different hospitals in the same region. For example, some areas in southern France are isolated and relatively difficult to access. The result is a significant number of vacant posts - an indication that they are experiencing recruitment problems.

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Apart from "hospital doctor" posts which are required to be advertised in the Official Journal, there are no public recruitment structures in place for other healthcare professions. This means that all information about vacancies has to come from surveys carried out by regional regulatory bodies or professional corporations.

An example of one such survey is the one carried out between 2004 and 2006 by the Paris region Agence Régionale d'Hospitalisation - an independent structure designed to maximise resources - of the number of vacancies in a number of paramedical professions. The survey showed that nursing is the profession that has the lowest vacancy rate (5% in 2006). Nurses specialised in operating block work (33% vacancy rate in 2006), in anaesthetics (19% vacancy rate in 2006) and in child care (12% vacancy rate in 2006) are the most sought after in hospitals in the Paris region. For physiotherapists, the vacancy rate was 13% in 2006. Because the Paris region is relatively unaffected by medical and paramedical recruitment problems, there is absolutely nothing to be gained in extrapolating these results and applying them to France as a whole.
2.3 Supply of Health Professionals

2.3.1 The supply of physicians

As of 1 January 2009, France counted 216,017 practising physicians (209,143 physicians in mainland France). Between 2001 and 2009, the number of physicians increased by 8.3%. In 2009, there were 335 physicians per 100,000 people in France (327 per 100,000 people in 200, but 340 per 100,000 in 2008). It should be pointed out that, although France has never had so many practising physicians, "there is general agreement that the country will soon be confronted with a serious shortage", whereas in the 1980s, at a time when there were nearly 220 physicians per 100,000 people, it was generally held that there was an oversupply of people working in medical professions.

The average age of physicians practising in France has risen from 46.5 years old in 2001 to 51 years old in 2009. As of 1 January 2009, there were fewer physicians under the age of 40 than there were physicians over the age of 50.

There are also increasing numbers of women in the profession. In 2009, women accounted for 39% of all practising physicians, as opposed to only 36.4% in 2001. This percentage looks set to grow further still - more women are now graduating in medicine than men. Women accounted for 52% of all newly-registered physicians in 2008.

Gender seems to be a deciding factor in influencing physicians’ choice of specialist field. There is a preponderance of women in a number of fields, with women accounting for more than 50% of staff. Others have almost no women practising in them whatsoever.

<table>
<thead>
<tr>
<th>Specialist fields where women are predominant</th>
<th>Proportion of women among the staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical gynaecology</td>
<td>85%</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>71%</td>
</tr>
<tr>
<td>Occupational medicine</td>
<td>70%</td>
</tr>
<tr>
<td>Medical genetics</td>
<td>68%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>64%</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>61%</td>
</tr>
<tr>
<td>Anatomy and pathological cytology</td>
<td>61%</td>
</tr>
<tr>
<td>Public healthcare</td>
<td>58%</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>54%</td>
</tr>
<tr>
<td>Child and adolescent psychiatry</td>
<td>52%</td>
</tr>
<tr>
<td>Haematology</td>
<td>52%</td>
</tr>
</tbody>
</table>

Table 1 Specialist fields in which women are predominant in 2009

| Specialist fields with very few women | Proportion of women among the staff |

As of 1st January 2008\textsuperscript{20}, there were 340 physicians per 100,000 people in mainland France. The disparity between regions at both extremes of the scale was 1 to 1.6 in 2008, as opposed to 1 to 1.7 in 2001. Provence-Alpes-Côte d’Azur and the Paris region both enjoyed particularly high densities of physicians. At the other end of the scale, the Picardie, Centre and Haute-Normandie regions have densities of doctors that are 20% lower than the average for mainland France.

\textbf{Table 2} Specialist fields with very few women in 2009

<table>
<thead>
<tr>
<th>Field</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopaedic and accident surgery</td>
<td>3%</td>
</tr>
<tr>
<td>Urological surgery</td>
<td>3%</td>
</tr>
<tr>
<td>Thoracic and cardiovascular surgery</td>
<td>5%</td>
</tr>
<tr>
<td>Vascular surgery</td>
<td>5%</td>
</tr>
<tr>
<td>General surgery</td>
<td>9%</td>
</tr>
<tr>
<td>Diagnostic radiology and radiotherapy</td>
<td>9%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>10%</td>
</tr>
<tr>
<td>Gastroenterological and digestive surgery</td>
<td>12%</td>
</tr>
<tr>
<td>Stomatology</td>
<td>16%</td>
</tr>
<tr>
<td>Otorhinolaryngology</td>
<td>17%</td>
</tr>
<tr>
<td>Medical resuscitation</td>
<td>17%</td>
</tr>
<tr>
<td>Cardiology and cardiovascular diseases</td>
<td>19%</td>
</tr>
</tbody>
</table>

\textsuperscript{20} Daniel SICART (2009), \textit{Les médecins – estimations au 1er janvier 2008} (Doctors - estimates as of 1 January 2008), DRESS (Department of research, analysis, assessment and statistics, part of the French ministry of health) – Statistics series.
If a distinction is drawn between general practitioners and specialist physicians, the map of medical densities in mainland France is very varied. The disparity between regions at both extremes of the scale is 1 to 1.8 - a greater disparity than for overall medical density.

**Figure – Density of specialists by French regions**
(as of January 1st, 2008)

The disparity for the density of general practitioners between extreme regions is lower than the disparity for the density of specialist physicians. In 2008, this density disparity was 1 to 1.4. With the notable exception of Brittany, there was a shortage of general practitioners in the north-west of France.

**Figure – Density of generalists by French regions**
(as of January 1st, 2008)
In 2008, nearly 54.7% of physicians were practising in urban areas of more than 200,000 inhabitants. And yet, only 47.6% of them were general practitioners, as opposed to 61.8% of specialist physicians. Only 6% of physicians were practising in rural communities, the majority of them general practitioners (12% of general practitioners were practising in these communities). The larger the community, the more women there are among these physicians: women accounted for 45.8% of physicians in the greater Paris region in 2008.

As of 1 January 2008, the majority of physicians were working independently (56.5%). Nearly a third of all physicians were based in healthcare centres, most of them in state-run hospitals (27.3% of the total number). 70% of all general practitioners and 46.9% of all specialist physicians were practising independently. Women are more likely to be working in a hospital environment (they account for 43.6% of all doctors based in state-run hospitals) than independently (fewer than a third of all physicians with their own surgery are women). The percentages relating to the preferred ways of working for young physicians who had just registered with the Council of the order of doctors in 2008 were more or less the same.
As far as physicians’ income is concerned\textsuperscript{22}, in 2007, physicians earned an average of €86,300 through their practices, after professional charges and various personal social contributions. This net income represented an average increase of 2.1% in real terms on 2006, taking all specialist areas together. This increase in income was enjoyed by physicians in all specialist areas, including general practitioners (3%). But not all physicians are on the same salary, depending on the specialist area they work in: the average income disparity between extreme specialist areas is 1 to 3.5. The most lucrative specialist areas for private practitioners are: radiology (€202,800 net per year), anaesthetics (€171,800 net per year), surgery (€126,900 net per year) and ophthalmology (€124,900 net per year). At the other end of the scale, the least lucrative specialist areas for private practitioners are: dermatology (€57,000 net per year), psychiatry (€57,900 net per year) and paediatrics (€68,500 net per year). General practitioners earn an average of €66,800 net per year. The percentage of costs in fees increased in 2006 - the last year for which statistics are available - to 50.5% for specialist physicians and 46.7% for general practitioners. Physicians’ salaries are more driven by prices than by their actual activity. For all specialist physicians, regardless of whether or not they exceed the standard reference rates, these excesses represented an average of 15.5% of their fees, with significant variation depending on specialist areas: 3.5% of radiologists’ fees and around 4% of cardiologists’ and pulmonologists’ fees, but 43% of stomatologists’ fees, 30% of surgeons’ fees and 27% of gynaecologists’ fees. As far as the change in the proportion of physicians’ fees that these charges exceeding the statutory fees represents, dermatologists and ophthalmologists enjoyed the biggest increase in 2007.

In 2006\textsuperscript{23}, on average, the incomes of private practitioners were slightly lower than those of independent pharmacists and dentists, but higher than those of salaried healthcare professionals. On average, they earned 26% more than hospital doctors. However, in terms of living standards, private practitioners and hospital doctors were at the same level. The incomes of male practitioners were about 1.7 times those of women, whereas their living standards were comparable.

In the hospital sector, the majority of physicians working in private clinics are paid as private practitioners and so are affected by changes in private practitioners’ remuneration. As far as the state-run hospital doctors are conserved, there is significant variation depending on a physician’s status, length of service, bonuses and allowances for being on duty or on call. So a “hospital practitioner” - the most standard status that physicians working in state-run hospitals achieve once they have passed the competitive examination that transforms their status from “doctor” into (almost) permanent practitioner - can expect to earn €48,000 per year before tax at the start of his or her career\textsuperscript{24} and €88,230 per year before tax at the end of it. Various bonuses

\begin{table}[h]
\centering
\begin{tabular}{|l|c|c|}
\hline
 & Men & Women \\
\hline
Independent & 5\% & 4\% \\
Employee & 30\% & 35\% \\
Locum & 10\% & 14\% \\
\hline
\end{tabular}
\caption{Different modes of practising medicine by type for newly registered physicians in 2008\textsuperscript{21}}
\end{table}

\textsuperscript{21} CONSEIL NATIONAL DE L’ORDRE DES MEDECINS (national council of the order of doctors) (2009), \textit{Atlas of medical demography in France - the situation as of 1 January 2009}.
\textsuperscript{22} Hélène FRÉCHOU, François GUILLAUMAT-TAILLIET (2009), “Physicians’ income in 2006 and 2007”, \textit{Études et résultats} no. 686.
\textsuperscript{23} Ketty ATTAL-TOUBERT, Nadine LEGENDRE (2007), “Comparaison des revenus des médecins libéraux à ceux des autres professions libérales et des cadres” (a comparative study of the incomes of private practitioners with those of other professions and managers), \textit{Études et Résultats} no. 578.
\textsuperscript{24} Figures as of 1 July 2009. MINISTRY OF HEALTH, \textit{Law of 18 August 2009 concerning fees, remuneration and bonuses for healthcare staff employed either permanently or on a part-time basis in public healthcare centres}.
and allowances can be added to this figure, depending on whether or not they practice exclusively in the public sector (€5800 per year before tax) or whether or not they spread their work across several different public healthcare centres (€4950 per year before tax). Working as an emergency or on-call doctor brings with it more bonuses: a hospital practitioner can expect to receive an extra €15,600 per year before tax for being on-call one day a week and one Sunday per month. So effectively, a hospital practitioner at the beginning of his or her career can conceivably earn nearly €75,000 per year before tax. How frequently a doctor is on-call can be adjusted depending on how his or her colleagues operate in the healthcare centre (some doctors want to be on-call less frequently than others), but the number of times that they are required to be on-call during a given period is mainly determined by the number of practitioners working at the centre in question. What this means is that it is not uncommon in certain hospitals experiencing recruitment difficulties to have one single physician having to be on-call throughout the year - except when they are on holiday, which forces the healthcare centre to call upon the services of locums. These locums can often be somewhat mercenary as far as their salary requirements and other perks are concerned (the quality of their accommodation and meals). These locums can sometimes earn up to €3000 for 24 hours of uninterrupted service in state-run hospitals.

As far as "part-time hospital practitioners" are concerned, their salary scale does not include bonuses and allowances for being on-call or on duty (which - as seen above - can significantly increase doctors' remuneration), and ranges from €29,800 per year before tax to €54,000 per year before tax.

There are other types of contractual status in state-run hospitals, both permanent and short-term: doctors can only practise with "hospital assistant" status for six years. Their annual income before tax (excluding bonuses and allowances for being on call or on duty) is €25,600 for the first year, increasing to €34,200 by the sixth year. This is the special status enjoyed by young graduate doctors who are preparing for the "hospital practitioner" competitive examination during the course of their six-year contract. A number of new dispensatory statuses have emerged in recent years, including the status of "contractual hospital practitioner", the remuneration of which varies depending on recruitment background and the type of work they do; As a general rule, they are recruited on the salaries that hospital practitioners earn at the start of their careers, which are then increased with the approval of the hospital manager up to grade 4 of the salary scale + 10%.

Medical staff working in university hospitals have special status (in decreasing order of prestige: university practitioners - university professors and hospital practitioners [PU-PH], university lecturers and hospital practitioners [MCU-PH], university hospital practitioners [PHU], university clinic directors-hospital assistants and university hospital assistants) if their responsibilities include teaching; this can dramatically increase their remuneration insofar as they are paid by both the hospital and the university. For example, someone with the status of "university lecturer and hospital practitioner (MCU-PH)" can expect a monthly salary in their first year of service of: €2190 before tax from the hospital plus €2070 before tax from the university - as well as various bonuses for being on call. Once all incomes have been totalled, a practitioner can expect to earn an annual salary of €85,000 before tax during the first three years of their having this status.

It should also be pointed out that hospital practitioners can work independently in state-run hospitals. This involves working privately on the premises of the state-run hospital with its medical staff, providing consultations, healthcare and carrying out medico-technical procedures. They may not spend more than 20% of their weekly working hours working privately, and the number of private consultations they give must not exceed more than 50% of the total number. So, physicians' average earnings in 200425 from private consultations were €61,126. Some brought in significantly higher incomes from private practice work: €632,898 earned by a urologist and €568,324 earned by an ophthalmologist in 2004.

So when all is said and done, the broad range of statuses and the complex way in which remuneration is divided up means that the salaries of physicians working in state-run hospitals

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is not a straightforward issue; if one looks at the statutory salary scale alone, the difference between the public sector and the private sector appears considerable. But once all the bonuses and allowances for on-call days are added, together with any private consultations carried out in state-run hospitals, the gap narrows. And some doctors working in certain specialist areas in state-run hospitals actually earn more than their private sector counterparts.

The means by which outpatient care is delivered have changed dramatically over the last decade. According to a panel of private general practitioners from five French regions (Bourgogne, Bretagne, Basse-Normandie, Pays de la Loire and Provence-Alpes-Côte d’Azur) 26, in 2007 they worked between 55 and 59 hours per week, including on-call and emergency time. Practitioners based in rural areas spent much more time outside the surgery. Physicians working as part of a practice - something which is much more common among young doctors - worked two to four hours less per week. In total, one in two practitioners said they would like work approximately 12 hours a week less.

More broadly, general practitioners said they worked an average of between 52 at 60 hours per week, divided up as follows: 27 33 hours of private consultations and visits, approximately 2 hours spent delivering healthcare within the context of a salaried position (working in another centre, such as a state-run hospital, a retirement home or school), more than 6 hours spent providing continuity care, nearly 2 hours spent carrying out unpaid work (including dispensing advice to patients over the telephone), 4.5 to 6.5 hours spent on admin work, at least 4.5 hours spent training other practitioners and providing them with information.

As far as salaried physicians are concerned, the SESMAT 28 survey carried out in 2007-2008 highlighted a certain unrest among salaried physicians. A significant proportion cited their dissatisfaction with the psychological support they received at work (67.3%). 58.2% of the physicians polled were fearful of making mistakes. And even greater cause for concern, 17.4% of the salaried physicians and pharmacists polled made known their intention to leave the profession. This is particularly the case among geriatricians, emergency physicians and pharmacists, with more than 20% of them indicating that they were considering leaving their jobs. The reasons for this that they cited included factors associated with salary, job offers from elsewhere, mental health and the poor quality of the teamwork they experienced. Surgeons and anaesthetists are most likely to perceive their salaries as low. More emergency physicians, anaesthetists and geriatricians than representatives of any other specialist field claimed to have received job offers for different types of work outside their own institutions during the course of the last 12 months. As far as the mental health of these healthcare professionals is concerned, emergency physicians, geriatricians and pharmacists suffered most from burn out, with the geriatricians most susceptible to psychological disorders (anxiety, depression or problems sleeping). The desire to leave the medical profession increases when the poor quality of the teamwork becomes an issue. This is the case across all specialist fields.

26 Marielle AULAGNIER, Yolande OBADIA, Alain PARAPONARIS et al. (2007), “L’exercice de la médecine générale libérale - Premiers résultats d’un panel dans cinq régions françaises” (Practising private medicine - preliminary results from a panel of five French regions), Études et Résultats n°610.

27 Philippe LE FUR, Yann BOURGUEIL, Chantal CASES (2009), “Le temps de travail des médecins généralistes - Une synthèse des données disponibles” (GP’s working hours - a synthesis of available information), Questions d’économie de la santé no. 144.

28 Madeleine ESTREYN-BEHAR (2009), “Influence du travail d’équipe sur la satisfaction professionnelle des médecins - Résultats de l’enquête SESMAT” (the influence of teamwork on the professional satisfaction of physicians - the results of the SESMAT survey), Le Concours médical volume 131-1.
FOCUS – THE CHANGE IN PERCEPTIONS OF THE PROFESSION FOR YOUNG PHYSICIANS

Younger generations of doctors no longer see their work as a "calling" in quite the same way as their elders. They are no longer prepared to make themselves permanently available, dedicating themselves unconditionally to the needs of their patients and sacrificing their personal and family lives. And consequently, younger physicians seem to be distancing themselves from this traditional professional "ethos". Without drastically reducing their working hours, they would, however, like some extra time for themselves, or failing that, would like a more clear-cut distinction between their working time and their free time. This is not so much due to the growing numbers of women in the profession - on average, women work 4 to 6 hours less than their male counterparts per week - as to changing trends in society. Young physicians of all types aspire to being able to enjoy a certain quality of life. This explains why many are leaving the specialist fields - surgery in particular - which suffer from working time and availability constraints, as well as being perceived as particularly challenging. Similarly, fewer of them are opting for jobs in university hospitals because of the difficult career path and very long working hours that this involves. Instead, they are opting for salaried positions and are tender to favour jobs where they can schedule their work loads as they wish.

Young physicians want to be able to reconcile professional life and personal life (the time they spend with their partners and families). Increasingly, being able to do this involves having to manage two careers - that of the physician and that of his or her partner. The result is that the type of job they opt for becomes less of a professional choice in the strictest sense and more of a choice based around their relationship. So the choice will be designed to meet various different needs and expectations: the young physician and his or her family will need feel as though they are flourishing, the location will need to be compatible with their partner's profession, and they must be able to practice their own profession as best they can. 

Having to take all of these considerations into account usually results in young doctors setting up in a large town - a university town if possible... a town that offers opportunities for leisure activities, professional opportunities for their partners and childcare and school facilities for their children.

For more details, see: Magali ROBELET, Nathalie LAPEYRE-SAGESSE, Emmanuelle ZOLESIO, (2006), Les pratiques professionnelles des jeunes générations de médecins – genre, carrière et gestion des temps sociaux : le cas des médecins âgés de 30 à 35 ans (the professional practices of younger physicians - type, career and social time management: the case of doctors between 30 and 35 years old), summary for the Conseil national de l'Ordre des médecins (national council of the order of doctors).

More than 60% of the students who took the examen classant national (national entrance examination) in 2007 were women.

National council of the order of doctors - Committee for young doctors report.

National council of the order of doctors - BVA INSTITUTE (2007), Attentes, projets et motivations des médecins face à leur exercice professionnel (the expectations, projects and motivation of doctors with respect to carrying out their jobs).
2.3.2 The supply of dental surgeons

As of 1 January 2009, there were 41,968 dental surgeons in France (41,116 in mainland France)\(^\text{33}\). And between 2001 and 2009, the number of dental surgeons increased by 2.10\%. Of all the healthcare professions looked at, dentistry is the one whose staff numbers have grown the least between 2001 and 2009.

There are increasing numbers of women in the profession. In 2009, women accounted for 37.2\% of all practising dental surgeons, as opposed to 32.6\% in 2001. But there have been women in the profession for a long time: although they accounted for 59.4\% of all practising dental surgeons under the age of 30 in 2009, they also accounted for 27\% of all dental surgeons age between 55 and 59. The proportion of women practising dentistry looks set to grow further still - more women are now graduating in the discipline than men.

Generally, the average age of practising dental surgeons in mainland France has risen from 44.9 in 2001 to 48.2 in 2009.

As of 1 January 2009, there were 67 dental surgeons per 100,000 people in mainland France - or one for every 1500 or so. But the national average is somewhat irrelevant, given the significant differences among regions. The disparity between regions at both extremes of the scale was 1 to 2.25 in 2009, as opposed to 1 to 2.2 in 2001. The four regions with the highest densities (Provence Alpes Côte d’Azur, Corse, Ile de France and Midi-Pyrénées) are where 40\% of all dental surgeons practise, but account for only 30.9\% of the French population.

*Figure 2* - Density of dental surgeons by French regions

33 Daniel SICART (2009), *Les professions de santé au 1er janvier 2009* (healthcare professions in France as of 1 January 2009), DRESS (Department of research, analysis, assessment and statistics, part of the French ministry of health) – Statistics series.
In 2009, nearly 50.2% of dental surgeons were practising in urban areas of more than 200,000 inhabitants. Only 7.9% of them practise in rural communities. With the exception of rural communities, which is where 38.6% of all female dental surgeons practise, the larger the community, the more women there are among these dental surgeons: women account for 42.6% of all dental surgeons in the greater Paris region.

As of 1 January 2009, almost all dental surgeons were working independently (90.8%), with those on salaries working mainly in healthcare centres or Social Security establishments. Dental care is less readily available in hospitals: less than 500 dental surgeons (less than 1%) are now practising in hospitals - and do so rarely on a full-time basis. Women, it should be noted, are more attracted by salaried work - 14.1% of them have opted for this mode of practice, as opposed to only 6.2% of their male counterparts. In mainland France, dental surgeons are increasingly practising as groups (40.5% in 2009, up from 30.9% in 2001) and are increasingly moving away from the single practice (51% of dental surgeons in 2009 as opposed to 62.1% in 2001). This is because of the advantages in working together as part of a group: the advice and experience of colleagues, being able to collectively manage the practice, staff and relations with healthcare organisations, lower investments, etc.

FOCUS – DENTISTRY IN FRANCE – BACKGROUND
The situation in France with respect to dentistry is somewhat peculiar - the profession seems to have been marginalised from the rest of public healthcare. Although the incidence of conditions requiring dental care is high, it was not until 2005 that the country's dental health became the focus of a nationwide action plan. It was the dental surgeons themselves who initiated the setting up of the dental care prevention scheme in France.
It should be noted that only a small percentage of the cost of dental care is reimbursed by Social Security. The cost of basic care is reimbursed, but the basic coverage rate for all other dental costs by the health insurance scheme is only 30%. Complementary bodies cover an additional 35%, meaning that the remaining 35% is payable by households.

The data relating to the income of dental surgeons focuses on those who practice privately. In 2006, it was estimated that dental surgeons earned 25% more than general practitioners and 22% less than specialist physicians. In 2007, dental surgeons’ average income (after contributions) stood at €81,400, with charges exceeding the statutory fees on the increase, representing 49% of their fees. Between 2000 2007, the average income of dental surgeons increased by an average of 2.2% (in constant Euros) each year. The measures taken in 2006 (increasing the price of consultations from €20 to €21 on 1 August 2006, together with the price of conservative care) were partly behind the increase in salaries seen in 2007. There is, of course, a great deal of variation within this average. Remuneration varies from region to region, and is also dependent on the types of procedures carried out.

As far as the average workload of dental surgeons is concerned, it would seem that their daily working hours are increasing. In 2000, 38% of all dental surgeons were working more than 10 hours per day, whereas only 5.3% of them were in 1993. A significant increase in the number of days per week that dental surgeons worked was also noted in the same period: in 2000, 50.8% of all practitioners were working between 5 and 6 days a week, up from 45.2% in 1993. But in 2000, the distribution of working hours was different for men and women: 60.1% of women were working between 3 and 4 days a week, as opposed to 44.6% of men, while 56.5% of men were working between 5 and 6 days a week, as opposed to only 39.9% of women. So it would appear that the growing numbers of women in the profession is having an effect on dental surgeons' workloads and how they organise their working hours.

And yet, people in the profession often highlight the fact that younger practitioners (both men and women) are tending to work shorter hours than their more senior colleagues. Weekly working hours and surgery opening times seem to be decreasing, although no survey has been carried out since 2000 that might confirm this trend. Young dental surgeons are following the general trend and are working shorter hours, preferring to spend more time with their families and on leisure activities.

2.3.3 The supply of pharmacists

As of 1 January 2009, there were 74,461 pharmacists in France (73,128 in mainland France). Between 2001 and 2009, the number of pharmacists increased by 21.45% (61,310 pharmacists in 2001).

There is a preponderance of women in the profession. In 2009, women accounted for 65.1% of all practising pharmacists, as opposed to 61.4% in 2001. The last few decades have seen a dramatic influx of women into the profession, with women now accounting for 56.3% of all pharmacists between the ages of 60 and 64 years old. But this trend is continuing, with women now accounting for three quarters of all pharmacists under the age of 30 (74.8% in 2009).

Generally, the average age of practising pharmacists in mainland France has risen from 44.9 in 2001 to 46.9 in 2009. The over-50s now account for 43.7% of all practising pharmacists.

As of 1 January 2009, almost all pharmacists were working in dispensing chemists (74.5%). In France, dispensing chemists have the monopoly on the retail sale of pharmaceutical products, so much so that for several years now, they have been playing a central role in the development of policies for keeping down the cost of healthcare, particularly in the prescription of generic drugs. 9.5% of pharmacists are employed by hospitals (both state-run and private), with the rest working in the pharmaceutical industry (7%) and medical test laboratories (5.7%). Women are more attracted by salaried positions: they account for 72.4% of all hospital pharmacists (employee status), but only 52.7% of independent pharmacists.

There is currently one dispensing pharmacy for every 2600 people in France (this means that there is a denser network of pharmacists than of post offices). More generally, as of 1 January 2009, the average density of pharmacists in France was 118 pharmacists for every 100,000 people. But there is variation according to region, with the densest coverage in the south-east of the country. The disparity between regions at both extremes of the scale increased between 2001 and 2009; it stands at 1 to 1.5 in 2009, as opposed to only 1 to 1.3 in 2001.

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37 Daniel SICART (2009), Les professions de santé au 1er janvier 2009 (healthcare professions in France as of 1 January 2009), DRESS (Department of research, analysis, assessment and statistics, part of the French ministry of health) – Statistics series.
38 Françoise MARIN, Eve MARIN, Auryane BARRANCOS (2006), Le métier de pharmacien: contenu et perspectives du rôle de premier recours (Pharmacy: what this first-resort role entails and what the future may hold for it).
Figure 3 - Density of pharmacists by French regions

In 2009, almost a third of all pharmacists are practising in rural areas (12.5%) or areas with fewer than 20,000 inhabitants. The proportion of women working in various types of urban units is more or less equivalent (+/-2.4%).

As far as income is concerned, a distinction should be drawn between income generated by practising privately in dispensing chemists and in other places - even though there is no public data available about remuneration in the pharmaceutical industry or in medical test laboratories. Between 1995 and 2002, the turnover generated by dispensing pharmacies increased (at constant prices) by +4.4% per year. In 2001, the average gross salary of a pharmacy license holder was €120,000, before tax; the average net income was approximately €102,000 per pharmacy license holder in 2001.

Pharmacists’ income varies depending on the geographical region in which they are practising and the legal form of their business. These disparities are to do with varying contribution rates and charges between regions (property costs, in particular), the age structure of the regional population (in regions with a high average age, more medicines are consumed) and the density of pharmacists (the more pharmacists there are in a region, the lower their income is likely to be). Nevertheless, pharmacists prefer to set up in the southern regions of the country where there is a high proportion of elderly people. But given the density of coverage, their incomes are not necessarily any higher. At the other end of the scale, in the north of France, despite the relative youth of the population, pharmacists have higher incomes than the national average - simply because there are fewer of them. So, the further north pharmacists set up, the more they are likely to earn: less than €111,000 before tax in the Aquitaine, Midi-Pyrénées and Provence-Alpes-Côte d’Azur regions in 2001, as opposed to more than €140,000 euros in the Picardie, Alsace and Lorraine regions.
2.3.4 The supply of midwives

As of 1 January 2009, there were 19,651 midwives in France (18,847 in mainland France)\(^{39}\). Between 2001 and 2009, the number of midwives increased by nearly 28.8% (15,263 midwives in 2001). Of all the healthcare professions looked at, midwifery is the one whose staff numbers have grown the most.

As of 1 January 2009, the vast majority of midwives are salaried employees (82.9% of all midwives in mainland France). Only 17.7% of midwives work privately; this percentage is growing - in 2001, only 13.8% of midwives were working privately.

Salaried employment can take a number of different forms: some are employed by hospitals, others by maternal and child welfare departments\(^{40}\) or local authorities\(^{41}\). As of 2009, three-quarters of all French midwives were employed by hospitals.

There is a certain distance between midwives working in the hospital sector and those practising privately\(^{42}\), with tensions arising between the two groups when there is an imbalance affecting on of the sectors. A shortage of midwives working in state-run hospitals can lead to increasing demands being made of midwives practising privately (consultations or antenatal classes, for example, are sometimes moved to the private sector). Conversely, a shortage of independent midwives at local level can lead to greater numbers of pregnant women registering with state-run hospitals.

As of 1 January 2009, 1% of all midwives were registered with locum agencies. But the available statistics do not provide a complete picture of the situation - a number of midwives combine their locum midwifery work with other salaried work. Locum work does, however, appear to be on the increase among newly qualified midwives - because of the better pay and higher levels of autonomy that practising this way can offer.

Generally, the average age of practising midwives in mainland France has risen from 41.2 in 2001 to 42.1 in 2009.

The average age varies according to the sector in which they practise. It is 51.4 for midwives working in maternal and child welfare units, and 48.8 for those affiliated to local authorities; it’s 43.1 for midwives working as part of a midwifery practice, and 45.1 for midwives practising on their own. The average age is 40 in state-run centres and in private centres which come under public sector hospital care, and 43.3 in all other private centres. And the average age of salaried midwives registered with locum agencies is 35.3.

These age differences depending on sector types can most likely be explained by different choices midwives make as they progress through their career: starting in state-run hospitals or as locums at the outset, they later move over to the private sector. (with the older generations moving over to maternal and child welfare units).

The profession is increasingly opening up to men. In 2009, they accounted for 1.65% of midwives, as opposed to only 0.65% in 2001.

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\(^{39}\) Daniel SICART (2009), *Les professions de santé au 1er janvier 2009* (healthcare professions in France as of 1 January 2009), DRESS (Department of research, analysis, assessment and statistics, part of the French ministry of health) – Statistics series.

\(^{40}\) Midwives working in maternal and child welfare departments are tasked with prevention and supervision. They deal with high-risk pregnancies in particular, playing both a medical and a psychosocial role: they carry out obstetric and psychological examinations, are involved in managing the risks of premature birth and supervise the treatment of all diseases associated with pregnancy (high blood pressure, diabetes, etc.).

\(^{41}\) Midwives working for local authorities hold information sharing sessions on health education and family planning. They are involved in giving out information to young people in schools and other associations, and are available for consultation in family planning clinics.

As of 1 January 2009, the density of midwives in mainland France was 130 for every 100,000 women aged between 15 and 49 years old. These densities are extremely unequal, varying dramatically from region to region. The disparity between regions at both extremes of the scale was 1 to 1.7 in 2009, as opposed to 1 to 1.6 in 2001. For example, the density of midwives in the Picardie region is 28% below the national average. At the other end of the scale, the Rhône-Alpes has 25% more than the average for mainland France.

The majority of midwives (50.8%) practise in urban areas of more than 200,000 inhabitants. Conversely, only 2.8% of midwives work in rural areas of fewer than 5000 inhabitants; of these, 76.2% are private practising - maternity care centres in communes of fewer than 5000 inhabitants are relatively rare nowadays. This low percentage of midwives in rural areas raises questions about how well the needs of parturients in these areas are met, and showing just how medicalised childbirth is in France and how readily women give birth in hospitals.

As far as midwives' pay is concerned, the data available is recent and reliable, and can be used to evaluate the remuneration of salaried midwives in state-run hospitals - which account for 57.5% of all midwives. In state-run hospitals, depending on her years of service, a midwife can earn between €23,000 and €33,000 gross per year - as well as between €4000 and €6000 of bonuses and allowances.

As a general rule, a proportion of midwives believe their salaries to be too low - given the levels of responsibility involved.

Those involved in the profession have a sense of there being a shortage of midwives. This is particularly the case within professional bodies - despite the numbers of practising midwives rising constantly, and at a greater rate than the numbers of births. The consequence of this perception is the feeling that midwives are constantly being overworked.

A number of factors have exacerbated this feeling: changes in the ways in which care is delivered to pregnant women (increase in short-stay prenatal hospitalisation, increase in the frequency of antenatal sessions, growth in the numbers of parturients who are not supervised in hospitals but who arrive through A&E), changes in working hours, changes in the personal
choices made by midwives, increases in their workloads and low numbers of gynaecologists-obstetricians.

According to the results of a poll published in 2003 that was carried out at the end of 2002 by the ONSSF (France’s national organisation of midwives’ unions), 44% of midwives are dissatisfied with their working conditions, whereas only 36% are satisfied. The main grievance raised by midwives related to the contents of their work: the emphasis appears to be mainly on medico-technical procedures with an ever-increasing admin work load.

According to the results of a poll published in 2004, between 11% and 25% of hospital midwives said they had not done any overtime in 2003. Midwives working in level 3 state-run referral hospitals for maternity care work the most overtime: only 8% of midwives did no overtime (as opposed to 10% in level 2 and 13% in level 1 hospitals), while 30% of them did between 101 and 200 hours in 2003 (as opposed to 15% in level 1 and 2 hospitals and 10% in PSPHs (private institutions involved in a cooperative programme with public hospitals) or clinics.

2.3.5 The supply of nurses

As of 507 January 2009, there were 507,514 nurses in France (495,834 in mainland France)\(^{43}\). Between 2001 and 2009, the number of nurses increased by 25.4% (404,564 nurses in 2001).

In pure numerical terms, the number of people working in the profession has risen substantially: there are more than twice the numbers there were in 1980 (246,000 nurses), and more than two-thirds more than there were in 1990. This represents an average yearly increase of 3.3%.

There are still vastly more women working in the profession than men. In 2009, 87% of all nurses were women. There has, nevertheless, been a gradual increase in men: numbers have doubled over the last 30 years in the state-run hospital sector (6.7% in 1975, 12.7% in 2009). But this gradual increase seems to be flattening out: in 2009, men accounted for 12.7% of nurses (18.7% of nurses in France's overseas territories); in 2001, they represented 12.9% of nurses (19.5% of nurses in France's overseas territories).

The average age of practising nurses has increased considerably over the last 20 years - from 34 years old in 1983 to 42.3 at the start of 2009.

As of 1 January 2009, the density of midwives working in mainland France was 803 for every 100,000 inhabitants. The unequal distribution of healthcare professionals in France also applies to nurses, despite the fact that the variation in density between regions has decreased between 2001 and 2009. In 2001, this variation in density was 1 to 1.9. In 2009, it has fallen to 1 to 1.6. Nevertheless, the Centre region has a density that is 21% lower than the national average, with the Limousin region boasting 31% more nurses than the national average.

\(^{43}\) Daniel SICART (2009), \textit{Les professions de santé au 1er janvier 2009} (healthcare professions in France as of 1 January 2009), DRESS (Department of research, analysis, assessment and statistics, part of the French ministry of health) – Statistics series.
As of 1 January 2009, the majority of nurses (70.9%) were working as hospital employees in either the public or the private sector. This percentage has fallen slightly since 2001 (72.9%). As of 2009, 14.8% were working independently - little change since 2001 (14.5%). The various other modes of salaried employment in 2009 are relatively diverse: 4.1% are based in centres for the elderly, 3.9% in centres for the disabled, 1.9% are employed by locum agencies, 1.3% in health centres, 1.05% in maternal and child welfare centres, and 0.85% work as school or university nurses. Between 2001 and 2009, there was a significant increase in the percentages of nurses working in centres for the elderly (2.5% in 2001) and for disabled people (0.81% in 2001).

In 2009, nearly 47.5% of nurses practise in urban areas of more than 200,000 inhabitants. 11.3% of nurses work in rural areas of fewer than 5000 inhabitants. In these rural areas, there is a majority of independent nurses (42%), since hospitals are only very rarely found in areas with such low populations. The proportion of women remains more or less the same across urban communities of different sizes.

As a general rule, nurses often begin their careers working in hospitals. On the one hand, this is because they are required to have spent three years working in a hospital during the six-year period leading up to their application to work privately. On the other hand, hospitals are seen as good places within which to learn, and so right from the moment they complete their training, they are keen to work in an environment in which they have opportunities to apply the healthcare techniques they have learned. This would explain why the more technical departments appear to be the ones in which new recruits are most interested. 85% of all nursing training institutes are ‘supported’ by hospitals, and interns make decisions about where they are going to work based on their experiences during their internships. Nevertheless, there is no real knowledge about the early years of nurses' careers, how their aspirations might change and how they think their career paths might unfold. New forms of professional career management seem to be emerging (switching over to humanitarian work
abroad, adjusting workload during the year, locum careers, etc.), but it is not easy to precisely measure these developments.

Statistics show that increasing numbers of nurses are carrying out locum work: this involved only 0.9% of nurses in 2001, as opposed to 1.9% in 2009. Younger nurses are particularly interested in this mode of work - despite the fact that the average age has increased from 32.9 years old in 2001 to 36.1 years old in 2009.

As far as salaries in state-run hospitals are concerned, general care nurses were earning \(\text{€}17,000\) before tax in July 2009 (plus bonuses and allowances of up to \(\text{€}4500\) depending on geographical area and family situation, in particular). By the end of their careers, this annual salary can increase to \(\text{€}29,500\) before tax (plus \(\text{€}5000\) of annual bonuses and allowances).

It should be noted, however, that specialist nurses (in childcare, anaesthesia and operating block work) earn more than general care nurses; these specialist nurses are better paid in state-run than in private hospitals. As of 1 January 2009, they accounted for 8.6% of nurses working in mainland France. As of July 2009, nurses specialised in anaesthesia care could earn a basic salary before bonuses of around \(\text{€}20,200\) before tax at the start of their career and \(\text{€}33,300\) before tax at the end. Nurses specialised in childcare and operating block work begin their careers on an annual salary (before bonuses) of \(\text{€}20,200\) before tax, and can hope to earn \(\text{€}31,400\) before tax by the end of their career (before bonuses). They can also - through sitting exams - take on additional supervisory and staff management roles across one or several departments or divisions, and eventually become health executives or even health centre managers. These additional roles carry financial benefits: \(\text{€}21,000\) a year (before tax) basic salary before bonuses increasing to \(\text{€}36,000\) for local level managers; \(\text{€}25,000\) a year (before tax) before bonuses increasing to \(\text{€}43,000\) a year (before tax) for health centre managers. These managers are responsible for organising the delivery of care and managing healthcare teams alongside the human resources managers. They are part of the management teams in state-run hospitals.

Private nurses earn considerably more. In 2007, the average income of nurses practising privately was \(\text{€}40,900\) net. Between 2000 and 2007, the income of privately practising nurses increased by an average of 3.1%. These incomes were increased in July 2007 as part of a new agreement with health insurance schemes. This agreement provides for new regulatory measures designed to reduce imbalances in the distribution of health care professionals across a particular region. The reimbursement of travelling expenses has been increased alongside fees and as of 2004, represents 20% of fee totals.

On 1 January 2000, the working week was reduced from 39 to 35 hours for nurses working in private hospitals. State-run hospitals followed suit on 1 January 2002. In theory, this switch from 39 to 35 hours per week is the equivalent of a 10.25% reduction in nurses’ working hours (but in fact, it’s a reduction of between 8% and 11%, varying from one state-run hospital to another). Reducing the number of hours in the working week for the entire hospital sector (state run & private) is the equivalent to cutting staff by 8.3%. The result is a slowing down in the increase of numbers of nurses since 2000.

Although the kinds of task in which nurses have always traditionally been involved (distributing medicines, monitoring a patient’s vital signs, providing pre-and post-operative care, watching out for any side-effects of treatment, changing dressings, monitoring wounds, etc.) remain their key areas of responsibility, the profession has still found itself having to adapt and diversify over the last few years. There are numerous examples of these new areas of responsibility: a great deal of importance is now being attached to traceability; new emphasis is being placed on quality with the recent introduction of the hospital accreditation system; the way in which hospital care is delivered has been reorganised; the search for increased productivity and

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44 Monthly index point value adjusted as of 1 July 2009: \(\text{€}4.59\). [Link](http://vosdroits.service-public.fr).
46 See 2.4 concerning nurses’ education.
efficiency has had a notable impact on the nursing profession, both in terms of the ways in which certain responsibilities are defined and in terms of the emergence of new responsibilities which a given institution now requires. When the amount of time that nurses have to carry out this expanded set of responsibilities remains the same or is even reduced, they often feel overloaded. In 2003, 49% of nurses working in health centres said that their working regime was set by production standards or deadlines that they had to meet in an hour or less\textsuperscript{47}. Nurses working in state-run healthcare centres (48%) complained more than their colleagues in the private sector (40%) about not having enough time "to do their work properly". And 57% of nurses polled in state-run hospitals did not think that they had enough colleagues in order for them to do their work properly. There has also been a deterioration of the nurse-patient relationship; in 2003, 73% of all nurses polled said that they had been verbally abused. As a consequence, many nurses - particularly hospital nurses in the public sector - feel that their mental health is being affected by their profession.

2.3.6 The supply of physiotherapists

As of 1 January 2009, there were 68,751 physiotherapists in France (66,919 in mainland France)\textsuperscript{48}. Between 2001 and 2009, the number of physiotherapists increased by 25%.

There are increasing numbers of women in the profession. In 2009, women accounted for 46.8% of all practising physiotherapists, as opposed to 42.4% in 2001. There is a preponderance of women among newly-qualified physiotherapists: they account for 59.7% of all physiotherapists under the age of 30.

Generally, the average age of practising physiotherapists in mainland France has risen from 41.2 in 2001 to 42.8 in 2009.

As of 1 January 2009, the majority of physiotherapists were working independently (78.9%), with those on salaries working mainly in healthcare centres (17.2%), mainly state-run (10.4%) and in centres for the disabled (1.9%). Women, it should be noted, are more attracted by salaried positions. They account for 67.5% of all physiotherapists who have opted for this mode of working, as opposed to only 41.3% who have chosen to practise privately. Of those working privately, the number of physiotherapists with their own surgery fell between 2001 and 2009, although they still account for the majority (61.6% of physiotherapists practising privately have their own surgery in 2009, as opposed to 66.2% in 2001).

As of 1 January 2009, the density of physiotherapists working in mainland France was 108 for every 100,000 inhabitants. This is one of the healthcare professions that has the greatest variation in density from region to region - although the disparities between regions at opposite ends of the scale appear to be shrinking. In 2009, this disparity was 1 to 2.3, as opposed to 1 to 2.5 in 2001.

\textsuperscript{47} Romuald LE LAN, Dominique BAUBEAU, (2004), "Les conditions de travail perçues par les professionnels des établissements de santé" (working conditions seen by professionals in healthcare centres), 	extit{Etudes et Résultats} no. 335.

\textsuperscript{48} Daniel SICART (2009), 	extit{Les professions de santé au 1er janvier 2009} (Healthcare professions in France as of 1 January 2009), DRESS (Department of research, analysis, assessment and statistics, part of the French ministry of health) – Statistics series.
47.7% of physiotherapists practise in urban areas of more than 200,000 inhabitants. Conversely, nearly 18.3% of physiotherapists practise in rural communities or in urban areas of fewer than 5000 inhabitants. Of all the professions analysed, it is the one that boasts the highest numbers of practitioners in rural areas. There is a preponderance of women (51.5%) among physiotherapists in the Paris region.

In 2007, the average income of physiotherapists practising privately was €37,500. Between 2000 and 2007, the income of privately practising physiotherapists increased by an average of 2.1% each year. In constant Euros, the income of physiotherapists increased in 2001 and 2002, before remaining stable for a period. It rose again in 2007 as a result of an expansion of their activities and an increase in standard reference rates - particularly for osteoarticular (fractures) and spinal (back) physiotherapy. Their average charge rates have remained unchanged since 2001 and their charges exceeding statutory fees - while very dynamic - are very low (1.5% of fees).

The income of physiotherapists in state-run hospitals is the same as for nurses. Newly-qualified physiotherapists were earning €17,000 before tax in July 2009 (plus bonuses and allowances of up to €4500 depending on geographical area and family situation, in particular). By the end of their careers, this annual salary can increase to €29,500 before tax (plus €5000 of annual bonuses and allowances).

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50 Ministry of Health (2009), Guide des carrières des personnels de la fonction publique hospitalière (Guide to careers for staff working in state-run hospitals).
2.4 Training routes for healthcare professionals

Basic training for the healthcare professionals we looked at (physicians, dental surgeons, pharmacists, midwives, nurses and physiotherapists) follows two different routes, as shown below.

Figure 7 – A summary of training routes for healthcare professionals

Physicians, dental surgeons and midwives all start university and attend the same classes in their first year before sitting a selective examination with quotas set for each of the professions. A *numerus clausus* system is used since the number of applicants greatly exceeds the number of available places for students. Depending on where they are ranked in the results of this exam, students are then able to go on to study either medicine, dental surgery or midwifery. Students are only allowed to sit the exam twice; large numbers resit. It is not uncommon, therefore, for students who wanted to become doctors to end up being dental surgeons or midwives - because their ranking was not high enough for them to get onto the course that they initially had their sights set on. From the second year, training is separate for each profession.

Pharmacists go to university and follow first-year modules before sitting a selective examination with quotas set for the maximum number of students admitted into the second year (*numerus clausus*). Students are only usually allowed to sit the exam twice; large numbers resit. The pass rate is very low for students sitting the exam for the first time.\(^{51}\)

Until now, nurses were not trained in universities (see below). Instead, they attended professional institutes that were separate and independent from universities, and supported by

\(^{51}\) In the faculty of chemistry at the University of Toulouse in 2007/2008, for example, the pass rate for students sitting the exam for the first time was 13%, as opposed to 38% for those sitting it for the second time. [http://www.pharmacie.ups-tlse.fr/](http://www.pharmacie.ups-tlse.fr/)
hospitals. These institutes accepted trainee nurses once they had passed a competitive entrance exam - an exam they could sit immediately after their *baccalauréat*.

For **physiotherapists**, there are two possibilities, depending on the region in which students want to to their training: Either they sit a selective exam after their *baccalauréat* (they often need a whole year in order to pass this very selective exam) and are accepted by a professional training institute; or, their professional institute works alongside the university and they spend their first year following the same modules as students training to enter other medical professions. They then sit the selective examination, as do all the other students. Whichever route they follow, there are quotas for the numbers of students that can gain entrance into physiotherapy training institutes.

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**FOCUS – CHANGES IN HOW BASIC TRAINING IS BEING DELIVERED FOR HEALTHCARE PROFESSIONALS FOLLOWING THE SIGNING OF BOLOGNA ACCORDS (BACHELORS-MASTERS-DOCTORATE SYSTEM)**

As part of the drive to create common standards for Europe's various education systems, a number of changes are going to be made to the ways in which medical and paramedical training programmes are delivered. One such change will be the introduction of a system whereby, starting in September 2010, students in their first year of medicine, dental surgery, pharmacy and midwifery will all study the same modules. The specifics of this change are still under discussion. It does look, however, as though competitive exams will be held for each discipline at the end of the first semester. Students will decide which path they then want to pursue on the basis of their ranking in these various competitive exams. Students will, in theory, be able to sit all the exams. However, each section will have a number of compulsory modules, and it would be very difficult to perform optimally in each and every exam.

As far as nurses are concerned, changes to their training were introduced for students starting their first year in September 2009. The national nursing diploma is going to become equivalent to a three-year university degree. This was not the case before, even though the training lasted 37 1/2 months. This reform has considerable consequences (see 2.4.5 below).

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52 Law no. 2009-833 of 7 July 2009 providing for the introduction of a joint foundation year of study for students of healthcare-related disciplines designed to facilitate the streaming of students.

53 Law of 31 July 2009 on the national nursing diploma.
2.4.1 Medical education

Currently, medical education in France is divided into three cycles or stages that ultimately lead to the awarding of a government-sanctioned ‘doctor of medicine’ diploma. The length of studies varies between 9 and 15 years, depending on the chosen speciality.

Students sit two competitive exams during their medical studies:
- The first is taken at the end of the first year: this is a selective exam (numerus clausus), resulting in only a few students being allowed to carry on with their medical studies
- The second is taken at the end of the second cycle: it ranks students by professional speciality (national classifying examinations).

The first cycle

In France, there is no selective entry to university. This means that the first year of medical study (PCEM1) is open to any student who has passed their baccalauréat. However, this first year ends with a selective exam: the number of students admitted for the second year of study (PCEM2), the numerus clausus, is set annually by a decree from Ministries of Education and Health, the aim being to limit the numbers of doctors in training.

This exam is very selective and is sat by students of three disciplines (physicians, dentists and midwives), as well as physiotherapists in certain regions. It focuses mainly on the sciences (not specific to each profession), including social sciences. Because of the large numbers of students attending first year modules and the considerable appeal of medical studies, the examination is highly selective: between one in ten and one in six students succeed at the end of the year.

The numbers of students who are admitted into the second year of medical study increased between 2001 and 2009, and now accounts for about 3.4% of the overall numbers of physicians.
The national board of physicians would prefer to select students as soon as they first enter university. This would go against the legal principle of not selecting students when entering university, which does have, however, some exceptions.

Successful students can attend second year modules. During this second year, they carry out a 4-week internship working as a nurse in a hospital - in addition to the grounding they are given in theory.

**The second cycle**

The second cycle lasts four years. It is made of 11 classes dealing with the theory of nursing. During this four-year period, students also carry out a 2- to 4-month internship in a hospital, working in a specific department (emergency room, paediatrics, etc.).

From the second year of this second cycle onwards, interns receive a small amount of money. Students are on call 30 times over this three-year period.

Each year ends with examinations. The second cycle ends with the *Certificate of clinical and therapeutic synthesis*.

The anonymous national classifying examinations are then held. On the basis of the results of these exams, medical students can be appointed junior hospital doctors in a given speciality (including general medicine). The specialist field and place of residency are determined by the student’s ranking.

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54 X. Deau, C-F. Degos and J. Roland (2007), Réflexion sur les études de médecine? Analyse de l’état actuel, réflexions sur leurs éventuelles intégration dans le système européen LMD et propositions de l’Ordre des Médecins (Discussions about studying medicine? An analysis of the current situation, discussions about how these studies might be integrated into the European LMD system and proposals from the Order of Physicians).

55 Until 2004, only new specialist physicians had to sit the residency examination, with the exception of new general physicians. There were therefore two groups of physicians:
- those who passed this exam
- those who were not required to sit this exam.
There are 11 specialist fields:
- General medicine
- Medical specialist fields
- Surgical specialist fields
- Psychiatry
- Anaesthesia
- Paediatrics
- Gynaecology-Obstetrics
- Medical gynaecology
- Public health
- Medical biology
- Occupational medicine.

The third cycle

The third cycle involves genuine professional training for new physicians. The length of the third cycle depends on the specialist field.

The third cycle for a student of general medicine lasts three years. For new general physicians, it includes training in theory and a six-month internship (4 compulsory hospital internships: one in gynaecological obstetrics, one in paediatrics, one in emergency room and one that can be selected by the student).

The third cycle for other specialist fields usually lasts four years (five years for internal medicine, surgical specialist fields and radiology). It leads to the diploma of specialised studies (diplôme d’études spécialisées – DES), which covers 30 areas. Some DES degrees are supplemented by further training. The diploma of complementary specialised studies (diplôme d’études spécialisées complémentaires – DESC) can be obtained after two more years. With a DES (and possibly a DESC) in hand, students write a thesis and submit it to a jury in order to be awarded the state diploma of doctor of medicine on which specific mention of ‘general medicine’ or the specialist field is made. The latter is compulsory in order to be able to practise privately or work as a hospital practitioner.

Given the advances constantly being made in the ways in which medicine is practised, a significant percentage of the medical knowledge acquired during this period of 9 to 15 years gradually becomes obsolete. This is why ongoing medical training is vital to ensure that the services provided by practitioners remain of the highest quality. At the outset, this was a deontological obligation. But a law brought in on 24 April 1996, and then confirmed by the law of 4 March 2002 made ongoing medical training obligatory. This law states that the purpose of ongoing medical training is to add to a practitioner’s knowledge and improve the quality of the care delivered to patients, as well as their well-being. All practising physicians, regardless of their specialist area and the sector in which they work, are legally required to follow ongoing medical training programmes.

As a result of this distinction, students studying to become general physicians could not ‘upgrade’ their course paths.
FOCUS – THE REGULATIONS PERTAINING TO ONGOING MEDICAL TRAINING, AS APPROVED IN 2006

Practitioners must submit a dossier with details of training programmes to the regional council for ongoing medical training which is examining them. The training programmes which are taken into consideration fall into four different categories:

- **face-to-face training programmes**, i.e., programmes that are delivered by authorised public and private organisations that the practitioner attends personally: 8 credits for one day, 4 credits for half a day or an evening.

- **individual and distance learning programmes**. These make use of all types of hardware or electronic media, including, for example subscriptions to periodicals or the use of medical works (2 credits per year limited to 10 credits acquired over a period of five years). When a training programme of this category is delivered by an authorised training body, it is the training body that is responsible for determining how many credits it carries.

- **professional and training situations** are situations in which practitioners carry out projects of their own, in their capacity as practitioners, either within or outside their usual sphere of work: these can include professional training of hospital employees, public interest missions to improve the quality and organisation of care and prevention, training activities and involvement in juries in the area of health, effective research projects and personal publications in the area of health. This work may be rewarded by credits on the basis of the amount of time spent carrying them out and in accordance with the values that have been established for each work type.

- **assessment of professional practices**. For this category, 100 credits are awarded to each physician who - over the five-year period - has complied with the requirement to have their professional practices audited. It is a legal requirement for physicians to have their professional practices audited, in compliance with the law of 13 August 2004; their professional practices are required to be analysed in respect of national recommendations. Practitioners decide themselves which activities should be audited, as well as the manner in which the audit should be carried out. The choice should relate to a disease that the centre in which they work frequently has to deal with, it should be in keeping with the policies of the centre, with regard to which problems have been identified, and should have implications with respect to public health.

In order to satisfy their obligations with respect to ongoing medical training, they should collect a minimum of 250 credits for each five-year period (a minimum of 150 credits in each of the first three categories, and a minimum of 100 credits in the fourth category). In the event of a practitioner failing to accumulate a minimum of 250 credits, the regional ongoing training council will, in consultation with the practitioner, draw up a "catch up" plan enabling them to make up the delay in their ongoing medical training programme.

In 2009, the law on Hospital, patients, health and regions was passed in order to simplify the ongoing professional training system. France’s MPs have therefore ratified the concept of **ongoing professional development**, which includes both ongoing medical training and the auditing of professional practices. The decree specifying how the law is to be enforced have not yet been published. This means that there is currently uncertainty about the manner in which various training programmes that have already been carried out will be taken into account by the new law. The purpose of this law is “to audit professional practices, add to practitioners’ knowledge and improve the quality and safety of care delivered to patients, as well as take public health priorities into account and manage health care expenditure”. A special organisation will be set up for the purposes of managing ongoing professional development. It will do this alongside different colleges and institutes for each specialist field. Standard reference documents could be drawn up for each of these specialist areas, and in the long term, physicians could be recertified. When all is said and done, beyond the simple change in terminology, the concept of ongoing professional development requires additional analysis, which will be provided by the laws.

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56 Law no. 2009-879 of 21 July 2009 hospital reforms relating to patients, health and regions.

57 This terminology should also apply to other healthcare professions. However, in the absence of any definitions relating to how ongoing professional development is implemented or operates, the following sections will present ongoing training for healthcare professionals as it actually exists in 2009.
2.4.2 The training of dental surgeons

The training programme involves three cycles: a first cycle of two years, a second cycle of three years and a third cycle of either one year (short third cycle) or three years for students who have successfully passed the dentistry entrance examination (long third cycle). There are 16 universities in France that offer dentistry.

Figure 9 – The training of dental surgeons

First cycle
At the end of the first year (PCEM1 - première année du premier cycle des études de médecine) of study - which is a joint foundation year for students of medicine, dentistry and midwifery - streaming exams are held. Only a limited number of students can pass these exams and go on to study dentistry. This number is determined statutorily each year.

The number of students who progress into the second year of dentistry studies - a number which is jointly determined on an annual basis by the ministries for health and education - has increased, both in absolute and in relative terms. In 1998, 800 students progressed into the second year. This number had grown to 850 by 2003, and 1097 by 2009. So the quota of students who progressed into the second year of their dentistry studies in 2001 - 1.9% of the overall number of dental surgeons in that year - accounted for 2.6% of the total number in 2009.
Before going into their second year, students are required to carry out a four-week nursing internship designed to familiarise them with care techniques, hospital hygiene and first aid.

The second year of the first cycle (PCEO2 - deuxième année du premier cycle d'études odontologiques) includes a number of core compulsory subjects (biology, anatomy and physiology), together with a number of other modules that students can choose themselves. These can either be modules designed to supplement the learning outcomes of the compulsory subjects, or they could be in completely different areas, such as law or economics. There are also a number of clinical internships.

**Second cycle**

The first year of the second cycle (DCEO1) of dentistry studies follows the same pattern as the second year of the first cycle. During the course of both these years, students carry out clinical internships for familiarising students with how hospitals work. These can be carried out in healthcare centres, as well as in teaching and dental research units, or in the dental surgery departments of hospitals.

After the first year of the second cycle, students start treating patients. Half of the total hours are spent carrying out internships or in clinic. In the second (DCEO2) and third (DCEO3) years of the second cycle, students start working as interns in both the dental and other departments of hospitals. In the third year, they carry out an introductory internship, working alongside a dental surgeon.

The Conseil national de l’Ordre des chirurgiens-dentistes (national council of the order of dental surgeons) would like dental surgeons’ basic training to involve longer internships, particularly in sparsely populated areas.

A certificat de synthèse clinique et thérapeutique (certificate of clinical and therapeutic synthesis) is awarded at the end of the second cycle, enabling students to progress to the third cycle.
Third cycle
Students have two possibilities for the third cycle.

A short third cycle, lasting one year, leading to a doctor of dental surgery diploma. This diploma enables dentists to practise autonomously, providing patients with complete dental care. During the course of this year, students learn more about the techniques involved in dental surgery, look at issues related to health accountancy and economics, and carry out clinical internships of a more varied nature (working in paediatrics, geriatrics, etc.). The national doctor of dental surgery diploma is awarded to students who have successfully completed all three cycles and defended their thesis.

Students who pass a competitive exam in either their fifth or sixth year of study are able to follow the long third cycle or dentistry hospital training. In addition to the national doctor of dental surgery diploma, students who follow this dentistry hospital training are awarded a certificate of advanced studies and are granted the title ancien interne (former resident).

The long third cycle is mainly designed to prepare students for a career in a university hospital. The competitive exam is held at national level. Very few places are available (34 in 2007). The training involves both theory and a number of clinical internships. Being able to carry out research in dentistry and sit university hospital competitive exams is subject to students having obtained a research Masters' degree.

Dentistry interns are paid between €1400 and €2000 gross per month depending on where they are in their hospital training. They can also earn money for being on duty or on call (approximately €590 per month for being on call one day a week and one Sunday a month).

Training for healthcare professionals in France is in the process of undergoing a number of changes, and will continue to do so for the next few years. This is so as to bring it into line with the Bologna accords, ensuring compatibility between higher education systems across Europe. But compliance with the "First degree - Masters - Doctorate" system will not affect the length of time that dental surgeons are required to spend in basic training - they will be given the grade of "master", which is already the case. European legislation sets the length of basic training at 5 years.

The cost of dentistry studies involves both University fees and associated material costs. University fees currently stand at approximately €200 per year for the first years and €500 for the last year of the second and third cycles - a total of around €1600 for all six years (€3000 for a long third cycle). Social security costs also need to be added (€200 per year, so between €1000 and €1500, depending on the length of the studies). Students who do not live with their families also have to pay for accommodation (outside Paris, approximately €200 per month for a room, €500 per month for a studio or small flat, amounting to a total of between €14,000 and €19,000 for a room, depending on the length of the studies, or between €35,000 and €50,000 for a flat), food, transport and leisure activities.

Means-tested grants can be awarded, as well as grants based on merit.

It's also important to remember that many of the students enrolled in the first joint year of study for medicine, dental surgery and midwifery (PCEM 1) follow private lessons (particularly in private school foundation classes).

Dentistry students are also required to obtain a box of surgical instruments for delivering dental care (drills for dental turbines, etc.). These cost at least €400 and will be needed throughout their studies. Frequently-used equipment may need to be replaced. Perishable equipment is often purchased jointly by the dentistry students' students union.
As far as ongoing professional training is concerned, dental surgeons are legally required to undertake ongoing professional training programmes, which must be delivered by an authorised organisation. The grading system that has been developed requires that each dental surgeon obtains 800 training “credits” over a period of 5 years, with a minimum of 150 credits per year (and a maximum of 180 credits per year). Each face-to-face training programme delivered by an authorised organisation is rewarded by 60 credits for a whole day, 30 credits for half a day and 20 credits for an evening of training. Three days of training per year are sufficient for a dental surgeon to comply with this training requirement. The numbers of dental surgeons attending training sessions have been constantly growing since 2006. In 2007, there were 58,523 registrations for training programmes. This number had grown to 86,000 in 2008 - an increase of 47%, with each practitioner attending an average of 2.1 training sessions per year.

### 2.4.3 The training of pharmacists

Pharmacy studies involve three cycles: a first cycle of two years, a second cycle of two years and a third cycle of either two years (short third cycle) or four years for students who have successfully passed the pharmacy entrance examination (long third cycle). There are 24 universities in France that offer pharmacy.

![Figure 10 - The training of pharmacists](image)

**First cycle**

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58 For more details, see: [http://www.ordre-chirurgiens-dentistes.fr/chirurgiens-dentistes/formation-continue.html](http://www.ordre-chirurgiens-dentistes.fr/chirurgiens-dentistes/formation-continue.html).

59 Since June 2006, 451 training organisations have been authorised. These include universities, faculties, reviews and works, as well as dedicated training companies (and associations).
At the end of the first year (PCEP1 - *première année du premier cycle des études de pharmacie*) of study, streaming exams are held. Only a limited number of students can pass these exams and go on to study pharmacy. This number is determined statutorily. The pass rate for this exam is 20%.

The number of students who progress into the second year of pharmacy studies - a number which is jointly determined on an annual basis by the ministries for health and education - has increased, both in absolute and in relative terms. In 1998, 2,250 students progressed into the second year. This number had grown to 2,400 by 2003, and to 3,097 by 2009. So the quota of students who progressed into the second year of their pharmacy studies in 2001 - 3.7% of the total number of pharmacists in that year - accounted for 4.1% of the total number in 2009.

Before going into their second year (PCEP2), students are required to carry out a two-month internship in a dispensing pharmacy, designed to familiarise them with dispensing medicines and train them in the areas of posology, product recognition, legislation and drug preparation. From the second year onwards, internships for introducing students to research are available for those who request them.

**Second cycle**
The two years of the second cycle include a set of joint foundation modules designed to equip students with knowledge that is essential, whatever the path they later decide to take (chemistry, life sciences, public and environmental health, science of medicine, etc.) and an optional programme for further developing their knowledge in areas of their choosing and gradually preparing them to carry out their particular specialist discipline at professional level, or preparing them for a career in research.

In order to progress from one year to the next, students must demonstrate that they have acquired the requisite areas covered in the joint foundation modules of the previous year.

In order to progress into the third cycle, students must pass exams in two additional subjects - as well as in the fourth-year joint modules.
**Third cycle**

At the end of the second cycle, students must choose between:
- a short third cycle of two years, designed for students who want to practise in a dispensing pharmacy or work in the pharmaceutical industry
- a long third cycle or hospital training period of four years, designed for students who want to work in research, hospitals or laboratories

The first year of the third cycle (the fifth year of study overall) is spent in a university hospital. This is the case for students registered on both the short and the long third cycles. Students practise in hospitals. At least half of them work in healthcare departments, and the others in pharmacy or biology departments. At the same time, they are given teaching in the corresponding area. The year is designed to familiarise students with prescribing drugs and carrying out biological analyses; it helps them address issues associated with therapeutic and biological follow-up, and teaches them about their future professional obligations to provide information and be vigilant, as well as their managerial responsibilities.

It is only at the end of this year that the long and the short cycles become separate out. The sixth year of the short cycle (i.e. the last year of study) includes a six-month internship in a dispensing chemist or in a pharmaceutical, industrial or business centre - or even in a central hospital pharmacy, together with modules on theory and help with viva preparation. After the viva, students are awarded the national doctor of pharmacy diploma.

Students who have opted for the long cycle sit the competitive hospital training exam at the beginning of the first year of the third cycle. Once they have passed this exam, house doctors can choose from four specialist fields so as to be awarded a Diplôme d’Études spécialisées - an advanced diploma in the specialist field in question: medical biology (for interns who want to work in test laboratories), hospital pharmacy, industrial and biomedical pharmacy or specialist pharmacy (for those who are interested in going into research). Pharmacy interns are paid between €1400 and €2000 gross per month, depending on what stage they are at in their hospital training. They can also earn money for being on duty or on call (approximately €590 per month before tax for being on call one day a week and one Sunday a month).

Training for pharmacists in France is in the process of undergoing a number of changes, and will continue to do so for the next few years. This is so as to bring it into line with the Bologna accords, ensuring compatibility between higher education systems across Europe. But these reforms will not affect the length of the time that pharmacists spend in basic training - they will be given a grade of "master", which is already the case. European legislation sets the length of basic training at 5 years - including a minimum six-month internship. At European level, however, pharmacists may practise as "techniciens avancés" ("advanced technicians") after three years of training (licence.) This intermediary level does not exist in France. Pharmacy technicians can have the level of their diploma raised by getting their training acknowledged at university level (up until now, the baccalauréat has not been required).

The cost of pharmacy studies - like for other university training - includes state university fees (between €200 and €500 per year depending on the year and €200 per year for Social Security coverage) and the cost of accommodation, food, transport, leisure activities, etc. Means-tested grants can be awarded, as well as grants based on merit.

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60 Hospital specialist fields are not recognised at EU level: the bill to have them accepted had been given a first reading in 2004, but had not passed its second reading because the directive sought to retain a general aspect and not to open up recognition of all specialist fields for each country. This means that if a French hospital practitioner wishes to work in another EU country, they need to carry out a specialist training programme that is specific to the country question (once their initial training has been completed and validated). [Interview with Mme SURUGUE, member of the Conseil national de l’Ordre des pharmaciens (national council of the order of pharmacists)].
As far as ongoing professional training is concerned, pharmacists can take advantage of provision in labour regulations (if they are an employee) and must comply with the legal obligation which is the responsibility of all practising pharmacists. Even though there are obligatory shared funds that exist to finance various existing training programmes, most privately-practising pharmacists still have to pay for their own ongoing professional training. Drug companies and wholesalers contribute by sponsoring conferences and advertising in the professional press.

### 2.4.4 The training of midwives

There are three phases in midwifery training. The first phase is the same as the first year of the first cycle of medicine - which students are required to pass in order to gain entry into midwifery school. Then there are two two-year phases, each made up of theory, practical experience and clinic work.

The national midwifery diploma is a higher education diploma issued by the various university medicine training and research departments (unités de formation et de recherche) who are authorised to do so. Training for this diploma is provided by 32 authorised specialist schools across France which are affiliated to hospital maternity Units.

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61 For more details, see: [http://www.ordre.pharmacien.fr/](http://www.ordre.pharmacien.fr/)
The first phase or year spent preparing for the competitive exam for entry into midwifery school

At the end of the first year (PCEM1 - première année du premier cycle des études de médecine) of study - which is a joint foundation year for students of medicine, dentistry and midwifery - streaming exams are held. Only a limited number of students can pass these exams and go on to study midwifery. This number is determined statutorily each year.

This number has remained relatively stable since 2005 (1000 in 2005, 1015 in 2009). This number had grown considerably between 2001 (760) and 2004 (975). The percentage of students who are admitted for study in a midwifery school as a proportion of the overall numbers of midwives is decreasing: in 2004, they accounted for 5.8% of the total number of midwives. By 2009, this percentage had fallen to 5.2%.

The second phase or the first two years of midwifery school

During this phase, the emphasis is placed on physiology, the aim being to equip students with a knowledge of standard obstetrics. At the end of this two-year period, students can carry out clinical and paraclinical observation of normal pregnancies. They can carry out standard duties and attend births that are free of foreseeable risks. This phase involves theory (27 weeks of teaching) and practical experience working in clinic (54 weeks).

Knowledge of the theory and performance in clinic are validated by continuous assessment. Progression through to the next year is contingent on the results of the continuous assessment for the previous year. Progression through to the first year of the third phase is contingent on the results of continual assessment, as well as a final exam.

The third phase or the last two years of training

This phase teaches future midwives to immediately recognise any pathologies associated with labour and to act accordingly - midwives play a vital role in risk prevention. Once they have completed this phase, students should be able to detect any medical, psychological or social risk situations during the course of pregnancy, and to warn, inform and educate in the areas of obstetrics, gynaecology and paediatrics. This phase involves theory (24 weeks of teaching) and practical experience working in clinic (51 weeks).
Knowledge of the theory and performance in clinic are validated by continuous assessment. Progression through to the next year is contingent on the results of the continuous assessment for the previous year. At the end of this last year of training, continuous assessment, a final exam and a viva relating to a professional dissertation are all used to test whether or not students have properly assimilated the knowledge delivered through the teaching modules. They are then awarded the national midwifery diploma.

Midwifery training is relatively intensive. This is evidenced in the difference between the numbers of students who start midwifery training and the number who actually graduate: nearly 17% of the first year students who sat the restricted ‘numerus clausus’ selected entry exam in 2003 did not graduate in 2007. Some of them repeat a year, while others just dropped out of the training. New recruits accounted for approximately 4% of all midwives in the period 2001-2007 (the numbers of students starting midwifery school account for more than 5% of the total numbers).

Training for midwives in France is in the process of undergoing a number of changes, and will continue to do so for the next few years. This is so as to bring it into line with the Bologna accords, ensuring compatibility between higher education systems across Europe. Midwife training is to be integrated into university education, which will give students access to research methods in areas such as physiology. This will mean that the people teaching the courses will be required to have masters degrees and doctorates - which is not currently the case as a general rule.

European legislation sets the length of basic training at three years, or at 18 months of additional training for nurses. This can lead to problems in France, with representatives from both professions protesting. Indeed, basic training in France lasts longer than this (five years). Midwives in France have a right to statutory limitation. Their area of expertise is extremely broad, as are their levels of autonomy: they are able to oversee vaginal deliveries which do not present complications, without having to systematically call upon physicians. The national council of the order of midwives believes that the midwifery training given in France is far more complete than that given in many other member states of the European Union. It would therefore prefer European legislation to increase the length and contents of basic training in midwifery for other member states to bring it into line with the French model: university level recognition of the training and recognition at masters level.

The cost of midwifery studies includes state university fees (between €200 and €500 per year depending on the year and €200 per year for Social Security coverage) and the cost of accommodation, food, transport, leisure activities, etc. Means-tested grants can be awarded, as well as grants based on merit. In 2007, almost a quarter of all midwifery students (25.8%) received grants from the Conseil Régional (regional council).

As far as ongoing professional training is concerned, midwives are required to maintain and supplement their knowledge so as to ensure that they are kept up-to-date with new techniques being used in their profession. Arranging ongoing professional training does not come under the direct responsibility of the state authorities, but the national council of the order of midwives is tasked with ensuring that the expertise of its professional members is kept up-to-date. Independent midwives can solicit support from associations helped by funding from the national state health insurance office. Private- and state-run centres hold ongoing professional training programmes for salaried midwives.

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62 Interview with a midwife from the Conseil national de l’Ordre des Sage-femmes (national council of the order of midwives).

63 For more details, see: [http://www.ordre-sages-femmes.fr/pro/formcont/formintro.htm](http://www.ordre-sages-femmes.fr/pro/formcont/formintro.htm).
2.4.5 The training of nurses

Nurses’ training is undergoing dramatic changes. This is so as to bring it into line with the training programmes of other member states in the European Union as part of the plan to harmonise university systems and within the context of the bachelors-masters-doctorate system reform. European legislation sets the length of basic training for nurses responsible for delivering general care at 3 years or 4600 hours of theory and clinical work. The amount of time set aside for theory represents at least a third, and the time spent on clinic work represents at least half of the minimum training length.

As of September 2009 onwards\textsuperscript{64}, students going into the first year of a nurses’ training course will be awarded the equivalent of a bachelor’s degree - in addition to the national nursing diploma - when they graduate in 2012. The consequences of this change are far-reaching. First of all, overhauling the system as part of the bachelors-masters-doctorate reform forces nursing training institutes to enter into agreements with universities - which makes the way they function more complicated: often, these institutes are supported by state-run hospitals, which themselves have links with the regional councils (which cover the costs of training) under whose responsibility they fall. This means that the university to which the hospital is attached will become another factor in the overall equation: it will have the right to inspect and oversee the training programmes being taught, as well as the quality of the people teaching them. In addition, these teachers will need to be qualified to at least masters degree level. Furthermore, having nurses educated to the equivalent of bachelors degree level working in state-run hospitals will lead to changes having to be made to the staff categories in use: category B nurses will become category A nurses, meaning a salary increase and so an increased financial burden for state-run hospitals.

![Diagram](Figure 12– The training of nurses)

Training is open to holders of the baccalauréat who pass the entrance tests. The new tests are made up of an eligibility test and an entrance test.

\textsuperscript{64} Law of 31 July 2009 on the national nursing diploma.
A written test, which involves an analysis of a topical document about a health and welfare issue. The text is followed by three questions, the answers to which will be used to evaluate the potential student's ability to understand, analyse, synthesise, present arguments and write.

An aptitude test which is designed to evaluate the student's capacity for logical and analogue reasoning, their ability to abstract, concentrate and resolve problems, as well as their numerical ability.

In order to be eligible for entry, candidates have to score a total of at least 20/40 in both tests. Candidates who are deemed eligible for entry by the jury are then authorised to sit an entrance test, which involves an interview with three people, all members of the jury. This interview, which deals with a health and welfare related theme, is designed to evaluate candidates' ability to follow the training programme, gauge how motivated they are and understand what their intentions are with respect to their professional development. To gain entry into a nurses' training institute, candidates must score at least 10/20 in the interview.

The maximum quota of students admitted into nurses' training institutes is set by a ministerial order every year. The number of students admitted has followed the same trend as the total numbers of nurses in France; it has risen considerably - from 17,330 in 1995 to 30,514 in 2009.

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**Training in a nurses' training institute**

The training lasts three years - six semesters of 20 weeks each, the equivalent of 4200 hours, with an estimated 900 hours of personal study time (300 hours per year). The total number of hours - 5100 - is the student's total workload.

The teaching modules are made up as follows:
- 2100 hours of theory in the form of lectures (750 hours), seminars (1050 hours) and guided personal work (300 hours);
- 2100 hours of clinical training.

The training is split between the theory and the internships. The theory lectures are either delivered by the teaching staff, or by outside professionals. (physicians, physiotherapists, nurses, academics, etc.). The weeks are 35 hours long - whether they be spent in lectures/seminars or carrying out internships.

The university grading system will be compatible with the *European Credit Transfer System* (ECTS). 30 credits will be awarded for each semester of training. Throughout the duration of the
course, continuous assessment is used to evaluate students. 180 ECTS credits are required before the national nursing diploma can be awarded.

Until 2011 (for cohorts of students who began their training before the reforms were brought in), the national diploma tests involve a viva for an end-of-study project. This written project must be 15 to 20 pages long and deal with an issue of professional interest. It is defended in front of a jury in a professional setting and lasts between two and four hours. This professional setting - a source of considerable stress for nursing students - will disappear with the reforms, starting in 2012.

The cost of nursing studies includes state university fees (€200 per year and €200 per year for Social Security coverage) and the cost of accommodation, food, transport, leisure activities, etc. Means-tested grants can be awarded, as well as grants based on merit. In 2007, almost a quarter of all nursing students (25.7%) received grants from the Conseil Régional (regional council).

Regarding ongoing professional training, it should first be pointed out that nurses with the national diploma can sit additional exams in order to further specialise and become anaesthetist nurses (24-month training programme after two years of practising), operating room nurses (18-month training programme after two years of professional experience), or childcare nurses (12-month training programme). After four years of professional experience, nurses can also sit additional selective exams and become health managers (42-week training programme) so as to manage teams of nurses across one or several healthcare departments.

More generally, ongoing professional development is a legal requirement for nurses. Both state-run hospitals and private clinics are required to earmark part of their wage bill for the ongoing professional training of their staff - including nurses. Independent nurses contribute on a yearly basis, via l’URSSAF (Social Security Contribution Collection Office) and a government contributory scheme for vocational training to a fund65. The latter is managed by professional syndicates that are a member of the National Union of Professionals. Each year, these professional organisations run a series of training programmes. They also approve programmes and cover the costs of training that meets criteria that they themselves set, and in accordance with budgetary limitations. Under this system, independent nurses can therefore have the costs covered for two of the training programmes on offer per year.

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65 For more details, see: [http://www.fifpl.fr/](http://www.fifpl.fr/).
2.4.6 The training of physiotherapists

Physiotherapists in France spend three years training for a national diploma in one of 39 institutes across the country.

**Entry into physiotherapy training institutes**

There are currently different options for gaining entry:
- either admission on the basis of a competitive exam (16 institutes); the entrance examinations include a biology exam, a physics exam and a chemistry exam, all based on the programme of study followed in the last year of a science *baccalauréat*. Candidates are admitted based on how they rank in the results of these exams - but the selection process is severe (5% get in). Candidates need more than a year to prepare for this competitive exam.
- or admission *after they get into the first year of medicine (PCEM 1)* – 23 institutes, including Vichy, Dijon, Nice, Bordeaux, Marseille, Nancy, Paris, Toulouse, Lyon and Orléans. The conditions and procedures for entry are agreed in conjunction with the Faculty of Medicine for the region, and vary a little from one region to another (specific module, the different weightings of the exams, etc.).

The maximum quota of students admitted into physiotherapy training institutes is set by a ministerial order every year. This number has been constantly growing since 1995. In 2009, 2139 students were admitted into physiotherapy training institutes.

![Figure 13 - The training of physiotherapists](image)

**Training in institutes of physiotherapy**

Physiotherapy training lasts three years, and is made up of 16 modules of theory (1012 hours), seminars and practical tutorials (848 hours) and internships (1205 hours) - either in hospitals or (mainly) in rehabilitation units. The training is designed to enable students to carry out the diagnoses and analyses that are required before any treatment can be prescribed, to select appropriate methods, to identify emergency situations and deliver first-aid until the arrival of a physician.
The first year of study is the first cycle, and is focused on the study of anatomy, morphology and physiology. It includes two introductory physiotherapy internships (one in a hospital, the other working alongside a physiotherapist).

Each institute has its own way of structuring the second cycle (second and third years); it involves a dozen modules that need to be validated, as well as internships (that are mainly carried out in hospitals).

Each module is evaluated by one or several compulsory written exams that are marked anonymously. Students have to score an average of 10/20 in all the written exams in order to pass the module. To progress into the next year, students need to pass all the modules. To get into the third year, they also have to have their hospital internships validated. Students' performance during these internships is assessed on the basis of their assiduity, their involvement in the work carried out by the department and an oral exam with the manager of the department in which the internship is carried out.

At the end of these three years, provided they have passed all their modules and internships, students sit a final exam which is based on two professional situations and have to defend a professional interest project as part of a viva. Students who score at least the pass mark in this exam (as well as in the exams that they sit in the previous years) are considered to have passed and are awarded the national physiotherapy diploma - which they need in order to practice, regardless of which sector they work in.

![Graph](image-url)

**graphic 7 - Number of graduates and percentage of graduates in relation to overall numbers of physiotherapists (2001-2007)**

The cost of becoming a physiotherapist involves both fees and associated material costs. The cost of training varies from institute to institute. The cost of training in a state-run institute is around the same as for other training programmes (approximately €200 per year). The cost of training in a private institute, on the other hand, is particularly high (between €5000 and €6000 per year in a non-profit-making institute; (between €8000 and €10,000 per year in a profit-making institute. Grants are available that are needs-based and/or awarded on the basis of merit. In 2007, 17.4% of all physiotherapy students had a grant from the Conseil régional (regional council).

As far as ongoing professional training is concerned, a professional training agreement has been drawn up between physiotherapy syndicates and the national state health insurance office. The aim is to make it easier for physiotherapists to access ongoing professional training courses and to ensure that they are able to keep pace with changes in methods and techniques for delivering care. Independent physiotherapists who sign up for authorised ongoing
professional training programmes can have their costs reimbursed by the national state health insurance office and can be compensated for the time spent on training (€224.40 per day up to a maximum of five days per year - a total of nearly €1120 per year). Physiotherapists who practise in hospitals and other healthcare centres have access to training that is provided as part of an ongoing professional training plan. This is financed by part of the centre's wage bill, which is dedicated to professional training.

2.5 Context of healthcare status and the healthcare system

2.5.1 The overall structuring of the national healthcare system

As far as healthcare policy and regulation of the healthcare system is concerned, responsibility is shared between the State, compulsory health care insurance bodies and local authorities.

The State
Every year since 1996 Parliament has passed a financing law which sets a ceiling for the rate of expenditure growth in the public health insurance scheme for the following year (Objectif National de Dépenses d’AssuranceMaladie, ONDAM). The Ministry in charge of health uses this framework set by Parliament to carry out most of the regulation. It distributes estimated expenditure among the various healthcare sectors, and determines quotas (numerus clausus) for the numbers of students allowed to study medicine - thus limiting the number of future physicians. It approves agreements with the national state health insurance schemes and the various organisations which represent healthcare professionals practising privately; it decides on the prices of medical procedures and drugs on the basis of recommendations put forward by ad hoc commissions. It determines safety standards in hospitals, etc. The ministry has branches throughout France's various regions and départements. Over the last 10 years, the state has set up a number of independent auditing committees and agencies. These work alongside the civil service, ensuring that missions that have been delegated or newly created are properly carried out. With respect to health security, monitoring and prevention, for example, a number of agencies have been set up, including the Agence française de sécurité sanitaire des produits de santé - the French agency for the safety of healthcare products. This agency assesses healthcare products from a scientific and medico-economic perspective, audits them and carries out hospital inspections; the Agence française de sécurité sanitaire des aliments - the French food safety agency - which assesses health and nutritional risks associated with all food products; the Institut national de veille sanitaire - the national health watch institute - which coordinates epidemiological monitoring and serves as a framework for measures designed to manage and prevent these risks. Another body - the Haute Autorité de santé - or French National Authority for Health - was set up to promote good practice and proper use of healthcare facilities among healthcare professionals and users of healthcare products, and to improve the quality of healthcare delivered in hospitals and through physicians.

Public health insurance scheme
There is a mismatch between the ethos at the heart of how the French healthcare system was designed and the way in which it is developing - a mismatch which is resulting in the emergence of a dual system. On the one hand, since it was set up in 1945, it has aspired to being able to cover the cost of healthcare for one and all - in keeping with William Beveridge's ideas on
welfare, with rights to welfare being inextricably intertwined with the concept of citizenship or with people's place of residence. On the other hand, corporate opposition to this principle has kept a number of special schemes alive, schemes which are based on Bismarck's theories of social legislation in which the welfare rights of workers and their dependents are conferred through their carrying out a particular profession. So when the Social Security system was set up in France in 1945, it was not able to realise its ambition of providing universal coverage and the result is a system that is structured around occupational schemes. The main scheme is the régime général - a general social security scheme which provides coverage for almost all employees working in manufacturing and the retail sector. The scheme exists alongside a scheme for agricultural workers, a scheme for independent workers, and various other company- or sector-specific schemes (mining, the Paris regional transport network, etc.). Each one of these three main schemes includes a national fund and structures set up at local level, based on variable geographic boundaries. For example, as far as the general scheme is concerned, there are 129 local funds (local sickness insurance funds) which affiliate policyholders and reimburse the cost of care, 16 regional funds which deal with accidents in the workplace and occupational diseases, (as well as monitoring hospitals and prevention measures), and a national sickness insurance fund for salaried workers.

It is compulsory to join a social security scheme in France. The nature of the affiliation is decided by a person's professional status - meaning that certain members of the population run the risk of being excluded from the state reimbursement scheme. Consequently, since the 1970s, there has been a drive to broaden medical cover. This drive culminated in 2000 with the passing of a law on universal medical coverage, providing that all 'standard' residents should enjoy medical cover. Universal medical coverage therefore serves as a safety net for the poorest members of the population, managed by the general scheme and financed by the State. So under the conditions of this coverage, foreign people living illegally in France are the only people who do not have access to this state-financed medical assistance scheme.

To compensate for the low reimbursement rates provided by the obligatory schemes, nearly 92% of people in France voluntarily take out complementary private insurance schemes (from mutuelles - mutual benefit associations - or instituts de prévoyance - social welfare institutions). They also provide holders of universal medical coverage policies with a basic contract. Complementary insurance coverage schemes can either be taken out individually or collectively. If they are taken out collectively by the employees of a particular company, the employer makes a financial contribution. Complementary insurance schemes top up the part that is not reimbursed by the compulsory health insurance scheme and pay for the cost of certain types of healthcare that are not covered, depending on the contract.

**Regional institutions**

Over the last fifteen years or so, there has been a drive to regionalise the way in which the healthcare system is structured and managed. This drive has initially focused on the regional departments of the State, which have been entrusted with increasing responsibility. The regional architecture of the healthcare system has become relatively complicated over the last 10 years or so because of the huge number of bodies involved and the confusion that surrounds their areas of responsibility.

Here again, a number of changes are in the offing with the creation of regional health agencies slated in for the first half of 2010. These will become the exclusive points of contact at regional level, ensuring that procedures for healthcare professionals are as simple as possible (a single point of contact for grants to help people set up their practices, for example) and that patients have equal access to healthcare and benefit from improved coordination in the field between healthcare professionals and hospitals / medical-social centres. To this end, the regional health agencies will bring the powers of the state and the national health insurance scheme together at regional level. They will bring together seven bodies which are currently

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66 Law no. 2009-879 of 21 July 2009 hospital reforms relating to patients, health and regions.
responsible for healthcare policy throughout France’s regions and départements: the DDASS/DRASS (regional departments for health and welfare affairs), regional hospitalisation agencies (ARH), regional public health consortiums (GRSP), regional medical insurance funds (CRAM), regional health insurance fund unions (URCAM) and regional healthcare missions (MRS). So these regional health agencies will actually have a very broad range of responsibilities: public health - including prevention - health promotion, health monitoring and safety, organising the delivery of care (including with respect to the medical-social sector), etc. One of its aims is to better root health care policy at local level. This is so as to better adapt solutions to local requirements and specific situations, to improve regional distribution of healthcare and to combat regional inequalities in health levels.

Local authorities
The local authorities will continue in their role - alongside the regional health agencies. The Conseil général - the General Council - will continue to work at regional level, financing welfare assistance as well as - in part - centres for the elderly and those who cannot live on their own. It will also finance child protection services, including the management of maternal and child welfare centres, providing consultations and free medical supervision, as well as having responsibility for preventing certain diseases (tuberculosis, sexually transmitted diseases, etc.). The Conseil régional (Regional Council) will finance the state-run centres that provide training in paramedical professions and will allocate grants to students; it may also be responsible for defining specific health-related aims for the region. It will develop and implement corresponding regional action plans.

2.5.2 Cultural and legal (constitutional) approach to healthcare

Health is a constitutional right, as stated in the Preamble of the Constitution of 27 October 1946 and reasserted by the Constitution of 4 October 1958: “the nation [...] undertakes to provide all its citizens - including children, mothers and aged workers - with health protection”. The jurisprudence of the Constitutional Council acknowledges the constitutional value of health protection that lawmakers may not infringe.

However, the application of this constitutional right can come into conflict with other constitutional rights, such as the protection of privacy in the area of health prevention, for example. Asserting the right to health, which was designed to defend the interests of the sick and people using the services of state-run hospitals, also comes up against the obligations which are imposed on healthcare professionals by the law and by regulations. People who do not enjoy good health are protected by the professional code of ethics of healthcare professionals.

The individual and collective rights of people in poor health have been the focus of more and more legislation:
- Law of 20 December 1988 on biomedical research
- Law of 9 June 1999 on palliative care
- Law of 4 March 2002 on the rights of sick people and the quality of the healthcare system
- Law of 4 August on public health policy
- Law of 22 April 2005 on the rights of sick people and end of life care

68 Law no. 2004-806 of 9 August on public health policy.
69 The issue of work satisfaction and working conditions was dealt with for each profession in 2.3 and its sub-sections, health results were looked at in 2.2 and the medical training system was examined in detail in 2.4.1.
The hospitalised persons charter appended to the circular of 2 March 2006 states that "a patient in a hospital is not only a sick person - he or she is first and foremost a person with rights and duties". This charter is available in seven languages and is given to all hospitalised people together with the hospital's welcome booklet. It applies to all state-run and private healthcare centres.

| **Right to access healthcare and right to access high-quality healthcare** |
| - right to healthcare for the most destitute |
| - right to healthcare for foreign nationals |
| - principle of non-discrimination in access to prevention and to healthcare |
| - freedom to choose the healthcare centre and the practitioners |
| - right to healthcare of a guaranteed level of quality through the certification of healthcare centres |
| - right to healthcare of a guaranteed level of quality by combating hospital-acquired infections and serious adverse events |
| - right to receive the most suitable type of healthcare and to be given therapy the efficacy of which is acknowledged and which can provide the highest levels of health safety with respect to established medical knowledge |
| - right to receive healthcare design to manage and relieve pain |
| - right to palliative healthcare and to high-quality end of life healthcare (banning of relentless treatment) |

| **Right to privacy and intimacy** |
| - right to intimacy |
| - right to dignity |
| - right to privacy |
| - right to confidentiality (including for minors and protected adults) |
| - right to secrecy of information (professional and medical secrecy) |
| - right to respect of religious beliefs and convictions |

| **Right to information and involvement in therapy decisions** |
| - right to be kept informed about one's state of health ("fair, clear and suitable" information) |
| - right to be involved in decisions about one's health (prior expression of "free and informed" consent) |
| - right to refuse care |
| - right to appoint a "trusted person" |
| - right to access health information (medical dossier) |
| - right to information, to object to information, to access, challenge and rectify any data which is subject to automatic processing |
2.5.3 Culture of patient expectations and how culture affects the needs of healthcare professionals

A subject that has been discussed a great deal over the last decade within the context of healthcare has been how to better meet patients' expectations. Initiatives that have been implemented by various patient organisations are responsible for this issue moving to the forefront of discussion. In the 80s and 90s, the emergence of AIDS and then the contaminated blood and growth hormone scandals, changed the ways in which these associations involved in healthcare operated. Patient associations no longer restricted themselves to being involved in conventional areas (such as providing support for sufferers, raising funds for financing research, etc.), but started trying to influence the choices being made in research and create a new type of patient who assumed much more responsibility for their own health. These various associations grouped together under the CISS (Collectif inter-associatif sur la santé – Inter-Association Health Collective), which plays a role in getting users' interests heard at various levels of the healthcare system.

The law of 4 March 2002 on the rights of patients and the quality of the healthcare system had a profound effect on the nature of the relationship between the physician and patient, by asserting the patient's autonomy through a humanist conception of the rights of ill people. By using the concept of "ill person", lawmakers assert the unity of the human being in the healthcare system and in the relationship between patient and carer. The ill person is no longer simply a "user" of the healthcare system or a simple "patient" within the framework of the special "doctor-patient" dynamic. The ill person has basic rights, the respect of which is at the basis of the professional and deontological obligations of all healthcare workers, and the non-respect of which constitutes a violation of the rule of law which can give rise to legal consequences.

The nature of the relationship which is entered into becomes less one that is based on the concept of hierarchy and more one that is governed by a contract: the ill person ceases to play just a passive role and takes on one that is much more active. They become actively involved in their own healthcare within the context of a balanced distribution of responsibilities between patient and carer. However, this relationship becomes more conflictual with the juxtaposition of a lay person's knowledge with that of a professional whose modus operandi have been defined in accordance with norms and standards. Also, discussions about risk versus benefit tend to invert the traditional relationship between physician and patient: it is now the patient who directs the relationship and the physician who cooperates.

The law of 4 March 2002 on the rights of sick people and the quality of the healthcare system has strengthened the patient's role, asserting users as key players in the functioning of the healthcare system. Within the context of this "healthcare democracy", people who represent users and patients now play key roles at various levels of the healthcare system. They are involved in formulating health policies, evaluating the quality of healthcare centres as well as certifying them - and in running state hospitals at local level. They also play a key role in conciliation and compensation for medical accidents, as well as many other areas.

Nevertheless, in spite of the growing importance attached to the role played by healthcare system users, their influence is still very limited. They are still involved in too unequal a way - which means that the role they play is often only minimal. Also, users are also still suspected of trying to defend partisan interests in a world in which there is growing recourse to legal intervention in the medical profession. The phrase used by P. LASCOUMES to describe this uncomfortable situation in which the "layperson’s knowledge" of those who represent patients and healthcare system users is interwined with that of professionals is appropriate: “Users in the centre, healthcare professionals in the middle”.

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70 P. LASCOUMES, “Représenter les usagers” (Representing users), in BASZANGER et al., Quelle médecine voulons-nous? (What type of medicine do we want?), Paris, Ed. La Dispute, 2002.
2.5.4 Regulating the healthcare professions: needs analysis, selection process and planning policy

Predictions for demographic change in healthcare professions have been the focus of a great deal of research for several decades now. The first measure introduced that was designed to regulate the healthcare professions involved regulating medical demography. Based on the principle that the need for healthcare is conditioned by the numbers of available healthcare professionals, the government decided to introduce quotas for regulating the number of people entering medical professions. So the \textit{numerus clausus} selective entry exam was introduced in 1971 after the first year of medical studies. In the 80s and 90s, with the numbers of medical professionals on the increase in spite of the \textit{numerus clausus}, the government looked for other ways to reduce the number of physicians and in so doing limit healthcare expenditure. One of these measures involved early-retirement for physicians. But at the end of the 90s, the situation started to change: the prospect of the baby boom generation retiring, together with the very unequal distribution of healthcare professionals throughout the country has resulted in the government raising the quotas for the numbers of people entering the professions and debating various ways for promoting a better distribution.

However, despite what is at stake, the government has only very recently seen fit to develop a forward-thinking policy on human resourcing in healthcare. The \textit{Observatoire national de la démographie des professions de santé} - France's national monitoring body charged with looking at the demography of the healthcare professions - was only set up in 2003 and is responsible for gathering and analysing knowledge and information about healthcare professionals. The birth of this monitoring body is evidence of France now having far more ambitious targets as far as human resource policy in healthcare is concerned.

Before, human resource policy in healthcare was only deployed at national level by implementing the \textit{numerus clausus} selective exam system and by applying quotas throughout France’s paramedical training institutes. Both these mechanisms are still used today and are part of the selection process for entry into medical and paramedical professions.

- Physicians, midwives and dental surgeons must all pass an exceedingly tough selection exam (\textit{numerus clausus}) at the end of the first joint foundation year of medical studies; their ranking in the various different quotas that are set on an annual basis by ministerial decree for each profession determines whether or not they can go on and study for their chosen profession.
- Pharmacists must pass an exceedingly tough selection exam (\textit{numerus clausus}) at the end of the first year of pharmacy studies; their ranking in the quota that is set on an annual basis by ministerial decree determines whether or not they can go on and study pharmacy.\footnote{Starting in September 2010, the first year of pharmacy studies will be merged into the first joint foundation year for physicians, dental surgeons and midwives.}
- Physiotherapists can only be admitted into a training institute - depending on the region in which the institute is located - once they have passed a highly selective entrance examination (which takes more than a year to prepare for) or once they have achieved a favourable ranking in the selection process at the end of the first year of their medical studies. Quotas are set for the number of people who are admitted to study in physiotherapy training institutes.
- Nursing students have to sit an exam. They are required to have the \textit{baccalauréat} before they can sit it. Quotas are set for the number of people who are admitted to study nursing.

But these quotas are set on the basis of analyses carried out by the \textit{Observatoire national de la démographie des professions de santé} of data provided by the \textit{Direction des statistiques du Ministère de la santé} (the Department of Statistics at the Ministry of Health). More work still has...
to be done in order to better determine real needs on a per-profession and per-region basis. Provision for meeting this need has been made in the so-called "Hospital, Patients, Health, Regions" law\(^{72}\) which was promulgated in July 2009: henceforth, a study that looks five years into the future should determine the number of students after the competitive hospital training exam (National entrance exam) that should be trained per specialist field, particularly general medicine, and per regional subdivision "in view of the demographic change affecting the medical profession in the various specialist fields concerned and in view of this change with regard to specialist care". Similarly, the law also makes provision, by ministerial decree, for determining the terms and conditions under which all students who sit the competitive exam at the end of their second year of medical studies are informed about the state's policy of redressing the poor distribution of medical expertise across the country and the measures being implemented to do this. This approach leaves the door open for measures designed to improve the geographical distribution of medical students throughout the region in which their faculty is based.

Indeed, the government always causes quite a stir whenever it considers the possibility of limiting the right of physicians to practise wherever they like - a right which came about as a result of the Liberal Charter in 1928. However, the amendment to the independent nurses' agreement provides for the implementation of zoning: the measures that have been implemented within the context of the agreement provide for the possibility of financial incentives in zones that are experiencing a shortage of independent physicians and nurses, while imposing restrictions to the state health service contract in those zones in which there is a surplus of them.

The restrictions on physicians and nurses being able to practise wherever they wish which were proposed in 2007 by the Haut Conseil pour l'Avenir de l'Assurance maladie (the high council for the future of France's state health insurance system) would be in addition to continued management of the numbers of students on the basis of regional needs analysis, so as to ensure that trained practitioners (in accordance with regional needs) did not set up practices in areas that were already very well covered.

Introducing restrictions on the areas in which medical professionals can set up is being considered because the introduction of financial incentives to work in a particular region has not succeeded in ensuring a better distribution of physicians across France - and so inequalities in terms of access to medical care remain. The impact that the 20% increase in the cost of consultations with physicians who are part of a practice introduced in 2006 has not yet been gauged. In the state-run hospital sector, the €10,000 hiring grant on high-priority posts which was introduced in 2002 for practitioners undertaking to take up or remain in "protected or priority recruitment" positions only seems to have been moderately successful.

Basically, planning policy for human resources in France's healthcare sector is in the process of being redefined. Precisely analysing the requirements for student physicians is most probably the first step along the way to a broader and more accurate planning system that will take account of all the healthcare professionals who are unequally distributed throughout France. (cf. above, 2.3).

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\(^{72}\) Law no. 2009-879 of 21 July 2009 hospital reforms relating to patients, health and regions.
3. Policy Framework

3.1 Immigration and emigration policies - an overview

France, a European country that previously had a high immigration rate, experienced a series of immigration waves of foreign workers (often accompanied by their families) in the 50s and 60s, and right up until the mid-70s. The first oil crisis slowed down France's active recruitment policies for non-EU foreign workers. But immigration did not cease altogether, fed mainly by family reunification drives and the influx of refugees. Traditionally, drives to reunite families have always been behind most decisions to emigrate: it was the reason given by 75% of all foreigners who were granted authorisation to stay in France for a duration of at least a year in 2004\textsuperscript{73}. But people emigrating to France for family reasons are not excluded from working - almost all the permits issued to people joining their families (residence permits, temporary residence permits issued for reasons associated with family and private life) grant people the right to work.

There has been a change in perspective since the introduction of the 2006 law on immigration\textsuperscript{74}, with professional immigration being considered in two separate and distinct ways. On the one hand, immigration is a solution for certain economic sectors experiencing significant recruitment difficulties (see 3.1.1). On the other hand, France currently needs to find top-quality professionals with high levels of expertise (see 3.1.2).

3.1.1 Professional immigration or how to match the supply of immigrants with the requirements of certain identified economic sectors

The 2007 law on controlling immigration\textsuperscript{75} formalised this type of professional immigration through a special form of entry, granted under certain circumstances, in the form of a temporary residence permit which bears the comment "employee". This law which, by definition, only applies to a very limited number of people, is intended to specify the framework within which non-EU immigrants have their status regularised on a case-by-case basis. The immigrants in question are people who "in view of their highly sought-after professional expertise, are likely to fully integrate into French society through their employment"\textsuperscript{76}. The aim is to enable non-EU immigrants to more easily take up jobs in certain determined sectors. Non-EU workers are now able to take up employment in professions which are currently experiencing recruitment difficulties, without the employment status being binding upon them. A list of 30 professions "experiencing recruitment difficulties" has been drawn up for each region in France. The number of jobs on this list varies depending on the various individual requirements of each region (for example: 8 jobs out of a possible 30 in Corsica, but 29 in Alsace). And only six jobs are open to all non-EU immigrants in all regions across France, without the employment status being binding upon them: Financial and accounting audit and control manager, IT software tester, IT specialist, public construction work analyst, public construction work contractor’s agent, public construction work site foreman.

\textsuperscript{73} M. DURAND, G. LEMAÎTRE (2007), La politique migratoire française face à un tournant (Migration policy in France at a turning point), OECD documents.
\textsuperscript{74} Law no.2006-911 of 24 July 2006 on immigration and integration.
\textsuperscript{75} Law no. 2007-1631 of 20 November 2007 on controlling immigration, integration and asylum.
\textsuperscript{76} Circular no. IMI/N/08/00012/C relating to the application of article 40 of the law of 20 November 2007 on the issuing of residence permits bearing the comment "employee" for exceptional entry.
In order to be granted a temporary residence permit bearing the comment "employee", non-EU immigrants must provide evidence of experience and/or expertise in one of the 30 professions listed. They must also provide evidence of a firm job offer from an employer in one of the regional listings detailing requirements in these 30 professions, in the form of a permanent employment contract - or, in exceptional circumstances, a short-term contract, but for a period of more than 12 months - the confirmation of which is dependent only on their immigration status being regularised.

It is, however, of vital importance to emphasise that no healthcare-related profession figures on this list of thirty jobs open to non-EU immigrants. What this means is that this professional immigration, the conditions of which are applied in accordance with the requirements of France’s various economic sectors, does not favour the migration of healthcare professionals and consequently does not serve to ensure that the country’s healthcare needs are more adequately met by human resources.

In 2007, a new legal instrument was implemented by the Ministry of immigration and integration: the agreements on concerted migration management and inclusive development. The clauses that make up these management agreements have been drawn up to support the three main aspects of the overall approach to migration - promoting professional immigration, combating illegal immigration and promoting inclusive development. Each one of these agreements deals with a specific negotiation which has been adapted to the individual requirements of each of the two signatory countries and to the immigration situation prevailing in each of the partner countries.

One section in each concerted management agreement deals with how legal immigration is structured, looking at all the issues associated with the movement of persons and the employment of students once they have finished their studies. It moves professional immigration back into central focus, enabling immigrants from the partner country to benefit from a regulatory system that extends beyond the common right established by the 2006 law on immigration. It includes clauses that provide for the opening up of the French labour market to include more professions than simply those included on the list of 30 professions experiencing recruitment difficulties in France. This widening of the market takes account of the joint requirements and the possibilities that have been stated by the partner native country. The concerted management agreement can also institute provisions for making it easier to issue new residence permits.

One section in each concerted management agreement deals with combating illegal immigration, introducing the idea of "shared responsibility in the fight against illegal immigration". So under the terms of the agreement, both parties undertake to readmit any of their citizens who are unlawfully present on the other party’s territory. Furthermore, they undertake to readmit third-country nationals into their territory if they have passed through territory belonging to any parties covered by the agreement. These concerted management agreements are therefore excellent tools for helping France to better manage immigration flow from those non-EU countries with which it has entered into these bilateral agreements.

The last section in each concerted management agreement relates to inclusive development and is part of a drive to reduce poverty in the countries which experience a high rate of emigration. Depending on the requirements stated by the native partner country, provision can be made for mobilising operators, associations and immigrants (either individually or collectively) in order to implement various forms of support for sectorial development (adult education, health, etc.), financial aid for promoting and supporting economic and social reintegration, the development of income generating activities, setting up businesses, or developing new codevelopment savings accounts for immigrants who want to finance investment operations that will contribute to the economic development of their native country.

As of September 2009, France had already signed nine concerted migration management agreements with the following countries: The People’s Republic of Benin, Burkina Faso,
Cameroon, Cape Verde, the Democratic Republic of Congo, the Gabon, Mauritius, Senegal and Tunisia.

The list of jobs open to non-EU immigrants has now been extended to healthcare professions through two of these concerted management agreements:

- As part of the concerted management agreement with Benin, signed in November 2007 and ratified in May 2009, medical imaging system operators and medical equipment maintenance technicians can now be recruited from Benin to work in France, without the labour market status being binding upon them. They are granted an "employee" residence permit on condition that they can provide evidence of an employment contract with an identified employer.

- As part of the concerted management agreement with Senegal, signed in September 2006 and ratified in May 2009, midwives and nurses can now be recruited from Senegal to work in France, without the labour market status being binding upon them. They are granted an "employee" residence permit on condition that they can provide evidence of an employment contract with an identified employer.

For the sake of providing a complete picture of the situation, it should be pointed out that there is a second list of jobs that is open exclusively to EU nationals whose home countries are still in a transitional phase with respect to their membership, and so who do not yet benefit from complete freedom to move about within the European Union. The countries in question are Romania and Bulgaria.

On 1 May 2006, the beginning of the second phase in the transitional period, the French government decided to start a progressive controlled lifting of restrictions on the free movement of immigrant employees from Estonia, Latvia, Lithuania, Hungary, Poland, the Czech Republic, Slovakia and Slovenia. This lifting of restrictions involved 61 professions experiencing recruitment difficulties. The same measures were also applied to immigrants from Romania and Bulgaria starting 1 January 2007 - the date these countries joined the European Union. The initial list of 61 professions has been supplemented by a further 89 professions, allowing immigrants from the aforementioned 10 new EU countries to carry out paid employment in 150 professions, without the employment status being binding upon them. The new list of 150 jobs, which currently only concerns Romanian and Bulgarian immigrants, accounts for 40% of the total number of job offers registered by France's national employment office in 2006, and now covers almost all professional fields (17 out of 22). All immigrants must have a work permit in order to carry out any salaried employment in France, regardless of the job or sector in question. Employers are required to pay taxes and dues to the French office of immigration and integration (fixed contributions and reimbursements). The new list now includes one healthcare profession: nursing auxiliary. Regulated healthcare professions (physicians, midwives, nurses and others) are already subject to certain conditions in relation to the recognition of professional qualifications within the framework of directive 2006/100/CE. In spite of the option open to Bulgarians and Romanians to be recognised as nursing auxiliaries in France before the end of the transitory period, there are some doubts as to just how influential this measure has been on migratory flows. The profession of nursing auxiliary is not considered to be particularly prestigious in France, nor does it attract a particularly high salary - geriatric departments and centres for the elderly and those who cannot live on their own have the greatest difficulty in recruiting for positions that are not considered easy. The language barrier is also an issue in this profession in which carers are required to come into particularly close contact with their patients - both in order to help with their personal hygiene and comfort, and to provide them with assistance as they go about their everyday lives, depending on their levels of autonomy. And although the managers of healthcare centres are willing to invest (financially) in initiatives to recruit physicians from overseas, there are not yet any guarantees that they are prepared to go to the same lengths and pay the French office of immigration and integration in

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77 Law of 18 January 2008 on the granting, without employment status being binding, of work permits to immigrants from EU countries which are subject to transitional measures.

78 Directive 2006/100/CE of the Council, dated 20 November 2006 adapting certain directives in the fields of free movement of persons as a result of Bulgaria and Romania joining the EU.
order to recruit nursing auxiliaries - staff whose presence is not considered so essential in the practising of a given medical activity.

3.1.2 Professional immigration or how to appoint highly-qualified healthcare professionals

Within the context of seeking to develop professional immigration, France is mainly seeking to recruit top-quality professionals with high levels of expertise. Various specific measures have been implemented in recent years designed to make it easier for these highly-qualified professionals to emigrate to France. These measures do not specifically concern healthcare professionals, although healthcare professionals can take advantage of them.

- The "carte de séjour "Compétences et Talents"" - the "Skills and Talent" residence permit can be granted to foreign citizens who are likely to make a significant and lasting contribution through their skills and talents to France’s economic development, as well as the development of their country of origin. The permit allows for a three-year stay and is renewable. In 2008, 76 of these permits were issued. Between January and June 2009, 199 were issued - an increase of 2211% on the first six months of 2008. "Skills and Talent" residence permits authorise foreign citizens to carry out a professional activity of their choice that is in some way related to their own personal project or area of expertise. Members of the bearer’s family are not subject to the family reunification procedure. They are issued with a "vie privée et familiale" or private and family life residence permit which gives them the right to work. In July 2009, no healthcare professional was granted a residence permit of this type.

- The "carte "scientifique"" or scientists’ residence permit is for non-EU citizens who hold the equivalent of at least a Masters degree, and who are intending to carry out research or teach at university level, or who are studying for a doctorate. The beneficiary must provide an agreement signed by the research or teaching centre specifying the amount of time needed in order to complete the work. The permit allows for a one-year stay. But at the end of the first year, overseas researchers can renew their residence permits for more than one year, but no more than four years. The period of time for which the permit is renewed must take into account the initial planned or estimated time needed in order to complete the work as stated on the agreement. These permits have only been available since 2009. As of 1 July 2009, 106 residence permits of this type had been issued.

- Special arrangements are in place for overseas citizens who have a French qualification equivalent to at least a Masters degree. In order for them to gain the professional experience they need so that they might complete their training, and with their aim being to return to their native country, they can be granted a six-month non-renewable temporary residence permit. During this six-month period, they may work up to 60% of the statutory working hours in a salaried position of their choice. Once they have come to the end of a fixed-term contract remunerated at one and a half times France’s SMIC or guarantee minimum wage, they are granted permission to stay in France and pursue their professional activity without the employment status being binding upon them. As of 1 July 2009, 132 young overseas graduates were granted a temporary residence permit.

- The "accords "jeunes professionnels"" are agreements covering young professional people that are drawn up in the spirit of reciprocity. Every year, they allow a fixed number of young people between the ages of 18 and 35 from both France and overseas who have either recently graduated or just started working to visit one of the other partner countries covered by the agreements. Agreements of this kind have been entered into with Argentina,
Canada, the US, Morocco, Tunisia and Senegal. The aim is to enable the beneficiaries of these agreements to develop their professional, linguistic and cultural knowledge, and so to improve their career prospects. The "young professionals" must speak the language of the host country sufficiently well and must either hold a qualification that is suitable for the post on offer or have relevant professional experience in the field in question. They are then authorised to work within the context of a fixed-term contract lasting between 3 and 12 months, with the option to extend it once or several times up to a maximum of 18 months, without the employment status being binding upon them. As a salaried employees, they are guaranteed the same treatment as French nationals in terms of working conditions, remuneration and welfare protection. Once they have completed this period of employment, they must return to their native countries. As of 1 July 2009, 46 young professionals have benefited from these agreements.

The "carte salarié en mission" or salaried employee temporary residence permit was mainly created to encourage greater intra-group mobility within companies. It is a response to the desire to take into account the specificities and requirements of multinational groups, making it easier for staff to move about and be posted to different country branches within the same company. People who have been employed by an overseas company for more than 3 months and who are on secondment in France working for a host company that has been part of the same group as their employer for more than three months may be granted such a permit (as of 1 July 2009, 30 employees had been granted one). Overseas employees of companies set up abroad who are hired directly by the company based in France that belongs to the same group as their previous employer may also be granted such a permit (as of 1 July 2009, 28 employees had been granted one). Applicants must have the relevant qualifications and technical skills and be able to provide evidence that they are being paid a gross monthly salary of at least one half times the SMIC or guaranteed minimum wage. This card is valid for a period of three years and is renewable.

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79 Henceforth, it has been decided not to set up any more of these "accords jeunes professionnels", but instead to include special clauses in the agreements on concerted migration management and inclusive development.
3.1.3 Significant international and European migration policies

A number of undertakings have been made at international level, particularly within the framework of the European Convention on Human Rights and the European Union.

Supplementary protocols to the European Convention on Human Rights include explicit references to the rights and freedoms of foreign nationals with respect to their expulsion. For example, article no.4 of protocol no.4 prohibits the collective expulsion of foreign nationals and requires that member states examine each individual dossier on a case-by-case basis.

The European Court of Human Rights therefore allows member states discretionary powers to grant overseas nationals authorisation to enter their territories and manage the terms of their stay. What this means is that - under the terms and conditions of the Convention - foreign nationals do not have an automatic right to enter and stay on the territory of a member state. The European Court considers, however, that any decision to turn away or remove a foreign national may lead to a violation of the Convention. So non-EU citizens can take advantage of the rights and freedoms granted by this Convention or by one of its protocols. In order for them to benefit from this protection, they must claim that the measure about which they are lodging a complaint runs the risk of violating one of the protected rights. More specifically, reference can be made to two rights. The first is the right to respect for private and family life (article 8 of the Convention which protects the "family nucleus" and which focuses on the relationships between parents and their children under the age of 18). The Convention does not guarantee the right to family reunification in a given member state. If, however, it is impossible for a family to live together as a unit in its native country, a foreign national may take advantage of the right granted to him by article 8 to remain on the territory of the host country. This is especially the case in situations where the interested parties have no family members in their native countries, with all members of their family living in the host country. The second right which can be referenced is the right to non-discrimination (article 14 of the Convention), i.e., the right to enjoy, without any discrimination, all the rights and freedoms that the European Convention on Human Rights lays out. Protocol 12, which came into force on 1 April 2005, extends the guarantee of non-discrimination in Article 14 of the European Convention on Human Rights to any right set forth by law. It also prohibits discrimination by a public authority on any grounds. To date, France has not yet ratified the protocol.

At EU level, the Treaty of Amsterdam brought policy on asylum and immigration under the responsibility of the European Union. With the signing of the treaty, policy on these issues was no longer to be negotiated between governments, but was defined by the community decision-making process which involves the Council of the European Union and other institutions. These joint policies have helped create an "area of freedom, security and justice" within the EU. This movement has been strengthened by the integration of the "Schengen acquis" within the framework of the first community pillar of EU policy. The regulations in force for crossing and checking the shared and outside borders of member states have therefore now been standardised across the EU.

The Hague Programme (2005-2010) identifies several key areas for priority action with respect to asylum and immigration, including the creation of a common asylum area that takes into account the effectiveness of a harmonised procedure, the implementation of an expulsion policy for illegal immigrants, and the introduction of measures allowing non-EU citizens to work in the European Union depending on the requirements of national job markets. The last area has been

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Discrimination is defined as a difference in the way individuals in comparable situations are treated without objective and reasonable justification. Criteria against which it is forbidden to discriminate include gender, race, colour, language, religion, political or any other opinion, national or social origin, membership of a national minority, fortune, birth or any other situation.
addressed within the framework of a directive, which was adopted by the Council of the European Union in May 2009. It makes provision for the introduction of a European "blue card", inspired by the American green card and intended for highly-qualified immigrants. With this tool, the European Union is sending out a triple message in which it conveys its determination to act, not only in the fight against illegal immigration, but also in order to develop possibilities for legal immigration - particularly immigration for professional purposes. Furthermore, it is making mobility within Europe easier for highly-qualified overseas workers. The aim is to make the European Union more attractive for highly-qualified workers than other regions across the world, such as North America, while at the same time taking into consideration the need to properly manage migratory flows - with respect to both its own requirements, as well as those of the native countries of the immigrants coming into it.

**FOCUS – THE EUROPEAN BLUE CARD IN PRACTICE**

Applicants have to meet certain conditions, including:
- they must have a signed employment contract or have a firm job offer for a minimum period of one year,
- they must submit a document proving that they meet the conditions to which national legislation subjects the carrying out of the regulated profession by EU citizens, or which attests to the relevant professional qualifications mentioned in the employment contract
- "they must not be considered a threat to public order, security or public health"
- they must earn a salary which is at least one and a half times the average gross salary of the member state, with the option for each member state to bring this salary threshold down to 1.2 times the average gross salary for certain professions which require high levels of expertise and which are currently experiencing a severe skills shortage.

The European blue card will be valid for a period of between one and four years for both the holder and the members of his or her family (who will also be authorised to seek employment) with the option to renew it. A European blue card can also be issued or renewed for short periods so as to cover the duration of an employment contract plus three months.

After 18 months legally living in the first member state as a holder of a European blue card, the bearer and the members of their family can, under certain conditions, move to another member state for the purposes of carrying out a highly-skilled job.

The holders of a European blue card also enjoy the same working conditions as the other citizens of the member state that issued the card. This includes entitlements with respect to salary and redundancy, freedom of association, teaching, training and recognition of qualifications, as well as a number of other measures provided for by national legislation regarding Social Security and pensions, as well as free access to the all areas of the member state's territory, within the limits laid out by national legislation.

After a period of five years, under more favourable conditions, they may be granted the status of long-term resident.

### 3.1.4 Recruitment policies including bilateral agreements and policies for the reciprocated recognition of qualifications

France has not implemented a wide-ranging policy to recruit highly-qualified workers from overseas, nor has it even implemented any kind of policy specifically designed to recruit healthcare professionals. There is only one notable initiative which should be mentioned - a nationwide drive to recruit Spanish nurses in France. Since that initiative, the only bilateral agreements that have been signed have been the concerted management agreements which extend the list of jobs that can be accessed by non-EU citizens to include healthcare professions (Benin and Senegal). The agreement that has been entered into with Quebec which provides for the mutual recognition of regulated professions covers healthcare professions in particular. Essentially, the only real global policy that establishes a system for the recognition of professional qualifications is the one implemented at European Union level within the framework of directive 2005/36/CE.
The system for recruiting nurses in France (2001-2003)

One of the initiatives that the government implemented in 2001 as part of a drive to compensate for the shortages which were bound to result from reducing the length of the working week in France (the hours of people working in healthcare centres were reduced to 35) included an agreement with Spain designed to recruit staff from among the 8000 unemployed nurses in the Iberian Peninsula. This agreement was signed by the International Migration Office (OMI) and France's four employers' federations for state-run hospitals, private hospitals, non-profit making private hospitals and cancer research units. These employers' federations were tasked with establishing a list of all vacant posts in France - which was then sent to a recruitment service based in Madrid. This service then had responsibility for communicating with healthcare staff in Spain and providing them with information about the various staffing requirements in French healthcare centres, as well as the various structures in place for welcoming them on their arrival. Following this initiative to reconcile supply and demand across the two countries, 502 Spanish nurses and 107 physiotherapists were put in touch with potential employers in France and applied for positions between March 2002 and February 2003 (although 59 nurses and 2 physiotherapists later withdrew their applications). The initiative resulted in firm job offers being made before the Spanish healthcare workers arrived in France.

In order to help them integrate, the Spanish candidates spent the first month in a training centre in the Paris area. A trainer, specialised in accelerated language teaching, helped them with their French language learning (grammar, lists of the most commonly used terms), as well as providing them with more technical teaching related to their healthcare work. After this training period, the candidates joined their employers, who took over responsibility for their training, as well as providing them with support - agreed under the terms of a charter that they had undertaken to observe. Nearly 300 of these Spanish healthcare workers were trained in 2003; fewer than 5% of them returned to Spain.

This drive is seen as an example initiative in the sense that this nationwide recruitment structure was set up on the basis of an association, with all the various bodies concerned working together seamlessly.

In December 2004, the French Ministry of health assessed the system that had been in place between 2002 and 2004 for recruiting Spanish healthcare professionals into state-run and private healthcare centres in France. A total of 848 people were recruited - 643 nurses, 200 physiotherapists and 5 medical electro-radiologists. The recruitment failure rate (the percentage of people who returned to Spain within two years of taking up their posts) was 8% at the end of 2003 which, according to the Ministry of Health, is comparable to the number of young French healthcare professionals who leave their posts having been recruited by healthcare centres when they finish their training.

However, this assessment has never been updated. This means there is no way of knowing if - seven years later - these Spanish healthcare professionals are still working in the French hospitals which recruited them, or if they have returned to Spain. It also means that it is impossible to know what mid-term or long-term impact this drive to recruit staff from other EU countries have had, when it could have been used as a template for other similar programmes.

The Understanding between France and Quebec (2008)

In October 2008, an agreement was signed between France and Quebec in a bid to establish common procedures for mutually recognising the professional qualifications of their citizens. Under the terms of the Understanding, the recognition of professional qualifications acquired in France or Québec will result in the individuals concerned being legally authorised to practise in the host territory. The nationality of the beneficiaries has no bearing on this recognition being granted. Once the mutual recognition arrangement has been established, beneficiaries can apply for a permit to practise in the host territory.
The various professional orders of both France and Quebec had to examine the professional qualifications required for these regulated professions in order to set up mutual recognition arrangements, while ensuring that the minimal training conditions defined by each party were observed. In the situations where there is no direct equivalent of a given training programme or apprenticeship qualification in the other country, or there is too great a difference between two programmes, the professional orders examine the options available for compensating for this difference: taking professional experience into account, conversion training, aptitude tests or additional training. The various professional orders are currently still in negotiations with a view to the recognition procedures being effective by 31 December 2009.

The procedures concern the following healthcare professionals: physicians, midwives, pharmacists and dental surgeons. With these arrangements, French physicians would no longer have to pass an entrance exam in order to practise in Quebec\(^81\); but during these negotiations, a mismatch emerged between the standard permit which is granted to Québécois physicians in France and the restrictive permit which is granted to French physicians in Quebec. Midwives and pharmacists are holding discussions, through their respective professional orders, about extended training. And the professional orders of dental surgeons in both countries are still in the process of developing a common reference framework. The specific conditions should eventually be finalised by the end of 2009 so that the system can be properly implemented.

- **Mutual recognition of professional qualifications within the framework of EU directives (directive 2005/36/CE in particular)**

The right to live and work in all the member states is one of the fundamental freedoms of the European Union. This was made possible for physicians back in 1975, with the implementation of various sectorial directives - which are the basis for directive 2005/36/CE\(^82\), which lays out the current legal framework\(^83\). These directives lay out the minimal training and recognition requirements for certain regulated professions, including healthcare-related professions (positions, pharmacists, midwives, dental surgeons, nurses). In particular, they define:
- the minimum length of basic medical and paramedical studies (a minimum of six years to obtain a qualification in medicine, five years for a qualification in dental surgery or pharmacy, three years for a qualification in midwifery, nursing or physiotherapy).
- the division between time spent on theory and practical training
- the minimum length of study for specialist medical fields
- ways of classifying various specialist medical fields\(^84\).

So, through this system of automatic qualification recognition, all member states are required to equally recognise the qualifications of all professionals who have qualified in another member state, and must consider these professionals in the same way that they consider their own citizens. It is thought that these measures will also apply to qualifications obtained in countries in the European Economic Area (Iceland, Norway), as well as in Switzerland. Recognition is automatic for all qualifications obtained after accession of the member state to the European Union; this means that German, Italian and Belgian qualifications are now widely recognised. The situation is more complicated for newly-qualified staff - qualifications awarded

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81 French office of immigration and integration, see Appendix.
83 France transposed this directive into its national legislation via the law of 30 May 2008.
84 This classification system can be problematic for specialist areas that are not recognised throughout all member states of the European Union. The example, in France, "infectious diseases" is considered an "over-specialist" instead of a "specialist" field for internists. An "infectious diseases" specialist in another member state could only be recruited as a general practitioner (part-time or assistant practitioner) in France, and not as a specialist (part-time or assistant practitioner). This can be a source of considerable frustration for physicians who have no choice but to carry out another specialist training course in internal medicine if they want their specialist expertise to be recognised. Such frustration can result in these specialists leaving France.
for training programmes that were begun before a given country joined the scheme are presumed not to respect all of the minimum requirements. These recently-qualified graduates need one - or in some cases two - additional certificates issued by their country authorities (usually ministries of health), specifying that their qualifications comply with the minimal training requirements as described in European directive 2005/36/CE, and that the candidates have a right conferring immediate entitlement to practise in their discipline - as illustrated in the diagram below.

Figure 14 - Recognition of EU qualifications for different training commencement dates for graduates of member countries that have joined the EU since 2004

This move to set up a system for automatically recognising EU qualifications throughout its member states is evidence of a drive to agree on minimum training requirements, but in no cases do the programmes comply with French standards - something which is of concern to some of the professional orders, since the training of healthcare professionals in France is "specific" and "more complete" than the programmes delivered in other member states - programmes which France is required to recognise. This is very much the point of view put forward by the National Council of the Order of Midwives - the minimum training period specified in the EU directive is only three years, whereas in France, midwives study for a minimum of five years - including a joint foundation year spent training with physicians and dental surgeons. The professional order is therefore working hard at EU level, alongside a policy officer for EU issues.

85 A representative of the National Council of the Order of Physicians had no hesitation in pointing out that "the qualifications delivered in certain countries [which have joined the EU mutual qualification recognition scheme] are completely worthless". The national council of the order of dental surgeons has a more dispassionate attitude, believing that the programmes are all of equal value with respect to the minimum training requirements set by the European Union. The National Council of the Order of Physiotherapists shares this point of view.
and the orders and authorities of other EU member states, looking into the possibility of raising the requirements for midwifery training.

But having a system whereby minimum training requirements are observed throughout the EU is still preferable to the situation regarding qualifications delivered from outside the EU which carry no such guarantees - except for those delivered within the framework of the mutual recognition understanding set up with Quebec, for example.

### 3.1.5 Codes of practice and other ethical recruitment frameworks

In 1999, without claiming to be motivated by concerns of an "ethical" nature, France\(^{86}\) set out its target of national self-sufficiency for the recruitment of physicians, prohibiting any "new" recruitments of physicians who had trained outside the EU, and who would not already have been recruited before the promulgation of the law. Nevertheless, physicians continued to be recruited from outside the EU - an illegal practice under the new law.

President Sarkozy reasserted this target of national self-sufficiency for the recruitment of healthcare professionals in a speech he made on hospital reforms in April 2008: "I don't want France to be another country involved in pilfering expertise from other countries. Immigration must not be seen as a solution to the difficulties in accessing healthcare that our country is experiencing"\(^{87}\).

However, no document has been drawn up that supports Sarkozy's assertion. There is no guide to good practice in recruitment, nor even a list of countries from which healthcare professionals should not be recruited. Neither are there any recommendations for guaranteeing the same rights to welfare, salary and training as for French healthcare professionals.

The assistant-director of the hospitalisation and healthcare department at the Ministry of Health tasked with human resources in the healthcare system gave an interview in which she stated that, in view of the simple regulatory role played by the Ministry - which is not the same as the NHS in the UK which functions as an employer - it could not take a leading role in initiating discussions about codes of ethics for recruiting healthcare professionals at international level - even though it agreed with the principles\(^{88}\).

There is, however, a regulation set by the Ministry of health (that hospital managers must observe), which stipulates that physicians who would not have been present in hospitals before 2004 (by way of exception until the end of 2011) unless they had passed the requisite tests authorising them to practise or unless their qualifications had been obtained or recognised in a European Union member state may not be recruited.

In actual hospitals and healthcare centres, any discussions on ethics are impeded by the shortage of medical resources (see below). However, the management organisations which are involved in European state funded-hospitals (HOSPEEM - the European Hospital and Healthcare Employers’ Association, and EPSU - the European Federation of Public Service Unions) signed a code of conduct in April 2008 on the recruitment of staff from other EU countries in hospitals. The French Hospital Federation (which represents state-run hospitals) is a member of HOSPEEM, and should therefore be tasked with ensuring the widespread adoption of this code of conduct, the aim of which is "the ongoing promotion of ethical recruitment practices"\(^{89}\). To date, the French Hospital Federation has not published a single document relating to ethical practices in this area.

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\(^{86}\) Law no. 99-641 of 27 July 1999 on the introduction of a universal medical coverage scheme.


\(^{88}\) See interview in *Appendix*.

\(^{89}\) [www.hospeem.eu](http://www.hospeem.eu); [www.epsu.org](http://www.epsu.org).
**FOCUS – THE ROLE OF ETHICS IN THE RECRUITMENT OF PHYSICIANS WITH OVERSEAS QUALIFICATIONS IN STATE-RUN HOSPITALS**

When a survey was carried out among management departments of state-run hospitals in June 2008, the issue of ethics was not spontaneously raised: 9% of those who took part in the survey admitted that they had "never considered the consequences that recruiting a physician with qualifications obtained overseas to their healthcare centre could have on their country's overall healthcare system". Nearly 3 in 10 managers completely dismissed the ethical dimensions, believing that it wasn't their role to "factor in the consequences of overseas recruitments into the running of their particular healthcare centre. The issue should be looked at at a national level".

But in spite of everything, 37% of managers in charge of medical affairs believed that "these appointments were questionable from an ethical perspective, but that they did not have any other candidates", and so they had no choice but to recruit a candidate who had qualified overseas. And a quarter of the managers polled (including two in University hospitals) thought that "if they didn't appoint the physician in question with the overseas qualification, he or she would most likely be recruited by another state-run hospital, while theirs continued to suffer staff shortages". Fundamentally, for more than 60% of the healthcare centres polled, the absence of any other candidates got in the way of any discussions about the ethical dimension of recruiting physicians who had qualified overseas.

### 3.2 Other policies which have an unexpected effect on the migration of healthcare workers

The policies which indirectly affect the migration of healthcare professionals are not development policies - currently, they are increasingly associated with immigration issues within the framework of the bilateral concerted management agreements (see 3.1.1). The rights of immigrants are in compliance with France's international commitments within the framework of the European Convention on Human Rights (see 3.1.3) and do not indirectly affect the migration of healthcare professionals, insofar as they fall directly within the scope of the immigration policy which has been in force since 2007.

On the other hand, *France's policy on recognising the qualifications of healthcare professionals that have been obtained outside the European Union* - in other words, outside the common system for automatically recognising EU qualifications - has doubtless affected the migration of healthcare professionals; the most recent modifications made to this recognition framework are also likely to have a real impact on the migration of healthcare professionals.

For qualifications obtained outside of the European Union, regulations impose automatic non-recognition - unlike the system in place between member states of the European Union/European Economic Area and assimilated countries (Switzerland).

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The questionnaire for the survey on the recruitment of physicians with overseas qualifications working as doctors, surgeons or obstetricians was distributed to 289 state-run healthcare centres. 65 filled in the questionnaire (22%). It was a declarative survey, and so was based on answers that the various healthcare centres had been willing to supply. But because the survey was carried out anonymously (in the end, only 12% of healthcare centres polled chose not to remain anonymous), the answers given were very honest, with people readily admitting that they did not comply with the legislation in force or that their practices were most certainly different from those defined at institutional level.
There is, however, an exception which applies to all healthcare professionals, be they nurses, physicians, dental surgeons, pharmacists, midwives or physiotherapists: when somebody who has qualified in a country outside the European Union has had their non-EU qualification recognised in an EU member state, allowing them to practise their profession and to acquire the nationality of the member state. If they then ask a second EU member state for authorisation to practise their profession (medicine, for example), this state has to “take into account all the qualifications and relevant experience of this citizen when deciding whether or not there are grounds for granting this authorisation”\(^91\). So, a physician who qualified in Argentina and who has had his qualification recognised by Spain (a country in which he has practised), should be granted preferential entitlement to practise in France (over other qualified physicians from Argentina who have not yet had their qualifications recognised in France). A commission has therefore been set up to look into the qualification and the applicant’s experience before recognising the qualification\(^92\).

3.2.1 The absence of a non-EU qualification recognition system for nurses and physiotherapists: back to basic training in order to be able to practise

In the first place, nurses seeking to practise as a nurse in France need either the French national nursing diploma, one of the qualifications recognised within the framework of directive 2005/36/CE or the Andorran nursing diploma. It should be pointed out that there is no system in place for recognising nursing qualifications awarded outside the EU. Nurses who have non-EU qualifications that are not recognised in France who still want to practise are required to sit the selection tests for entry into nursing training institutes in order to be awarded the French national nursing diploma. They may be exempt from up to 2 years of studying by the director of the nursing training institute in question upon notice from the technical council and after they have successfully passed the institute’s admission test. This decision is taken on the basis of the candidate’s level of initial training, although they must still sit the final exam after three years of training.

Similarly, physiotherapists seeking to practise in France need either the French national physiotherapy diploma, one of the qualifications recognised within the framework of directive 2005/36/CE or the Andorran physiotherapy diploma. There is no system in place for recognising physiotherapy qualifications awarded outside the EU. Therefore, people with physiotherapy qualifications from outside the European Union who are unlikely to be able to take advantage of any of the measures which are applicable to citizens of EU member states - or of any states in the European economic area or the Swiss Confederation - who wish to practise in France must sit the selection exams for entry into an institute of physiotherapy training\(^93\) in order to obtain the national diploma of physiotherapy.

For both of these paramedical professions, not having a national French qualification amounts to not being able to practise in France. The only way (with some dispensations) for holders of non-EU qualifications in these fields to practise in France is for them to go back to basic training

\(^91\) CJEC law of 14 September 2000: case C-238/98 HOCSMAN c / French Ministry of employment and solidarity.
\(^92\) Article L.4111-2 II of France’s public health code: \textit{In the event of an examination of the professional qualifications attested by this diploma and based on relevant professional experience revealing significant differences with respect to the qualifications required in order to practise the profession in France, the relevant authorities can request that the interested party undertake a compensatory measure which may involve either an aptitude test or a conversion training programme, to be decided by the applicant.}
\(^93\) The total number of candidates who are admitted to study in an institute of physiotherapy training with a physiotherapy qualification from outside the EU during the course of a given year is added to the quota of first-year students that the institute is able to take in for the year under consideration, and may not exceed 3%.
in an appropriate institute. The process lasts 3 to 4 years (if there are no dispensations) and a minimum of one year (if the most dispensations are granted). This length of time dissuades many nurses and physiotherapists with non-EU qualifications from coming to work in France.

### 3.2.2 Recognising non-EU qualifications in medicine, midwifery, dentistry and pharmacy: recognition after a long, complicated process

- **Conditions for being able to practise medicine, midwifery, dentistry and pharmacy in France**

People wanting to practise these four professions must:

- be holders of the requisite French qualification or of a qualification that is recognised within the framework provided by EU directives

- be holders of French or Andorran nationality, or be a citizen of another member state of the EU or European Economic Area, or of Morocco or Tunisia

- be registered on the regulated professional's official role

It is noteworthy that not holding French (or EU) citizenship is what prevented non-EU citizens from practising in France, despite the fact that they had carried out all their training in France, sat the same exams as their French colleagues, and had been awarded the qualification of ‘doctor’ in one of the four professions. Previously, they did not have the right to practise under the same conditions as French nationals and had to apply for and acquire French nationality in order to be able to practise in accordance with certain determined statutes. A law has finally been passed enabling physicians, midwives, pharmacists and dentists with qualifications in medicine, midwifery, pharmacy and dentistry obtained in France - and who have carried out all of their training in France and been awarded their diploma in France - to practise under the same conditions as French citizens who qualified in France.

- **Recognising non-EU qualifications**

In view of the conditions in which medical professions are practised, the basic rule is that non-EU professional medical qualifications must be recognised. It is this recognition of the qualification by the relevant French authorities that enables medical professionals to practise in France.

The issue of the guarantee provided by non-EU qualifications currently seems much more important, given how ‘easy’ it is for hospitals to appoint physicians with EU qualifications. From interviews, it has emerged that rumours are going around about the inferior quality of medical practitioners from various central European countries, and practitioners with non-EU qualifications are establishing themselves as well-regarded representatives of French medicine in the face of EU-qualified physicians who have neither a sufficiently sophisticated mastery of French, nor enough knowledge of how medicine is practised in France.

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94 For pharmacists, the Quebecois qualification is already recognised, following the mutual professional qualification recognition agreement (see 2.1.4).

95 Law no. 2009-879 of 21 July 2009 hospital reforms relating to patients, health and regions.
FOCUS – PHYSICIANS WITH NON-EU QUALIFICATIONS WHICH HAVE NOT BEEN RECOGNISED

Physicians with non-EU qualifications practising in France include:

- practitioners with non-EU qualifications who have obtained authorisation to practise in France and who have been able to enjoy a career as a hospital practitioner like their French colleagues, having passed the tests involved in the authorisation procedure; it is difficult to know exactly how many of them there are in France, because the official lists on which they are registered only take the nationality of the physicians into account, and not the nationality of the qualification they hold. And many of these practitioners have obtained French nationality. According to their union representatives, more than 10,000 practitioners have been granted authorisation to practise over the last 10 or so years.

- practitioners with non-EU qualifications which have not (yet) been recognised in France who practise medicine to a limited extent under the responsibility of a senior physician; as of March 2007, 6087 such practitioners were working in state-run hospitals in France. Also included in this category are physicians who come and do additional training in France. They account for nearly half of these physicians and often decide to stay and practise in France when they finish their training.

The physicians in the last category should not normally be able to practise in France, since their non-EU qualifications are not recognised: without a recognised qualification, they cannot be registered on the official list of practising physicians. Many of them were, however, recruited by state-run hospitals at the end of the 1990s, or even after 1999, which was when legislation was passed to prohibit the appointment of any non-EU qualified physicians. These physicians are not able to fully practise medicine in France and can only be appointed under certain conditions. They may only practise under the responsibility of a department manager, as if they were still trainee doctors (interns).

Given how difficult it is to recruit medical staff in state-run hospitals - particularly those in isolated areas which do not have a great deal of appeal, given the issues associated with the demography of the medical profession and the unequal distribution of physicians working in different specialist fields across France (practising in the public sector as well as privately) which stems from the lifestyle choices and requirements of new generations of physicians, state-run healthcare centres have had to appoint physicians who qualified in countries other than France. This overseas medical workforce has therefore served - and continues to serve - as a balancing variable in hospitals. Regulations regarding the type of work they are authorised to carry out are unclear and so are very much open to interpretation. And the very detailed legislation that governs what they can and cannot do holds little weight in the face of staffing issues at local level which can sometimes drive hospital managers to circumvent the rules (particularly with respect to the limited numbers of times per month that they can serve as duty physicians, their not being authorised to be on call and their being able to prescribe prohibited drugs). The presence of this overseas workforce has, however, perpetuated the inequalities in the way medical expertise is distributed throughout France - something that the state authorities have only recently started to address. But given the growing recruitment difficulties that the medical profession is facing, this balancing variable in the form of non-EU qualified physicians is becoming even more unavoidable.

Although France has not always been very clear as far as recognising the qualifications which govern the practising of medical professions (see above), the current situation requires much more strictness with regards to the quality of these non-EU qualifications.

This is why the measures in place for verifying people’s knowledge and their grasp of French have become more stringent and now form the basis of the procédure d’autorisation d’exercice - the tests that they are required to sit in order for them to be able to practise. These tests involve verifying the knowledge of non-EU qualified medical staff - both their basic knowledge

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96 Telephone interviews with Jamil AHMIS (chairman of the Federation of Health Practitioners or FPS) and Talal ANNANI (chairman of the National Union Group for General Practitioners with Qualifications from Outside the EU or INPADHUE), both chairpersons of the two unions which represent practitioners who have qualified in countries outside the EU.

97 DIRECTION DE L’HOSPITALISATION ET DE L’ORGANISATION DES SOINS (hospitalisation and the structure of healthcare delivery) (2007), Survey of physicians who qualified outside the EU.

98 The procédure d’autorisation d’exercice, in its current form, results from article 83 of law no. 2006-1640 of 21 December 2006 on the financing of the social security system for 2007. This law is clarified by law no. 2007-123 of 29 January 2007, and replaced the new procédure d’autorisation which was introduced in 2004.
as well as their practical knowledge. From 2010 onwards\(^99\), physicians will no longer have to sit exams to test their knowledge of French - instead they will simply have to submit a document certifying that they have the requisite knowledge of the language.

There are two different ways to sit these tests. Up until now, candidates have been able to sit them twice; from 2010 onwards, candidates will be able to sit them up to 3 times:
- as a *concours* or competitive exam - which does not cover all specialist fields, and for which quotas have been set for each specialist field\(^100\).
- as an exam - during the current transitional period up until 31 December 2001, so that non-EU qualified practitioners who have been practising in France since before 10 July 2004\(^101\) can have their situation regularised in as simple and as straightforward a way as possible. All specialist fields are affected by these changes and practitioners (physicians, midwives, dental surgeons, pharmacists) only need an average of 10/20 in order to pass.

If they pass the tests, they are appointed. Physicians and pharmacists are appointed as associate assistants for a period of three years at the end of which their expertise is assessed. They can get dispensation for this period if they have already practised as associates for a period of at least three years prior to their passing the exam. Starting in 2010, midwives and dentists will be required to practise as associate assistants for a period of one year. At the end of this period, they submit their dossiers to the committee tasked with deciding whether or not authorisation to practise their particular specialist field (or profession) should be granted. Starting in 2010, they will be able to submit to this commission a maximum of three times. Should the commission consider that the practitioner could benefit from a practical internship in a specialist field, it can request that the practitioner provide proof of having practised in this field before resubmitting to the commission.

It is not possible to match the current quotas that have been set for the competitive exam to the needs for physicians - it is not possible to know before the exams are sat at how many physicians will pass for each of the given specialist fields. It will only really be possible to properly set these quotas so that they properly match requirements once this transitional period has ended - provided the Ministry for health carries out an accurate needs analysis study. Incidentally, passing the highly selective competitive exam will be evidence of the high quality of the candidate's qualification - the quota system in place will mean that even very good candidates will not get through. Candidates who do not pass will not be able to practise in France.

Basically, these tests that physicians, midwives, dental surgeons and pharmacists who have qualified in countries outside the EU are required to pass are evidence of France's willingness to recruit the most brilliant medical expertise from all of the world.

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\(^99\) Law no. 2009-879 of 21 July 2009 hospital reforms relating to patients, health and regions.

\(^100\) In 2008, only 15 places were available in anaesthetics for more than 130 candidates.

\(^101\) Healthcare professionals who have been practising since before 10 July 2004, must have been practising under the following conditions: * for physicians, dental surgeons and pharmacists, with the following statuses:
- associate assistant, associate manager, associate manager practitioner; university responsibilities as assistant university head of clinic or university associate assistant, provided they have been tasked with hospital responsibilities at the same time; student working as an intern; nurse. * for midwives, they must have practised as a midwife or paediatric auxiliary nurse or auxiliary nurse, provided that the responsibilities were held in a maternity unit.
3.2.3 The non-training intern system in medicine and pharmacy

Among the physicians who have not had their non-EU qualifications recognised (see FOCUS), there are a certain number who are carrying out specialist or complementary training programmes. These physicians must be registered with a university in order to study for the Attestations de formation spécialisée (Specialist training certificates) or Attestations de formation spécialisée approfondie (Advanced specialist training certificates) in order to get positions in hospitals. They practise under the direct responsibility of the practitioners under whom they are working, in departments that have been specially authorised to take on interns. As a rule, they are appointed to intern posts which have been left vacant following the departure of their previous occupants to other positions. The length of the contract is therefore only six months (the length of an intern’s semester), but it can be renewed up to a maximum period of two years. The system has often been abused - by people submitting successive university registrations beyond the authorised time limits (by changing university, for example), or through hospital managers not checking the requirement that interns be registered at a university, or making sure that they had the requisite visas, etc.

The Attestations de formation spécialisée (Specialist training certificates) and Attestations de formation spécialisée approfondie (Advanced specialist training certificates) were very popular among immigrant practitioners, hoping to be able to remain in France under a different status afterwards. A certain number of these practitioners who had started practising in France with this status registered to have their qualifications recognised via the procédure d’autorisation d’exercice.

The system will be changing in September 2009, with the introduction diplômes de formation médicale spécialisée (specialist medical training qualifications) and diplômes de formation médicale spécialisée approfondie (advanced specialist medical training qualifications). This is not the only change, with the conditions for being able to register becoming increasingly strict and restrictive. Candidates now need a certificate proving that their French language skills are of the requisite level, as well as an agreement with their original universities specifying the length of the training programme and stipulating that they must return to their home countries once their training is complete. The number of times they can renew their registration is limited, and holders of a diplôme interuniversitaire de spécialisation (joint university diploma in an advanced specialist field) or diplôme interuniversitaire de spécialisation complémentaire (joint university diploma in an advanced comp entry specialist field) may not register. Candidates also need to pass tests designed to gauge their knowledge and expertise in medicine, which relate to the national ranking exam programme (competitive hospital training exam). The number of places available in each discipline and specialist field for each region is determined on an annual basis by the ministries for further education and health. The exams are held every year before 15 March (in the cooperation and cultural action departments of France’s embassies overseas). Not all disciplines and specialist fields are available every year.

By tightening the conditions under which candidates can register and managing the number of places available at national level - essentially ending the freedom that healthcare units had to make their own choices - the government is making its intentions very clear: candidates can only register and be appointed as students working as interns for a temporary period. Trainee physicians have to return to their native countries after a few semesters spent in France. The government is therefore restricting the international recruitment of physicians which had been going on via this channel.
3.3 Shifts in politics and major political parties affecting policy change; approach to health and approach to migration

- Political parties and migration policy

The party in power (the centre-right UMP party) promotes the idea of "managed immigration" founded on the basis of quantified objectives designed to regulate migratory flows. The aim is to make admission easier for overseas nationals who are likely to play a significant and lasting role in France's economic development, but to protect the country from unwanted waves of immigration by tightening the legal conditions for acquiring French nationality, securing asylum and reuniting families. The introduction of a quota policy is being considered, with a number being established on an annual basis for the maximum number of immigrants allowed to come and settle in France, together with an economic immigration objective accounting for 50% of this number. Within this number would be quotas for general professional categories, as well as for countries of origin within the framework of concerted migration management agreements entered into with the countries in question.

The opposition party (the Socialist party) opposes any global quota restrictions, considering them ineffective and discriminatory. However, political pragmatism has led it to admitting the need to quantitatively target and open up certain professions that are experiencing recruitment problems and to negotiate bilateral agreements on co-development and "shared immigration" with the countries in question.

- The introduction of a quota policy?

In order to implement Nicolas Sarkozy's quota policy, a Commission on the constitutional framework for the new immigration policy was tasked on 30 January 2008 with thinking about defining normative immigration quotas within the framework of a quantitative migratory flow regulation system.

However, the report that it submitted on 16 July 2008 was unenthusiastic about the introduction of such a quota system: "Restrictive migratory quotas would be impossible to implement or pointless. The government does not have any discretionary power for setting the numbers for the two main sources: family immigration and asylum seekers [...]. A policy that limited migratory contingents would be of no real use with respect to immigration for professional purposes, would be ineffective against illegal immigration, and as far as other types of immigration are concerned, would be incompatible with our constitutional principles and the commitments we have made at European and international level".102

- Political parties and health policy

The party in power (the centre-right UMP party)103 promotes a healthcare system founded on the principles of "quality, proximity, transparency and innovation" that is faithful to the values of freedom, responsibility and solidarity. This implies a desire to reduce expenditure on healthcare by tackling fraud and by increasing the contributions made by complementary bodies, while restructuring the healthcare delivery system around the attending physician. Under such a system, quality is maintained through the implementation of a policy to manage medical

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102 P. MAZEAUD (2008), Pour une politique des migrations transparente, simple et solidaire (for a transparent, simple and unified migration policy), Report by the Commission on the constitutional framework for the new immigration policy.
demography so as to increase the numbers of physicians and better distribute them throughout the country, and through modernising hospital management at hospital catchment area level. It also advocates better prevention.

The opposition party (the Socialist party)\(^{104}\) advocates a policy which “is primarily based on reducing inequalities between people and regions in terms of access to care”, prioritising public healthcare and prevention policy for state-run hospitals and ensuring that statutory fees are not exceeded.

Throughout the parliamentary procedure which led to the passing of the “Hospital, Patients, Health, Regions” law\(^{105}\) in July 2009, the political debate focused on the powers that had been given to the regional health agencies and the creation of Communautés hospitalières de territoire or regional hospital communities. The fear was that the main purpose behind these initiatives was to facilitate budget cuts by transferring certain activities away from local hospitals or doing away with them altogether, without ensuring that equivalent services could be accessed as easily elsewhere. As far as the governance of hospitals is concerned, people voiced their concern over a system which ran the risk of leading hospital managers to put economic considerations before patient well-being and avoid more costly procedures.

### 3.5 Incentive schemes used to retain or recruit healthcare professionals

A number of different schemes have been implemented to recruit and hang on to healthcare professionals over the last few years, although their success rate has never been evaluated. They target healthcare professionals during their basic training or when they first start practising, and come in the form of financial incentives or schemes to improve the conditions under which they practise.

At national level, the government and the national state health insurance office favour financial assistance to help people set up or remain in post, as well as information tools. At regional level, most of the measures involve training and support for the various initiatives of healthcare professionals who are interested in structuring their work differently (setting up as part of a group practice, delegating certain tasks or becoming involved in telemedicine). It is important to highlight the growing role played by regional authorities. Growing numbers of local initiatives are being introduced to ensure access to a range of first resort care structures. These policies are diversifying, and are becoming more solid and better structured. This can sometimes lead to local authorities trying to outdo one another in bids to attract healthcare centres, knowing the important role they can play in urban planning. They are one of the facilities that contribute to the appeal of a community and can often lead to the emergence of other projects.

- **Incentives during basic training**

The period during which healthcare professionals are doing their basic training is seen as a good time for the state authorities to intervene - this is the time during which it is possible to influence the choices of these future physicians about where they are going to practise. In these situations, incentives take the form of grants for students in the third cycle which are allocated by the regional authorities. In compliance with the law of 23 February 2005 about rural regions, these grants come in two separate forms. For physicians, they can involve financial help for students wanting to carry out their general medicine internships in regions in which there is a deficit of healthcare professionals. These internships, which have been compulsory since 2006,
are designed to give students experience of working independently as part of a practice in a rural community. In order to encourage students to set up in these areas, certain regions - such as Burgundy, for example - reimburse a percentage of the accommodation and travel expenses of these students.

These grants can also be designed to ensure that trainee physicians end up practising in a particular region. During their third cycle studies, they can receive up to €24,000, on condition that they undertake to practise in a region in which there is a deficit of healthcare professionals for a period of up to 6 years.

FOCUS – THE RECIPROCATED HEALTHCARE CONTRACT IN BURGUNDY
Since 2005, Burgundy's Regional Council has been inviting nurses, physiotherapists and midwives to enter into a contrat réciprosanté - a reciprocated healthcare agreement - within the framework of its professional training initiatives. This scheme has been introduced alongside the allocation territoriale d'études - the regional study allowance - and commits these future healthcare professionals to practising for periods of between one and three years in the Burgundy region when they finish their training. The healthcare or social-welfare centre where they do this is the centre which will have contributed to financing their allowance.

From their second year of studies onwards, students receive (in addition to their training allowance):
- €465 per month if they sign a contract with an urban-based hospital or clinic,
- €600 per month if they sign a contract with a social-welfare, geriatric or psychiatric unit or one that is based in a rural community or in a community that is considered "fragile".

- Incentives for practitioners as they set up

For practitioners who are in the process of setting up, the government's aim is to attract them to regions in which there is a deficit of healthcare professionals, or to get them to remain in post. The various incentive schemes that have been set up in order to do this are implemented by the State, institutional partners (the healthcare insurance system and other healthcare professionals) or the regional authorities.

The schemes have been adopted in succession, without any kind of overall strategy and all within a short period of time. The result is that they have a number of weaknesses, the main one being the diversity of the zoning that they relate to.

Some of these are financial incentive schemes, aimed mainly at physicians. These can take the form of tax exemption schemes, for example. The salaries of healthcare professionals who provide continuity care (up to a maximum of 60 days per year), and the incomes of independent healthcare professionals practising in rural regeneration areas are not subject to tax. The incomes of the latter are completely tax-free for the first five years, and are then subject to progressively higher levels of tax over the next nine years.

Healthcare professionals can also take advantage of tax exemption schemes if they set up a practice in a community of fewer than 2000 inhabitants or in a rural regeneration area. They can receive the gains from this exemption scheme during the course of the year which immediately follows their setting up for a period of between two and five years. Surgeries set up in urban regeneration zones, sensitive urban zones and urban free zones can also take advantage of this measure for a period of up to 5 years.

Healthcare professionals can also be exempt from having to pay social security contributions under certain conditions when they take on an employee in a rural regeneration area (partial exemption from employer’s contributions for a period of 12 months).

There are a number of other schemes, mainly available through regional authorities: grants are available to help practitioners settle in to the region; professional premises or accommodation can also be provided; and there are schemes which reimburse investment or operating costs.
The state healthcare insurance system pays physicians who practise as part of a group in areas suffering from a shortage of medical practitioners and who have committed to remaining in post for a minimum period of three years 20% extra on their fees. There are special dispensations in place from having to respect the conventional care delivery system so that patients who consult physicians who have recently set up in areas suffering from a shortage of practitioners are not penalised for failing to respect the attending physician’s regulations. These dispensations are granted for a period of five years to any physician who sets up in an area which is suffering from a shortage of medical practitioners.

The conditions under which medicine is practised in France have been adjusted It is now possible to open a secondary surgery, and the status of collaborateur libéral or independent colleague has been created. These new means of structuring one's professional activity are encouraging practitioners to set up in fragile sectors. In addition to these measures, there is also a new support scheme for recruiting locums. This is designed to enable healthcare professionals practising in regions in which there is a shortage to enjoy terms which are more favourable than those provided by ordinary law.

4. Migration Flows

4.1 General migratory profile

4.1.2 Immigrants

4.1.2.1 Number of immigrants

Over the decades, France’s overseas population has become very diverse, both in terms of its make-up, and in terms of the varying lengths of time that the various communities that make it up have been based in France. It is also a population that is constantly changing. Some people’s aim is to secure French nationality, while others intend to return to their native countries at some point or move to yet another destination. As 1 January 2006, INSEE, France's National Institute for Statistics and Economic Studies, estimated that there were 3.5 million non-French citizens living in mainland France. Between 1999 (which was when the last census was carried out) and 2006, the population of non-French citizens increased at a higher rate than the population of France as a whole (8.7% as opposed to 4.9%). Among these non-French citizens were 528,700 who were born in France: most of them will become French through “droit du sol” - the tradition of granting nationality to those born on French soil which is offered to children over the age of 13.

In 2008, France welcomed 192,523 new non-French citizens onto its territory. The majority of them (45%) have emigrated for family reasons (86,770). More than a quarter of these immigrants are students (50,280). One in five non-French citizens have emigrated to France for professional reasons (38,892) - France has been seeking to develop professional immigration in recent years. Recorded inflows increased by nearly 8.4% between 2007 (177,537) and 2008.

106 France’s total immigrant population (including those who had obtained French nationality) stood at nearly 4.9 million in 2005 - 8.1% of the total population. See appendices.
108 Statistics provided by the French Office of Immigration and Integration, based on inflows recorded through medical visits.
The estimated working population of non-French nationals\textsuperscript{109} between the ages of 15 and 64 was 1,486,140 in 2007 - 44\% of whom were from other EU member states. The working population of non-French nationals accounts for 5.4\% of the overall working population - a proportion which has remained constant over the last three years. 57.5\% of the working population of non-French nationals is male - as opposed to 52.5\% for the working population in France. However, the proportion of women is increasing: the proportion of men in the working population of non-French nationals has fallen by 3\% since 2004, whereas it has only fallen by 0.5\% for the working population of French nationals.

In 2006, 60\% of the non-French national population was concentrated in three regions of mainland France. Four in ten non-French nationals were living in either the Paris region, or (trailing far behind) Rhône Alpes or Provence Côte d’Azur (11\% and 9\%). In the Paris region, one in eight people are non-French nationals. There was also a higher-than-average number of non-French nationals living in Corsica and Alsace (around 8\%). Conversely, there are relatively few non-French nationals living in the west of France. In Brittany, Basse-Normandie and the Pays de la Loire regions, they account for less than 2\% of the population.

4.1.2.2 Main countries of origin of immigrants

In 2006, two in five non-French nationals (40.4\%) were from either Portugal, Algeria or Morocco: these three nationalities accounted for nearly 1.5 million people. 35\% of France’s population of non-French nationals are from one of 25 EU countries, 31\% are from either Morocco, Algeria or Tunisian and 13\% are from Asia. In total, the proportion of Europeans has been falling since 1975 (61\% in 1975 as opposed to 40\% in 2006), while the proportions of Africans (35\% as opposed to 43\%) and Asians (3\% as opposed to 13\%) have been rising.

As was the case in 1999, 1.2 million of France’s non-French national population is from one of 25 EU countries. This stability arises from a combination of two steady trends: the numbers of Spaniards and Italians have been falling through mortality, while large numbers of Portuguese nationals have been acquiring French nationality. More than 70,000 Portuguese nationals acquired French nationality during this period, with two-thirds having at least started the application process before their 18th birthday.

4.1.3 Emigrants

As of 31 December 2008, there were 1,427,046 French nationals\textsuperscript{110} registered with French consular offices outside France - a 7.6\% increase on the number recorded the previous year. It should be pointed out that French nationals living abroad are strongly advised to register with the consular office of the country in which they are living, although it is not compulsory to do so\textsuperscript{111}. This means that the information held by consular offices cannot be used to accurately gauge the numbers of French people living abroad. France’s Ministry for Foreign Affairs estimates that there are more than 2 million French nationals living abroad. Over the last 10 years, the number of French expats has been increasing regularly at an average rate of approximately 3.6\% per year.


\textsuperscript{110} Statistics regarding the number of French nationals living abroad, available online at: http://www.mfe.org.

\textsuperscript{111} Registering with a consular office can help make certain administrative procedures easier - such as the issuing of identity documents, voting in certain elections and receiving information sent out by France’s embassies and consulates on issues such as security.
graphic 8 – Top ten country destinations for French nationals

(Number of French nationals registered with consular offices as of 31 December 2008)

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of Nationals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Switzerland</td>
<td>138849</td>
</tr>
<tr>
<td>United States of America</td>
<td>117076</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>112560</td>
</tr>
<tr>
<td>Germany</td>
<td>106842</td>
</tr>
<tr>
<td>Belgium</td>
<td>90588</td>
</tr>
<tr>
<td>Spain</td>
<td>82050</td>
</tr>
<tr>
<td>Canada</td>
<td>68075</td>
</tr>
<tr>
<td>Israël</td>
<td>56585</td>
</tr>
<tr>
<td>Italy</td>
<td>46224</td>
</tr>
<tr>
<td>Morocco</td>
<td>36818</td>
</tr>
</tbody>
</table>

FOCUS – THE LIVES THAT FRENCH NATIONALS LIVING ABROAD LEAD Results of an opinion poll carried out among French nationals living overseas in 2007

Two-thirds (67%) of the French nationals living abroad who replied to the survey were men. The majority of them (60%) were living as a couple (married or otherwise). They were relatively young: 56% of the French nationals living abroad were under the age of 35 (72% were under the age of 40).

Most of the French people living abroad were managers and were working in the private sector. 46% of those who replied to the survey were on an average income of less than €45,000 per year. But 23% of the French people living abroad stated that they earned more than €76,000 per year - a far greater proportion than for French nationals living in France. A significant percentage of those who replied to this survey were managers and were working in the private sector. More than half of the French people living abroad were employed by a locally-based company or were on a local contract, and 80% were salaried employees. Most of the contracts were fixed-term contracts of more than five years. In two-thirds of all cases, the spouse was also working.

For those who replied to the survey in 2007, the reasons for living abroad were (more than one choice possible):
- to broaden their cultural horizons (53%)
- to provide them with more career opportunities (50%)
- the desire to leave France (45%)
- the appeal of the assignment/post (39%)

112 TNS SOFRES survey “Expatriés, votre vie nous intéresse” (Expats, we are interested in what you are doing) (June-September 2007), available online at: http://www.mondissimo.com/pdf/expatrie_votrevie_2007.pdf. An opinion poll, the results of which are online on the CEM International Web portal, especially for expats: www.mondissimo.com. All visitors to the mondissimo.com site were invited to take part in the survey via an invitation behind a recruitment banner on the homepage. There was also a banner on the Les Échos (daily newspaper) website, announcements in Les Échos and adverts on TV5 - the French language channel which is available abroad. Because of the way the survey was carried out and because of the intrinsic nature of this opinion poll, the results should be viewed with caution and are only designed for one particular purpose. It remains, however, the only source of data about the status and personal and professional characteristics of French nationals living overseas.
4.1.4 Money transfers

To date, little has been found out about the phenomenon of immigrants living in France transferring money back to their native countries.

But a recent initiative set up by the Inter-ministerial Committee for International Cooperation and Development for France and the African Development Bank has shed some light on patterns with regard to money earned by immigrants from certain African countries (Morocco, Mali, Senegal, the Comoro Islands) being sent back to their native countries. From an economic and sociological standpoint, these countries are all very different. But they all have strong migratory links and share a history with the same developed country - France. In each of them, the relative weights that these transfers of funds represent is considerable. In 2005, it varied between 9% of the GDP (for Morocco) and 24% of the GDP (for the Comoro Islands), meaning that indirectly, immigrants from these countries who had settled in France were the main suppliers of funding. These four countries have historic and linguistic associations with France, which is why many generations of their citizens have settled there. But in recent years, Spain, Italy and the US have become additional emigration destinations for them. Nevertheless, France is still the destination of choice for the citizens of these four countries. This trend, which has become more pronounced in recent years, is particularly marked in Senegal and Morocco, despite the fact that money from France accounts for 35.8% and 37% respectively of all funds transferred. This trend is much less pronounced in Mali and the Comoro Islands, with money from France accounting for 64.7% and 97.2% respectively of all funds transferred. Altogether, in 2005, immigrants from these countries living in France sent back €1507 million to Morocco, €449 million to Senegal, €295 million to Mali and €70 million to the Comoro Islands. On a per-household basis, this amounts to between €2460 per year to the Comoro Islands and €7700 per year to Mali. The range of amounts sent back per working immigrant is between €100 and €160 per month, with little variation (10% to 15% of their income).

The amounts being transferred are relatively stable for people aged between 25 and 40. They then increase in absolute terms for people over the age of 40. This is partly a reflection of the fact that people tend to earn more money as they get older, but is mainly because immigrants over the age of 40 tend to invest more money in property in their native countries. This results in considerably higher sums being transferred on an individual basis. However, the correlation between age and higher amounts being transferred is less pronounced in Morocco than in the other three countries.

An analysis of the situation carried out by the African Development Bank demonstrates the importance of socio-professional category. The higher the socio-professional category, the higher the relative value of the amount transferred tends to be, but the lower the absolute value is and the frequency with which transfers are made. Immigrants from higher socio-professional categories aspire more to improving their own personal situation and are less easily influenced by any social pressure that their parents might exert on them in their native countries. They also invest more in property and in the productive sector. Of all the socio-professional categories, they have the greatest savings ability. Managers and people working independently only account for 15% of the total number of people who send money back to their home countries; three-quarters of the people who send money back work in low-grade positions, or positions with little in the way of stability.

Most of the immigrants who send money back to their home countries live in the Paris region - 90% of all Malians, 63% of all Senegalese and 49% of all people from the Comoro Islands living

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African Development Bank (2008), Les transferts de fonds des migrants, un enjeu de développement (the transfer of money earned by immigrants - an issue in development). Available online at: http://www.co-developpement.org/docs/AFDB_Transfert_fonds.PDF.
in France; immigrants from Morocco are more widely scattered throughout the country, with only 31% living in the Paris region.

In 2006, the Interministerial Committee for International Cooperation and Development for France commissioned the French Development Agency to set up a monitoring body tasked with looking into the cost of international financial transfers. The vast majority of immigrants seem to be poorly-informed about the various options available through the banking sector and only have a very vague idea of the real costs involved in transferring money abroad. A website has been set up by the AFD (the French development agency) which provides information about all the services that are available through various different operators and finance companies, together with the costs involved, and the terms and conditions under which money can be transferred (prices, the amount of time transfers take and guarantees). The site can be accessed at [http://www.envoidargent.fr/](http://www.envoidargent.fr/). Immigrants wanting to send money to any one of sixteen countries (countries in both Africa and Asia) can use the site to compare different options available through different banks and money transfer companies.

In 2008, France introduced the compté épargne codéveloppement - the codevelopment savings account -, designed to reduce the tax payable on the savings of immigrants and maximise their yield. Immigrants living in France whose native countries have signed up to the scheme can thus open such an account and be exempt from having to pay tax on their savings114. The initial amount deposited into the account must be at least €50, while the maximum may not exceed €50,000. The account may be kept open for between 1 and 6 years. It is up to the various banks which offer this type of account to decide on the interest rates which are applied to it. Money in the account can only be withdrawn if the saver is able to prove that it is for the purposes of investing in a developing country. Permitted types of investment include the setting up of, purchase of or acquisition of holdings in a local company, the buying out of a business, etc.

### 4.1.5 Irregular migration

Illegal immigration is difficult to quantify - for a number of reasons. An immigrant's presence in France can be deemed "illegal" in a variety of different contexts. They can be breaking immigration laws from the moment they arrive on French territory... or sometime afterwards if they had initially been granted a visa or not required visa, but then remained in France beyond the validity period of their visa or for more than three months - after which, in all situations, they are required to apply for a temporary residence permit. Non-French nationals who enter France illegally are not registered, and so may not be counted. Two factors make it difficult to accurately gauge the number of illegal immigrants in France. The first is to do with the changes in status which regularly affect non-French nationals living illegally in France. By definition, this makes for a population which fluctuates greatly. The second is to do with the various border crossings that are possible in Schengen space: non-French nationals who have entered France illegally may have entered Schengen space legally or illegally before arriving on French territory. Conversely, they may leave France any time and enter another Schengen space country. But illegal immigration can be looked at both in terms of illegally entering and illegally remaining on French mainland territory.

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114 Law of 4 December 2008 which amends the law of 23 March 2007, which determines the countries whose nationals may open a codevelopment savings account: Afghanistan, Algeria, Angola, Benin, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, the Central African Republic, the Comoros, the Republic of the Congo, the Democratic Republic of the Congo, the Ivory Coast, Cuba, Djibouti, the Dominican Republic, Eritrea, Ethiopia, Gabon, Ghana, the Gambia, Guinea, Guinea Bissau, Haiti, Kenya, Laos, Madagascar, Mali, Morocco, Mauritania, Mozambique, Namibia, the Niger, Nigeria, Uganda, Rwanda, the Democratic Republic of São Tomé and Príncipe, Senegal, Sudan, Sierra Leone, Suriname, Tanzania, Chad, the Palestinian territories, Togo, Tunisia, Yemen, Vietnam, Zimbabwe.
4.1.5.1 Illegal entry into French territory

There are three indicators for assessing the migratory pressure applied to the borders of mainland France: the numbers of people who are placed in border waiting zones, the numbers who are returned directly to the border by immigration services, and the numbers who request asylum at the border.

Those who are placed in border waiting zones are non-French nationals who do not have authorisation to enter French territory when they arrive at the border, or whose request for asylum or entry is in the process of being examined in order to determine whether or not this request is manifestly without grounds. The majority of people placed in border waiting zones are not granted authorisation to enter France.

There has been a significant reduction in the numbers of people being placed in these waiting zones since 2001. This can be attributed to stronger dissuasive measures being implemented in airports, and the introduction in France of the Airport Transit Visa (ATV) for nationals of certain African countries. This downward trend, which started in 2002, plateaued in 2007. In 2007, 15,827 non-French nationals were placed in waiting zones by border police.

| Nations whose citizens were most frequently placed in waiting zones in 2007 |
|-------------------------|------------------|
| China                   | 2,543            |
| Brazil                  | 1,815            |
| Russia                  | 1,002            |
| Bolivia                 | 730              |
| Iraq                    | 702              |
| Paraguay                | 473              |
| Palestine               | 430              |
| Algeria                 | 349              |
| Sri Lanka               | 333              |
| India                   | 328              |

Table 4 - Nations whose citizens were most frequently placed in waiting zones in 2007

Those who are turned away at the border are non-French nationals who are not granted authorisation to enter French territory - either upon their arrival at the border, or after a period spent in the waiting zone. These are people whose intention was to enter France illegally, but who have not been able to do so. Figures for the numbers of people who are turned away at borders are put together by the border police central management department and provide a means of knowing how many people are refused entry when they arrive at the border, regardless of what happens afterwards. In addition to those who are refused entry, there are also people who are immediately sent away ¹¹⁶ by the services on the authority of the police without any particular procedures being implemented by the border authorities when the non-French national illegally crossing the border is stopped. In 2007, 16,374 people were refused entry and 10,219 were immediately sent away.

¹¹⁵ GENERAL SECRETARIAT OF THE INTERMINISTERIAL COMMITTEE ON IMMIGRATION CONTROL (2008), Les orientations de la politique de l'immigration (Immigration policy orientations).
¹¹⁶ These are people who do not fall into any particular formal category and are distinct from people who are sent way on the basis of decisions made by the police. These decisions take time to implement (the person in question is detained, their repatriation is organised, etc.) and fall into the category of expulsions. Sending people away is simply the implementation of border controls.
Requests for asylum at the border increased dramatically - by a factor of 20 - between 1996 and 2001. The numbers then fell considerably between 2001 and 2004. The figures for 2007 show a clear increase: there were 5123 requests for asylum at the border in 2007 against only 2984 in 2006 - an increase of more than 70%.

4.1.5.2 Illegal residence on French territory

It is extremely difficult to gauge the number of people living illegally in France. Figures ranging from 200,000 to 400,000 people have been put forward. Various indicators can be used for gauging the number of people living illegally in France, such as the number of people stopped, the number of people being detained and the number of people receiving state-funded medical assistance.

The number of non-French nationals stopped in France without any official residence permit has risen dramatically since 2004, reaching 70,000 by the end of 2007. This trend became more pronounced during the first half of 2008, with an almost 40% increase on the first half of 2007.

The number of people placed in administrative detention includes non-French nationals who are waiting to be escorted back to the border by virtue of a police or ministerial deportation order, those facing readmission and those who are banned from entering French territory - either as a principal penalty or an additional penalty.
In 2007, additional administrative detention centres were opened in Nîmes, Metz, Rennes and Perpignan, meaning a further 311 places - an increase of 22.5% on the previous year. The average length of the time spent in detention has been stabilising since 2005 and now stands at around 10 days.

<table>
<thead>
<tr>
<th></th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theoretical capacity of centres</td>
<td>-</td>
<td>944</td>
<td>1016</td>
<td>1380</td>
<td>1691</td>
</tr>
<tr>
<td>Number of persons detained</td>
<td>28,155</td>
<td>30,043</td>
<td>29,257</td>
<td>32,817</td>
<td>35,246</td>
</tr>
<tr>
<td>Average number of days spent in detention</td>
<td>5.6 days</td>
<td>8.5 days</td>
<td>10.2 days</td>
<td>9.9 days</td>
<td>10.5 days</td>
</tr>
</tbody>
</table>

Table 5 - Numbers of people placed in administrative detention centres

The increase in the number of people being stopped or placed in detention is evidence of increased mobilisation among the border controls. In this respect, it should be noted that although the border police - by their vocation and as evidenced by their results - are still the main body involved in combating illegal immigration, the number of procedures that have been established by more general departments, such as the police and the Gendarmerie, has increased significantly. The mobilisation of these departments - including both vocational operational bodies and departments that serve the national police force, resulted in excellent results for 2007 in the fight against non-French nationals working illegally and in limiting the impact that Romania's and Bulgaria's entry into the EU has had. As far as the fight against non-French nationals working illegally is concerned (which is leading to the development of increasingly well-organised channels as a result of it being closely linked to illegal immigration), the growing involvement of all reporting police and gendarmerie departments led to the implication for breach of the labour code of 14,445 people in 2007, against 12,219 in 2006 - an increase of 18.2%. The proportion of non-French nationals implicated out of the overall number is 33.4% - 4831 people.

Since 1 January 2000, which was when the law on universal medical coverage came into force, a *state-funded medical aid* scheme has been available - subject to resources - to cover the cost of healthcare for people who do not meet the required stability and residence conditions in order to be able to take advantage of universal medical coverage. Since 1 January 2004, the condition for being able to take advantage of this welfare benefit has been uninterrupted residence in France for more than three months. As of 31 December 2007, 183,722 non-French nationals living illegally in France had taken advantage of this state-funded medical aid scheme. They may benefit from the scheme for up to one year. A person living illegally in France can enter it and then cease to be covered by it as soon as this maximum period of time has elapsed. The number of beneficiaries continues to include people who entered the scheme on a given date and then ceased to be covered by it less than one year later, either because they now meet the requisite conditions for residency, or so that they may take advantage of universal medical coverage, or so as to be covered by the national state health insurance scheme in compliance with the usual criteria, or because they are no longer on French territory. This means that on a given date, the numbers may include people who are no longer living in France illegally.
The number of beneficiaries of the state-funded medical aid scheme (2000-2007)

**4.1.5.3 Figures and information on return migration flows**

The expulsion of non-French nationals living illegally in France can be carried out in a number of different ways. The main measure used to sanction illegal residency is a police order to have the person in question escorted to the border. Deportation orders\(^{117}\) are for removing non-French nationals from French territory whose behaviour constitutes a serious threat to public order. They are issued by the criminal courts as a main sanction or in addition to a custodial sentence and prohibit non-French nationals from entering and remaining on French territory either indefinitely or for a specific period of time. The number of these orders issued in 2007 (112,010) was considerably higher (37.1%) than the number issued the previous year (80,946). This increase can be attributed to the reforms made to the obligation to leave French territory, which came into force on 1 January 2007, and which applies to non-French nationals whose applications for a residence permit have been refused, or whose applications to have their residence permit renewed have been refused, or whose residence permit had been withdrawn altogether. In such cases, non-French nationals have a period of one month following the issue of the deportation order to leave the country. Once this period has elapsed, the order becomes automatically enforceable by the state.

However, not all deportation orders which are issued are actually carried out. In 2007, only 20.7% of all orders issued were carried out. This amounted to 23,196 non-French nationals being deported from French territory in 2007. However, the total number of non-French nationals deported from France increased by 250% between 2001 and 2007. The most significant growth has been in a number of voluntary repatriations, with an increase of more than 130% between 2006 and 2007. The schemes in place for repatriation and resettlement have become considerably more developed, with a clear increase in repatriations since 2007 and a widening of the geographical area in which resettlement assistance is available.

\(^{117}\) The legal status of deportation was changed by the law of 26 November 2003 on immigration control, residence of foreign nationals in France and nationality, which introduced protection against deportation of non-French nationals who had established links with France (the so-called "elimination of the double penalty" reform).
provided. Repatriation programmes distinguish between voluntary and humanitarian programmes. Non-French nationals who are eligible for these voluntary repatriation programmes are citizens of non-EU countries who have been refused residency in France and are under obligation to leave French territory, or who are required to be escorted to the border as soon as they cease to be detained. The scheme includes help organising repatriation (securing of travel documents, reimbursement of airline ticket and additional transport upon arrival in the native country, travel to departure airport and, in the native country, welfare support for people living very precariously) and financial help (€2000 for a single adult, €3500 for a couple, €1000 for a child under the age of 18 up to a maximum of three children, and then €500 for additional children), paid in instalments (30% pace in France before departure, 50% paid 6 months after repatriation and 20% paid 12 months after repatriation).

In 2007, this voluntary repatriation scheme helped 2040 people (including 358 spouses and children), the majority of whom were single adults without children from China, Algeria, Moldavia and Serbia who were residing in the Paris region.

Non-French nationals who are eligible for the humanitarian repatriation scheme are citizens from either EU or non-EU countries who are either destitute or in a highly precarious position, children under the age of 18 who are on their own upon the request of the magistrate or, if need be, as part of an initiative to reunite a family and any other non-French national who is not eligible for help within the framework of the voluntary repatriation scheme. In addition to the same arrangements as those made within the context of voluntary repatriation schemes, financial assistance of €153 per adult and €46 per child is available (€300 per adult and €100 per child as part of an experiment that has been underway since 26 November 2007).

In 2007 this humanitarian repatriation scheme helped 2898 people (including 836 spouses and children), mainly from Romania (1693), Bulgaria (496) and Mali (79).

4.1.6 Assessment and analysis of migratory flows

- Government institutions responsible for migration policy

Since 2002, combating illegal immigration has been a priority for the government. As soon as it was set up in May 2007, France's Ministry of Immigration, Integration, National Identity and Co-development - a fully fledged ministry - was given a number of major objectives by both the President and the Prime Minister, and is now specifically tasked with looking into all these issues.

An independent central administrative body with its own budget also came into existence on 1 January 2008. Its role is to support the initiatives being carried out by the various different bodies tasked with implementing this public policy.

At regional level, all police departments now have a regional "immigration, integration, national identity and co-development division" which meets to handle expulsion-related issues. These divisions work under the authority of the chiefs of police and are responsible for clearly distributing tasks among the various national security departments and foreign national offices of police departments in order to carry out deportation procedures. They are also responsible more widely for ensuring better communications with the Prison Administration Department and judicial bodies.

- Operational bodies involved in controlling migratory flows

The introduction of a proactive policy for controlling migratory flows has led to a number of changes at operational level - including the creation of an immigration police force in the summer of 2005. In 2006, a special department of the national police was tasked with the
running of this immigration police force - the *Central Directorate of Border Police*. This department is tasked with overall management responsibilities. Its activities are mainly supported by:
- the *Central office tasked with combating illegal immigration and the employment of non-French nationals without the requisite permits* which coordinates the gathering and centralisation of information at national level, as well as the fight against organised crime related to illegal immigration,
- the *national railway police department*, set up in 2006: this department is responsible for checking international trains and combating illegal immigration over the rail network. It also ensures that trains and stations have suitable security measures in place,
- *50 mobile search squads* functioning at zone and regional level, which serve as key tools for carrying out searches and investigations,
- dedicated air resources, grouped together within the central aeronautical police bureau, which is mainly used for escorting and sending back problematic detainees. These resources should be boosted in 2008 with the chartering of two new Beech aircraft - one in mainland France and the other in Guyana.

### 4.2 Inflows and outflows of healthcare professionals

It is important to bear in mind that there is very little data available in France about the immigration and emigration of healthcare professionals - no more than is already in the public domain. A great deal of the statistical data on the migration of healthcare professionals in this section has been collected from the various professional orders. They only have a small amount of qualitative data about the numbers of healthcare professionals from various different countries working in France: no specific studies have been carried out which include data on gender, age, previous professional experience, geographic distribution, the movement of these foreign healthcare professionals around France, their leaving the healthcare sector to work in another area, etc.

The *Conseil national de l’Ordre des médecins* (national council of the order of physicians) has, however, been putting together a more sophisticated analysis of these healthcare professionals and their characteristics since 2007. This means that the data available about physicians will end up being more accurate and more detailed than the data on other healthcare professionals (without it ever being completely exhaustive).

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118 As of 1 January 2008, the border police counted 9332 civil servants - an increase of more than 2000 since 2004. This increase is partly due to the creation of France's national railway police department. At Roissy airport, the numbers of border police grew by 26% in five years, from 1356 on 1 January 2002 to 1712 by 1 January 2008.
4.2.1 French healthcare professionals who have emigrated

The phenomenon of French healthcare professionals emigrating has not been examined in any particular detail by the professional orders\textsuperscript{119} or by the public institutions\textsuperscript{120}.

In 2000, the OECD put the expatriation rates for nurses and physicians at 1.9% and 2%, respectively\textsuperscript{121}.

In 2000, 8975 French nurses were registered as living in another country. The main destinations for French nurses tend to be countries that share a border with France: almost a quarter of all French nurses living abroad were in Switzerland (26%), with 7.8% in Portugal, 7.7% in Spain, 4.5% in the UK and 1.3% in Luxembourg. Some, however, had also settled in North America, mainly in the US (15.3%) and Canada (6.4%).

In 2000, 3940 French physicians were registered as living abroad. More than a third of them were in North America - mainly in the US (26%) and Canada (10.4%). The main European countries that they had settled in were Spain (12.6%), Switzerland (10%), the UK (5.5%) and Portugal (4.2%).

The destination countries for nurses and physicians are consistent with the main destination countries for all other expats as outlined in 4.1.3 (although the data available does not refer to the same time period).

4.2.2 Healthcare professionals who have immigrated to and/or qualified in France

There are several types of data available for looking into the issue of “foreign” healthcare professionals in France:

- healthcare professionals who were born overseas (and who might since have acquired French nationality); this data category was only used in France\textsuperscript{122} for the 1999 census\textsuperscript{123}.
- non-French national healthcare professionals, data held by most of the professional orders
- healthcare professionals who have qualified abroad, since the system in place for recognising the qualification depends on the category of qualification (and not on the nationality).

Basically, the most discriminating condition is currently the qualification obtained abroad. Indeed, many healthcare staff born overseas have acquired French nationality. The condition for having French nationality was discarded in the summer of 2009 so as not to discriminate.

\textsuperscript{119} The professional orders do not have any reliable data about the emigration of their members. Some of them have introduced a "special list" to which healthcare professionals who have emigrated can have their names added - should they so wish. The national council of the order of physicians adds the names of emigrated physicians to a special list in return for a contribution - meaning that the resulting list is not exhaustive. As 1 January 2009, 571 physicians’ names were on this "special list" - whereas 3940 physicians had emigrated in 2000. The number of physicians who have emigrated and who are registered with the national council is therefore proportionately very low. But these orders can get information through their counterparts (or other institutions which are involved in approving qualifications) who may contact them in order to find out about the qualifications or even behaviour and moral standards of a given healthcare professional. Through these contacts, it could be possible to aggregate all this data so as to have a more detailed picture of the situation regarding healthcare professionals who have emigrated. This has not (yet) been done.

\textsuperscript{120} During an interview with the deputy director in charge of human resources at the Ministry of Health, it emerged that the Ministry of Health had no information about healthcare professionals who had emigrated, and that there were no systems in place for tracking their movements.

\textsuperscript{121} OECD (2007), Perspectives des migrations internationales (International migration outlook).

\textsuperscript{122} Used by the OECD in: OECD (2007), Perspectives des migrations internationales (International migration outlook).

\textsuperscript{123} See Appendix.
against overseas students who had done all of their studying in France\textsuperscript{124}. Where the qualification was obtained - depending on whether it was obtained in an EU or in a non-EU country - is what determines whether a healthcare professional can practise in France without having to resort to specific procedures for having their qualifications recognised. Non-French nationals are recruited with various different statuses, depending on the country in which their qualification was obtained. These different statuses can lead to significant differences in salary compared with people who qualified in France or people whose qualifications have been recognised as being equivalent to a qualification awarded in France.

4.2.2.1 Non-French national physicians and/or physicians who qualified overseas

A clear distinction should be drawn between two categories of physicians. The first category is for physicians who qualified in an EU country who, through being able to have their qualifications automatically recognised, are registered with the national order of physicians and are able to practise under the same conditions as their French colleagues - as can physicians who qualified in non-EU countries who have had their qualifications recognised in France. The second category is for practitioners who qualified outside the European Union and who are appointed with "associate" status until they are able to have their qualifications recognised.

- Non-French national physicians registered with the National Order (who practise under the same conditions as French physicians)

As of 1 January 2009, there were 9631 EU or non-EU physicians registered with the National Order of physicians\textsuperscript{125}, an increase of 3.43\% on the previous year. Of these 9631 physicians, 9112 were still practising and 519 were retired. \textit{As of 1 January 2009, non-French national physicians registered with the National Order accounted for 4.6\% of the overall number.}

As far as geographical distribution is concerned, it should be noted that outside the capital, non-French national physicians have set up in the border regions of northern and eastern France (regions which border on Belgium, Luxembourg and Germany). This most probably has something to do with the high proportions of Belgians and Germans among the numbers of non-French national physicians practising in France. The Provence-Alpes-Côte d'Azur region also has a density of non-French national physicians which is higher than the national average. \textit{As of 1 January 2009, the nationalities which were best represented among the non-French national physicians practising in France registered with the National Order were Belgians (16.4\%), Romanians (12\%), Germans (10.9\%) and Algerians (10.3\%).}

\textsuperscript{124} Law no. 2009-879 of 21 July 2009 hospital reforms relating to patients, health and regions.
\textsuperscript{125} It should be pointed out that this does not include EU or non-EU physicians who have not yet had their qualifications recognised and who have been appointed as associate practitioners in state-run hospitals, or non-French nationals who have acquired French nationality.
<table>
<thead>
<tr>
<th>Native country</th>
<th>Proportion of the overall number of non-French national physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>16.4%</td>
</tr>
<tr>
<td>Romania</td>
<td>12%</td>
</tr>
<tr>
<td>Germany</td>
<td>10.9%</td>
</tr>
<tr>
<td>Algeria</td>
<td>10.3%</td>
</tr>
<tr>
<td>Italy</td>
<td>8.3%</td>
</tr>
<tr>
<td>Morocco</td>
<td>7.7%</td>
</tr>
<tr>
<td>Tunisia</td>
<td>4.5%</td>
</tr>
<tr>
<td>Spain</td>
<td>3.4%</td>
</tr>
</tbody>
</table>

**Table 6 - The main nationalities of non-French national physicians (as of 1 January 2009)**

*Three specialist fields account for more than 50% of non-French national physicians: general practice, anaesthesia and psychiatry. It is noteworthy that these three specialist fields are currently experiencing recruitment difficulties in France.*

<table>
<thead>
<tr>
<th>Specialist field</th>
<th>Proportion of the overall numbers of people working in the specialist field</th>
</tr>
</thead>
<tbody>
<tr>
<td>General medicine (or general medicine as a specialist field)</td>
<td>36.2%</td>
</tr>
<tr>
<td>Anaesthesia</td>
<td>9.5%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>5.5%</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>5.3%</td>
</tr>
<tr>
<td>Radiology and medical imaging</td>
<td>5.1%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>3.9%</td>
</tr>
<tr>
<td>General surgery</td>
<td>3.1%</td>
</tr>
<tr>
<td>Gynaecology-obstetrics</td>
<td>3%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>2.9%</td>
</tr>
<tr>
<td>Orthopaedic and accident surgery</td>
<td>2.5%</td>
</tr>
</tbody>
</table>

**Table 7 - The main specialist fields in which non-French national physicians work (as of 1 January 2009)**
Non-French national physicians are younger than French physicians; The average age of French physicians is 51. The average age of non-French national physicians is 46 (43 for women and 48 for men).

Figure 15 - Age pyramid of non-French national physicians registered with the National Order

FOCUS – ROMANIAN PHYSICIANS PRACTISING IN FRANCE

Romania’s joining the EU on 1 January 2007 seems to have signalled the beginning of a major influx of Romanian physicians into France. As of 1 January 2007, there were only 204 Romanian physicians practising in France. By the end of November 2007, their number had grown to 656 (a 3.2 fold increase in 11 months). As of 1 January 2009, there were 1063 Romanian physicians practising in France (a 5.2 fold increase in 24 months)\(^\text{127}\).

The average age of these Romanian physicians brings the average age of physicians in France down: the average age of all Romanian physicians in France is 39 (average age of 46 for non-French national physicians, but 51 for all physicians registered with the National Council of the Order of Physicians). 35% of all male and 62% of all female Romanian physicians are under the age of 40.

70% of all Romanian physicians practising in France are women. The vast majority of Romanian physicians (nearly 90%) are salaried employees. Four specialist fields account for more than 50% of Romanian physicians: general medicine (312 Romanian physicians, i.e. 29.3% of all Romanian physicians practising in France), anaesthesia (94, i.e. 8.8%), psychiatry (80, i.e. 7.5%) and radiology/medical imaging (75, i.e. 7%).

As far as geographical distribution is concerned, there are four regions in France which - as of 1 January 2009 - had more than the national average number of Romanian physicians; these were Paris and three of France’s border regions (Lorraine, Alsace and Rhône-Alpes). Regions in western France (with the notable exception of Brittany) had considerably fewer than the national average number of Romanian physicians.

\(^{126}\) CONSEIL NATIONAUX DE L’ORDRE DES MEDECINS (national council of the order of physicians) (2009), Atlas of medical demography in France - the situation as of 1 January 2009.

\(^{127}\) This phenomenon was explored by A. DREXLER in June 2008 and described in Le défi du recrutement des médecins à diplôme étranger dans les hôpitaux publics (the challenge of recruiting physicians with overseas qualifications in state-run hospitals). In the 65 state-run hospitals that took part in the survey, 97 Romanian physicians had been appointed over the last 18 months (i.e. since Romania’s accession to the EU and the implementation of more flexible systems to recognise Romanian qualifications).
Physicians who qualified outside France and who are not registered with the National Council of the Order of Physicians (who may only practise in restrictive conditions, under the responsibility of a senior physician who is registered with the National Council of the Order of Physicians)

Non-French national physicians registered with the National Council of the Order of Physicians are those whose qualifications have been recognised as having equivalent qualifications in France and who have obtained authorisation to practise. This is, in a manner of speaking, "the norm". So, in France, a number of practitioners who hold qualifications that were awarded abroad (particularly in non-EU countries for which there is no automatic qualification recognition system in place) have been appointed - and continue to be appointed - in French hospitals (mainly in state-run hospitals) and are able to practise under the responsibility of a physician who is registered with the National Council of the Order of Physicians. There were 6788 such physicians practising officially in French hospitals as of March 2007. Not all healthcare centres replied to the survey, but extrapolating from the number which did, the total number of physicians who are not fully able to practise medicine in France is nearly 8000. Furthermore, this information is based on declarations made by the healthcare centres themselves, some of which may have under-estimated the number of overseas qualified practitioners who are not fully able to practise medicine, since appointments made since 1999 do not comply with current regulations. In short, this number is not necessarily reliable and has doubtless been underestimated. These physicians have until the end of December 2012 to obtain authorisation to practise and register with the National Order.

In addition to these numbers that were working in hospitals as of March 2007, there are a further 10,000 practitioners who have obtained authorisation to fully practise medicine through various other procedures that have been in place since 1995 (and so are now registered with the National Order). These 10,000 practitioners do not figure clearly among the statistics held by the National Order, since they are physicians who have acquired French nationality - even though they were originally non-French National physicians who qualified abroad.

As far as the conditions under which they are authorised to practise are concerned, although they work under the responsibility of a senior physician, the regulations which govern the kinds of assignments that can be entrusted to these "associate" practitioners and how their daily work in hospitals is structured are somewhat unclear. These physicians, who are not able to fully practise medicine in France, can only be appointed as faisant fonction d'interne (students working as an interns), associate assistants or associate manager practitioners until they satisfy the various requirements for having their qualifications recognised in France. They may then be granted authorisation to practise medicine in France. They have neither the same rights and responsibilities as their colleagues who are registered with the National Order, nor the same

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128 See 3.2.2.
129 These numbers were ascertained as part of a survey carried out by the Ministry of Health via the deconcentrated administrations at regional level on the basis of "declarations" made by each healthcare centre. 85% of the healthcare centres concerned (both the state-run and private institutions involved in cooperative programmes with public hospitals) took part in the survey, with 6087 physicians who are not fully able to practise medicine in France being declared in state-run hospitals and 701 in private institutions involved in cooperative programmes with public hospitals. DIRECTION DE L'HOSPITALISATION ET DE L'ORGANISATION DES SOINS (HOSPITALISATION AND HEALTHCARE DELIVERY MANAGEMENT), June 2007, Survey of physicians who qualified outside the EU.
130 In June 2008, 684 physicians who were not fully able to practise medicine were declared to be working in 57 healthcare centres (not registered with the National Order). If there are 1000 state-run healthcare centres in France and these 57 centres are representative of the total, then there are nearly 12,000 associate physicians. [A.DREXLER (2008), Le défi du recrutement des médecins à diplôme étranger dans les hôpitaux publics (the challenge of recruiting physicians with overseas qualifications in state-run hospitals).
salaries. Their salaries are usually lower than those commanded by French physicians. The *faisant fonction d’interne* status is the most insecure. Physicians appointed with this status are paid less than medical students - although often they are physicians who have qualified and specialised outside the European Union and who have come to work in France with their families in return for a gross monthly salary of €1242.60 - less than the average income in France. This forces them to work as duty physicians or to be on call on a regular basis so as to boost their income.

<table>
<thead>
<tr>
<th>HOSPITAL PRACTITIONER (standard status in state-run hospitals)</th>
<th>ASSISTANT (asst contract practitioner)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross monthly salary - grade 1 (without being on call, on duty, or other bonuses)</td>
<td>€4028.95</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ASSOCIATE ASSISTANT (physician with a non-recognised overseas qualification)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross monthly salary - grade 1 (without being on call, on duty, or other bonuses)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PRATICIEN ATTACHE or ASSISTANT PRACTITIONER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross monthly salary - grade 1 (without being on call, on duty, or other bonuses)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOUSE PHYSICIAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>STUDENT WORKING AS AN INTERN (physician with non-recognised overseas qualifications or non-French national physicians in the process of specialising; enrolment with a faculty of medicine at the same time is compulsory)</td>
</tr>
</tbody>
</table>

---

131 This status used to be awarded in recognition of qualifications obtained overseas for physicians who had obtained authorisation to practise in France. It was awarded between 1995 and 2002. It was only intended to be a temporary status; practitioners could then sit the competitive exam to become "hospital practitioners".

132 This status is awarded to non-EU qualified practitioners who work restrictively under the authority of another physician - because they do not (yet) have recognised qualifications. They have until the end of 2012 to pass the requisite exams (or competitive exams) in order to be granted authorisation to practise; otherwise, they will no longer be able to practise medicine in France beyond this date.

133 This status is awarded to non-EU qualified practitioners who work restrictively under the authority of another physician - because they do not (yet) have recognised qualifications. They have until the end of 2012 to pass the requisite exams (or competitive exams) in order to be granted authorisation to practise; otherwise, they will no longer be able to practise medicine in France beyond this date. Only associate assistant practitioners get the same basic salary as French physicians employed on a comparable grade (assistant practitioners).

134 The conditions for being awarded this status are in the process of being modified so as to prevent the system from being abused - and to avoid in particular specialist physicians or huge numbers of medical staff being “cheaply” recruited with this insecure status.
Table 8 - Comparison of gross monthly salaries (grade 1) for different comparable statuses between (French) physicians registered with the National Order and non-French national physicians

| Grade 1 (without being on call, on duty, or other bonuses) | €1357.78 | €1242.60 |

4.2.2.2 Non-French national dentists and/or dentists who qualified overseas

Relatively few dentists immigrate to France, although the phenomenon is not completely nonexistent. In 2008, out of nearly 42,000 dentists in France, 450 were from other countries in the European Union; they accounted for 1% of the total overall number. 91 EU-qualified dentists in France had their qualifications recognised through new recognition systems in place in 2005/2006. Qualifications obtained in six countries accounted for more than 85% of the overall numbers of dentists whose qualifications were recognised in France in 2005/2006.

<table>
<thead>
<tr>
<th>Country in which qualification was up obtained</th>
<th>Number of qualifications recognised in 2005/2006</th>
<th>Proportion of qualifications obtained per country in relation to the overall number of qualifications recognised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>35</td>
<td>38.4%</td>
</tr>
<tr>
<td>Spain</td>
<td>16</td>
<td>17.6%</td>
</tr>
<tr>
<td>Poland</td>
<td>10</td>
<td>11%</td>
</tr>
<tr>
<td>Italy</td>
<td>10</td>
<td>11%</td>
</tr>
<tr>
<td>Germany</td>
<td>4</td>
<td>4.4%</td>
</tr>
<tr>
<td>UK</td>
<td>4</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

Table 9 - The main countries from which recognised dentistry qualifications were obtained (2005/2006)

As far as non-EU citizens are concerned, the migratory flows recorded by the National Order of Dentists are mainly from sub-Saharan Africa, countries in North Africa and the Lebanon.
4.2.2.3 Non-French national pharmacists and/or pharmacists who qualified overseas

As of 31 December 2008, there were 934 non-French national pharmacists registered with the National Order of Pharmacists, accounting for 1.3% of the total overall number. These pharmacists were mainly from Morocco (217, 23.2% of the overall number), Belgium (116, 12.4% of the overall number) and Cameroon (78, 8.35% of the overall number). North Africa and other countries in the European Union are the main sources of immigrant pharmacists in France.

Figure 16 - The main geographical areas from which pharmacists coming to live in France originate (as of 31 December 2008)

Between 2005 and 2007, 129 pharmacists who had qualified in another EU country had their qualifications recognised in France. Five countries accounted for more than 80% of the overall number of countries in which pharmacy qualifications recognised in France were obtained.

<table>
<thead>
<tr>
<th>Country in which qualification was up obtained</th>
<th>Number of qualifications recognised in 2005/2006</th>
<th>Proportion of qualifications obtained per country in relation to the overall number of qualifications recognised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>42</td>
<td>32.6%</td>
</tr>
<tr>
<td>Italy</td>
<td>30</td>
<td>23.2%</td>
</tr>
<tr>
<td>Spain</td>
<td>16</td>
<td>12.4%</td>
</tr>
<tr>
<td>Germany</td>
<td>9</td>
<td>7%</td>
</tr>
<tr>
<td>Poland</td>
<td>8</td>
<td>6.2%</td>
</tr>
</tbody>
</table>

Table 10 - The main countries from which recognised pharmacy qualifications were obtained (2005-2007)
4.2.2.4 Non-French national midwives and/or midwives who qualified overseas

As of 1 January 2008, there were 671 midwives from other EU countries registered with the National Order of Midwives, accounting for 3.5% of the total overall number. These midwives were mainly from Belgium (561, 83.6% of the overall number), the UK (46, 6.8% of the overall number) and Germany (24, 3.6% of the overall number). Nationals from these three countries account for 94% of all EU-country midwives who are registered with the National Order of Midwives.

Between 69 and 147 EU qualifications have been recognised each year in France since 2004. The majority of these have been Belgian since 2004: each year they account for at least 87% of all qualifications recognised in France. Over the last five years, 447 Belgian qualifications have been recognised by France.

![Bar chart showing the main EU countries from which recognised midwifery qualifications were obtained (2004-2008)](chart)

**graphic 12** - The main EU countries from which recognised midwifery qualifications were obtained (2004-2008)

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135 A number of these qualifications are held by French nationals who decided to study in Belgium in order to avoid the French *numerus clausus* selective exam. See 4.3.1.
4.2.2.5 Non-French national nurses and/or nurses who qualified overseas

In 2004, 7058 of the nurses working in France had been born abroad, 1.6% of the total overall number\(^\text{136}\). According to the majority union of professional nurses\(^\text{137}\), the immigration of nurses is relatively limited, and is restricted to movements between France and neighbouring border countries.

There is no system in place for recognising nursing qualifications obtained outside the EU - so the only ones that are recognised are from other EU member countries\(^\text{138}\).

**In 2006, 343 nursing qualifications obtained from other EU member states were recognised by France.** Qualifications obtained in Belgium (292) accounted for 85% of the overall number. Qualifications obtained in Spain accounted for 5% (18) of the overall number of nursing qualifications recognised, while German qualifications accounted for 2% (7).

4.2.2.6 Physiotherapists who qualified overseas

Only physiotherapists who qualified in EU member states can register with the National Order of Physiotherapists. There is no system in place for recognising physiotherapy qualifications awarded outside the EU\(^\text{139}\).

During the period 2005 to 2007\(^\text{140}\), 3976 physiotherapists with qualifications from 17 different European countries were granted authorisation to practise in France (Belgium, Spain, Germany, Poland, UK, Netherlands, Italy, Switzerland, the Czech Republic, Sweden, Hungary, Denmark, Austria, Latvia, Iceland, Portugal and - since 2007 - Romania). Physiotherapists from four countries accounted for 90% of all recognition requests. The vast majority were from Belgium (2101, or 52.8% of the total number of qualifications recognised); this high number can be explained by the fact that 1529 French people went to study in Belgium before returning to France in order to practise.


\(^{137}\) The Order of Nurses was not created until a law was passed in 2007. The Council of the Order of Nurses and the way it is structured made it possible to track statistics about nurses once it had been set up.

\(^{138}\) See 3.2.1.

\(^{139}\) See 3.2.1.

\(^{140}\) National Council of the Order of Physiotherapists (2008), *Official Order of Physiotherapists’ bulletin*, no.5.
Figure 17 - Native countries of physiotherapists whose qualifications were recognised in France during the period 2005 to 2007

Of all the qualifications recognised between 2005 and 2007, the nationalities that were the best represented were the French (1663 in total - 42% of the total number of recognised), who look for ways of avoiding the *numerus clausus* exam which students in institutes of physiotherapy training are required to sit in France, as well as the Spanish (1252 or 31%) the Belgians (563 or 14%) and the Polish (197 or 5%).

### 4.3 Context of Migratory Flows

#### 4.3.1 Migration potential of healthcare professionals

The migration potential of healthcare professionals in France is influenced by the international situation and is governed by international bilateral agreements that have been set up to promote the professional immigration of qualified healthcare professionals (see 3.1). One such example is the concerted management agreement with Senegal, ratified in May 2009, which is designed to encourage the emigration of Senegalese midwives and nurses to France. Similarly, the agreement that has been entered into with Quebec which provides for the mutual recognition of qualifications is supposed to increase the movement of healthcare professionals between France and Quebec by facilitating immigration.

Whether or not healthcare professionals can emigrate depends on the nature of the regulations in place for recognising qualifications (see 3.2) The lack of any system in place for recognising the qualifications of nurses and physiotherapists obtained outside the European Union forces people wanting to emigrate to redo their training in France and does not act as an emigration incentive for these healthcare professionals. Conversely, the various systems in place for recognising the qualifications of physicians, dentists, midwives and pharmacists obtained outside the European Union - although complex - are appealing for holders of these qualifications. These systems for recognising non-EU qualifications are to be combined - particularly for physicians (as well as pharmacists) - with conventional recruitment conditions, even though they contradict French hospital regulations: it may appear possible to practise in France (albeit in a limited way), even without qualifications being recognised. But the new exam procedures in place for granting authorisation to practise in France to practitioners who have been in France since before 2004, or the competitive exam for practitioners who have been in France since 2004 (or for those who are still in their native country) inverse the traditional
picture and run the risk of being an obstacle to immigration. At any rate, these new tendencies are in keeping with the government's desire to close the floodgates and recruit only the best. It goes without saying that systems for recognising EU qualifications encourage migratory flows within the European Union. There is still the question of how permanent these migratory flows are if they are motivated by the desire to earn more money, when newly arrived immigrants will have seen their salaries standardised upwards. Their motivation can only be personal or professional - healthcare professionals in France are not particularly overpaid. As far as people's reasons for wanting to emigrate to France are concerned, the private lives of healthcare professionals are very often mentioned by the professional associations. In a survey carried out in 2003 of healthcare professionals from other EU countries who had emigrated to France, 40% of those who took part specifically mentioned love, marriage, their partner's work and personal and family reasons as the main factors behind their decision to change country. The professional reasons which emerged in this survey were linked to there being too many physicians in their native country, there only being limited opportunities to specialise, etc.

The systems in place for automatically recognising qualifications delivered in other EU countries have led to people trying to avoid going through the French healthcare training system - which is structured around the numerus clausus selective exams and other quota systems designed to restrict access into paramedical schools. The result is that considerable numbers of students decided (after one or two unsuccessful attempts at the end-of-first-year competitive exam) to go and study in Belgium. Midwives and physiotherapists in particular would do this. They would register at Belgian schools in which there is no numerus clausus system, do their studies and get qualified. Then once they had their qualification, these French nationals would return to France and get their Belgian qualification recognised by the French authorities. Once their qualifications had been validated, they would register with the National Order (or with the relevant authority before the National order of physiotherapists was set up, for example) and could then practise their profession in France under the same conditions as people who had qualified under the French system. This tendency was relatively widespread - in 2006, 94% of all EU midwifery qualifications recognised in France were awarded in Belgium. Given the huge numbers of people coming to study in Belgium and the significant sums of money that were being invested - at a loss - in training costs, the Belgian government decided to implement measures to regulate the numbers of healthcare professionals (particularly midwives and physiotherapists): the government put a 30% limit on the numbers of foreign students who could train in certain institutes starting in September 2006 - except if they had been living in Belgium for more than three years. If more than 30% of the students enrolled in these training institutes were from overseas, a lottery system was to be used in order to decide who was to be allowed entry among these non-Belgian nationals. This regulation ran the risk of being seen as discriminatory and - given that it impeded free movement of EU citizens throughout the European Union - could be called into question. But until the European Commission has established its position on this issue, this regulation has dramatically reduced the numbers of French nationals going to Belgium to study.

141 Associations and unions of healthcare professionals enjoy pointing this out. It is true, however, that there is a considerable difference between being a salaried healthcare professional in the public sector and working privately. There are also disparities across various healthcare related professions (see 2.3.1).
143 The information in section 4.2 also shows that more qualifications from Belgium were recognised than from any country, accounting for 85% of all nursing qualifications, 38.4% of all dentistry qualifications and 32.6% of all pharmacy qualifications recognised. But the presence of French nationals among these newly-qualified professionals can only be a matter of speculation - whereas for physiotherapists and midwives, nationality of professional and nationality of qualification have been compared, precisely in the light of this practice being so widespread.
144 The measures also applied to chiropodists, hearing-aid specialists and occupational therapists.
Instead, they now go to Romania in order to get around the constraints of the French training system. In September 2008, 35 French students enrolled in the first year of a medicine degree delivered in French at the University of Cluj in the north-west of Romania. Most of these French medicine students had already failed the end-of-first-year competitive exam twice in France. The number of French students enrolling on courses in Romania has grown since 2007, which was when Romania entered the European Union. Any training begun after this date now results in the awarding of a qualification which is automatically recognised by all other member states. Basically, the ease with which healthcare professionals and students can move about within the European Union and the avoidance of certain constraints that this mobility entails are reasons to call into question the training system such as it has existed until now.

4.3.2 Patterns of return migration of healthcare professionals

Statistical data relating to healthcare professionals either leaving France or immigrating to France is relatively limited and is not tracked by state institutions. So once a healthcare professional has registered with the relevant Order and has had their overseas qualification recognised, there is no way for the Order to know if the healthcare professional is still practising in France or has gone back to their native country. Similarly, French healthcare professionals who have emigrated are not specifically identified as returning emigrants when they come back to France and re-register with the relevant Order. This means that there is no way of knowing exactly how many healthcare professionals who have emigrated end up returning to France.

However, what emerges from interviews and informal conversations with healthcare professionals across the world is that French people who go and live in the US or Canada usually only do so for a temporary period of time - on a research grant, for example, in order to complete a certain project. They enjoy considerably higher profiles - particularly physicians - once they have done research or taught in North America.

As for healthcare professionals who emigrate to France from other countries, evidence would suggest that a number of Romanian physicians fail in their attempts to set up in France. A number of unscrupulous recruitment agencies are quick to paint a very rosy, but less-than-realistic picture of life in France in order to attract Romanian physicians. This is because they get commissions (often large sums) from the hospitals or regional authorities who recruit them. These East European physicians (Romanians in particular), whose recruitment has been greatly facilitated by the EU qualification recognition system, are very often given complex posts in areas which are considerably less appealing than the imaginary Paris that exists in the minds of foreigners. And they are often the focus of mistrust (either from other colleagues or from their patients). Their salaries may be higher than in their home country, but the quality of life they enjoy is often not what they expected. It would seem that a number of Romanian physicians who have tried working in France since their country joined the European Union in 2007 have already thrown in the towel and gone home.

145 Unfortunately, the National Council of the Order of Physicians holds no specific data relating to this phenomenon. But this data is needed in order to work out the average period of time that Eastern European physicians with EU qualifications (whose salaries would be considerably lower in their native country) spend practising in France. It would reveal which of these emigrations were simply temporary stays, and which were permanent.
4.3.3 General immigration and emigration patterns of healthcare workers
(i.e. regional distribution patterns)

For those healthcare professionals for which data is available, their geographical distribution has been explored in 4.2. As a very general rule, healthcare professionals tend to migrate to the Paris region, border regions in the north and east of the country and of course Provence-Alpes-Côte-D’azur in the south-east. In fact, as of 1 January 2007, 56% of all anaesthetists working in the Ardennes, just south of the Belgian border, were non-French nationals.

It is still the case that there is a preponderance of non-French national healthcare professionals (or professionals who have qualified abroad) in those areas of the country that are currently experiencing difficulties in recruiting people trained in France. Indeed, as of 1 January 2007, more than a quarter of the anaesthetists working in the rural areas of Burgundy (Yonne, Nièvre) were non-French nationals. This figure was closer to 30% for the same period in the Aube département.

Once they have started practising, there is no specific data available on the movements of healthcare professionals who qualified in France or abroad within a given region - or even between different regions.

4.3.4 Effect of institutional bodies on migration, specifically on the recruitment of professionals or students in the healthcare profession

The role played by the Ministry of Health has been outlined in the previous sections: it does not want to be responsible for the recruitment of healthcare professionals at international level, since it is not an employer. Consequently, various employer federations have taken on responsibility for this - as evidenced by the drive to recruit Spanish nurses to French hospitals in 2001-2003.

But bodies representing the State on matters of health policy at regional level have succeeded in persuading healthcare centres to take part in various operations to recruit physicians at international level. They have done this through recruitment agencies, also known as head-hunters. One such example was an operation carried out in 2008 in the Nord-Pas-de-Calais and Picardie regions under the auspices of two regional hospitalisation agencies: around 20 Romanian physicians were recruited through PARAGONA - a recruitment agency - for healthcare centres in both regions which are currently experiencing recruitment difficulties. Similarly, regional authorities (the mayor's office, the general council, the regional council) get support from recruitment agencies to attract (and retain) non-EU qualified physicians to certain areas that are categorised as "medical deserts" - areas in which physicians who trained in France are reluctant to practise.

FOCUS – USING RECRUITMENT AGENCIES
The term "recruitment agency" is something of a generic concept which includes a wide variety of organisations:
- agencies, which seek to distinguish themselves from "head-hunters", the serious approach of which they question, citing the frequent lack of any training programmes for non-French national physicians;
- head-hunters, which have found new prospects in healthcare;
- other intermediary bodies that are set up as associations, but which offer paid-for services.
All of these agencies together have in common their relative lack of experience in hospital healthcare, as well as a general lack of experience for those which have specialised in recruitment for hospitals and clinics.

Increasing numbers of healthcare centres experiencing recruitment difficulties are using such agencies.

Recruitment agencies target different clients (state-run hospitals, private hospitals, regional authorities) and then offer them different types of healthcare professional (either only EU-qualified citizens - which is less of a risk - or healthcare professionals who qualified outside the EU). They offer a varied selection of services, which can include French language training courses, as well as recruitment possibilities in accordance with a number of different conditions. There are a number of different guarantees associated with the services they offer. Prospective employers can request that the language skills of the healthcare professional in question be of a particular level on the Council of Europe's scale. They can have their CV references checked or ask for additional, more detailed assessments. The candidates can be interviewed in their own country, and a reserve candidate can be found in the event of the first one withdrawing. The average amount of time it takes to recruit someone is between six months and year.

The costs can be set in a number of different ways: they can be degressive as the number of candidates recruited increases, they can vary depending on how difficult it is to find a particular profile, etc.

The cost of recruiting a physician varies from €6000 to €42,000 for the various recruitment agencies that were contacted.

Basically, as far as hospitals are concerned, using recruitment agencies (that some people have described as a lottery given some of the candidates who have come through the process) involves investing a great deal of money for results that are far from guaranteed.

4.3.5 Working conditions of healthcare professionals who have emigrated to France or a particular region

For healthcare professionals who have emigrated to France and who have succeeded in having their overseas qualifications recognised, there are no differences in their working conditions and those enjoyed by their French colleagues and/or those who are registered with the National Order. The question of disparities in working conditions only arises for practitioners who have been granted authorisation to work in state-run hospitals in France, but without having had their qualifications recognised (pharmacists, dentists, midwives, physicians). Because of the huge numbers of non-French nationals who are recruited, working conditions can vary - particularly among physicians - depending on whether or not they are registered with the National Order.

Physicians with qualifications obtained outside the EU who are not registered with the National Order but who work in hospitals have statuses which do not guarantee them the same salaries as those enjoyed by physicians who are registered with the National Order, despite the fact that they have equivalent status but a recognised qualification. The statuses of these "associate" physicians are also precarious: students working as interns are recruited for periods of six months, associate assistant practitioners have renewable 12 month contracts, etc. Up until now, students working as interns were only recruited to unfilled positions once house doctors had made their selections. This means that non-French national physicians can have difficulty finding a post as a student working as an intern, if they are not certain of being to stay for more than six months (the length of a hospital training internship).

146 [A.DREXLER (2008), Le défi du recrutement des médecins à diplôme étranger dans les hôpitaux publics (the challenge of recruiting physicians with overseas qualifications in state-run hospitals). The results of this survey carried out in June 2008 revealed that nearly 3 in 10 healthcare centres had used a recruitment agency to recruit physicians who had qualified overseas.
Also, the various statuses set aside for practitioners with non-recognised non-EU qualifications do not grant the same authorisation to practise as the status awarded to practitioners who are registered with the National Order. These non-EU qualified practitioners can diagnose patients, they can treat them and provide them with both health and preventive care, but remain under the authority of the department manager for all that they do. This means that they can only prescribe medicines on the authority of the department manager. Consequently, their working conditions can vary greatly, depending on which department or hospital they work in. Although what they are authorised to do is limited, certain department managers are willing to give these practitioners a relatively free rein and a measure of independence (which contravenes the regulations in place and can lead to legal issues for the department manager). Other department managers, on the other hand, might consider these overseas-qualified physicians as simple interns or students, giving them less than gratifying tasks and exploiting their abilities (which is in compliance with the regulations in place limiting these physicians to only being able to practise under the responsibility of their department manager. These regulations can result in difficult working conditions - especially from a psychological perspective, with certain physicians questioning the skills they have acquired)\(^{147}\).

Furthermore, because of their low salaries, associate physicians can sometimes find themselves having to work longer hours. This is why students working as interns so often elect to be on call - their salaries are considerably lower than those of interns (interns' salaries increase as they advance through their hospital training, whereas the salaries of students working as interns do not change). Fundamentally, the situation has repercussions not just on the working conditions of these physicians, but also on their present and future living conditions. This is likely to lead to difficulties with respect to their income, as well as their pensions and career development.

There is a certain stigma associated with the differentiation within hospitals between different groups of healthcare professionals on the basis of the country in which their qualifications were delivered (EU/outside the EU) rather than on the basis of just their professional skills. People with the same skills and comparable workloads either are or are not hospital practitioners... or they are or they are not "associate" practitioners. Non-EU qualified physicians have struggled over the years - not just to amend their status, but to change the terminology used to refer to them - which draws attention to them and makes them feel inferior.

#### 4.3.6 Quality of life enjoyed by healthcare professionals who have emigrated to France or a particular region

There is no data available - at either national or regional level - for analysing the quality of life enjoyed by healthcare professionals who have emigrated to France. One might consider that quality of life can be affected by working conditions and that non-French national healthcare professionals who have immigrated to France have no cause to be envious of other healthcare professionals, except with regard to the differences in working conditions. Quality of life most probably varies depending on geographical location (with people in southern and eastern regions in France enjoying the best quality of life).

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5. Results of qualitative interviews

5.1 Findings from the interviews with key stakeholders and experts

- Sample of experts and representatives of key stakeholders:

<table>
<thead>
<tr>
<th>Organization</th>
<th>Position</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>MINISTRY OF HEALTH</td>
<td>Assistant director of health service human resources</td>
<td>Ms Emmanuelle QUILLET</td>
</tr>
<tr>
<td>FRENCH OFFICE OF IMMIGRATION AND INTEGRATION (OFII)</td>
<td>Director general</td>
<td>Mr Jean GODFROID</td>
</tr>
<tr>
<td></td>
<td>Deputy director general</td>
<td>Ms Carole LELEU</td>
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<tr>
<td>NATIONAL MONITORING BODY FOR THE DEMOGRAPHY OF HEALTHCARE PROFESSIONALS (ONDPS)</td>
<td>Chairman</td>
<td>Pr. Yvon BERLAND</td>
</tr>
<tr>
<td>INSTITUTE OF RESEARCH AND INFORMATION IN HEALTH ECONOMICS (IRDES)</td>
<td>Research director</td>
<td>Dr. Yann BOURGUEIL</td>
</tr>
<tr>
<td>NORD PAS DE CALAIS REGIONAL COUNCIL</td>
<td>Vice-chairman</td>
<td>Mr Michel AUTES</td>
</tr>
<tr>
<td>NATIONAL COUNCIL OF THE ORDER OF PHYSICIANS</td>
<td>Chairperson of the “Public health” department</td>
<td>Dr Irène KAHN-BENSAUDE</td>
</tr>
<tr>
<td></td>
<td>Chairman of the “Training and medical skills” department</td>
<td>Dr Xavier DEAU</td>
</tr>
<tr>
<td>NATIONAL COUNCIL OF THE ORDER OF PHARMACISTS</td>
<td>Representative for European and international issues</td>
<td>Ms SURUGUE</td>
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<tr>
<td>NATIONAL COUNCIL OF THE ORDER OF DENTISTS</td>
<td>Vice-chairman</td>
<td>Mr Gilles BOUTEILLE</td>
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<tr>
<td>NATIONAL COUNCIL OF THE ORDER OF MIDWIVES</td>
<td>National advisor</td>
<td>Ms Marianne BENOIT TRUONG CANH</td>
</tr>
<tr>
<td></td>
<td>Policy officer for EU issues</td>
<td>Ms Julie-Jeanne REGNAULT</td>
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<tr>
<td>NATIONAL COUNCIL OF THE ORDER OF PHYSIOTHERAPISTS</td>
<td>Vice-chairman</td>
<td>M. VAILLANT</td>
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<td></td>
<td>Secretary-General</td>
<td>M. PASTOR</td>
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<tr>
<td></td>
<td>Assistant Secretary-General</td>
<td>M. EVENOUN</td>
</tr>
<tr>
<td>NATIONAL UNION OF PROFESSIONAL NURSES</td>
<td>Chairperson</td>
<td>Ms Marie-Hélène FEUILLIN</td>
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<tr>
<td>UNION OF NON-EU QUALIFIED PRACTITIONERS</td>
<td>Chairman</td>
<td>Dr Talal ANNANI</td>
</tr>
</tbody>
</table>

Findings

148 www.sante-sports.gouv.fr
149 www.ofii.org
150 www.sante-sports.gouv.fr/dossiers/sante/observatoire-national-demographie-professions-sante-ondps
151 www.irdes.fr
152 www.nordpasdecalais.fr
153 www.conseil-national.medecin.fr
154 www.ordre.pharmaciens.fr
156 www.ordre-sages-femmes.fr
157 www.cnomk.org
158 www.syndicat-infirmier.com
159 www.snpadhue.com
International migratory flows of healthcare professionals - a phenomenon that is poorly understood in France.

What emerges from the interviews is that there is a lack of knowledge and data regarding international migratory flows of healthcare professionals in France. This lack of data is most acute with respect to French healthcare professionals moving abroad; the various professional Orders that have been set up allow expats to remain in contact with other colleagues in their profession in France in return for a financial contribution. But it is having to pay this cost - as well as being far from France and so less inclined to register with the professional Order - which has led to data about this phenomenon being so fragmented. And the Ministry of Health, which is responsible for regulating France's healthcare system, does not keep any additional data.

As far as immigration is concerned, there is a little more data available. Because it is compulsory for non-French nationals to register with their relevant professional Order, the various Orders are able to track their movements. However, the Order of physicians has indicated that there are no guarantees that everybody who has to is registering with the Order. It cites an example of an Italian physician who qualified in Italy and is head of a biochemistry laboratory in a major university hospital in the Paris region. Although he has been practising for around 10 years, he is not yet registered with the Order of physicians. It should also be pointed out that the information held by the Order of physicians does not take into account non-EU qualified physicians who practise in hospitals, but who do not have the right to register with the Order until their qualifications have been officially recognised. What is more, because the Order of nurses has only recently been set up and is not yet fully operational, the movement of nurses is not yet being properly tracked.

There is also a certain indifference on the part of the people polled with respect to this issue. Although the Orders have access to databases which they could use to look into this phenomenon in more detail (profiles of healthcare professionals, how they practise, the types of location in which the practise, etc.), with the exception of the Order of physicians, the other Orders make do with summary quantitative data. Furthermore, the Ministry of Health - which has emphasised its role as a regulatory body, specifying that, unlike the NHS in the UK, it does not seek to recruit healthcare professionals - does not keep data on migratory flows or stocks, or get involved in discussions about the ethics of recruitment and has not been involved in the debate on the use of recruitment agencies. This means that it is not in a position to quantify this phenomenon.

A consensus to reject coercive measures designed to tackle the unequal geographical distribution of healthcare professionals in France.

The various people polled were all in agreement with respect to the question of healthcare professionals and their demographics - although more from a qualitative than a quantitative viewpoint. Admittedly, the numbers of physicians leaving the profession are not always offset by the numbers of those entering it; initiatives to reduce the number of hours in the working week have resulted in the need for extra staff who have to carry out their jobs in conditions that are much more stressful, with shortages of nurses in particular; a lack of interest in the elderly has led to a lack of paramedical staff working in geriatrics; newly-appointed medical staff do not conceive of the profession in the same way as their elders and their desire for more time to themselves for family and leisure activities means that greater numbers of healthcare professionals have to be recruited.

The distribution of healthcare professionals throughout France has thus become unequal, with each profession experiencing it to varying degrees. And the situation is set to worsen unless the public authorities can provide a solution. Some people are awaiting “a restructuring of medical and paramedical care through the offer of primary care”60, the tackling of the “real problem of

60 M.Michel AUTES, Vice-chairman of the Nord-Pas-de-Calais Regional Council.
town planning and services on offer" - which would explain this unequal distribution 161- or the regionalisation of the way in which healthcare delivery 162 is regulated. All of the key players who were polled, however, were against the implementation of coercive measures, which are not accepted in France. This is evidenced in the rejection of the move to introduce penalties for physicians in areas which have a surfeit of medical staff refusing to do locum work in deficit areas, a move that was rejected during the debate on the “Hospital, Patients, Health, Regions” law in the summer of 2009. However, one person from the Order of physicians stressed that physicians had a responsibility to meet the requirements of public health and that as such, "the Government had to face up to its obligations, and so should take on a more interventionist role with respect to which regions newly-qualified physicians are allowed to set up in"163. However, there are no guarantees that the National Council for the Order of Physicians would officially rally behind the Government if it once again suggested restricting physicians’ freedom to set up wherever they liked.

- Recruiting healthcare professionals from abroad - a means of compensating for the lack of professionals at national level

Given the unequal distribution of healthcare professionals throughout France, using healthcare professionals from abroad is seen by a number of people as a useful means of compensating for the deficit experienced in certain regions. However, according to the Order of physicians, non-French national healthcare professionals who register with them follow the same tendencies as French nationals - i.e., they are more attracted by Paris and regions in the southern part of the country. Others, on the other hand, have talked about how recruiting physicians from other countries has the potential to save the healthcare system in certain areas in France: for example, according to Michel AUTES, an elected representative in the Nord Pas-de-Calais region, a hospital in Frommies, a small town in northern France, “was saved by the arrival of doctors from Poland”164. He also recognises that he is caught between wanting to do something about the need for healthcare professionals in his region and recognising the imbalance that recruiting people from overseas can create in their native countries.

This issue of recruiting overseas healthcare professionals to compensate for the lack of French national healthcare professionals often leads to discussions about the numbers of French nationals who are eliminated by the numerus clausus selective exam. “Admittedly, the numbers of people getting through numerus clausus exam has been increasing over the last few years. But we are still faced with a real problem. There are many young people in France who do exceptionally well in their baccalaureates, and then average around 70% in their end-of-first-year exam, but - because of the numerus clausus - can’t continue with their studies and have to turn to another profession. And we have young, unqualified people working in both state-run and private hospitals in France - something which is going to become cause for concern”165. As a National Order of Dentists puts it, “it would be better to train French students rather than recruit people from other EU member states or even countries outside the EU.”

161 Pr. Yvon BERLAND, Chairman of the ONDPS.
162 Dr. Yann BOURGUEIL, IRDES.
163 Dr Xavier DEAUL, National Council for the Order of Physicians
164 M. Michel AUTES, Vice-chairman of the Nord-Pas-de-Calais Regional Council.
165 Pr. Yvon BERLAND, Chairman of the ONDPS.
International migratory flows - calling the French healthcare training system into question

The National Orders of midwives and physiotherapists have supplied very accurate data on the sheer numbers of French students who leave France to go and study in Belgium - which until recently extended them a warm welcome - in order to avoid the *numerus clausus*. The Order of midwives was opposed to this trend - for ethical reasons as well as because of the training costs which Belgium was having to bear unfairly. The Order of physiotherapists underlines "the problem of equity and social inequality between those French students who have the financial means to..." and so end up having to abandon the idea of practising the profession if they do not make it through the selection procedure in France. Having recently joined the European Union, Romania is now where French students go in large numbers, having failed the end-of-first-year medicine exam, offering "a short training course in return for a fee".

The chairman of the National monitoring body for the demography of healthcare professionals believes that this phenomenon is leading to "a change in practices that will one day render the numerus clausus completely outmoded. If this trend continues, we may one day ask ourselves if there is any point in imposing a numerus clausus system if students are heading in their hundreds towards a different training system. Indeed, the situation is far from trivial in certain regions of the country. In Provence-Alpes-Côte d'Azur, large numbers of newly-qualified medical professionals are from abroad."

The Ministry of Health does not view the situation in the same way and believes that "these various avenues for avoiding the numerus clausus exam do a great deal to encourage a harmonisation of qualifications at EU level", and do not necessarily call into question the validity of the *numerus clausus*. And harmonisation is very much at the forefront of debate, since all the medical professions have now signed up to the Bologna accords.

Automatically recognised EU qualifications: do they comply with French requirements?

It emerges from the interviews that representatives of certain professions consider the level of recognition required within the framework of directive 2005/36/CE to be insufficient: this is particularly the case with regard to midwives, whose basic training lasts three years (or 18 months if they already have a nursing diploma). The National Council of the Order of Midwives believes that "midwifery training in France (five years of basic training) is far more complete than that given in many other member states of the European Union". The Order is therefore currently working at European level for the recognition of a university training programme and for a training programme recognised at Master II level - as will be the case in France with the bachelors-masters-doctorate reforms.

The National Council of the Order of Physicians considers the training delivered in France - which is not being asked to harmonise upwards - to be of a higher quality than that delivered in a certain number of other EU member states. These thoughts appear to be shared - particularly with respect to qualifications awarded in countries that have only recently joined the EU... mainly Romania. As the chairman of the National monitoring body for the demography of healthcare professionals puts it, "When it was just a question of the English, the Belgians and the Germans, the situation was not so problematic. But it has become more complex with the introduction of different standards. The level of training attained by Romanian students is very different to that attained by their counterparts in France and other EU countries. And the situation is cause for a great deal of..."

166 Dr Irène KHAN-BENSAUDE, National Council for the Order of Physicians.
167 According to the National Order of Dentists, training programmes are standardised across all 27 EU member states. The National Order of Physiotherapists considers that training programmes are of comparable levels across the EU, with the exception of Poland, a country in which there are two levels of training, and so two levels of quality.
168 Ms Marianne BENOIT TRUONG CANH, National council of the order of midwives.
Concern. It looks as though posts are being filled with physicians. But what is certain is that not all these physicians have been trained according to the same high levels of strictness. For countries which have only recently joined the European Union, the difference is dramatic. The chairman of the national union group for practitioners with qualifications obtained from outside the EU shares this opinion about holders of EU qualifications - which are more prized than non-EU qualifications: “It’s a pity to go and see a doctor from an East European country - particularly Romania - who has a poor command of French and lacks experience in the French healthcare system... when you can see a non-EU qualified practitioner who has both a good mastery of French and knowledge of French medicine, but whose expertise is not officially recognised”.

Ultimately, one might question how objective these remarks are. Some, however, put out a challenge, suggesting that maybe the level of medical training available in France is not all that good after all: “is our system really so wonderful? In medicine, the technical side of things is not the only one that counts. The human relations aspect is disregarded in training French physicians”\(^{169}\).

By way of a conclusion, using overseas qualified healthcare professionals to make up for the shortage of French national healthcare professionals is a way of redressing their unequal distribution across the country. If - as some claim - these qualifications are not awarded in recognition of equivalent levels of training, then there are issues concerning the quality of healthcare delivered that need to be addressed. The chairman of the national monitoring body for the demography of healthcare professionals asks if “recruiting healthcare professionals from abroad to compensate for the lack of French national staff is not running the risk of negatively affecting the quality of healthcare delivered in a certain number of hospitals - particularly state-run hospitals - and thus exacerbating inequality among the population with respect to illness and how it is treated?”

When all is said and done, the interviews raised some major questions about the healthcare system as a whole – questions which should encourage the various bodies involved in the delivery of healthcare to hold an all-encompassing discussion about international migratory flows.

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\(^{169}\) M. Michel AUTES, Vice-chairman of the Nord-Pas-de-Calais Regional Council.
5.2. Results of the case study

5.2.1 Introduction to the case study

The findings from the qualitative interviews carried out with the experts and key stakeholders in France highlight the existing unequal geographical distribution of health professionals in France, present not only at a regional level, but also within regions enjoying an overall high density of health professionals. It was also found that the coercive measures aiming to tackle this unequal distribution, envisaged by the French government, were widely rejected by healthcare professionals throughout the country. Consequently, the recruitment of professionals from abroad could represent a means to compensate for the deficit experienced in certain regions. The interviews also illustrated the general lack of consistent and complete data, and pinpointed a poor understanding of the migratory flows of healthcare professionals in France.

In order to obtain a better understanding and a more in-depth analysis of the migration and mobility process of health professionals, we carried out a case study concentrating on the category of medical practitioners, including general practitioners and specialists, in two contrasted regions: the Nord-Pas-de-Calais (NPDC) region located in the North of France, and the Provence-Alpes-Côte d’Azur (PACA) region located in the South of France.

The Nord-Pas-de-Calais region enjoys a medical density of 300 doctors/100 000 inhabitants\textsuperscript{170}, representing a slightly lower density than the Metropolitan France average situated at 308,8 doctors /100 000 inhabitants\textsuperscript{171}. The region is considered to be an overall ‘unattractive’ region that encounters difficulty attracting and retaining health professionals. In contrast, Provence-Alpes-Côte d’Azur represents the region which enjoys the highest medical density in France, 408,7 doctors/100 000 inhabitants. Despite its overall ‘attractiveness’, there exists an unequal distribution of medical professionals with costal areas enjoying the highest medical density. The characteristics that define and distinguish between an attractive and an unattractive region will be discussed in more detail later on in the report.

\textsuperscript{170} Patrick ROMESTAING and Gwénaëlle LE BRETON-LEROUVILLE, Atlas de la démographie médicale en région Nord-Pas-de-Calais. Situation au 1er janvier 2009, Conseil National de l’Ordre des Médecins (CNOM)

\textsuperscript{171} Patrick ROMESTAING and Gwénaëlle LE BRETON-LEROUVILLE, Atlas de la démographie médicale en France. Situation au 1er janvier 2010, Conseil National de l’Ordre des Médecins, page 8
We focused on the medical category as this group accounts for the largest number of foreign practitioners (nationality and/or diploma) in France. According to the National Council of the Order of Doctors, foreign doctors (defined by their nationality) amount to 10,165 in 2010, and represent at least 4.7% of all doctors registered with the Order. To this percentage, one should add the doctors holding a foreign non-EU diploma, who are employed by hospitals and practice under the responsibility of other physicians, but have not yet have obtained the right to practice on their own, and are therefore not registered with the Order (please see section 4.2.2.1 for more details). According to a report written by the European Federation of Employed Doctors and the Federation of Health Practitioners (FPS), the latter union representing non-EU doctors, in 2008 there were 7,000 non-EU doctors who worked in French hospitals, but had not obtained the right to practice medicine in France, and were therefore not registered with the Order. However, these figures should be considered with caution as the number of non-EU trained doctors practicing in French hospitals declared in existing studies is not consistent. For example, the 2008 OECD report states that there are at least 6,000 accounted foreign doctors working in French hospitals, although, in reality, their number is closer to 10,000.

Furthermore, doctors also represent the category of health professionals for whom there exists a shortage of labor in certain regions. The term ‘shortage’ should be understood as a lack of doctors in certain areas in France that encounter difficulty attracting and retaining doctors. According to the National Council of the Order of Doctors, the reduced number of accepted medical students between 1983 et 1993 (numerus clausus system), the large number of doctors reaching the retirement age, the increasing demand for primary health care due to an ageing population, the decreasing number of liberal practitioners, along with the geographical maldistribution of the medical cohort causes unequal access to care throughout France. In 2009, the National Council of the Order of Doctors estimated that 2.3 million people live in the 634 French areas considered to be ‘difficult’ in terms of access to care. Consequently, some areas encountering difficulty attracting and retaining French-trained medical personnel hope to recruit foreign-trained doctors to fill-in the available positions which are not sought by French-trained professionals.

Focusing on the medical profession in the selected regions enabled us to compare as much as possible the medical demography and the recruitment difficulties encountered by the two regions mentioned above. This in turn shed light on the unequal distribution within the two regions. Secondly, it provided an in-depth understanding of recruitment means used by hospitals in both regions, along with the expectations and factors that determine settlement and practice choices of French-trained and foreign trained professionals. This allows for a better assessment of the impact of the current recruitment strategies used by hospitals to attract manpower. Lastly, by focusing on each step of the migration process, we were able to examine i) the factors that pushed doctors to migrate to France, and more specifically to settle in the two regions; ii) their experience upon their arrival in France in terms of administrative procedures to obtain a visa and work permit, and to validate their diplomas and professional experience; iii) their experience during the job search and recruitment process; iv) the perception that other colleagues and hospital administration have of them; v) their future mobility perspectives.

In terms of methodology, as for the findings presented in section 5.1, the conclusions drawn for the case study resulted mainly from qualitative interviews. Foreign doctors as well as French doctors, including the vice-president of the French National Association of Medical Students (ANEMF) were interviewed, along with employers (public hospitals), public institutions such as

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172 Serdan DALKILIC, Melih MERIC, Patricio TRUJILLO, Evaluation au sein de l’Union européenne de la qualité des diplômés internationaux en médecine (DIM) venant de l’extérieur de l’UE, 2008
173 Fédération Européenne des médecins salariés
174 Fédération des Praticiens de Santé
the Ministry of Health and the National Observatory of the Demography of Health Professions (ONDPS), a recruitment agency, and other employers such as the French Hospital Federation, the president of the Federation of Health Practitioners (representing non-EU doctors), and the French representative of non-EU doctors within the European Federation of Employed Doctors. Please find below a table highlighting the breakdown of the interviews. Please note that all interviews conducted with doctors have been kept in an anonymous form.

Interviews with doctors:

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<thead>
<tr>
<th>First name</th>
<th>Country of origin</th>
<th>French region of settlement</th>
<th>Medical specialty</th>
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<tr>
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<tr>
<td>Bassim</td>
<td>Irak</td>
<td>Paris</td>
<td>Specialist (imagery)</td>
<td>Employed public hospital</td>
</tr>
<tr>
<td>Maria</td>
<td>Romania</td>
<td>Bucharest</td>
<td>Specialist</td>
<td>Employed public hospital in Romania but wishes to emigrate to France</td>
</tr>
<tr>
<td>Irina</td>
<td>Romania</td>
<td>Bucharest</td>
<td>Specialist (cardiologist)</td>
<td>Employed public hospital in Romania but wishes to emigrate to France</td>
</tr>
</tbody>
</table>

Interviews with key stakeholders:

<table>
<thead>
<tr>
<th>Institution</th>
<th>Position</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lille University Hospital</td>
<td>Director in charge of medical affairs</td>
<td>Thibault DOUTE</td>
</tr>
<tr>
<td>Lille University Hospital</td>
<td>Chair of the Department of Anesthesiology and Critical Care Medicine</td>
<td>Prof. Benoît Vallet</td>
</tr>
<tr>
<td>Boulogne-sur-Mer Hospital</td>
<td>Manager in charge of medical affairs</td>
<td>Mr. FAUQUER</td>
</tr>
<tr>
<td>Valenciennes Hospital</td>
<td>Manager in charge of medical affairs</td>
<td>Ms. VAN DE ZANDE</td>
</tr>
<tr>
<td>Valenciennes Hospital</td>
<td>President of the body representing the medical personnel</td>
<td>Dr. SABOUNTCHI</td>
</tr>
<tr>
<td>Sambre-Avesnois Hospital</td>
<td>President of the body representing the medical personnel</td>
<td>Philippe PARADIS</td>
</tr>
<tr>
<td>Nice University Hospital</td>
<td>Director in charge of medical affairs</td>
<td>Stéphane SWEERTAEGGHER</td>
</tr>
<tr>
<td>Marseille University Hospital</td>
<td>Director in charge of medical affairs</td>
<td>Loïc MONDOLONI</td>
</tr>
<tr>
<td>Marseille University Hospital</td>
<td>President of the body representing the medical personnel</td>
<td>Jean-Paul SEGADE</td>
</tr>
</tbody>
</table>
In addition to the qualitative interviews, official studies published by the National Council of the Order of Doctors, the National Observatory of the Demography of Health Professions along with a national survey carried out by the National Union of Young University Hospital Doctors (ISNCCA) were also used in order to complete and compare the results found during the qualitative interviews with existing studies. Please keep in mind that most of the statistics on the medical practitioners presented in the studies are based on the place of birth, and not on the country where the doctors were trained. This gives a distorted image of the mobility of medical professionals as many received, at least partial training, in the receiving countries. Furthermore, it is not clear whether once an individual obtains French citizenship whether he is considered and reported as a French national, or whether he is still part of the ‘foreign-born’ cohort. It should also be noted that the authors of the report distanced themselves enough from the findings presented in these reports as not to over-represent the stand of any union or institutional body on the situation of the medical demography in France.

Before proceeding with the presentation of the findings, we wish to make a note on the difficulties encountered in carrying out the case study. Difficulties obtaining the required interviews represented the major obstacle. The initial draft of the case study selection involved interviewing hospital administrations, along with French and foreign doctors who were employed by them. This would have enabled us to compare the results obtained from the interviews with the hospital administration, the presidents of the unions representing the medical personnel, and French and foreign doctors. Similarly, an equal number of EU, non-EU and French-trained doctors were intended to be interviewed in order to allow for an accurate representation of the general make-up of the workforce in the two regions. Similarly, the Regional Health Agencies responsible for defining the regional health provision, which impacts the overall recruitment strategy and policy of hospitals, along with mayors of small towns which experienced difficulty recruiting general practitioners were also included in the original interview sample. Lastly, liberal medical practitioners, along with those hired by private establishments were also intended to be interviewed.

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176 Inter Syndicat National des Chefs de Clinique Assistants des Hôpitaux de Ville de Faculté
As you can see from the table above, although we were able to obtain a significant number of interviews with the public hospital managers in charge of medical affairs, we were able to interview few of the other categories mentioned above. We especially encountered great difficulty obtaining interviews with doctors irrespective of their origin. In order to protect their privacy, the hospital establishments which were contacted did not wish to give out the names of doctors who were employed with the hospital. Furthermore, most of the French doctors who were contacted directly refused to participate in the study. The interviews carried out with foreign doctors were not much easier. As the questions touched upon personal choices and decisions, many foreign doctors were reluctant and did not wish to openly discuss their migration experience. Even when the interview request came from the hospital employing them, the task was just as challenging. For example, a small hospital in the Nord-Pas-de-Calais region had agreed to help us interview the foreign doctors who were hired by the institution. The questionnaires were distributed to fifteen foreign doctors, and a meeting was arranged in order for doctors to have an open discussion about their migration experience to France. None of the contacted doctors submitted the anonymous questionnaires and no one attended the organized meeting. Similarly, we contacted the president of a union representing doctors coming from a specific non-EU country. Despite the fact that the questionnaire was submitted prior to the interview, the association did not wish to participate in the survey. In addition, some of the non-EU doctors who were contacted, although formally registered with the Unions representing non-EU doctors, were offended by the fact that they were categorized as non-EU doctors. They declared having immigrated to France many years ago, and having acquired the French citizenship. Therefore, they did not wish to be labeled as non-EU doctors despite their registration with a union representing doctors holding non-EU medical diplomas, and requested to be treated on an equal basis as French-trained doctors. This shows that doctors who have foreign credentials, but have now been working for a long period of time in France want to be assimilated to the French medical cohort.

As a result, the interviews carried out with doctors are not representative of the general make-up and distribution of doctors in terms of nationality in the regions of Nord-Pas-de-Calais and Provence-Alpes-Côte d’Azur. Consequently, the findings and conclusions drawn are solely representative of the interviews carried out during this study, and should not be extrapolated and generalized to a broader context. In order to draw any general conclusions, the results found in the interviews will need to be further explored in the future by comparing them to the results obtained from a larger sample.

5.2.2 A comparison of the two regions

5.2.2.1 A general comparison of the demography of both regions

According to the 2010 Atlas of the Medical Demography in France177, there are 261 378 doctors registered with the Order, among which 216 450 are still currently exercising. Among these, 5259 doctors have registered for the first time with the Order. For Metropolitan France, this translates into a medical density of 308.8 doctors per 100 000 inhabitants. In general terms, Southern regions (Rhône-Alpes, Provence-Alpes-Côte d’Azur, Languedoc-Roussillon, Midi Pyrénées, Aquitaine), along with the Paris region (Ile-de-France), and Alsace enjoy a (slightly) higher density than the average, while Northern and Centre regions suffer from a low(er) medical density. However, even regions enjoying an overall high medical density suffer from medically-deserted area.

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In this section of the report, we will try to compare the medical demography in the Nord-Pas-de-Calais and the Provence-Alpes-Côte d’Azur and highlight the recruitment difficulties encountered by both regions.

The Nord-Pas-de-Calais

The Nord-Pas-de-Calais region, located in the North of France, is considered to be an overall unattractive region due to its geographical location causing certain areas, within the region, to encounter difficulties recruiting and retaining medical professionals. According to a 2009 report published by the National Council of the Order of Doctors\textsuperscript{178}, there are 12,265 practicing doctors currently registered with the Order. The region enjoys a density of 300 doctors for 100,000 inhabitants, which is slightly below the Metropolitan average (308.8 doctors/100,000 inhabitants). Within the region, the Nord department benefits from a higher density (330.8/100,000 inhabitants) than does the Pas-de-Calais department (245.7/100,000). The average age of doctors registered with the Order is 49 placing them within the national average (50 years of age\textsuperscript{179}). Female doctors represent 35.6% of registered doctors. The picture below illustrates the distribution of doctors within the region.

With regard to the composition of medical specialties, in January of 2009, there were 7704 general practitioners registered with the Order, representing 54% of all registrants. It should be noted that the Nord department accounts most of them (68%). 6557 specialists are also registered in the region. Once again, the Nord department accounts for most of them (74%).

In terms of the new registration\textsuperscript{180} trend (figures for the year 2008-2009), among the newly registered doctors, a significant portion (41.5%) are general physicians. They tend to be young, having an average age of 33. Most of them settle in urban areas, and most specifically in or around the city of Lille. Furthermore, the close border with Belgium also has an effect on the young practitioners by attracting French practitioners to work abroad, but also by attracting

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\textsuperscript{178} Patrick ROMESTAING, Gwénaëlie LE BRETON-LEROUVILLOIS Atlas de la démographie médicale en région Nord-Pas-de-Calais. Situation au 1\textsuperscript{er} janvier 2009, page 8 consulted on http://www.conseil-national.medecin.fr/demographie/les-atlas-regionaux-966 in December 2010

\textsuperscript{179} Michel LEGMANN, Patrick ROMESTAING, Gwénaëlle le BRETON-LEROUVILLOIS, Atlas de la Démographie Médicale en France. Situation au 1\textsuperscript{er} janvier 2010, Conseil National de l’Ordre des Médecins, page 11

\textsuperscript{180} The term ‘registration’ should be understood as doctors registering with the Order of Doctors for the first time
Belgian doctors to work in France. The majority of the newly registered doctors prefer being employed by hospitals rather than setting up their own practices. Their settlement patterns and practice choices represent a challenge to the region as the majority of general physicians who have recently retired used to practice as liberal practitioners in both rural and urban settings. For this reason, the region faces difficulty replacing retired liberal practitioners. In the last ten years, there was a 79% drop in the number of liberal practices that set up practice in this region. However, the settlement and practice choices observed in Nord-Pas-de-Calais reflect the national trend among young practitioners; the reasons behind these choices and their implications for the medical demography and access to care will be discussed in more detail later on in the report.

It needs to be mentioned that the Regional Health Authority, along with the Regional Union representing liberal practitioners181, and the Regional Council have been working together for the past five years to study ways to attract liberal practitioners to settle in the areas considered not attractive. Along with the national measures182 which have been taken to make the general practice appealing to students, training established general liberal practitioners to become internship supervisors has had an effect on attracting young professionals to the region. For the past two years, established practitioners are encouraged to host and train medical students or young graduates in their practices. This not only allows students to get hands-on-experience, but also to discover the region. It is also beneficial to the established professionals as students can help with paperwork. By forces to teach, this exercise also forces them to think about and reconsider, if necessary, the way they practice. It helps established practitioners modernize or reorganize their ways of doing things. Although the program is still fairly new, until now, several young professionals applied to become general liberal practitioners in the region.

To summarize the situation in the Nord-Pas-de-Calais, although the region has enjoyed steady registrations over the years, and benefits from a medical density almost within the average, the mode of practice of the doctors who decide to settle in the region has changed over the years. The number of liberal practitioners, and especially general medicine liberal practitioners has decreased considerably. This represents a major challenge for organization of health care provision. As we will see later on in the report, this situation is not specific to the Nord-Pas-de-Calais, and causes concern to most regions in France.

**Provence-Alpes-Côte d’Azur**

The findings for the Provence-Alpes-Côte d’Azur region contrast the ones found for the Nord-Pas-de-Calais. 24 550 doctors are registered in the Southern region, amounting to 9.5% of all national registrations183. The region is considered to be one of the most attractive regions in France due to its geographical location and enjoys the highest medical density in France (408 doctors / 100 000 inhabitants). The average age of doctors is 51, and female doctors account for 38%.

However, the distribution of doctors is not homogenous within the region. For example, the department of Bouches-du-Rhône enjoys a higher medical density than does Alpes-de-Haute-Provence. Generally, coastal areas which have access to the sea enjoy the highest medical density of all departments from the region and attract many doctors who wish to settle in the

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181 URME – Union régionales des médecins exerçant à titre libéral
182 A major step towards making general medicine appealing to students is the fact that it is now considered a specialty on its own. Prior to this change, many students who would not qualify to become specialists, would become general practitioners. This had a direct impact on the appeal of general medicine, as it was not a choice, but a consequence of the failure to become specialists.
Meanwhile, rural or remote areas within the same region have more difficulty attracting doctors. The picture below illustrates the distribution of doctors within the region.


Figure 20. Distribution of doctors within the Provence-Alpes-Côte d’Azur

In terms of new registrations (figures for the year 2008-2009), the average age of doctors who register with the Order for the first time is 34 years. 66% of them chose to be employed, while 15% exercise as liberal professionals, while 19% do only replacements and act as locum doctors. With regard to medical specialty, 40.9% are general practitioners. The other most common specialties are: anesthesiology, psychiatry and general surgery. Among the newly registered doctors, 37% choose to settle in Marseille, the regional metropolis; Nice being the second most attractive place. It should be noted that both cities have a university hospital. With regard to retirement trends, as for the NPDC region, most retiring doctors (71%) are general practitioners.

To summarize the situation in the Provence-Alpes-Côte d’Azur, although the region is ranked as the most attractive region in France and enjoys the highest medical density, the region also suffers from an unequal distribution of its health professionals as costal regions attract more doctors than the ones found in the country side.

5.2.2.2. The recruitment difficulties encountered by the regions

Ten hospitals were interviewed for this case study. Six hospitals from the Provence-Alpes-Côte d’Azur region (Briançon, Dignes, Hyères, Orange, Nice and Marseille University Hospitals) and four hospitals from the Nord-Pas-de-Calais region (Lille University Hospital, Boulogne-sur-Mer, Valenciennes, and Sambre-Avesnois) accepted to speak to us about their recruitment challenges. Although the hospitals of Maubeuge, and Fourmies, all located in the Nord-Pas-de-Calais, refused to gives us an official interview, we did find out some information about their recruitment challenges during the interviews with the other hospitals from the same region.

From the interviews, we cannot conclude that there are any region specific recruitment challenges, meaning that one region faces very specific challenges not found in the other region. The only challenge that could be classified as region specific, and which was expressed in the interview with a hospital in the NPDC, is the perception and pre-formed opinion that some doctors have about some towns from the NPDC region. As a result, the hospital tries to attract and retain as many interns and students to the hospital in order to allow them to discover the region during their internships. The public hospital manager in charge of medical affairs ensured
that once interns have a chance to discover the beauty of the region and the quality of life that it can offer, many of them decide to stay and work in the region. Attracting interns represents a means for the hospital to overcome any negative pre-formed opinions about the town and allow interns to develop a sense of loyalty to the town and region.

The recruitment challenges expressed by the hospitals which were interviewed were related to their difficulty in finding doctors specialized in certain areas, their impossibility to offer attractive wages and their ability to compete with the private sector. In addition, smaller-size hospitals usually found in smaller towns also face the challenge of competing with larger hospitals or university hospitals found in the regions’ major cities which tend to attract most candidates.

With regard to the recruitment difficulties in certain medical specialities, the table below summarizes the specialty area that represented a recruitment challenged to hospitals interviewed in both regions (please note the information below was gathered during the conducted interviews and is based on declarative statements):

### Nord Pas de Calais

<table>
<thead>
<tr>
<th>Specialty Area</th>
<th>Lille University Hospital</th>
<th>Boulogne-sur-Mer Hospital</th>
<th>Valenciennes Hospital</th>
<th>Sambre Avesnois Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurological surgery</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Ear-nose-throat surgery</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology/Imagery</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Anaesthesiology</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oncology</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Radiotherapy</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Cardiology</td>
<td></td>
<td></td>
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<tr>
<td>Endocrinology</td>
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<td></td>
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<td></td>
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<tr>
<td>Pediatrics</td>
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</table>

Table 11 – Recruitment difficulties for certain medical specialties in the Nord-Pas-de-Calais region

### Provence-Alpes-Côte d’Azur

<table>
<thead>
<tr>
<th>Specialty Area</th>
<th>Digne Hospital</th>
<th>Orange Hospital</th>
<th>Hyeres Hospital</th>
<th>Marseille University Hospital</th>
<th>Nice University Hospital</th>
<th>Briançon Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatry</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology/Imagery</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopedics Surgery</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anaesthesiology</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Care</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Table 12 – Recruitment difficulties for certain medical specialties in the Provence-Alpes-Côted’Azur region

From the tables above we can notice that the specialties for which most of the interviewed hospitals encounter difficulty recruiting are: radiology/imageries and anaesthesiology. However, it can be observed that the lack of specialists in these fields is encountered in both regions, and we cannot draw any correlations between the lack of specialists in one field and geographic location. According to the hospital managers in charge of medical affairs, the lack of specialists is a national problem linked to the appeal of those fields to medical students, and to the number of doctors trained in those areas rather than their availability in one particular region. This statement seems to be supported by the table; the majority of the hospitals have difficulty finding specialists in imagery and anaesthesiology regardless of the region where they are
located. Three of the interviewed hospital managers stated that the *numerus clausus* system and the general French organization of care in France are to be blamed for the small number of trained and available doctors in certain specialties in France. Similarly, an official from the National Observatory of the Demography of Health Professions (ONDPS) also stressed the fact that the majority of specialists settle in large urban areas. Their settlement is also linked to the existence of hospitals. Therefore, a thorough study should be done between the unequal distribution of hospitals within regions and that of specialists. The policy implications and impact of the French health system will be discussed in more detail in the last section of the report.

Hospitals which compete in attracting difficult to find specialists also need to offer them attractive wages. In four of the interviews carried out (all found in the PACA region), public hospital managers in charge of medical affairs stated that they were unable to compete with private hospitals which offered doctors attractive financial packages. Most of them signalled that the field of radiology, imagery and anaesthesiology are the fields where the competition with the private sector is the most fierce; doctors preferring to work in the private sector in these fields. This observation also corresponds to the findings in the table above where it can be noticed that most hospitals encounter recruitment difficulties in these areas.

The appeal and reputation of the institution as play an important role in the success to recruit and attract doctors. University hospitals and hospitals found in major cities in both regions have minimal difficulty attracting doctors. These hospitals are sought after because they offer career development opportunities, ‘quality’ working environments, state-of-the-art equipment, well-trained medical teams, renowned professionals, and social and professional opportunities for the doctor’s families as these hospitals are usually located in large urban areas. Small-size hospitals usually found in small towns or more remote areas face much more difficulties. For example, the small hospital in the PACA region has difficulty competing with hospitals in nearby bigger cities such as Avignon, Montpellier, and Marseille. Also, doctors don’t want to find themselves working alone or in small teams because that translates into working extra hours, overnight and week-end shifts. As it was previously mentioned in the report, most doctors, and especially young medical professionals, search for a balanced professional and private life, where they are able to afford some leisure time. Furthermore, two small-size hospitals which were interviewed also declared not being able to offer the same opportunities for career development as larger-size hospitals. For example, a doctor who wishes to be the head of and manage a large medical team will not be able to do so within a small-size hospital; therefore, he will choose to exercise in a larger hospital that can offer him such an opportunity. However, the size of the hospital is not the only factor; the reputation of certain units and medical teams also play an important role in the recruitment process. For example, a small hospital in the NPDC region is able to attract cardiologists very easily due to the reputation of its cardiology unit. The unit has a good reputation in the region, and thanks to this, the hospital never encountered any recruitment difficulties in this area. Meanwhile, another regional hospital which is larger in size faces much more difficulty.

Lastly, one very important element which affects the recruitment process is the career opportunities of the spouse and available infrastructure to raise a family. As mentioned earlier in the report, health professionals, and especially young health professionals search for a balance between their professional and private lives. Due to the length of medical studies, most young doctors are in a relationship when they finish their studies. As a result, the professional opportunities of the partner are also taken into consideration, and the decision to choose a location is made as a couple. Furthermore, young couples also wish to be able to have access to public services and infrastructure to raise a family (schools, recreational activities, transportation, etc.).
Further to the findings presented in section 2.3.1, in this part of the report we wish to examine the expectations and the factors that influence the decisions of young French practitioners when choosing a location where to settle and an employer.

A 2006 study carried out by the National Observatory of the demography of health professions (ONDPS) illustrated that the most important factors that affect the most the choice of doctors to settle in a particular area are the following:

- the personal characteristics of the person including the knowledge about the area and the familiarity with the area, the fact of being in a relationship, and the gender, male doctors being more likely to settle in remote areas
- professional expectations (group practice, reasonable work load, the quality of professional relations)
- quality of life (the size of the town/city, the existing infrastructure including access to schools, transportation and cultural facilities, and the profession of the spouse/partner)

Similar results were also found by the National Union of Young University Hospital Doctors (ISNCCA) which carried out a national study in November 2010 in order to identify the expectations of young doctors in terms of employment opportunities. This will help the union compare these expectations to the current situation, and make proposals that will diminish the gap between these expectations and reality (if such gap were to be identified from the survey results). Although the full results of the study were not available at the time when this report was written, we were able to obtain the five top factors that influence the decision of young doctors when choosing their location.

When asked 'what factors determine the choice of professional location?', the survey respondents ranked these factors as being most important:

- The quality of life provided by the region (43% consider this to be very important)
- The career opportunities of the partner/spouse (43% consider this to be very important)
- The quality of team work (42% consider this to be very important)
- Access to public services (39% consider this to be important)
- Proximity to a hospital (38% consider this to be important)

We also had the opportunity of interviewing the presidents of the body representing the medical personnel from three hospitals, two from the NPDC region and one from the PACA region. This body defines (in accordance to the objectives determined by the administrative supervisors and the hospital general manager and overall directorate) the medical project of the hospital, organizes the medical activities undertaken by the institution and defines the strategy forward to ensure the quality of the care provided. We therefore asked the presidents to identify the factors they considered to play a important role in the decision process of doctors when choosing the area of settlement to exercise their profession. The quality of life provided by the region, along with public infrastructure and access to schools, hospitals, transportation, cultural and recreational activities, along with the career opportunities of the spouse were stated as being the most influential ones.

The vice-president of the French National Association of Medical Students (ANEMF) was also interviewed for the micro study. With regard to the choice of settlement, he declared that most

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185 ONDPS – Observatoire National de la Démographie des Professions de Santé
186 Inter Syndicat National des Chefs de Clinique Assistants des Hôpitaux de Ville de Faculté (ISNCCA)
187 « Quels facteurs seront déterminants dans le choix du lieu de votre exercice ? »
young doctors prefer to settle in areas that offer them a good quality of life, such as Ile-de-France, Provence-Alpes-Côte d’Azur, Languedoc-Roussillon, and Rhônes-Alpes. The geographic setting (access to the mountains or to the sea), and access to cultural activities and existing infrastructure (public services including transportation and schools, etc.) play a major role in their decision where to settle. Most medical students, as they finish their studies later than students in other fields, tend to be in a relationship at the time of graduation. As a result, the professional opportunities of the partner are also taken into consideration. Furthermore, most young couples take into consideration the conditions offered by the region to raise a family (i.e. access to school and extra-curriculum and cultural activities, transportation, etc.).

This was further emphasized by an official from the National Observatory of the demography of health professions (ONDPS)\(^{189}\) who validated the importance of these factors, and further stated that in order to attract doctors to a certain area, the region needs to also attract other professionals fitting within the same socio-economic category to settle. This allows the creation of social links between individuals of the same socio-economic category. Furthermore, as the location is chosen jointly, the partner's access to social networks along with professional opportunities also affect the choice of the final location.

Lastly, the presence of University Hospitals should not be forgotten. University hospitals attract the 'best and brightest' health professionals, which in turn also attract liberal practitioners, as they want to have access to the best medical teams and specialists. Therefore university hospitals within the regions can have an impact on the health human resource organization within a region. From the interviews carried out in the Nord-Pas-de-Calais region, it was clear that the Lille University Hospital plays a major role in the human resource organization in the region. It was not as clearly stated during the interviews carried out in the PACA region. However, this does not mean that the university hospitals Nice and Marseille do not have a similar impact and implication in the planning and structure of the human resources.

The Lille University Hospital is aware of the recruiting difficulties encountered by the other hospitals in the region and therefore wishes to play a significant role in the region. In the NPDC region, the Lille University Hospital has set up a part-time programme with other hospitals for the region, whereby newly graduated students sign up for a two year training program whereby their time is shared between the Lille University Hospital and another hospital within the region. During the first year, they spend 80% of their time at the Lille University Hospital, and 20% in another hospital within the region; the second year, they share their time equally between the two institutions (50% - 50%), and during the third year they settle permanently in the second institution. This shared program allows for a gradual and smooth transition for both students and the receiving hospitals.

The Lille University Hospital also wishes to set up partnerships with other hospitals which have difficulties attracting doctors. For example, by allowing doctors to work in two institutions at the same time (e.g. Lille University Hospital and a smaller-size hospital such as Boulogne-sur-Mer), doctors won’t have the impression of being isolated and “stuck” in one place and will more likely accept to work in small-size hospitals located in overall ‘unattractive’ towns. Furthermore, the hospital wishes to give young doctors, who settle in small-size hospitals within the region, the possibility to continue their training at the Lille University Hospitals. For example, they could come to Lille once a week to learn a certain technical act, and practice the rest of the time.

Although the Lille University Hospital is not required to be as implicated as we have seen above, we can notice that it plays a major role in the planning and organization of human resources in the NPDC region. We can also wonder why during the interviews we did not sense the same type of implication for the university hospitals located in the PACA region. One reason that could explain this is the ‘attractiveness’ of the region itself. As mentioned previously,

\(^{188}\) ANEMF – Association Nationale des Etudiants en Médecine en France
\(^{189}\) ONDPS – Observatoire National de la Démographie des Professions de Santé
the PACA region is considered to be an overall attractive region, containing several poles of urban areas with large hospitals. On the contrary, the NPDC region is considered to be an overall unattractive area containing one major pole of attraction, Lille. Therefore, it could be implied that the Lille University Hospital has a great responsibility and needs to play an active role in the organization of care within the region. However, a second very important reason has to do with the dynamism of the respective university hospitals. The Lille University Hospital wishes to become a center of excellence for Northern Europe. This project started in 2006 and aims to be achieved by attracting 'the best and the brightest' medical professionals from all over Europe via exchanges and research facilities. Therefore, it seems ‘natural’ that other hospitals in the region benefit from the positioning of the university hospital.

5.2.2.4. Factors that define the appeal of an employer in the eyes of young French doctors

Young doctors want “security”. This statement was made several times during the interview with the vice president of the French National Association of Medical Students (ANEMF). It refers to the desire of young professionals to be employed by hospitals, rather than exercise as liberal practitioners. The liberal practice is associated with the fee for service method of payment, working long hours, administrative and secretariat burdens and tasks, and isolation: “One of the biggest fears of young doctors is to set up practice and feel isolated”. Throughout their training, young doctors have always been part of teams, so it very difficult to find themselves in an isolated area with no access to other medical professionals. This is the reason why many of them work as replacements before deciding to set up their own practice. According to the National Council of the Order of Doctors, among practitioners who choose to practice as replacements for liberal practitioners, 32% declared not wishing to open their own practice. The main reasons that drove doctors not set up their own practices are the following: cumbersome administrative aspect (79%), the feeling of loneliness (53%), shifts and on-call duties (50%), and the companion’s profession (36%).

On the other hand, practice conditions such as an adequate human resources support in a medical team, access to a medical team, reasonable on-call schedule, administration flexibility, financial security and attractive wages (usually offered by the private sector), the presence and access of different specialists, and working within a team are associated with the conditions offered by hospitals. These working conditions are very appealing to young medical professionals, who mainly opt to be employed by hospitals. However, hospitals are not equally attractive. According to the Director of Medical Affairs of the Nice University Hospital, the factors that make a hospital attractive are: a high level of training and skills of a medical team, state of the art equipment, a good working environment, a manageable workload, balanced and coordinated shifts and on-call duties, financial compensation, and the location of a hospital.

Two proposed solutions were made by the vice-president of ANEMF in order to attract young doctors to settle in remote areas and to practice as liberal practitioners: group practice, such as the maisons de santé, and the mixed mode of practice. According to the interviewee, both solutions enable doctors not to feel isolated. The group practice allows them to feel part of a team, have access to other specialists, and share overhead costs. In a group practice, the administrative and secretariat tasks are taken over by an assistant thus enabling the doctor to focus on this medical profession. In addition, the mixed mode of practice whereby the doctor is employed by a hospital, but also works as liberal practitioners (having the status of ‘praticien attaché’) allows the doctor not to feel isolated, giving him access to a medical team. Furthermore, the “employed” status also offers the doctor a certain financial security which is not guaranteed by the liberal practice.
5.2.2.5 The recruitment means deployed by hospitals

From the interviews carried out with the public hospital managers in charge of medical affairs in the Nord-Pas-de-Calais and Provence-Alpes-Côte d’Azur regions, we were not able to observe any major differences in the recruitment means deployed by the public employers of the two regions. All hospitals used very similar recruitment means: referrals made by doctors already working in the hospital, recruitment agencies, increasing the number of recruited interns, job postings, partnerships with other regional hospitals, agreements with foreign countries and recruitment of foreign doctors.

### Table 13 – Recruitment means used by hospitals

<table>
<thead>
<tr>
<th></th>
<th>Lille</th>
<th>Boulogne-sur-Mer</th>
<th>Valenciennes</th>
<th>Sambre-Avesnois</th>
<th>Digne</th>
<th>Orange</th>
<th>Hyères</th>
<th>Marseille</th>
<th>Nice</th>
<th>Briançon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal referrals</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Recruitment agencies – permanent positions</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Recruitment agencies – interim</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Increased number of students/interns</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Job postings</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Partnerships/collaborations with other hospitals from the same region</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agreements with foreign countries</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recruitment of non-EU doctors with valid diplomas</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Recruitment of non-EU doctors with non-validated diplomas</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Recruitment of Eastern European doctors</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recruitment of other EU doctors</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As we can see from the table above, the most common means of recruitment for all hospitals is through referrals made by the doctors working in the respective hospitals. All the hospitals which were interviewed declared that this is the means that they mostly rely on. It is also the preferred means because doctors recommending other doctors is supposed to guarantee a successful match. Furthermore, during the interviews, it was also noted that the “reputation” of certain doctors will also have an impact on attracting other doctors of equal reputation. Recruiting a certain doctor with a good reputation in one specialty usually leads to having a strong medical team in that particular specialty. However, it should be pointed out that large hospitals are the one which are mainly able to do this, as they tend to attract the “best” medical professionals.

Most hospitals which were interviewed did not declare using recruitment agencies for permanent recruitments. However, hospitals encountering recruitment difficulties in certain areas (specialties) also frequently employed temporary placements recruitment agencies. Overall, throughout the interviews, most hospitals considered this means to be very expensive as these interim recruitment agencies charge a service fee for each placement in addition to an already high fee for the locum doctor. For example, two hospitals located in the PACA region declared paying expensive fees raging between 600 and 1000 euros per day in order to obtain locum doctors in addition to search fees paid to the interim agencies. A university hospital within the same region also declared finding the fees too high in comparison to the work quality provided by the locum doctors. According to this hospital, the professional diligence of a locum doctors does not match that of a doctor hired on a permanent basis. This opinion was shared by several other hospitals within the same region. Some hospitals also pointed out that some interim agencies do not check the professional qualifications of the locum doctors they hire, and therefore one of the interviewed hospital found itself in a situation where the locum doctor did not know how to deal with a fairly basic emergency situation. In conclusion, the overall impression of most of the interviewed hospital was that of disappointment between the expenses encountered in hiring medical professionals on a temporary basis and the received professional satisfaction.
However, it would be unfair to omit successful placement examples. Several hospitals declared having built successful relationships with interim agencies. This is the case for two medium size hospitals located in the PACA region and one medium-size hospital in the NPDC region. All three hospitals work with the same recruitment agency. The agency seems to do strict screening of the replacement doctors it hires with regard to their diploma and qualifications, as many of the locum doctors are foreign. At the end of each placement, the agency also asks the hospital to evaluate the doctor. If the locum doctor that does meet expectations, the agency no longer matches that doctor with the same hospital. However, the main reason behind their positive experiences is due to the fact that most of the doctors used become ‘regular’ replacement doctors. For example, one of the hospitals declared employing the same locum doctor on a monthly pre-defined period on a regular basis. Having the same doctor work in the hospital for a recurrent period of time allows for a relationship to building with the other doctor and a follow-up with a patient. The question that could be asked here is whether or not these hospitals would rather prefer to permanently hire foreign-trained doctors instead of having locum doctors.

5.3 The migration process

5.3.1. The demographic profile of foreign doctors including both EU and non-EU doctors

According to a 2010 study carried out by the National Council of the Order of Doctors, in January 2010, there were 10,165 foreign doctors (including both EU and non-EU nationalities) registered with the National Council of the Order of Doctors. This figure shows that the number of foreign doctors in France has increased by 20.6% in three years. As it will be discussed later on in the report, this is mainly due to a large wave of mobility of doctors coming from Eastern European countries, mainly Romania, which took place after the last two EU enlargements. Currently, foreign doctors represent 4.7% of the total number of doctors registered in France. In terms of new registrations, in the year of 2010, 880 doctors registered with the Order for the first time. A third of newly registered doctors are of Romanian nationality, followed by Belgians and Italians. It should be noted that the number of doctors from Northern African countries, who have been traditionally represented in the top three nationalities has significantly decreased in the past 11 years. Today, they only represent 12.1% of new registrants come from North African countries, in comparison to 45.6% in 1999. A reminder needs to be made with regard to the term ‘foreign’ as defined by the National Council of the Order of Doctors. The terms refers to the nationality of the individual, and does not necessarily reflect the country that delivers the medical diploma. Furthermore, it is not clear whether a foreign-born doctor who has obtained the French citizenship is assimilated into the statistics concerning the French medical cohort, or whether he remains, for statistical purposes, in the foreign category.

Among the foreign doctors registered with the Order, 64% of them possess the citizenship of a European Union Member State (6487 doctors). The fact that a large portion of foreign doctors

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191 The term foreign doctors, as defined by the National Council of the Order of Doctors, refers to doctors having foreign citizenship
192 In November 2007, there were 8431 foreign doctors registered with the Order. This is documented in
come from EU countries is also found in the 2008 OECD report examining the health workforce demographics in France. In terms of breakdown by citizenship category, doctors having a Romanian citizenship represent the largest category of foreign doctors (15.4%), followed by Belgians (15.1%), Algerians (10.9%), Germans (9.6%), and Italians (8.4%). If we were to focus on the first three categories, and use the information provided by a report published by the Order (CNOM 2010), we could summarize the following information:

<table>
<thead>
<tr>
<th>Number of registered doctors</th>
<th>Age average</th>
<th>Gender composition</th>
<th>Peaks in the selection of the area of settlement</th>
<th>Area of specialty</th>
<th>Mode of exercise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Romanian</td>
<td>1253</td>
<td>40</td>
<td>71% women</td>
<td>General medicine (321)</td>
<td>84% employed 1.4% liberal 2% mix</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Paris region (highest concentration)</td>
<td>Anesthesiology (118)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nord-Pas-de-Calais</td>
<td>Psychiatry (100)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Lorraine</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Alsace</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rhone-Alpes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Belgians</td>
<td>1228</td>
<td>48</td>
<td>65% male</td>
<td>General medicine (371)</td>
<td>50.6% liberal 42.1% employed 7.3% mix</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nord-Pas-de-Calais (highest concentration)</td>
<td>Anesthesiology (129)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Paris region</td>
<td>Medical imagery (93)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rhone-Alpes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Provence Alpes Cotes d'Azur</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Languedoc Roussillon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Algerians</td>
<td>886</td>
<td>50</td>
<td>75% male</td>
<td>General medicine (298)</td>
<td>74% employed 15.3% liberal 10.8% mix</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Paris region</td>
<td>Psychiatry (67)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Homogeneous distribution throughout the territory without any particular number peaks in any other regions</td>
<td>Medical imagery (65)</td>
<td></td>
</tr>
</tbody>
</table>

Table 14. The three largest categories of foreign doctors and their main characteristics

If we were to analyze this information in more detail, and compare it to data given for French doctors, on average, foreign doctors tend to be just slightly younger than their French counterparts (average age of 46.7 in comparison to 50 for French doctors). The make-up in terms of gender is similar to that of the French. The proportion of foreign women doctors is larger than that of male doctors (59%), and is similar to French doctors (56% of French doctors are women). As mentioned earlier in the report, we are noticing an overall general trend towards the feminisation of the profession. However, it should be noted that between January 2006 and December 2007, the Order witnessed a peak of 236.2% increase in the number of registered women practitioners. This large increase is due to the registration of Romanian doctors, who were mostly female. This wave has been stabilized, as the new proportion of registered Romanian female doctors fit within the average trends (57% female foreign doctors registered in 2007, and 53% in 2008).

With regard to the settlement patterns, the study conducted by the Order also shows that EU and non-EU doctors tend to follow similar settlement patterns as their French counterparts: urban and around high healthcare facility densities. As it was discussed previously in the report, doctors, regardless of their origin, are attracted to urban areas that can offer them abundant employment opportunities, career development, and social networking possibilities to them and their families. Foreign doctors who accept to settle in remote areas tend to do so in the early years of their arrival in France, and only as a temporary option. The settlement patterns and projections of foreign doctors will be discussed later on in the report. However, it should be

noted that according to the CNOM study, the region where foreign doctors settle is very much linked to the country of origin. This can be mainly explained by the existence of migration networks. The existing migration literature on networks\(^{195}\) show that existing migrant networks formed in the country of destination affect the settlement location of newly arrived cohorts. Nevertheless, as it will be explained later on in the report, supply and demand also affect the choice of location. For example, recruitment agencies are currently hiring Romanian doctors to respond to the labor demand of certain regions in the North and Center of France. Therefore, the settlement of the newly hired doctors does not depend much on the existing migrant network, but it responds to a demand. The border effect also plays an important role. For example, 90% of replacement doctors in the Nord-Pas-de-Calais region come from Belgium.

In terms of mode of practice, 28.8% of all registered foreign-born doctors choose the liberal mode of practice, while 64.3% chose to be employed and 7% choose to do both. Most of the newly registered doctors, between January and December of 2009, choose to practice under the 'employed' status. This can be mainly explained by the administrative procedure required to set up practice, along with the non-attractive aspects of the exercise such as heavy workloads. Furthermore, as mentioned previously, the employed status also guarantees a certain financial security. Among the foreign nationalities, Belgians (29.8%) are the doctors that tend to exercise the most as liberal practitioners, followed by Germans (13.4%) and Italians (7.4%). On the other end of the spectrum, Romanians represent the category that exercise the most under the 'employed' status (22.7%), followed by Algerians (11.1%).

With regard to the selected specialties, 33% of foreign doctors are registered as general practitioners. The nationalities that compose this group are:

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Proportion of doctors registered as general practitioners (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgian</td>
<td>21.9</td>
</tr>
<tr>
<td>Maroccan</td>
<td>12.5</td>
</tr>
<tr>
<td>German</td>
<td>9.6</td>
</tr>
<tr>
<td>Tunisian</td>
<td>9</td>
</tr>
<tr>
<td>Romanian</td>
<td>8.9</td>
</tr>
</tbody>
</table>

Among specialists, the nationalities most represented are: Romanians (15.4%), followed by Belgians (15.1%) and Algerians (10.9%). Most foreign specialists tend to settle in Nord-Pas-de-Calais, Lorraine, Alsace, Rhône-Alpes, and Provence-Alpes-Côte d'Azur.

Furthermore, in the first paragraph we mentioned that the number of foreign doctors increased by 20.6% over the last three years. According to the Order, the significant increase in the number of doctors holding a Romanian citizenship has had a considerable impact on the overall number increase. According to the statistics registered by the Order, in 2007 alone, the year of Romania's accession to the EU, the number of Romanian doctors registered with the Order increased by 321%. The table below shows the comparison between the most represented nationalities for doctors in France in 2007 and 2010, and highlights the shift that has taken place with regard to the most representative categories by nationality. It can be observed that in a three year lapse, Romanian doctors went from not being represented in the top five most represented nationality groups to becoming the most represented nationality group.

It can be argued that this shift in the overall nationality make-up is a direct consequence of the enlargement, and therefore the possibility of Romanian health professionals to freely move within the EU, and benefit from an automatic diploma and professional experience recognition. This will be discussed in more detail later on in the report, along with the fact why other A8 countries did not migrate as massively as the Romanian doctors.

5.3.2. Factors determining migration to France

Based on the findings presented in section 4.3 of the report, the information gathered through the qualitative interviews for the case study, and the existing literature on migration, in this part of the report we would like to study the factors that push health professionals, and more specifically, doctors, to migrate to France.

From an economic perspective, people migrate from an economically less developed country to a more developed country in order to increase their economic prosperity. Disparities in wages act as ‘pull-factors’ in attracting migrants to richer countries. ‘Push factors’, such as poverty, unemployment and low wages clearly drive people to leave their countries of origin for new destinations in search of fortune.\footnote{Castles, S. and Miller, M. (1998) The Age of Migration: International Population Movements in the Modern World, 2nd Edition, Macmillan Press} \footnote{Geddes, A. (2003) The Politics of Migration and Immigration in Europe. London: SAGE Publications} \footnote{Vujicic, M. et al. (2004), The Role of Wages in the Migration of Health Care Professionals from Developing Countries, Human Resources for Health, Vol.2, No 3}. In the interviews carried out for the micro phase, economic factors clearly play a significant role. In all the interviews carried out with doctors coming from Eastern European countries (mainly Romania), wages, and other financial incentives and compensations were clearly identified as decisive factors in their decision to migrate. For example, the average salary of a Romanian doctor is 400 euros; by coming to France, his salary is likely to be ten times as high. Although living expenses are higher in France than in Romania, his purchasing power and living standards increase in France. Furthermore, the economic crisis forced the Romanian government to reduce public spending, and there cut public employees salaries (including doctors) by 25%. In addition, in order to fulfill EU requirements the government also implemented measures to combat corruption. As a result, a law was passed in 2010 penalizing health officials who accept unofficial payments for their services. These combined measures directly affect the financial situation of doctors, who not only experienced official salary cuts but also additional unofficial payments which partly compensated for the low salaries.

<table>
<thead>
<tr>
<th>Proportion of foreign-born doctors in 2007 broken-down by nationality (total number of registered doctors: 8431 doctors)</th>
<th>Proportion of foreign-born doctors in 2010 broken down by nationality (total number of registered doctors 10 165 doctors)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgians 17%</td>
<td>Romanians 15,4%</td>
</tr>
<tr>
<td>Algerians 15%</td>
<td>Belgians 15,1%</td>
</tr>
<tr>
<td>Germans 11%</td>
<td>Algerians 10,1%</td>
</tr>
<tr>
<td>Marocans 10%</td>
<td>Germans 9,6%</td>
</tr>
<tr>
<td>Italians 8%</td>
<td>Italians 8,4%</td>
</tr>
</tbody>
</table>

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It was observed from the interviews that the health professionals who decide to migrate, not only seek economic prosperity for themselves, but also for their family. The overall well being of their families, and more specifically, the possibility of offering their children better living conditions and “opportunities in life” was also systematically stated throughout the interviews. It should also be noted that the impact of wage differentials in the decision to migrate was not directly stated during the interviews with doctors coming from Maghreb countries. However, offering a better life to their children and helping their families who stay back home were declared to have played an important role. For example, an Algerian doctor living in Aix-de-Provence declared that although she has not been able to validate her diploma and practice in France, she is glad to have come to France so that she can offer her three children “living conditions and professional opportunities” that they could not have in Algeria. Given the fact that she cannot exercise her medical profession, she does temporary odd-jobs to support her family, as she has not been able to obtain a permanent working visa which would allow her to find full-time employment. Furthermore, the Romanian doctors which were interviewed also declared that by working in France, thus earning a higher salary, they would be able to help their parents and relatives who stay back home. As a result, we can observe that the economic factors not only impact the individual who makes the decision to migrate and his immediate family who accompanies him, but also family members who stay behind. Although the amount of remittances sent back to the family was never stated during the interviews, it is to be hypothesized based on the existing literature199 that remittances also impact the economy of the country of origin. It was also noted that among the Romanian doctors who were interviewed, senior and young professionals did not have the same incentives to migrate. Young doctors seemed to be more willing to migrate than did senior doctors (over 45 years of age). The senior doctors who were interviewed declared that their situation in Romania, although not considered to be “great” provided them with a satisfactory lifestyle. Therefore, when considering the prospect of migrating to a new country, the decision was more difficult to make because they benefited from an “established situation” in their country of origin. Moving to a new country entails adapting to a different system, and therefore, at least in the beginning, accepting to be treated as a ‘novice’ by the doctors who are already established in that country and institution. The doctors who made this statement backed their argument by giving examples of colleagues who returned home after an experience abroad. Their colleagues were not able to adapt or did not wish to “start from scratch” in a new country and medical establishment. This issue was further highlighted by the Paragona recruitment agency, which encountered three situations whereby senior Polish doctors who had decided to migrate to Sweden, moved back to Poland after several months because they could not accept being treated as “beginners’ by the other Swedish doctors. Overall, we can state that the economic prosperity and higher wages offered by EU-15 countries200 can act as a pull-factor in attracting doctors from A8201, EU-202 and non-EU countries. Although we cannot make a general comment, and the impact would require to be studied for each specific case, we could forward the hypothesis that the higher the wage differentials, the higher the impact and attraction of health professionals to richer countries. However, wage differentials are not the only factor that affects the migration process. Surveys exploring health workers’ reasons to migrate also identify improved working conditions, better living conditions, and career opportunities to also play a major role in the decision to

200 EU15: Austria, Belgium, Denmark, Germany, Greece, Finland, France, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, and the United Kingdom
201 A8 countries: Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, and Slovenia
202 EU-2: Romania, Bulgaria
Almost all interviewees declared that France offers them better and safer working conditions than their home countries. This affords them the opportunity to focus on their vocation, medicine, and improve their skills as a doctor, and carry out their most important duty, caring for patients. Furthermore, their long-term career advancements and opportunities were also seen as more positive in France than in their home countries. For example, three Romanian doctors (two who are currently practicing in Romania and one who has recently moved to France) highlighted the fact that the lack of equipment and consumable materials prevents them from carrying out their duties within the hospital. They stated feeling “tired” of having to struggle to obtain access to certain equipment or “embarrassed” about asking patients to bring in consumables necessary to care for them. The lack of opportunities for continuous education and continuous career development were also stated as elements of discontent. Lastly, the dismay of a corrupted health system was also brought up in several interviews. One doctor gave an example of how hospital funds are misused in the hospital that employed her in Romania. Her unit decided to purchase an additional scanner than cost a given sum. However, the hospital director, the unit administrator and public figures involved at the municipality level registered the cost to be twice as high as the actual cost, and the differential was divided between the three officials. She gave this example to illustrate the fact that funds do exist in hospitals, but they are inappropriately and unlawfully used, leaving units without any funds for consumables for patients. She furthered declared that she wishes the entire health system would collapse in order to send a signal to the Ministry that there is need for change.

One factor that was not highlighted by Eastern European doctors during the interviews, but was pointed out in most interviews conducted with doctors from Maghreb and African countries, is the role university exchanges, specialization training and professional development programs play in the migration process. Many of the interviewed doctors arrived in France via these programs, and decided to stay in France once already present in the country. Besides highlighting the fact that educational and professional training programs also play an important fact in the migration process, it also underlines the fact that a decision can be made either prior to embarking into the migration process or once already present in the host country.

However, it would be simplistic to assume that individuals migrate either due to increasing opportunities or based on a rational comparison of the relative costs and benefits. Factors such as historical and cultural ties also explain migration movements (Castles and Miller 1998, p. 23). For instance, James Hollifield has argued that networks, civil, political and social rights of immigrants in the host society, and shifts in public opinion also play a major role in sustaining migration flows, regardless of economic cycles. As a result, migratory movements can be explained by state relationships, historical ties established between sending and receiving countries, and interactions between social networks developed by migrants (Castles Miller 1998).

Most interviewed doctors coming from African countries knew at least one person from their home country who already lived in France prior to embarking in the migration process. The information obtained by talking to their fellow countrymen, and the experience of these individuals, along with their impressions affected the interviewees’ wills to migrate. Later on in the report, we will illustrate the importance of the migrant networks in the search for employment. Also, most of the interviewees underlined the cultural and historical ties between their home country and France. For those interviewees that came from Algeria, they highlighted

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203 Vujicic M., Zurn P., Diallo K., Dal Poz M., The Role of Wages in Slowing the Migration of Health Care Professionals from Developing Countries. Human Resources for Health, 2004;2:3
the fact that they felt very close to France because they used to be a colony, and their country’s history was connected to France’s history. They further stated that this factor enabled them to easily adapt to the French lifestyle and feel “at home”. Lastly, the fact that they spoke the language also played a significant role in the decision to move to France.

For individuals coming from Eastern Europe, cultural ties also played an important factor. For example, the Romanian doctors who were interviewed declared “feeling close” to France because Romania is considered to be a Francophone country. Starting the end of the XVIII century, many writers, artists, and politicians studied in France or wrote their works in French. Furthermore, at the beginning of the XX century, many doctors did their medical training in France, and the medical universities were shaped around the ‘French model’. This allowed for exchanges and for the terminology used to be influenced by the French language. Most interviewees also declared speaking at least some French before coming to France, but they also stressed the facility that they have in learning it due to the fact that Romanian is a Latin language.

However, the role of the EU legislation and more specifically, the automatic and mutual recognition of educational and professional credentials granted by the EU directive 2005/CE/36 plays in the mobility of health professionals coming from A8 and EU-2 countries. It is the accession of these countries that has enabled medical professionals to settle and practice in France. Without this effect of the EU enlargement, most doctors from A8 and EU-2 countries would not have been able to benefit from such freedom of mobility and settlement. Consequently, the immigration peak of Romanian doctors, which has been witnessed for the past three years, would have had a very limited chance of happening.

In summary, the interviews conducted for the case study allow us to conclude that the most important factors stated to have influenced the decision to embark in the migration process are the following:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Doctors coming from EU countries</th>
<th>Doctors coming from non-EU countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wage differentials and possible economic prosperity</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Better living conditions (including those of the family, especially children)</td>
<td>X</td>
<td>Relevant for all EU countries and EU-2 countries</td>
</tr>
<tr>
<td>Ability to financially help or support family members or relatives in the home country</td>
<td>Relevant for all EU countries and EU-2 countries</td>
<td></td>
</tr>
<tr>
<td>Rejection of a corrupted health system</td>
<td>EU-2 countries</td>
<td>Not declared during the interviews</td>
</tr>
<tr>
<td>Better professional and career development opportunities</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>The ability to speak or quickly learn the language</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Historical or cultural ties</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Migrant network</td>
<td>Not declared during the interviews</td>
<td>X</td>
</tr>
<tr>
<td>University and/or training exchange programs</td>
<td>Mentioned during only two interviews</td>
<td>X</td>
</tr>
<tr>
<td>Credential recognition including diploma and professional recognition</td>
<td>X</td>
<td>No</td>
</tr>
</tbody>
</table>

Table 15. Factors for migrating to France

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5.3.3. Factors determining the choice of the region and place of settlement of foreign doctors

In this section of the report, we will study the factors that most affected the choice of the interviewees when deciding where to settle. Before we examine the factors, it should be noted that the number of interviews which was carried out, along with the fact that the nationalities of the those who were interviewed are not representative of the make-up of all foreign doctors in the two respective regions. Therefore, the results described below should not be generalized and applied to all medical professionals who settle in the two regions. Further investigation including a region-wide survey would be necessary to draw any general conclusions.

Most doctors interviewed in the Nord-Pas-de-Calais region came from Eastern Europe, and declared that their decision to move to this region was very much linked to the job placements that the recruitment agencies offered them. Before coming to France, most of them had wanted to move to Paris, as Paris holds a special place in the image they had of France. As a side note, it should be mentioned that their image of Paris was shaped by movies, photos, books, and stories they heard of France, as most of them have never actually been to Paris prior to arriving in France. However, before making the final decision to move that Nord-Pas-de-Calais, most had a possibility to visit the place where they would live and work. This allowed them the possibility to make sure that they would not feel isolated, as for most of them, this represented a major concern. The majority of the doctors interviewed came from urban cities in Romania, and were employed by hospitals. As a result, they wanted to make sure that they lived or had easy access to urban surroundings. During the interviews, they stressed the fact that they needed to be able to develop a social network, have access to stores, recreational and cultural activities, and transportation. Furthermore, the age of the Romanian doctors who were interviewed was young; as a result, those who had small children or those who planned on having children also made sure they would have access to schools. The interviewees also inquired about other Romanians living in nearby areas. The possibility of contacting people having a similar background also represented an important factor in the decision-making process.

Furthermore, it should be noted that the doctors interviewed in the NPDC region had all been employed by hospitals in their respective countries. Consequently, they wished to continue being employed by hospitals. There are two main reasons behind this request: as newly immigrants they did not wish to feel isolated, so working in a hospital provided them the opportunity to feel part of a team and develop relationship with colleagues. Second of all, some feared that by working as liberal professionals they would not have a steady income. Some stated that it takes time to build a loyal clientele, especially for immigrant doctors.

Without generalizing, from the interviews that were carried out in the Nord-Pas-de-Calais region, we noticed that having access to a network, be it social or professional, represent a crucial factor in a doctor's decision to settle in an area, regardless of that doctors origin (French or foreign-born). The migration process of a Romanian doctor illustrates this very well. She first arrived in France through an employment offer in a hospital in Saint-Malo, the Brittany region. However, her stay turned very short when she started feeling isolated. In the hospital where she worked, she did not have a sense of “being welcomed and wanted” by her colleagues. As a side note, she states that when reflecting back that feeling might have come from the difference in the work place environment between France and Romania. In Romania, she declared being used to a “true camaraderie” between co-workers. She referred to her colleagues as “family”. Her experience in France was much different. It should also be noted that she worked for fifteen years in the same hospital in Bucharest, and only three months in the one in Saint-Malo. In addition, the fact that she did not speak the language also prevented her from properly and fluently communicating with her colleagues, thus building relationships. In the hospital and in the city, she was not able to find any other Romanian speaking people. Furthermore, she declared finishing work around 6-7 pm, and everything would be closed. She was also not able to sign up to any cultural activities which could have helped her feel more integrated into the local social life. As a result of all these factors, she felt “lonely” and decided to return to
Romania after only three months. She did not, however, reject the idea of returning to France. Just recently in September 2010, she accepted a position at the Lens Hospital in the NPDC region. However, before accepting this job offer, she made sure she had access to other Romanians, and there would be plenty of activities so that she would not feel isolated. She declared being “very selective and demanding with her employer”, as she wanted to make sure that her experience in Saint-Malo would not reproduce itself. For this reason, before accepting the position, she spent a couple of days in her unit and met with everyone in order to make sure that she would feel comfortable with and “welcomed” by her future colleagues.

Consequently, we could conclude that from the interviews conducted in the NPDC, the first factor that played a major role in the settlement decision was the employment offer, but afterwards, the urban settings, and everything that they entail (opportunity to create social networks and access to established migrant communities) also played a major role in the decision-making process.

For the Provence-Alpes-Côte d’Azur region, the doctors interviewed in this region came mostly from North African countries. The large majority declared that they had known someone already living in the place where they settled, and this fact played a major role in their decision to settle in that area. Some also added that knowing that there is a large community of individuals from their home country also affected their settlement decision. Among those who declared that they had known someone already living in the region, family ties or marital ties were often cited. A quarter of the interviewed individuals stated that they settled in the place of residence of a family member or a future spouse. For example, a Chinese doctor met her husband during a holiday in Mali, and when her husband decided to move to Marseille, she followed him. She declared not knowing much about France, and about the possibility to have her medical credentials recognized, but following her husband seemed natural. Some of the other doctors who were interviewed declared arriving in France and settling in the PACA region thanks to the university or training exchange programs in which they participated.

For the doctors interviewed in the PACA region, which were mainly non-EU trained doctors, it seems that migrant communities, personal ties and relationships played a major role in their decision to settle in the region. Furthermore, institutionalized exchange programs also enabled some of them to discover the region, and decide to stay in France. We have seen the same means be used by hospitals which attract interns to allow them to familiarize themselves with the region, which can afterwards influence them to settle in the same region.

In conclusion, we can notice from the two regions, that besides the quality of life a certain region can offer, social networks which include migrant communities, personal and family ties, and professional relationships play an important role in the settlement process. Human ties which are existent prior to settlement or which develop once an individual settles in a place affect one’s “loyalty” towards an area.

### 5.3.4. The experience of foreign doctors in France

The interviews conducted during the micro phase of the study do not allow us to make accurate regional comparisons. However, we can state that overall it seems that non-EU doctors encountered more difficulty in settling in France than did their European counterparts. This is largely due to the cumbersome administrative procedures to obtain visas and work permits, and to have their diplomas and professional experience recognized. Some of the interviewed doctors declared that during the first several years after their arrival in France doctors they enrolled in university courses just to be able to obtain a student visa “carte de séjour – mention étudiant” and stay in France. For example, an Algerian doctor who arrived in Aix-en-Provence in 2003 with a student visa, has been obliged to keep enrolling in school ever since just to be able to obtain a visa and legally reside in France. Last year, she asked for a work permit, but it was
refused. At the moment she resides illegally (with no visa) in France as she has three children who are enrolled in school, and struggles to support her family by doing odd jobs for which she is not declared to the authorities. Next fall she plans to enroll in a university program once again to obtain a student visa. Another example is that of an Irakian doctor who arrived in France in 1996 as a student. He too renewed his student visa six times before marrying a French citizen and obtaining a permanent resident card.

In addition to immigration related difficulties, the process required to validate their diploma was qualified by the doctors who were interviewed as being long, difficult and laborious (for information on the recognition of non-EU qualifications, please refer to section 3.2.2 page 78). First of all, there seems to be a lack of information available to them when they first arrive in France. This was mentioned several times during the interviews. The doctors who were interviewed declared that when they first arrived in France, they could not identify a body which would inform them of the different steps of the validation process. This was especially difficult for doctors who did not live in large cities. For some of them, this resulted in the loss of several years because they were not aware of their rights. Almost all agreed upon the fact that it takes a lot of patience and courage to go through the process of diploma validation and recognition. For this reason, some of the interviews declared necessary to join a union representing the interests of non-EU doctors. Being part of a union allows them to be informed of the procedure and their rights. The president of the union representing non-EU doctors (FPS) confirmed that fact that he meets many doctors who turn to him because they are lost in the administrative 'mayhem' that represents the diploma recognition process. He also stated, on a personal note, that it took him 15 years in order to sort out his situation and obtain the full rights to practice in France. He further underlined the fact that this length of time is not unusual.

The president of the FPS Union also stressed the fact that the administrative hurdles for both immigration and diploma recognition will tend to dissuade doctors from coming to France in the future, pushing them to choose other countries such as Canada, United States and Australia as their destinations where the migration and professional recognition procedures are not as long and complicated. Although the following observation needs further investigation, we can notice that since 1999, when the legislation prohibited the appointment of any new non-EU qualified physician (although recruitments of non-EU doctors have taken place since this date), the number of North-African doctors, who traditionally represented one of the largest categories of new foreign registrants in France, decreased significantly. For example, in 1999, new registrants coming from Northern-African countries represented 45.6% of all foreign registrants, while today they only represent 12.1%. However, these figures should be read and interpreted with caution as many North-African doctors obtain their French citizenship before registering with the Order.

Furthermore, some interviewees declared that had they known that it was going to be so difficult, they would not have migrated to France. Although some stated having considered going back home at one point, this option became impossible once they had children who were born in France or created strong social links. It should not be forgotten that some of the doctors left everything behind in their home countries in order to be able to immigrate to France. For example, an Algerian doctor declared wishing to return to her home country. She deeply regretted migrating to France, as she had not obtained the right to exercise her profession. However, two out of her three children were born in France, and grew up and were enrolled in school. France was their home country. Consequently, it was impossible for her to take them away and bring them to a country which represented her home country, but was foreign land to her children. This example illustrates the fact that despite the difficulty of a migration process, the bigger the initial investment (leaving family behind, selling property, leaving professional placement), and the longer the stay in the host country, the more difficult it is to return to the

country of origin or to move somewhere else. This option becomes even more complicated if children are born and raised in the host country. As mentioned previously, social ties that are built in the host society can have a powerful effect on rooting an individual in a specific place. As a result, during several interviews it was stated that they had no other choice but to “make it” in the host country, so they to fight and “armor themselves with patience”.

Furthermore, a high level of frustration and injustice was expressed during the interviews by non-EU doctors. The frustration of most non-EU doctors interviewed was linked to the fact that Eastern European doctors have their qualifications automatically recognized. On average, the non-EU interviewees consider themselves to be better trained, and have better language capacities than Eastern European doctors. This frustration was also expressed by the president of the FSN as he stated that non-EU doctors have a better reputation in hospitals [than do Eastern European doctors] as they are better trained and have better language skills. As a result, the non-EU doctors who were interviewed found unjust granting automatic diploma and professional based on a country’s membership to a supranational body.

For the Eastern European doctors that were interviewed, the experience was much different. Thanks to the EU directive 2005/CE/36, they were able to obtain their diploma recognition very easily. No one has mentioned encountering any difficulty during the process. Furthermore, as most of them were recruited via agencies, they had the possibility to come and visit the place where they settled prior to making their final decision. It is important to highlight this fact because this gives them control over their decision to accept or not the position and puts them in a favorable position vis-à-vis their employers. This situation is much different from the one experienced by non-EU who have to sometime accept positions such acting as interns. Furthermore, in some cases, the hospital that hires them takes care of all immigration administrative procedures, such as obtaining a visa. For example, a hospital in the Nord-Pas-de-Calais informed us that five years ago, it went out of its way to welcome a Polish doctor. All the administrative procedures for him and his family were taken care by the hospital, along with the enrollment of his child in school. The hospital also paid for language classes for the entire family, and assisted the doctor’s wife to find a position in her field. Similar examples can also be found in newspaper articles. Eastern European doctors are brought into small towns that encounter difficulty hiring French doctors, and the city hall makes all necessary arrangements to suit the needs of the newcomer. These arrangements include providing them with a facility to exercise their profession (cabinet medical), to finding housing, enrolling their children in school, etc. For example, a small hospital in the NPDC declared having made all the necessary arrangements including administrative arrangements to obtain visas for the entire family, the temporary rental of an apartment, and the enrollment of the doctor’s children in school just so a Polish cardiologist would agree to work for the above mentioned hospital. Another example found in the media also shows that sometimes despite all efforts, foreign doctors decide not to stay. For example, a Romanian doctor was hired by a village in the Pyrénées region. The mayor offered to pay the rent for her office during nine months, along with six months for her rent. He also helped her obtain the required work permit. Despite all these efforts, the doctor chose to settle elsewhere just one year after her arrival208.

In summary, we can conclude that the EU legislation facilitates the mobility and migration process of doctors coming from EU countries, allowing them easily settle and practice their profession in France or anywhere else within the EU. This is not the case for non-EU doctors who struggle in order to obtain the necessary work permits and the right to practice in France.

208 Article found on http://lcifr.fr/france/societe/le-medecin-prend-la-fuite-le-village-se-revolte-5917823.html consulted in December 2010
5.3.5 The experience of foreign doctors during the job search

The interviews that were conducted enabled us to identify two different factors that play a significant role in the job search process for Eastern European doctors and non-EU doctors. Once again, a regional comparison cannot be made; however, a distinction between the experiences of EU and non-EU nationals exists.

As mentioned previously, recruitment agencies played a major role in the recruitment process of Eastern European doctors. Most agencies have offices open in Easter European countries and hire doctors directly in the country of origin. This is the case for an agency that we interviewed for the case study. It is a Swedish agency that started recruiting for French hospitals in 2009. It has a training campus in Poland and recruitment offices in Romania. For example, a Romanian doctor who wishes to work in France will first go through a two day evaluation where his credentials are evaluated by doctors from Romania and the receiving country. In addition, his aptitude to learn a new language will also be tested, along with his motivation to emigrate. Once he passes this stage of the recruitment process, and before he is placed in a French hospital, he goes through four months of training on the campus based in Warsaw and via the internet. The training consists of intensive language classes, and information sessions about the receiving country including professional differences he will encounter in a French working environment. During this time, both the employer and the potential employee have a chance to meet to further explore the potential success of the match. In the near future, the agency wishes to set up partnerships with university hospitals in regions encountering difficulty recruiting doctors in order to train and prepare Eastern European doctors for their future employment with smaller size hospitals within the same region.

In addition to recruiting Easter European doctors via specialized agencies, forums are also organized in the countries of origin. For example, there is a large recruitment forum, qualified as the largest health recruitment forum in Europe, that takes place in several large Romanian cities once a year. These types of forum allow recruitment agencies and interested medical professionals to meet directly and discuss employment opportunities abroad. Furthermore, agencies also recruit directly on university campuses. Once a health professional showed an interest in an employment opportunity, it is the agency that leads the process and makes the necessary arrangements for job interviews and administrative requirements.

For the non-EU doctors who were interviewed, it is the existing migrant network, and more specifically doctors of the same nationality already practicing who played a major role in their job search process. Most of the interviewees declared having found their position by knowing another doctor coming from their home country. The role of professional migrant networks was also confirmed by the Union representing foreign doctors (FPS). The reason behind this mode of recruitment is linked to the fact that doctors from a particular country who are already have a position have the ability to evaluate the degree and experience of the individual seeking a position; the foreign doctor can better evaluate the candidate than a French employer because he is more familiar with the requirements to obtain the degree in the country of origin or the quality of that degree. This method of recruitment was also mentioned by the Directors of Medical Affairs, in charge of hiring in French hospitals. Although hospitals have implemented other recruitment means (please see section above, xxx) they do heavily rely on this aid from foreign doctors when they are recruiting for position where French-trained doctors are unavailable or uninterested.

From the examples above, we can notice that for Eastern European doctors, recruitment agencies play an important role in the recruitment process, whereas professional migrant networks seem crucial to non-EU doctors in their employment search and recruitment. However, this does not mean that professional migrant networks will not play as much of a role for Eastern European doctors as it does for non-EU doctors at the moment. The migration of Eastern European doctors is much more recent, and the development of professional migrant networks is still very young. In the future, if Eastern European doctors will continue to migrate,
we might notice the rise in the importance of migrant networks and the decrease of that of recruitment agencies for Eastern European doctors as well. The observation that has been made in this section of the report is only relevant to the current time frame.

5.3.6 The perception of foreign doctors by their French and foreign peers, hospital administrations and patients

When foreign doctors including EU and non-EU doctors were asked to give their impression on how they are perceived and treated by other foreign doctors, French doctors, the hospital administration, and patients, almost all answered in the same manner: fairly. By the word fair they meant that if they were competent, they were treated fairly by everyone, regardless of the country where their diploma was issued. The expression ‘there are good foreign doctors, and there are bad foreign doctors just as there are good French doctors and bad French doctors’ was stated several times by different individuals. Overall, among the foreign doctors who were interviewed, there were not any complains or discrimination felt from their peers, hospital administration or patients. This observation was also supported by the president of the Union representing non-EU doctors, FPS. However, two Romanian doctors who were interviewed experienced some animosity from non-EU doctors who did not have the full rights to practice in France, and who occupied the positions such as acting as interns in the hospitals that hired them. One of the Romanian doctors was told by a non-EU doctor that it was not fair that she got her position in the hospital because the non-EU doctor felt that she was more qualified than the Romanian doctor was since she spent several years in that hospital and had seniority. Furthermore, the non-EU was also partially trained in France. Therefore, she felt unjust the fact that the Romanian doctor was granted the right to exercise. The other Romanian doctor who also felt some hostility from a non-EU declared having been told by a non-EU doctor to improve her French before coming back to work. The injustice felt by some non-EU doctors towards Eastern European doctors was mentioned previously and these two cases are examples of how the ‘injustice’ could be translated in the work place.

In order to compare the perception of doctors with that of their employers and French peers, we also asked the nine hospitals which were interviewed to comment on the perception that the administration and French trained doctors have of foreign doctors. Overall, we received a similar answer to the one expressed above, especially for non-EU doctors coming from francophone African countries. Foreign doctors were perceived as being competent and fitting well within the hospital structure. For example, the public hospital manager in charge of medical affairs in an institution in the Provence-Alpes-Côte d’Azur region where non-EU doctors make up for 30% of all doctors stated “[…] non-EU doctors are very well perceived by their peers having obtained a French diploma, they are considered competent and are perfectly integrated in the small units/departments of the hospital”. Attention should be paid to the words ‘small units/departments of the hospital’ – does this tacitly imply that they are not sufficiently integrated within the larger unit. When the question was asked, the interviewee refused to comment.

There were three other managers in charge of medical affairs who did not wish to express this point on behalf of their respective institutions, but declared that they have heard French doctors say that they do not consider foreign doctors as their equals. The declarations made by the three interviewees are the following: “[…] there is no real notion of equality, but there is a true sense of their utility in the services”, “non-EU doctors are second-class doctors, assistants, therefore, they have to work twice as hard to prove their capacities”, “[non-EU] doctors are doctors without a diploma and certain French doctors believe that their training does not meet the level of French doctors”. The president of the Union representing non-EU doctors also confirmed the fact that despite the fact that no direct discrimination suits have been reported to

\[209\] “[…] les PADHUE sont très bien perçus par leurs collègues diplômés en France, ils sont considérés comme compétents et sont parfaitement intégrés dans les petites unités de l’hôpital”
the union, non-EU doctors do feel that they need to make more efforts and to constantly prove themselves in front of their French peers. These examples show that improvements need to be made on behalf of the hospitals in order to better welcome and integrate foreign-trained professionals so they do not feel inferior to French-trained doctors.

Eastern European doctors, and particularly Romanian doctors did not receive a very positive appraisal. Three interviewees stated that Eastern European doctors have an equivalent level to that of French doctors in everything that is related to medical theory, but the technical aspect of their training and the organization of program taught in Eastern European universities are different. To them, these are the aspects that differentiated Eastern European doctors from French doctors. Two other institutions also stated that despite the overall decent level of Eastern European doctors, some have language problems, language difficulties that most non-EU doctors coming from Francophone African countries do not have. Another hospital manager in charge of human resources of one institution situated in PACA stated that the Eastern European doctors hired by the institutions (mainly Romanian) were viewed by their French peers as non-EU doctors, meaning “doctors that need to be supervised”. Yet another institution from the same region did not specifically comment on the value of the diploma or professional competencies of Eastern European doctors, but distinguished between doctors coming from “old Europe” and “new Europe”; the new Europe meaning countries that joined the EU in 2004 and 2007. However, the Director of Medical Affairs of a hospital located in the PACA region affirmed the fact that she does not hire Romanian doctors because she heard that Romanian doctors were good general practitioners, but there were some problems with specialists because “[…] they are not trained like the French”.

What conclusions can be drawn from these examples? Although we cannot make any generalizations, we can notice that the statements made by some of the institutions interviewed for the micro phase of the project, correspond to the findings highlighted in section 5.1 of the report. Despite the European equivalence of diplomas, European diplomas do not seem to have the same value in the eyes of the French employers and their French peers. The distinction between “old Europe” and “new Europe” is made, and Eastern European diplomas tend to carry a stigma with them. This implies that in some cases there is no automatic acceptance of Eastern European doctors by their foreign and French peers despite the equivalency of their diploma. In order to be accepted and treated as an equal they need to prove themselves. The same goes for non-EU doctors. But, as mentioned previously, no generalization should be made as these observations are too few to be significant. A more elaborate study at the national level should be made before any conclusions can be drawn. A study where the evaluation of foreign doctors by patients would be also taken into account, and where the perception of “old Europe” practitioners would also be studied.

5.3.7 The mobility perspective of foreign doctors

In this section of the report, we would like to touch upon the declarations made by foreign doctors with respect to their wish to permanently or temporarily settle in France.

From the conducted interviews, it was noticed that most non-EU doctors intended to permanently settle in France. Those who expressed their intent to settle permanently stated that when they decided to move to France, they left everything behind in their home country and dedicated years of their lives in order to “make it” in France. They felt as if they had “sacrificed” too much in order to obtain their right to practice to leave everything now and move somewhere else. There were however three exceptions. One doctor stated that had she known that it was so difficult to obtain the recognition of her qualifications to practice in France, she is not sure
whether or not she would have migrated to France. She arrived in France in 2002 and until now has not been able to obtain her diploma recognition. She enrolled and attended several courses at the University of Medicine in Marseille and obtained several certificates, and did some internships, but has not been able to obtain the right to practice. She is, however, grateful for being able to offer a “better future” to her children. Another doctor, from Irak, also regretted coming to France, and stated his intent to move to the United Arab Emirates to open his own practice. He has now obtained the right to practice after eight years of struggle. He had to redo most of his training in France in order to be able to practice. Right now he has a full-time position, but feels that he could earn a higher salary in the United Arab Emirates (UAE). He has friends who had emigrated to the UAE and who are enjoying a “very high standard of living”, so he would like to do the same. The last example is of a doctor who emigrated from China. She first immigrated to Mali, where she met her husband, who is Malian, and who decided to come to France. She followed him to France. She does not regret living in France because that is “the country where her husband enjoys living and where her daughter was born”, but dislikes the difficulty to obtain the right to exercise her profession. She is currently unemployed, but plans to pass the required examinations and obtain her license. Other doctors did not express an explicit desire to leave, but mentioned that if they had to migrate to another country, they would choose the United States, Canada or Australia. However, most non-EU doctors which were interviewed stated permanently settling in France.

Overall, the Eastern European doctors who were interviewed did not express the same commitment of staying in France. Although they expressed the fact that they are aware of having better professional opportunities in France, and that they could offer a better life to their children in France, they did not exclude the fact of going back to their home countries one day. The Romanian doctors who were interviewed affirmed having a position in Romania which enable them to “at least survive”. The social network and family ties were also mentioned as factors that could influence their decision to go back. In general, from the conducted interviews, the Eastern European doctors did not seem to have the same pressure to ‘succeed’ and become integrated in France as did the non-EU doctors. The move to France was considered more of an experience and the decision to permanently settle was not a definite one, meaning that the return to their country of origin was an option. This finding was also validated by the recruitment agencies that we interviewed which stated that Eastern European doctors do not hesitate to go back to their country of origin if the living and working conditions in France do not correspond to their expectations. One note was however made to the impossibility of some doctors whose positions are frozen in their hospitals of origin, so these doctors do feel more pressure than others to succeed.

From the interviews carried out for the case study, it can be observed that the difficulties that non-EU doctors encounter with regard to the immigration and diploma validation procedure make their return home very unlikely. As mentioned previously, once the personal investment in the migration process becomes high, and once the individual undertakes the permanent settlement process, it is difficult to turn back. If the individual does decide to return home, he will embark in yet another migration process, meaning that the return home also entails adjusting to old ways of living, finding employment, reintegrating former social networks; and the individual returning home is not the exact ‘same’ individual, as the experience of migration impacts a person. For Eastern European doctors, it is not the same experience as for non-EU doctors as the initial state of mind often differs. The geographical proximity, the mobility and diploma recognition granted by the European Union allows them flexibility in their choices, and alleviates some of the pressure that permanent settlement involves. As mentioned above, non-EU doctors stated that they felt they had to succeed in France; this statement was not once made by Eastern European doctors. On the contrary, almost all of them declared not excluding the possibility to return to their home countries.
6. Conclusion

In conclusion of this report, we would like to place the international recruitment of health professionals into the overall national health human resources planning strategy. In very general terms, human resources planning involves projecting the right numbers, mix, and distribution of medical professionals to meet the demand for health services. As other European countries, France encounters several challenges when planning the human resources required to meet the health needs of its population.

First of all, it is necessary to project the adequate number of doctors to meet the healthcare demand of a growing older population, and to take into account the “baby boom” generation of physicians who are reaching retirement age, along with the rapid feminization of the profession. As it was mentioned previously, the average age of French-trained physicians has been increasing, and we have been witnessing a shift in the age distribution of doctors in the past decade. Similarly, the young generations of physicians are also demanding a changed work-leisure balance, with extra time dedicated for their personal lives.

Managing geographical maldistribution represents a second major challenge for the French government. Doctors can choose to freely settle anywhere within the country. To avoid heavy workloads, lack of equipment and/or supplies, and inappropriate facilities, doctors to settle in urban areas, resulting in inadequate access to care in rural and remote areas.

Diminishing existing specialty imbalances is another important task. To tackle this issue, efforts have been made to increase the attractiveness of the general practice through exposure during residency. The numbers allocated to each specialty have also been administered in such a way to compensate and correct the existing imbalances.

Consequently, efforts have been made to optimize the workforce. Such measures involve: i) the increase of retention through management policies (especially in remote areas) ii) the recognition of foreign credentials, iii) the adoption of an efficient skill mix whereby the role of nurses is developed, such as the pilot project whereby the management of dialysis was delegated to nurses, and v) the improvement of productivity by linking payment to performance which can be seen in public and private hospitals.

Lastly, international recruitment has also been proved to be a temporary solution to human resource shortages. International recruitment can have an impact on the total number of physicians. However, the recruitment of migrant doctors raises several policy issues as doctors need to be authorized to practice in the receiving country and to be appropriately integrated into the health system. Sending and receiving countries also need to cooperate together to promote ethical recruitment and avoid the risk of causing massive shortage or brain drain in sending countries. As a result, ethical concerns about international recruitment also need to be part of the national health human resources planning.

In France, the international recruitment of health professionals as a means to compensate workforce shortages does not play a major role in the organization of health care delivery (Cash and Ulmann 2008). Although the number of foreign doctors has increased in the past few years, mainly as a consequence of the European enlargement, the share of foreign doctors in the overall stock remains minimal. However, within a European context that allows for the free

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mobility of EU citizens and the mutual recognition of qualifications is likely to continue to occupy a place on the political agenda. It is therefore important to study the integration and retention of foreign-trained professionals in the national health workforce, the relationship between international recruitment and national training policies, the role of international recruitment on settlement in remote areas, along with the cooperation with sending countries.

Enhancing the integration and retention of foreign-trained professionals in the national health workforce

Attracting doctors to developed countries, including France, is part of a global race among countries to attract “the best and the brightest”. The changes in the migration policies in developed countries, and most recently European countries show that they are becoming more selective of high-skilled immigrants in general, rather than specifically oriented towards medical professionals. As presented in the section 3.1 of the report, the French immigration legislation has undergone several changes in the past ten years in order to attract more high-skilled migrants and to match the supply of immigrants with the requirements of curtained identified economic sectors. This shift in the French immigration policy was also highlighted by the stand France took on immigration during its presidency of the European Union in 2008. Immigration and the acceptance of the European Pact on Immigration and Asylum by all twenty-seven countries represented an important issue on the French political agenda. Defining restrictionist immigration policies in France, and ultimately Europe, by aiming to attract mainly high-skilled immigrants was one of the top issues on its immigration agenda, and France instrumentalized the European arena in order to bring supranational legitimacy and to universalize its national policies to the entire European Union by introducing them into the European immigration and asylum policy. Consequently, attracting skilled medical professionals to France is part of a larger national policy aiming high-skilled professionals in general, and more specifically a policy that aims to match demand and supply in certain professional sectors.

However, regardless of the shift in immigration policy, once immigrant health workers arrive in the destination country, they need to be able to practice their profession, otherwise there is a loss of skill and brain waste in the medical field (OECD 2008: p. 45 – 46). It is obvious that in order to practice one’s profession in a different country one must obtain recognition of his qualifications, and language proficiency in order to be a registered professional. However, as shown previously in the report, the procedure for recognition of diploma and qualifications of non-EU trained medical professionals is a long and laborious process which often times entails further training, working as an intern, and lots of patience. From the conducted interviews, it was shown that the process was complex and caused much frustration to the non-EU trained doctors, which in some cases accepted working low-pay and/or low-skill occupations below their level of qualifications. This type of situation can lead to “[…] [a] loss of social status and, often, financial resources, [which] can produce lower motivation for health professionals and difficulties in societal integration” (OECD 2008: p. 45). Although many foreign-trained doctors are able to work in public hospitals as trainees, some are forced to accept occupations in other fields in order to financially support themselves and their families, leading to brain waste as qualified skills are not used. Furthermore, as stated in some interviews, some of the doctors who immigrated to France will not hesitate to re-migrate to other countries where they feel their credentials will be better recognized. Among the destinations that were most often cited, Australia, Canada and the United Stated were the top three. Countries like Canada have made

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strides in the way they integrate foreign-trained medical professionals into the domestic health system. During these past few years, Canada has made the qualification process more clear to international medical graduates, and has invested 75 million dollars to fully integrate, through further training and placements, 1000 physicians and 500 other health care professionals into the Canadian health system.

Therefore, it is very important for a receiving country to define retention and integration policies for foreign health workers. Such policies could include facilities to improve language skills, offer work placements that provide further training, if required, and more specifically match skills with occupations, and offer an environment that allows foreign health workers to adjust to host countries.

International recruitment and national training policies

Increasing or decreasing domestic training is one of the most direct means a country has to expand or diminish the stock of physicians. France introduced the numerus clausus system in 1971 in order to: i) be able to select the most “capable” applicants, ii) use the system as a “cost-containment” mean, as reducing the supply of doctors results in a decrease in health expenditures (OECD 2008: p. 25), and iii) reduce the country’s training budget. The number of students who were able to enter the second year of the medical school was steadily reduced from the 1970s until the early 2000s. This policy has had a direct impact on the stock of doctors available today. In a report published in 2009, the Ministry of Employment, Labor, and Health (unit DREES) affirmed that until 2020 there will be a gap of 10% between the supply and the demand for doctors needed to care for a growing ageing population. Focusing on numbers to plan the medical workforce can prove to be ineffective and perhaps, irrelevant in the European context. In this part of the report, we address the relevance of such a system given the European context which allows for free movement and settlement of its citizens, and automatic diploma and professional recognition among Member States.

During the interviews carried-out for the project, we systematically asked our interviewees if they consider the system to still have relevance. The answers that we received varied greatly and stirred heated debate as the question touches upon a very sensitive subject. Among the doctors who were interviewed, the majority argued that the numerus clausus system guarantees a certain level of quality and training strictness, specific to France and other “advanced” countries. A similar feeling was also shared by the vice-president of the ANEMF, the body representing French medical students who felt that French students are better trained in comparison to others. Similarly, as it was illustrated earlier, French officials, including the National Council for the Order of Physicians do not consider EU credentials to be equal, despite the mutual recognition of diplomas offered by the EU legislation (please see section 5 of the report for more details).

However, we are also witnessing French students, who are not admitted in the second year of medical studies choose to study in other European countries. Since the European enlargement

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218 According to the Cash and Ulmann report cited above, the number of students allowed to enter the second year of medical studies in the 1970s was fixed at around 8700 and continuously dropped to reach 3500 in the 1990s.
220 Direction de la recherche, des études, de l’évaluation et des statistiques (DREES)
In 2004 an 2007, Eastern countries are also becoming destinations of choice. For example, the medical school in Cluj, Romania has seen its number of foreign students increase since Romania’s accession to the EU in 2007. It currently enrolls 1800 foreign students, among which 262 students are French. The French students who choose to study in Cluj do not need to pass an entry examinations (in comparison to their Romanian counterparts), but have to pay a 5000€ annual tuition fee. A large portion of the curriculum is taught in French, and once they obtain their diplomas, they are free to practice anywhere within the European Union. The possibility to study and obtain a recognized degree from a Romanian university is still very recent, and until now, only two French students have graduated. According to the investigation conducted by the newspaper, Le Figaro (article referenced below) most French students will choose to return to France upon graduation, as did the two students mentioned above who are now working in two Parisian hospitals.

This example, and more generally, French students studying abroad in Eastern European countries still raises three important policy issues. Firstly, one could wonder whether France should still continue to fix numerical limits and regulate training via the *numerus clausus* system given the European context that allows students to bypass the system and still be able to practice in France. If French students, who are not admitted into the second year, obtain medical degrees from other European countries and then return to practice in France is the current system still relevant? Secondly, it was mentioned previously that French officials and medical peers do not consider Eastern European qualifications to have the same value as French ones. This raises the question of the integration of the French students, who obtain their degrees abroad, into the French health system. How will they be integrated into the profession and viewed by their peers? Will they have the same status as Eastern European health professionals? Lastly, will the European automatic recognition of diplomas result in a “free rider” phenomena in France, whereby the country will not have adequate incentives to train sufficient health workers due to the possibility of either having French students train abroad in other EU countries or rely on doctors coming from EU doctors (OECD 2008: p. 35)? Importing health workers from other EU countries to compensate a temporary need for workers can represent a “quick-fix”, whereas training extra doctors and seeing a return on the training investment is a long process that takes many years.

To summarize, the assumption of a positive relationship between the number of available doctors and healthcare utilization has led France to implement a *numerus clausus* system. However, experience has shown that focusing on numbers is too restrictive and does not solve problems such as the unequal distribution of doctors and specialty imbalances. Similarly, given the freedom of movement and settlement offered by the European context, limiting national training in order to affect the available stock seems to be ineffective as students find a way to bypass it by studying abroad, and then returning to practice in France. In conclusion, the policy issues raised above should be studied and incorporated in the medical workforce planning.

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222 OECD Observer, International Migration of Health Workers. Improving International Co-operation to Address the Global Health Workforce Crisis, OECD report, 2010

International recruitment and settlement and retention of health workers in remote areas

Studies have shown that in most OECD countries, including France, domestic-trained and foreign-trained doctors tend to "settle and practice in affluent, metropolitan areas" (Stordeur, Leonard 2010: p. 11). As a result, rural and remote areas have difficulty attracting foreign-born or domestic trained doctors to settle as liberal practitioners. The challenge becomes even more difficult as the majority of doctors prefer to be employed, rather than set up their own practice. Furthermore, doctors can freely choose the location where they wish to settle. The 2009 measure aiming to allocate the professional placement of young doctors and therefore ensure a better geographical distribution was highly contested by the young physicians, and later abandoned by the government. Consequently, areas encountering difficulty attracting and retaining doctors need to deploy similar efforts and incentives to attract either foreign-born or French doctors. Nevertheless, before discussing suitable policies to achieve this objective, it should be stressed once again, that there is a small difference between foreign-born and French trained. From the interviews which were conducted for the study, it was found that during the first years after arrival in France, they are more likely to settle in towns, cities or urban peripheral areas considered to be unattractive than their French-trained counterparts. However, once they are established, foreign-born doctors tend to follow similar settlement patterns as their French counterparts.

The World Health Organization policy recommendations on ‘increasing access to health workers in remote and rural areas’\(^\text{224}\) focus on four specific categories of recommendations: education, regulatory, financial, and personal and professional support. France has already tested a considerable number of suggested policies. For example, among the recommended education oriented policies the following have been already put in place\(^\text{225}\): i) rural exposure via internships as part of the training curriculum, ii) the location of medical schools outside the capital and major metropolitan areas along with the allocation of a greater enrollment quota in these medical schools, despite the fact that most medical schools are still mainly found in the capital and regional metropolis and iii) admission policies to attract students with a rural background. Furthermore, scholarships have been given to students who commit themselves to working in a rural area after graduation. Just recently, in the summer of 2010 a new contract\(^\text{226}\) aiming to attract medical students to rural and remote areas was introduced by the French government. In exchange for a 1200€ monthly scholarship, the medical student agrees to settle in an area which encounters difficulty attracting and retaining medical professionals for several years, and agrees to study a medical discipline which has a deficit in the number of students specializing in that area. If the student dishonors the contract, he is obliged to pay back the amount of money that he received during his studies. The first contracts have started to be signed in December 2010, and clauses such as the required number of years of commitment, the exact amount that would need to be paid back should the contract be breached still needed to be clarified.

Other local initiatives exist as well, such as the one described in section 5.2.2.1.. As a reminder, in the Nord-Pas-de-Calais region, liberal, general practitioners who are already established within the region are encouraged to welcome and become internship supervisors to young medical students or graduates. This allows medical students to discover the region and to have a hands-on-experience of what is like to be liberal practitioners. It also helps the established practitioners, as training forces them to step back from their daily practice and reconsider and reflect on their way of practice. In many cases, this exercise helps them modernize and revisit their habits. Having students present in their practices, also represents a practical aid to the

\(^\text{224}\) World Health Organization, Increasing access to health workers in remote and rural areas through improved retention. Global policy recommendations, World Health Organization report, 2010

\(^\text{225}\) This information has been gathered through the interviews with the representative from the Ministry of Health, ONDPS and a meeting organized by the Ministry of Foreign Affairs on the organization of the French Health Workforce in France.

\(^\text{226}\) Contrat d’engagement de service public
supervisors as the students help with paperwork. However, this example should be placed in the broader context, as finding measures aiming to attract liberal practitioners to unattractive areas in the NPDC region represents a priority for the Regional Health Administration, the Regional Council, and the Regional Union of Liberal Practitioners.

The role of local/community hospitals also needs to be mentioned. In France, 25% of local hospitals are situated in remote areas, such as mountainous zones. Five European studies evaluating the role of local/community hospitals found that they reduce the need for patients to go to larger, regional hospitals. This is especially important for elderly individuals, as many primary care needs can be treated at local hospital facilities. By acting as front line hospitals, local hospital can play an important role in the regional organization of health services, as they can treat medical conditions that do not require a complex combination of medical skills and medical devices. This in turn alleviates some of the pressure put on regional hospitals.

During our interviews with the Ministry of Health and the National Observatory of the Demography of Health Professionals (ONDPS), we have asked if any studies evaluating the impact of these measures have been done. We were not able to obtain any information of existing studies evaluating these practices, but learned that incentives aiming to attract students to study in unattractive regions, with the objective of having them settle in these regions once they graduate have little effect. After graduation, students do not seem to show strong attachment to the region where they undertook their medical studies, and therefore move to other regions. Consequently, the training location seems to have limited impact on retaining students in the area. Similarly, it was also pointed out by the ONDPS that financial incentives also seem to have a limited impact as most students undertaking medical studies are not sensitive to scholarships or financial help. The majority of medical students come from socio-economic categories which allow them to be able to forego the 1200€ scholarship offered in exchange to committing to settle in a rural or unattractive area. Similarly, small financial incentives of any kind seem to have a limited effect on young graduates, as it has been shown that doctors who settle as liberal practitioners in rural or remote areas tend to earn higher wages than those who settle in urban area. This can be mainly explained by a higher demand for care in comparison to the supply of doctors.

However, the conducted interviews showed that the improvement of living conditions in rural or remote areas, and investment in the overall infrastructure and services offered by a region or an area can have a major impact on attracting and retaining health professionals, including both French-trained and foreign doctors. Although we were not able to find a study specific to evidence-based successful measures to enhance the retention of doctors in remote areas, from the current studies for nurses, improving the working environment including flexible work arrangements, family-friendly initiatives, and safety practices have proven to be effective.

For doctors, during the interviews it was stated that allowing cooperation between health workers in urban and rural or remote areas provide health professionals who settle in the latter area have proven to have a positive effect on retention. For this reason, group practice is slowing proving to be an incentive that shows positive results in attracting and retaining physicians in rural and remote areas. Similarly, it was declared throughout the interviews that attracting other professionals from a similar socio-economic category of that of doctors can

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227 URME – Union régionale des médecins exerçant à titre libéral
have an impact on retaining health professionals. As it was mentioned earlier in the report, this allows the establishment of professional and social networks which play a significant role in attracting health professionals to unattractive areas. Furthermore, in France, doctors wishing to set up practice in remote areas can benefit from a variety of aids and services including financial help to set up practice, and tax exemptions. Furthermore, certain municipalities also offer professional facilities or housing to attract doctors to villages which lack medical care. The social security also offers assistance by providing doctors who wish to set up their practice with information tools that help them visualize the healthcare offer and activity in the region they wish to settle. However, these tools had a very limited success rate of only 10% at the end of 2005.

Unfortunately, it was not possible to obtain a clear picture of the evaluation and impact of the rural and remote area retention strategies that have been employed in France. Consequently, we would like to stress the fact that policy interventions need to be guided by five key questions that take account of the design, implementation, monitoring and evaluation of appropriate policies: relevance, acceptability, affordability, effectiveness, and impact (WHO 2010).

Cooperation with sending countries

In the previous section of the report it was shown that the majority of foreign-born doctors in France come from other European countries. Furthermore, since the enlargement of the EU in 2007, we have noticed a large number of Romanian doctors who have immigrated to France. As discussed in the section 3.1 of the report, the recruitment of doctors from certain European countries and non-EU countries facing health workforce shortages raises a number of ethical questions and concerns. Codes of practice and intergovernmental agreements have been proposed by international organizations such as the World Health Organization in order to promote ethical forms of recruitment from low-income countries. These agreements contain clauses whereby receiving countries agree to share the training costs, hire health workers for a limited period of time and returning them to their home country, and/or only recruit the surplus of health professionals found in the country of origin (Buchan 2007). Most of these agreements are carried out with African, South-Asian or South-American countries.

Little attention has been paid to Eastern European countries who also face important shortages of health professionals due to a high number of health professionals who decide to emigrate. The mobility of health professionals coming from European countries raises the debate between one’s right to freely circulate and settle within the European Union and the impact that migration of health professionals can have on the country of origin. For example, according to the president of the Romanian Order of Physicians, 8331 doctors have obtained their “certificate of conformity”, a certificate that allows Romanian doctors to have their diplomas recognized within the EU since its accession to the European Union, and 7 000 medical professionals signed up to attend recruitment forums that would enable them to emigrate to other EU countries. The Romanian Order of Physicians has also conducted a survey that suggests that half of Romanian doctors intend to leave the country within the next five years. This example

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233 Several codes of practice, which are not legally binding, have been drafted during the past few years: WHO Global Code of Practice on the International Recruitment of Health Personnel (2010), the Pacific Code of Practice (2007), the Scotland Code of Practice (2006), the Commonwealth Code of Practice (2003), the UK Code of Practice (2001/2004)
suggests that communication and cooperation is necessary not only with traditional sending countries, but also with other European Member States as the risk for massive health shortages can occur within the EU borders.

Reducing reliance on international migration of health workers and ethically recruiting if necessary, assessing the current stock of health professionals including its composition, and forecasting its possible evolution, improving workforce distribution and medical specialties, and understanding the mobility between the public and private sector are all components of a dynamic health human resource planning, necessary to tackle the current health challenges encountered in France (Stordeur and Leonard 2010: p. 23; OEC 2008: p. 78).

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The ‘Mobility of Health Professionals’ allowed us to first stress and reiterate the current transformations of the French healthcare system with regard to human resources management and planning. These issues include, but are not limited to the following: the unequal distribution of the health professionals even within regions enjoying high medical densities, and the consensus to reject coercive measures designed to tackle this issue, the growing number of female practitioners and the consequent implications, the policies aiming to make general medicine and the liberal practice mode appealing to students and young professionals, the local initiatives to attract and retain health professionals in rural and remote areas, etc.).

In addition, this study shed some new light on several issues that have not been explored in-depth in the existing literature. First of all, the qualitative interviews allowed us to observe that the international migration flow of healthcare professionals is a poorly understood phenomenon. There not only is a lack of knowledge and data regarding international migratory flows (especially for French professionals going abroad), but there is also a lack of interest, and a certain indifference of the Orders to quantify and qualify in detail the migration of health professionals, despite existing quantitative and qualitative information. The study also highlights the impact of the European legislation on the immigration of medical professionals coming from countries which recently joined the EU. Without the EU directive, allowing the mutual recognition of medical qualification among EU Member States, the migration boom of Romanian-trained doctors wouldn’t have been possible. This migration boom also highlights the need for European cooperation among Member States in order to avoid massive shortages or brain drain in the sending countries. We often associate ‘brain drain’ with sending countries in South-Asia or Africa, but brain drain and massive shortages of health professionals can also occur within the EU. Therefore, cooperation among EU states is crucial. Furthermore, the EU context also raises the question of the existing national training policies, and more specifically the relevance to maintain the numerus clausus system in light of the possibility for French students to train in other EU countries and to return to practice in France. Lastly, the project allowed us to examine the relevance and feasibility of recruiting health professional from abroad as a means to compensate the deficit experienced in certain regions. Although we do not believe that recruiting foreign-trained professionals should represent a long-term solution, studying the migration process of individual medical professionals provided a better understanding of i) the factors motivating immigration to France, and the importance of existing migrant networks in the migration and recruitment process of foreign-trained doctors; ii) the laborious process of non-EU doctors to obtain their professional qualification and the importance to allow them to practice in order to avoid brain waste and future migration, and to ensure a better social integration; iii) the settlement patterns and perspectives of both EU and non-EU doctors, and more specifically, the finding of a similar settlement pattern to that of French-trained doctors for established foreign-trained professionals, and the likely hood for permanent versus circulatory settlement for non-EU doctors in comparison to EU doctors.