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**Extending the Ontario's Nurse
Practitioner role in the French liberal
Primary Health Care model: potential
interest?**

Grégory Vignier

Special Thanks

To my patient wife...

And to myself who did the job, after all.

To be healthy is priceless.

To treat got one.

G. Vignier

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List of acronyms

NPs : Nurse Practitioners

GPs : General Practitioners

PHC: Primary Healthcare Center

LCT: Long Term Condition (“Affection Longue Durée” equivalent)

1 Introduction

Did you know when in Canada the word “nurse” etymologically means¹ “who takes care of young children”, the same word in French means “who takes care of cripples“?

Did you know that two modern countries with similar resources, nurses and physicians, and with a similar aim, “offer the best Primary Health Care system to the population”, use however two different approaches?

So, same, but not the same?

We often compare our systems - and whatever the system is: financial, economic, social...- because of both “political aspects” and “performance culture”.

Even the WHO compares our healthcare systems. “What is the best healthcare organization or system in the world?” is the message hidden behind their annual ranking.

But sometimes the question should be different. The question could be: “with the same resources, why did we choose this solution instead of another one?”

If we take the Canadian –Ontario- example and the French one, they both have a strong primary health care system, good physicians, nurses, and medical technology.

But according to the (to read carefully) WHO worldwide ranking their strategies and results are different.

The comparisons between healthcare systems often are an engine to implement modifications in its own organization. But comparing values against others values do not make any sense by the simply reason of the impossibility to measure it.

Maybe taking a leaf out of someone is a way to get onto its issues, like the medical demographical challenges France is facing to, shortage of physicians in the Primary Health Care field, like Ontario’s Province already faced thank to the Nurses Practitioners.

Does France should gets inspired by Ontario and try to implements this solution which has been studied in many research teams and politic leaders?

To do so it’s necessary to better understand history from both France and Ontario, read their current organization and analyze why France should get inspired by the Nursing Practitioner model.

¹[The nursing myth](#)”, by PhD Michel Nadot, May 12th 2011

2 Nursing Profession

2.1 In France

The nursing profession is one of the biggest corporations in France.

It's one of the 3 "paramedical" professions, with Physiotherapist and Chiropracist, being self-regulated by its National Board, as notified in the Public Health Code.

A recent Senate² report says: "into the healthcare professions organization core, there is the Physician position, and competences from others healthcare professionals are built as derogation to its own monopoly, protected itself by the illegal practice of medicine".

The main historical dates of the nurse profession in France are:



² Rapport relatif aux métiers en santé de niveau intermédiaire- Hénart- Berland- Cadet- janvier 2011 – page 5

But if the nurse role in France has been historically performed by volunteers at the very beginning, the “nursing profession” has been formalized upon the Church and its nuns³.

It’s still today an important image of the nurse, a true cliché, where empathy and tolerance are the keywords. However, in an old monarchical system where the physicians had (ever) every power and kept secrets on their drugs, they had the willingness to create an official nurse profession to help them at Hospital.

Although the nurse profession is today relatively independent according to the Public Health Code, the nurses are still considered in France as “physicians ‘employees”.

2.1.1 Law

The Public Health Code regulates the nurse profession by the Decree n°2004-802 of 29th July 2004⁴.

For a better understanding of the Nurse profession in France, it’s important to notify the Decree separates the “nursing acts”, to the “medical acts performed by a nurse with a medical prescription” and the “medical acts performed by a nurse with the physical presence of the physician -prescriber”.

All the nursing acts are notified in articles R 4311-1 to R 4311-15-1 of the Public Health Code.

The Nurses in France must be registered to the Board of Nurses to practice⁵. Only 25% of nurses are registered, but the French government is not going toward a cancellation of practice permission against the nurses not registered yet. The shortage of nurses in France is a bigger power than no other one.

This situation perfectly illustrates the difficulties for such a big and plural corporation to share the same values and talk in unison.

During the last decades, the nurse profession has been unable to obtain any new mission or financial compensations, while the healthcare system was already evolving and the others medical corporations with it.

But, for the last two years, facing against some public health challenges such as cost control and a better (fast) access to the healthcare system, the nurse profession obtained two new “possibilities”:

- To renew some medical prescriptions (contraception⁶) and medical devices (set of bandages)
- To provide some specifics medical acts only in her hospital if an official permission by the Health Regional Authority and a specific “on-site live training” has been obtained by the nurse targeted.⁷

³ [“The nursing myth”](#), by PhD Michel Nadot, May 12th 2011

⁴ [Decree n° 2004-802](#) of 29th July 2004

⁵ [Law n° 2006-1668](#) of 21st December 2006 Art. L. 4312-1

⁶ [Article D4311-15-1](#)

However 65% to 70% of the nurses seem to refuse this last measure according to the total lack of visibility and potential risks on the nurse corporation itself⁸.

2.1.2 Demography

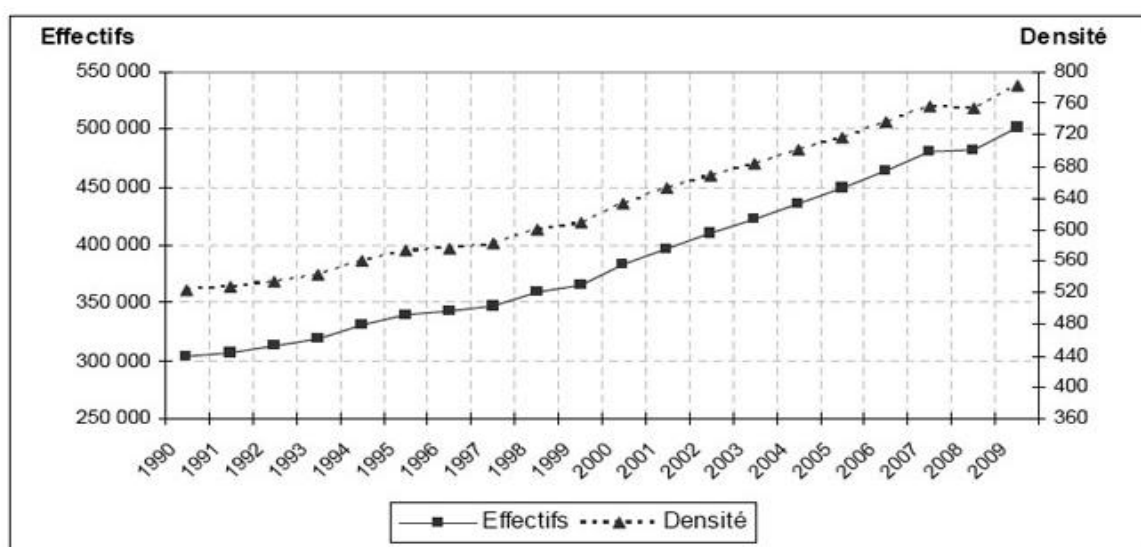
In 2010, 520 000 nurses are registered⁹ for 65 millions of people in France.

There are 8 nurses for 1000 people.

Almost 75 000 nurses work as a self-employed primary care nurse. A primary care nurse is also considered as a homecare nurse, having both activities.

Around 6000 nurses¹⁰ work in “SSIAD”, which are home care public centers. Those centers are active players of the Primary Health Care system in France.

According to the DREES¹¹, from 57 800 in 2006, self-employed nurses will be 116 100 in 2030. This means a 2,9% annual growth rate and the doubling in 25 years.



Sources : répertoire Adeli.

Champ : infirmiers âgés de moins de 65 ans, en activité au 1^{er} janvier, France entière.

See above: [Growth of nurses since the last 20 years \(density by 100 000 people\)](#)

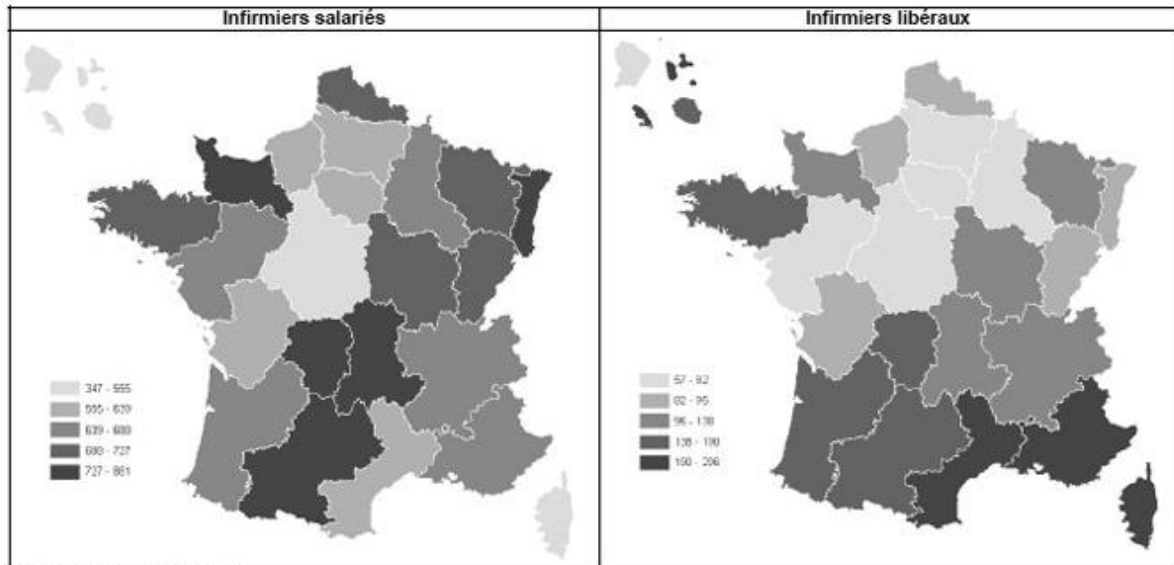
⁷ [Article 51 from law HPST](#)

⁸ [National Nurse Survey](#), by Gregory Vignier, National State Board of Nursing, 2012

⁹ Source : DREES, 2012

¹⁰ [Les services de soins infirmiers à domicile en 2008](#), Dominique Bertrand, Direction de la recherche, des études, de l'évaluation et des statistiques (Drees), n° 739, septembre 2010

¹¹ [DREES](#) Direction de la recherche, des études, de l'évaluation et des statistiques



Sources : Répertoire Adeli.

Champ : Infirmiers libéraux et salariés en activité au 1^{er} janvier 2009, France entière.

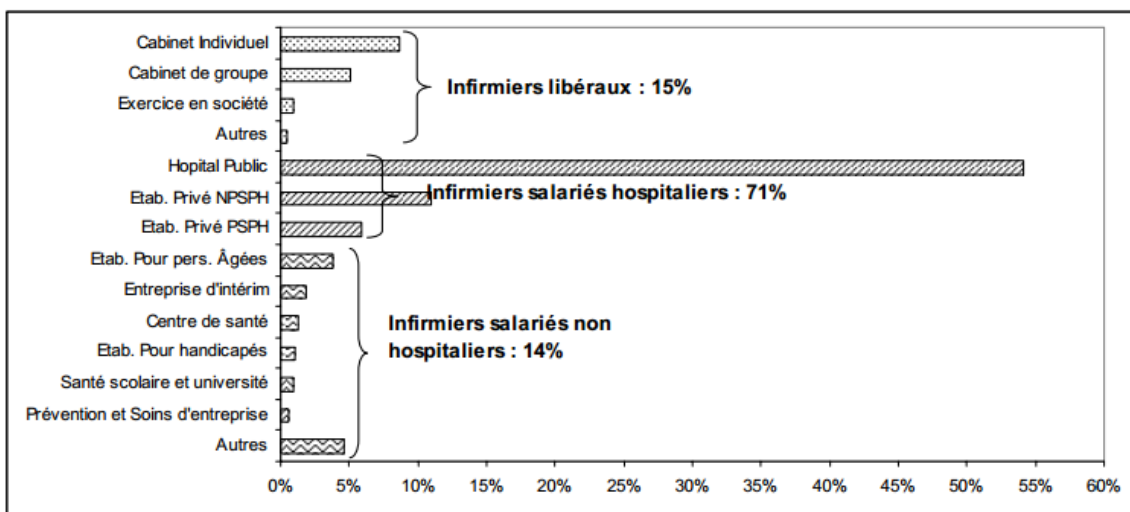
Note : afin de pouvoir comparer les cartes, les classes contiennent le même nombre de régions.

See above: [Regional density of homecare nurses and hospital nurses, 2009](#)

Repartition:

Following the ADELI¹² directory, nurses are employed:

- 15 % as self-employed in Primary Care Nurse (office),
- 54 % as nurse in public hospitals
- 17 % as nurse employed by private hospitals (6% in nonprofit)
- 4 % as nurse in long-term care,
- 10 % as travel nurse, occupational nurse, school nurse, etc.



Sources : répertoire Adeli.

Champ : infirmiers de moins de 65 ans en activité au 1^{er} janvier 2009, France entière.

See above: [nurses' allotment in France](#)

¹² [La profession infirmière : Situation démographique et trajectoires professionnelles](#) by Muriel BARLET & Marie CAVILLON n° 101 – novembre 2010

2.1.3 Education

Since only 2012 the nurse's studies are integrated to the License/Master/Doctoral (LMD) program¹³.

However the final diploma is not a university diploma, but an equivalent one, which means it has the same level only.

Nursing programs are performed in the 326 nursing schools attached to a hospital. Since the recent reform schools are attached to a university too, but the teachers are still the same: nurses and physicians.

The studies' duration is about three years, both "on-site" training and classroom training. After a nursing diploma, new graduates can either start practice or become a nurse specialized.

There are three different specialties:

1. Operating Room nurse (must work during 2 years before to start the 18 months of studies)
2. Anesthesia nurse (must work during 2 years before to start the 24 months of studies)
3. Pediatric nurse (12 months, no previous nursing practice requested)

Two years of hospital practice as a registered nurse are requested before to work as a Primary Care nurse – self employed.

Although a strong demand by the nursing profession¹⁴ (80%), there are no advanced practices which could open a new category of nurses: the nurses' practitioners (NPs).

This last topic is a huge difference between Ontario and France.

¹³ [Bologna agreement, 1999](#) (EHEA)

¹⁴ [National Nurse Survey](#), by Gregory Vignier, National State Board of Nursing, 2012

2.2 In Ontario, Canada

The history of nursing in Ontario is linked to the Canadian one. At its beginning, Canada was called “nouvelle France”, and populated of French citizens, including Ontario.



2.2.1 Law

The *Nursing Act, 1991*¹⁵ and the *Regulated Health Professions Act*¹⁶, 1991 determine how the nursing profession is regulated in Ontario.

¹⁵ [Nursing Act, 1991](#)

¹⁶ [Regulated Health Professions Act, 1991](#)

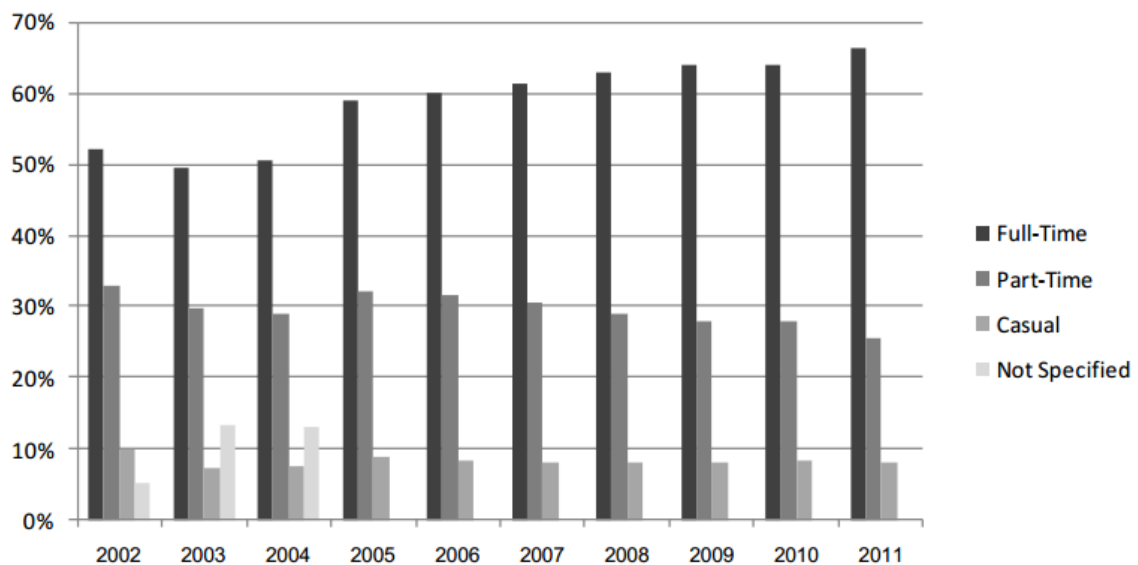
The *Nursing Act, 1991* contains a scope of practice statement and controlled acts authorized to nursing, as well as provisions and regulations specific to the nursing profession. It includes definitions of the classes of nurse registration, entry-to-practice and title protection regulations, and regulations on initiating controlled acts.

2.2.2 Demography

The College registers three groups of nurses – Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Nurse Practitioners (NPs). A total of 150,149 nurses renewed their membership with the College for 2011. Employment status was reported as follows¹⁷:

Employment Status	RN		RPN		NP		Total	
	#	%	#	%	#	%	#	%
Employed in Nursing	97,017	86.9	30,997	84.5	1,684	93.6	129,698	86.4
Employed in Nursing and Non-Nursing	1,785	1.6	922	2.5	47	2.6	2,754	1.8
Employed in Non-Nursing	3,408	3.1	1,589	4.3	6	0.3	5,003	3.3
On Leave ¹	2,166	1.9	917	2.5	30	1.7	3,113	2.1
Not Employed	7,296	6.5	2,252	6.1	33	1.8	9,581	6.4
Total	111,672	100	36,677	100	1,800	100	150,149	100

In 2011, 66.4% of members employed in nursing in Ontario stated that they worked full-time, an increase of 2.5 per cent over 2010 and the highest reported rate of full-time employment in ten years¹⁸:



¹⁷ [Membership Statistics](#), College of Nurses of Ontario, 2011

¹⁸ [Membership Statistics](#), College of Nurses of Ontario, 2011

The top five RN employers, positions and primary areas of practice in 2011 are given below:

**RNs Employed in Nursing in Ontario
Top Five Nursing Employers 2011**

	2011	
	#	%
Acute Care Hospital	56,699	52.8
Long-Term Facility	8,955	8.3
Public Health Unit/Department	4,180	3.9
College/University	3,628	3.4
Community Care Access Centre	3,524	3.3
Other Employers	26,336	24.5
Not Specified	4,025	3.7
Total	107,347	100

**RNs Employed in Nursing in Ontario
Top Five Nursing Positions 2011**

	2011	
	#	%
Staff Nurse	69,498	64.7
Case Manager	4,137	3.9
Middle Manager	3,787	3.5
Public Health Nurse	3,353	3.1
Visiting Nurse	3,261	3.0
Other Positions	21,473	20.0
Not Specified	1,838	1.7
Total	107,347	100

**RNs Employed in Nursing in Ontario
Top Five Primary Areas of Practice 2011**

	2011	
	#	%
Geriatrics	8,908	8.3
Acute Care	7,493	7.0
Critical Care	6,951	6.5
Emergency Care/Emergency	6,624	6.2
Maternal/Newborn	6,242	5.8
Other Areas of Practice	69,291	64.5
Not Specified	1,838	1.7
Total	107,347	100

The nurse repartition in Ontario is mainly employed in Acute Care Hospitals as a Staff nurse and in many different specialties.

2.2.3 Education

With the exception of Quebec, all Canadian provinces/territories require a bachelor's in nursing (BN or BScN) to enter the profession.

Bachelor's programs can be completed in two to four years.

Master's programs are available all across Ontario and doctoral programs are available too.

Some of the main masters allow accessing to new positions such as¹⁹:

- Nurse Practitioner (NP): A Registered Nurse in the Extended Class with additional education and experience who has the competencies and legal authority to

¹⁹ [Membership Statistics](#), College of Nurses of Ontario, 2011

diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform procedures within their legislated scope of practice.

- Advanced Practice Nurse – CNS: a Registered Nurse in the General Class who has gained additional knowledge and skills through graduate education and experience. A Clinical Nurse Specialist (CNS) has expertise in a specialized area of nursing. A CNS provides direct care, participates in research, provides leadership, educates and consults with health care teams. A CNS may work with individuals, families, communities, employees or organizations, and may focus on illness care and wellness care.

As part of the process for becoming a Registered Nurse in Ontario, an applicant must first successfully complete the Canadian Registered Nurse Examination (CRNE)²⁰.

2.2.4 Focus on the Nurse Practitioner

The NP role has been officially recognized in 1960, to improve access to care in areas too far away from healthcare centers or PMC.

In 1990, some medical specialties such as neonatology, cardiology, nephrology, etc, faced against a shortage of physicians. It has been once again an opportunity to look for solutions such as NPs roles.

A Nurse Practitioner (NP) is a nurse with advanced university education who works both independently and in collaboration with other health professionals to provide quality health care services. NPs take care of the physical, emotional, mental and social aspects of their clients' health needs²¹.

The nurse practitioner role is based on advanced nursing practice.

Advanced nursing practice is an umbrella term describing an advanced level of clinical nursing practice that maximizes the use of graduate educational preparation, in-depth nursing knowledge and expertise in meeting the health needs of individuals, families, groups, communities and populations. It involves analyzing and synthesizing knowledge; understanding, interpreting and applying nursing theory and research; and developing and advancing nursing knowledge and the profession as a whole.²²

What does an NP do?

As a member of the health care team, NPs can:

- Diagnose illness and injuries
- Perform physical check-ups
- Order and interpret diagnostic tests
- Provide counseling and education

²⁰ [Canadian Registered Nurse Examination](#)

²¹ Nurse Practitioners' Association of Ontario

²² [Canadian Nurse Association](#)

- Provide treatment
- Order procedures
- Refer clients to other health care professionals and specialists
- Prescribe medication
- Manage chronic diseases such as diabetes, COPD and asthma

As of 2011, NPs can:

- Treat, transfer and discharge both in-patients and community out-patients from hospital.

(NPs will be able to admit patients to hospital as of July 2012)

- Cast fractures and reduce dislocations
- Order blood products and oxygen

The NPs specialties in Ontario are:

1. NP- Adult
2. NP- Pediatric
3. NP- Primary Health Care
4. NP- Anaesthesia

The following tables show the breakdown of Nurse Practitioner specialties²³:

NP Speciality	#	%
NP - Adult	331	18.3
NP - Paediatrics	142	7.8
NP - Primary Health Care	1338	73.9
Total	1811	100
Members with Two Specialities		11

A large part of the NPs are practicing in the PHCs.

NP-Adult and Pediatric:

Adult and Pediatric NPs work with clients and families in hospitals and outpatient clinics. NPs may specialize in areas such as dialysis, orthopedics, neonatal intensive care, critical care or oncology.

NPs explain health conditions and expected benefits of any treatment, and provide guidance to help clients maintain health and prevent complications.

²³ [Membership Statistics](#), College of Nurses of Ontario, 2011

NP-Primary Health Care :

NPs in Primary Health Care provide primary health care services.

A visit to an NP in primary care can include treatment for an acute illness, a routine prenatal check up, a well baby exam, the monitoring and treatment of chronic illnesses and screening tests such as immunizations and PAP tests.

NP-Anaesthesia:

The NP-Anaesthesia role was introduced in Ontario in 2010.

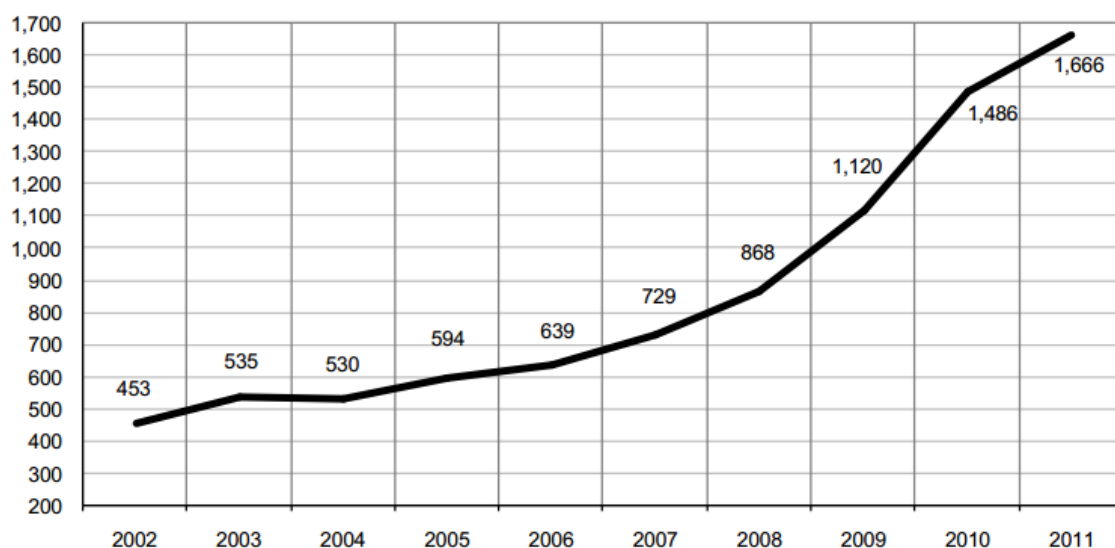
These NPs conduct pre-admission assessments, provide anaesthesia services, and monitor clients during operations. They also manage a client's pain after a procedure or operation.

Where do NPs work?

NPs work in rural and urban areas including:

- Family Health Teams
- Community Health Centers
- Nurse Practitioner-Led Clinics
- Hospitals including emergency departments
- Rehabilitation facilities
- Long-term care facilities
- Schools and workplaces
- Home health care agencies

For 2011, 1,666 NPs reported employment in nursing in Ontario, an increase of 12.1% over 2010²⁴.



²⁴ [Membership Statistics](#), College of Nurses of Ontario, 2011

3 Primary Health Care organizations

According to the W.H.O²⁵, the ultimate aim of primary health care is “better health for all²⁶”.

If this definition could also match with any other health care organization, such as hospitals or health insurances companies, it sounds more relevant for a vision of the global health care system.

But they had identified five key elements to achieving that goal:

- reducing exclusion and social disparities in health (universal coverage reforms);
- organizing health services around people's needs and expectations (service delivery reforms);
- integrating health into all sectors (public policy reforms);
- pursuing collaborative models of policy dialogue (leadership reforms)
- increasing stakeholder participation.

In many countries with private practice and health insurance, primary care continues to be physician-centred and oriented towards curative services. Group practices and teamwork are emerging, but most GPs still work alone. They often compete with specialists for patients. Their gate-keeping role is limited if patients can go freely and without additional financial cost directly to a specialist or to a hospital outpatient department. A general trend has been to introduce market elements (for example in France or Germany), along with elements of integrated care. Traditionally, the trade-off between equity, efficiency and choice in these countries is bent towards more choice and efficiency and less equity.

But Ontario's choice, challenged by a shortage of physicians, has been to promote the nursing role by creating a “Nurse Practitioner” position (NP). They continue to work in total independence as opposed to the medical assistants.

If there is no “ideal model”- it's all about the willingness to offer an efficient healthcare system or not to the population- Ontario's model shows that coordination between healthcare professionals is possible despite the resistances and is now structurally strong both in the law²⁷ and on the field.

²⁵ [World Health Organization](#)

²⁶ Dr Margaret Chan Director-General of the World Health Organization - [Almaty, Kazakhstan \(2008\)](#)

²⁷ [Ontario's Action Plan For Health Care](#), 2012, Government of Ontario

3.1 In France

The French system is based since more than 60 years on 2 principles:

- Liberty to choose his own physician
- Solidarity with the share of medicine costs through a National Insurance (Bismark model).

The “liberal” French system born around 1792, when physicians graduated from a medical school were in direct concurrence with charlatans.

One century after and the disappearance of charlatans thank to the physician who makes free the medical consultation for all citizens, physicians were looking for more autonomy against the French government.

After a difficult period where the French State decided to force physicians to accept to be paid under a national price (1945), the “liberal medicine” continued to be the only main provider of primary cares, keeping control on all modification of its liberal practice²⁸.

3.1.1 Organization

The organization of the primary health care offer in France is determined by the principles of the private office medicine from 1927: allowance to choose his own physician, absolute respect of confidentiality, autonomy in the therapeutically strategy choice, payment of each medical act performed and directly by the patient, liberty of installation for the office localization.

The principles are today detailed in the Article L1411-11 from the Public Health Code.

Those physicians and nurses (then physiotherapists and midwives) coexist with some others health care organization employing nurses such as:

- Maternal and Infant services protection (PMI)
- Community health care center (SSIAD) managed by the city
- Fire Department services with nurses (SDIS)
- Home Care Center attached to Hospitals (HAD)
- Nurse school offices
- Primary Care centers from the National Health Insurance
- Occupational nurse offices
- Associations (SOS Medecin, etc.)

Primary Health Care centers are well developed and offer a huge quantity of various services. However, they are not organized into a hierarchy and not centralized. Their allotment is not optimized and makes some region without enough care offers.

²⁸ Frederic Bizar, « [Analyse historique et économique de la médecine libérale de la révolution à nos jours](#) »

In consequence, a major part of the healthcare coordination is performed either by the families either by private offices nurses.

In 2012, the global health expenditure was 4840\$ / person following a W.H.O report.

3.2 In Ontario, Canada

In the late 1990s and early 2000s, the issues dominating Primary care in Ontario were the growing shortage of primary care physicians and deteriorating patient access to care. This was the era of “orphan Patients”, patients without access to family doctors. Physicians were overworked and dissatisfied, medical students were not choosing family Practice, and there was an outmigration of Physicians (“brain drain”) to other jurisdictions.

Over the last decade, there has been a significant reform to primary health care in Ontario in terms of models of care delivery as well as modes of physician payment. A main objective of this reform and investment was to improve patient access and quality of care relative to the traditional fee-for-service model. In addition, the reform aimed to enhance Ontario’s competitiveness with respect to physician remuneration to try to address the critical shortage of primary care physicians in the province.²⁹

3.2.1 Organization

Ontario Province’s population is 12.7 million with 85% urban living.

4519\$ per capita (WHO report) is the official total healthcare expenditure in Canada.

The Regional Health Authority receives a budget from the province to provide specific, negotiated services to the population in its geographic area.

Ontario, with a population of 12.7 million, 85% urban, has created a modified RHA structure known as Local Health Integration Networks (LHINs)

Primary Health Care (PHC) is the first point of contact between a patient and the health care system (Source: [Government of Ontario, Canada](#)).

Primary care in Ontario strives to provide for comprehensive primary health care to respond to the needs of the whole person, and ensure continuity of care, acute and chronic disease management, as well as health promotion and disease prevention.

The current core elements of primary health care are:

- Common basket of services — comprehensive primary care;
- Expanded access through the Telephone Health Advisory Service and extended hours of practice;
- Voluntary patient enrolment with a physician;
- Patient-based funding;

²⁹ Primary Care in Ontario: reforms, investments and achievements by Boris Kralj PhD, Jasmin Kantarevic PhD, OMA Department of Economics

- Inter-disciplinary care;
- Grouped or networked practices;
- Extended hours of access;
- Access to preventive care and comprehensive care incentives.

Primary care providers in Ontario work in a number of different models:

- Family Health Teams
- Community Health Centres
- Family Health Networks
- Family Health Groups
- Comprehensive Care Model (CCM)
- Family Health Organization (FHO)
- Rural-Northern Physician Group Agreement (RNPGA)

Family Health Teams

Family Health Teams (FHTs) are a key part of Ontario's plan to build a stronger health care system. They help keep Ontarians healthy, they give Ontarians better access to doctors and nurses, and they reduce wait times for services.

Family Health Teams are groups of health care professionals, such as physicians, nurse practitioners, nurses, social workers and dietitians who work together to provide primary care for a group of patients. They provide a wide range of services including health promotion, treatment services, chronic disease management and prevention, rehabilitation and palliative care. They are available nights and weekends to provide health advice and care so their patients do not have to go to hospital emergency departments for non-emergency care.

Community Health Centres

Community Health Centres (CHCs) employ teams of physicians, nurse practitioners, nurses, counsellors, community workers and dietitians that serve high-risk communities and populations who may have trouble accessing health services because of language, culture, physical disabilities, socioeconomic status or geographic isolation. They focus on addressing the underlying conditions that affect people's health, such as poor diet, poverty, housing problems, violence and lack of education. They improve access to primary care and help strengthen communities.

Family Health Networks

Family health networks (FHNs) are groups of physicians who work as a network along with a nurse-staffed after hours telephone advisory service to provide primary care for

their patients 24 hours a day, seven days a week. The networks emphasize illness prevention and comprehensive care for patients.

Family Health Groups

Family Health Groups (FHG) offer comprehensive primary health care services to their enrolled patients. Family Health Groups offer regular office hours plus extra After Hours blocks of office time. FHG physicians are also on call to a ministry funded Telephone Health Advisory Service (THAS) outside of regular office hours that takes phone calls from their enrolled patients.

Comprehensive Care Model (CCM)

The Comprehensive Care Model is designed specifically for solo primary care physicians. These physicians offer comprehensive primary health care services to their enrolled patients including regular office hours plus one three hour block of after hours services per week. Like their group counterparts, CCM physicians also emphasize illness prevention for their enrolled patients.

Family Health Organization (FHO)

The Family Health Organization Model represents the alignment of Primary Care Networks and Health Service Organizations into one model. FHOs are groups of physicians who provide comprehensive primary health care services to their patients with a focus on illness prevention. Through Institutional Substitution Program Grants, allied health professionals are part of some of the teams as well. FHOs provide care during regular and extended office hours and patients have access to a nurse staffed Telephone Health Advisory Service.

Rural-Northern Physician Group Agreement (RNPGA)

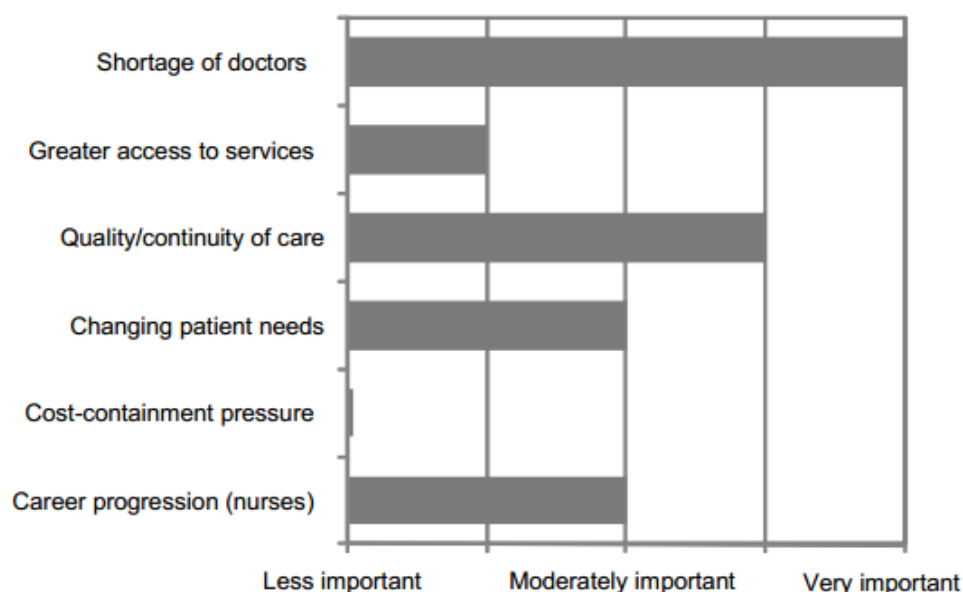
The RNPGA serves rural and northern communities with a complement of one to seven physicians. The group of physicians provides comprehensive primary health care services during regular and extended office hours. Additionally, emergency services are provided 24/7 and patients have access to a nurse-staffed Telephone Health Advisory Service. Like all other primary care models, RNPGA physicians also emphasize illness prevention for their enrolled patients.

4 Improving the French efficiency of primary care model

In response to shortages of doctors and to ensure proper access to care, some countries have developed more advanced roles for nurses. Evaluations of nurse practitioners from the United States, Canada and the United Kingdom show that advanced practice nurses can improve access to services and reduce waiting times, while delivering the same quality of care as doctors for a range of patients, including those with minor illnesses and those requiring routine follow-up. Most evaluations find a high patient satisfaction rate, while the impact on cost is either cost-reducing or cost-neutral. The implementation of new advanced nursing roles may require changes to legislation and regulation to remove any barrier to extensions in their scope of practice³⁰.

A study from Delamaire & Fortune tried to define a trend of why the French model should be improved.

Graph 1: Main reasons for promoting advanced roles for nurses in France



Health's response to OECD questionnaire (2009)

4.1 A demographic challenge

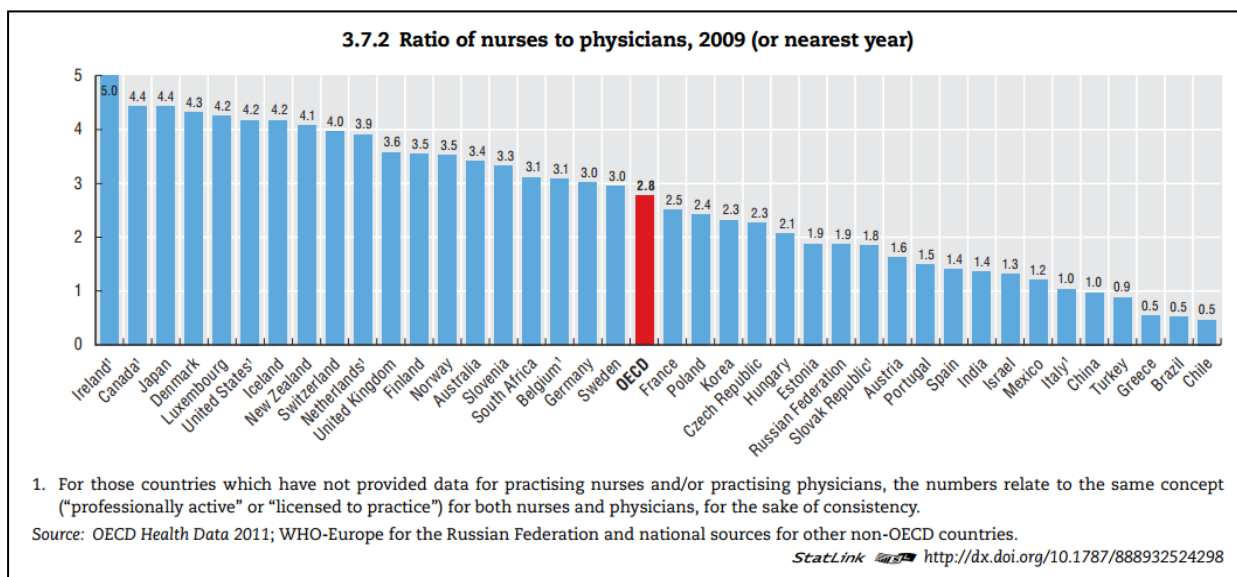
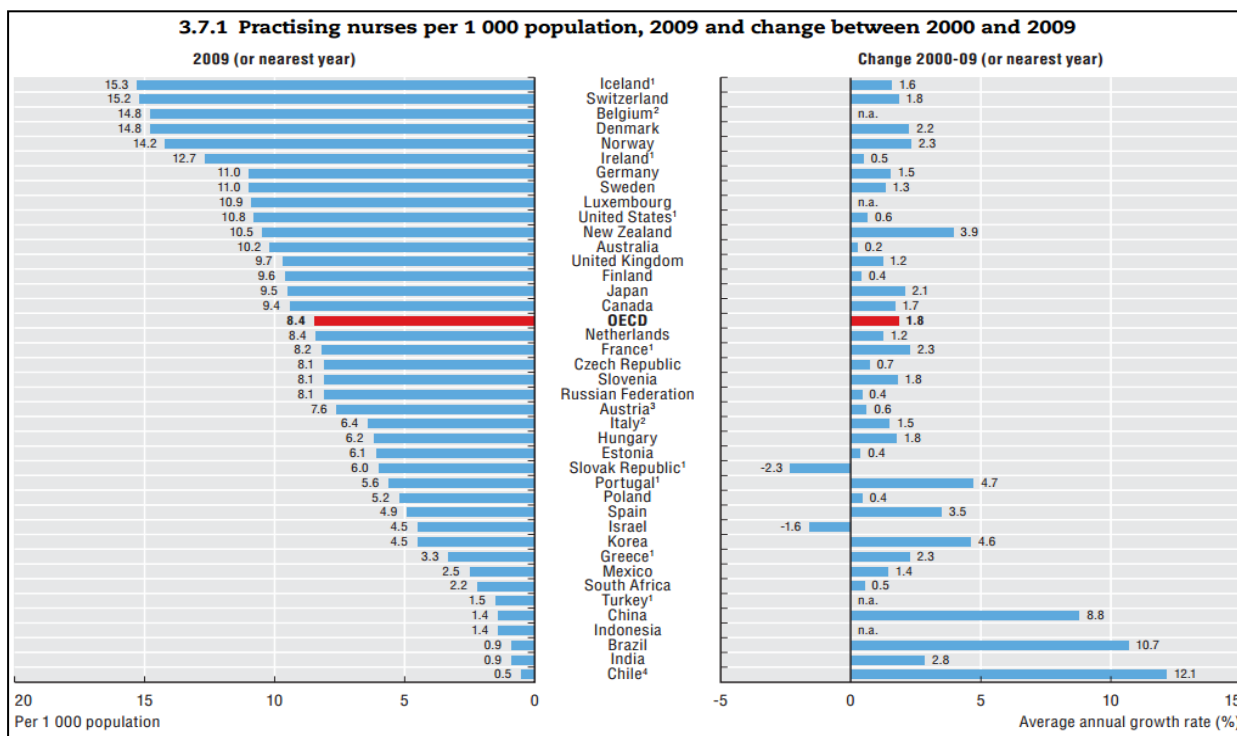
The main issues regarding the Primary Care offer is still a matter of physician's availability and cost for the society.

³⁰ Delamaire, M. et G. Lafortune (2010), « [Les pratiques infirmières avancées : Une description et évaluation des expériences dans 12 pays développés](#) », Éditions OCDE

The comparison between France and Ontario may explain some of the differences about strategic choices and results.

4.1.1 Rapid overview about France and Canada

Comparison between Ontario and France must start with a global overview with the OECD figures³¹ and studies, including the province of Ontario in the Canadian line.



(1) Data include not only nurses providing direct care to patients, but also those working in the health sector as managers, educators, researchers, etc

If France is closed to the OECD average, Canada gets the highest rate of nurses to physicians, due to its shortage of physicians.

³¹ [Health at a Glance 2009](#): OECD Indicators - OECD © 2009 - ISBN 9789264061538

4.1.2 The political context:

The health professional demography plays a crucial role both in the health professional regulation and access to care.

Even if nurses are, according to the Canadian or French laws, independents, the physicians are still the cornerstone into the healthcare system.

Moreover, to avoid talking about physician demography while trying to create new jobs in France like NPs is not possible:

- Firstly regarding to the strong medical lobbying running both in Senate and Congress, which literally stops any alternative or suggestion impacting physicians.
- Secondly regarding to the physician missions in the Public Health Code.

Ontario's physician demography made Congress think about a solution allowing to better reduce wait times and coordination to access to the healthcare system. Despite of the strong policy to hire foreign physicians, the shortage of family practitioners made think about new solutions such as improving nurses competences. **Nurses Practitioners have been the solution to better access to the healthcare system regarding the shortage of physicians**, then to better control coordination between health professionals³².

It is interesting to compare the medical demography between both Ontario and France:

	Physicians (/1000)	Nurses (/1000)
France	3,34	8,2
Ontario	2,16	9

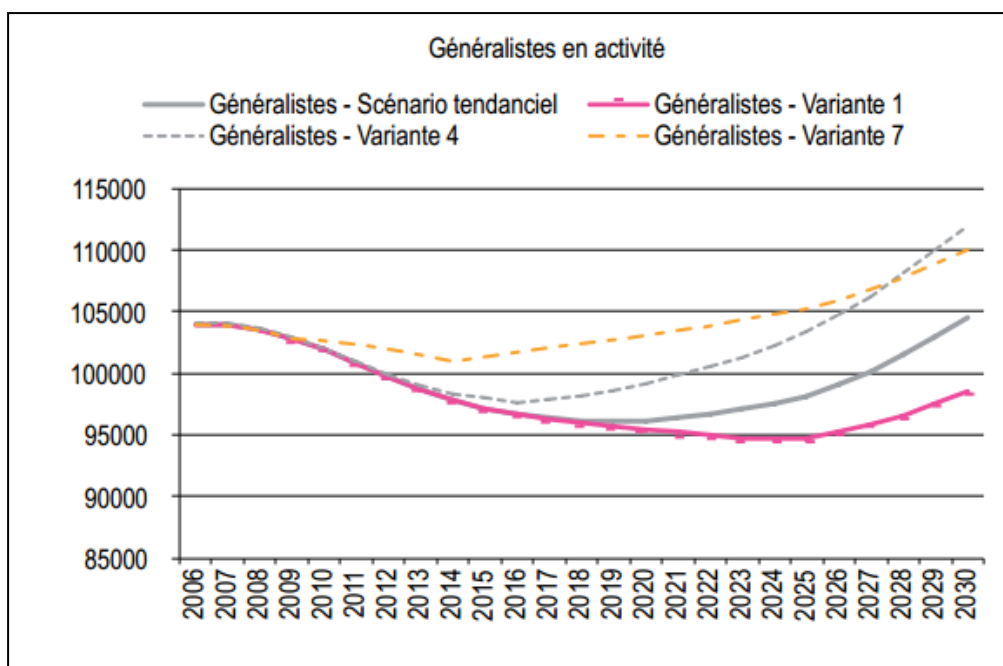
Source: OECD 2012

With almost 33% less of physicians than in France, **Ontario made a political choice to improve nurses' competences in order to reduce the lack of access to care.**

³² [Trends in Healthcare](#): Nurse Practitioners in Canada in 2010 by Veronica Johnson p26

4.1.3 The France situation:

In 2030, there will be 105 000 physicians³³ in primary care practice, instead of 104 000 in 2006: 0,6% more only (see below).



« La démographie médicale à l'horizon 2030 », DREES N°12, 2009

But, according to the INSEE study³⁴, the population in France will increase around 11% more (see below).

Year	Population in France	0-19 (%)	20-59 (%)	60-64 (%)	65 + (%)	75 + (%)
2005	60 702 000	24,9	54,3	4,4	16,4	8,0
2030	67 204 000	22,6	48,1	6,1	23,2	12,0

Source: « Projections de population 2005-2050, pour la France métropolitaine » (Insee Résultats n°57, septembre 2006).

Note: 75+ are already included in the % of 65+. 100% are the addition of the 4 firsts columns.

Thus, the rate of 60+ will be more important than actually, and it represents a strong part of the medical consultations requests.

According to a study from the DREES³⁵, **48%** of Primary care medical consultations come from the **60+ population**.

Thus, 42% of those consultations are related to the regular chronic disease follow up³⁶.

³³ « La démographie médicale à l'horizon 2030 », DREES N°12, 2009

³⁴ « Projections de population 2005-2050, pour la France métropolitaine (Insee Résultats n°57, septembre 2006).

³⁵ « Enquête sur les consultations et visites des médecins généralistes libéraux », Drees, 2002

Regarding the previous figures:

- The number of primary care physician per 1000 population will be in 2030: 1,56 VS 1,71 in 2005. **Almost 9% less.**
- The percentage of 60+ will be 29,3% in 2030 VS 20,8% in 2005. **Almost 40% more.**

Conclusion: in France, until 2030, **physicians will be less numerous, there will be more patients.**

Those figures must be related as well to the average age of patients admitted in hospitals in France:

Level of complexity (disease; 1 the less complex, 4 the most)	Private sector (average age in years)	Public sector (average age in years)
1	53,4	46,27
2	71,23	67,79
3	74,99	71,82
4	74,19	70,84

Source : PMSI³⁷

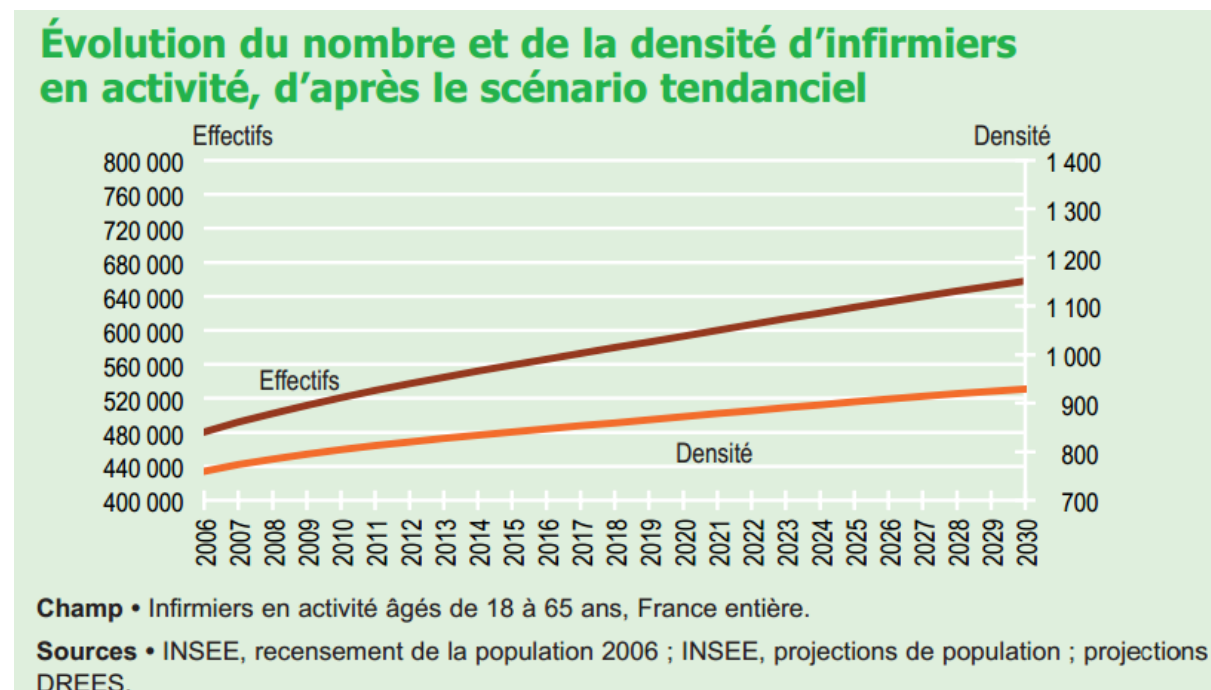
Conclusion: **the more the level of complexity is, the higher is the age of the patient.**

³⁶ « Enquête sur les consultations et visites des médecins généralistes libéraux », Drees, 2002

³⁷ "Global data comparison, « L'activité des CHU dans le PMSI », study by ATIH, May 2009, p. 46

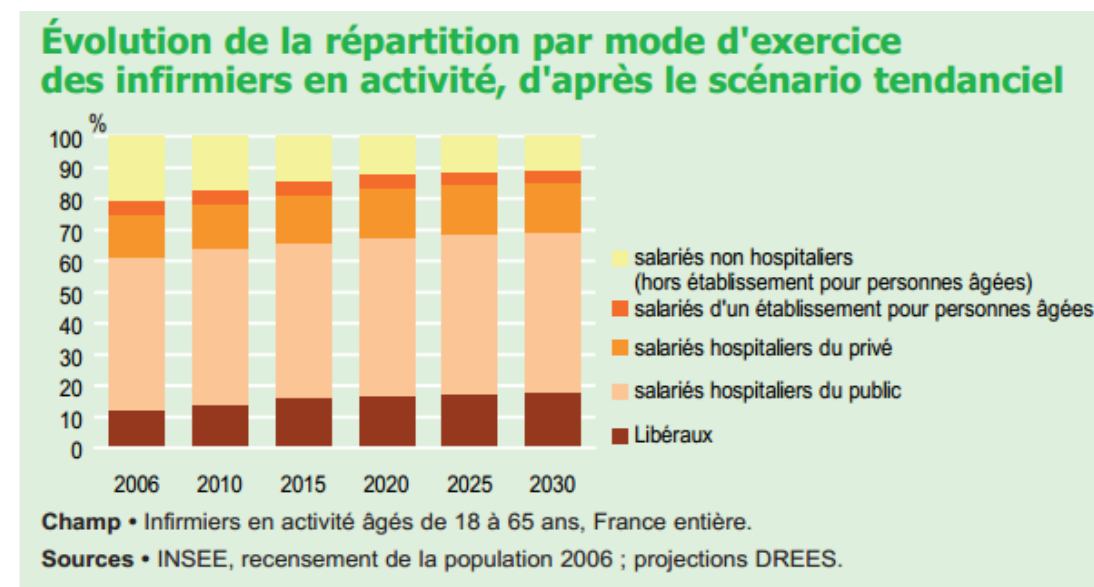
4.1.4 The Nursing potential solution:

If the quantity of physicians in France should decrease or be stable for the next 20 years, the nurse demography might be different:



The nurses quantity might increase³⁸ from 500 000 to 650 000, so 30% more in less than 20 years (while there will be 40% more 60+ patients).

Thus, nurses in “private practice” covering the Primary Care needs should increase too³⁹:



The quantity of Primary care nurses should increase from 75000 in 2012 to 100 000 in 2030

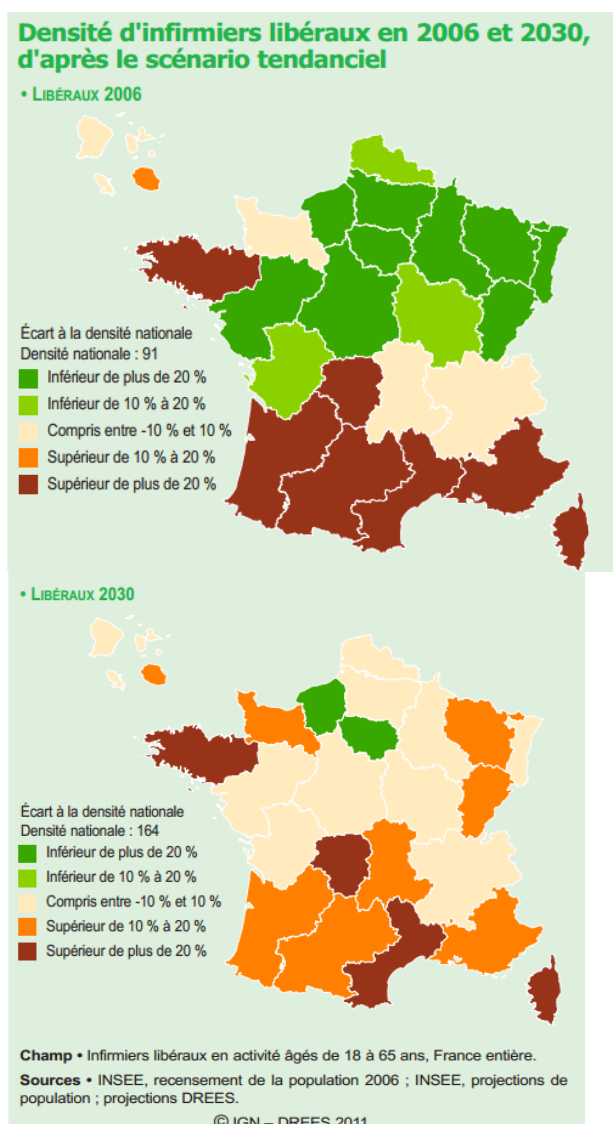
³⁸ « [La démographie des infirmiers à l'horizon 2030](#) », DREES, N°760, May 2011

³⁹ « [La démographie des infirmiers à l'horizon 2030](#) », DREES, N°760, May 2011

An important point is the geographical allocation of nurse resources. As in Ontario, France faces against some issues in this public health challenge.

However, it's important to notify the willingness of private practice nurses, under their labor union negotiations, to be proactive on such a challenge. As of today, they are one of the rare corporations to accept **the restriction of “free installation”**. It's not possible anymore to open a private practice office without the acceptance of the Regional Health Authority: only the “medical deserts areas” are allowed to let a nurse open an office⁴⁰.

This measure should improve the access to care for populations living in areas under-served:



Following those figures and scenario, nurses might be a solution to face against the potential shortage of physicians drawn by the DREES office.

⁴⁰ [Agreement number 3](#) between Private Practice Nurses and French Government, May 2012

4.2 Financial aspect

If the Nurse Practitioner role sounds as a potential solution regarding the shortage of physician to come then the cost control challenge of global medical expenses, some studies have been performed in order to ensure the solution might be as relevant.

One had the objective to assess the efficacy and the cost of a French team work experiment between nurses and GPs for managing type 2 diabetes patients. All these results showed there are **no difference in costs** between the intervention and the controlled group⁴¹.

A second study⁴² based on 11 trials and 23 observational studies, with the objective to determine whether nurse practitioners can provide care at first point of contact equivalent to doctors in a primary care setting, concluded that increasing availability of nurse practitioners in primary care is likely to lead to high levels of patient satisfaction and high quality care. **There were no impacts on costs.**

A recent Senate report⁴³ shows that **60% of total health expenditure comes from people touched by Long Term Condition LTC** (ALD – Affection Longue Durée -), and this figure **should increase until 70%** in 2015. Moreover, the **LTC patients represent only 14%** of the 65 millions National Health Insurance recipients⁴⁴.

Following the French society of general practice of medicine (SFMG), 80% of medical issues are immediately and directly treated by physicians. Moreover, **only 1% of consultations need to be oriented** toward a hospital and 5% toward a specialist⁴⁵.

Regarding the shortage of physicians, the studies showing there is no impact on medical expenses with NPs, and the necessity to better reduce LTC rate – and first costs from far away- , the NP position seems to be a solution to face against those challenges if the quality of care delivery is as good as the physicians one.

⁴¹ [“Effect of a French experiment of team work between general practitioners and nurses on efficacy and cost of type 2 diabetes patients care”](#) by Julien Mousquès, Yann Bourgueil, Philippe Le Fur, Engin Yilmaz, vol 98, n°2-3, 2010/12, 131-143

⁴² Horrocks S, Anderson E, Salisbury C. [Systematic review of whether nurse practitioners working in primary care can provide equivalent care to doctors](#). BMJ 2002; 324: 819-823

⁴³ M. Frédéric Van Rookeghem speech, Director of CNAMTS, for the Health and Social Senate commission, 1st July 2009

⁴⁴ Source: CNIL, [RNIAM](#)

⁴⁵ [“The patient and his GP”](#), April 2010, page 2.

A last but important study⁴⁶ published in 2009 demonstrated that the more higher-care-needs patients were attached to a primary care practice, the lower the costs were for the overall healthcare system (for the total of medical services, hospital services and drugs). For example, for very-high-care-needs diabetic patients, the average annual hospital cost in fiscal 2007-2008 for those in the lowest attachment group was \$16,988, whereas the hospital costs for those in the highest attachment group was \$5,909.

Direct costs were lower for nurse practitioner consultations than for GP consultations at study practices. This was also the case for direct costs plus costs from a societal perspective for patients aged <65 years. Direct costs of consultations at study practices were lower than those of reference practices, while practices did not differ for direct costs plus costs from a societal perspective for patients aged <65 years. Cost differences are mainly caused by the differences in salary.

The overall finding of this evaluation was that **there is a clear inverse relationship between the level of attachment to a primary care practice and costs, for higher-care-needs patients**. Thus, the more patients go to the same practice, the lower the overall annual costs are to the healthcare system.

This study is in accordance with the Primary Health Care professionals' expectations, which are more coordination between home and hospital, targeting particularly the disease management programs.

4.3 Quality aspect

The quality of cares is a crucial and major topic of discussion. During many years, physicians hostile to such a reform -integrate NPs into the healthcare system- tried to demonstrate the lack of efficiency to transfer medical acts to NPs.

But the Journal of Medicine Association in 2000 published a study saying there are **no differences in term of quality of primary cares delivered by either a NP or a physician**⁴⁷.

The ONDPS (French National Observatory on the Demography of Health Professions) and HAS (French "High Authority in Health"), which assessed the initial pilot projects, concluded that: "All the projects presented show that it is possible for non-medical workforce to perform medical acts without danger to patients through a reorganization of the work process and close collaboration with doctors"⁴⁸ (HAS, 2008).

⁴⁶ ["Increasing value for money in the Canadian Healthcare System: new findings of the contribution of primary care services"](#), Marcus J. Hollander, Helena Kadlec, Ramsay Hamdi and Angela Tessaro, *Healthcare Quarterly*, 12(4) 2009: 30-42, 2009.

⁴⁷ Primary care outcomes in patients treated by nurse practitioners or physicians *JAMA*. 2000; 283:59-68

⁴⁸ ["Comment favoriser des formes nouvelles de coopération entre professionnels de santé ?"](#) HAS, Avril 2008

As a previous study explained it in the “financial aspects” chapter, “increasing availability of nurse practitioners in primary care is likely to lead to high levels of patient satisfaction and high quality care”.

These points should demonstrate the groundless criticism of all who complain about the return of an inefficient medicine with the introduction of NPs.

4.4 Education modification

If the NP role seems to be a relevant solution against the future challenges, a major issue is the total absence of any government willingness to introduce this new concept.

One elementary evidence is there is only one school providing a Master degree in Sciences of nursing.

In October 2009, to promote new advanced roles for nurses, a new Master degree was jointly developed by the University of Aix-Marseille and the National School of Public Health (EHESP).

In Ontario a nurse must study during 5 to 7 years to become a NP (part-time possible), when in France it takes 3 years then 2 years in part-time (1100 hours the 1st year). It means all candidates must relocate 1 week per month in Rennes.

Moreover, the quantity of students is weak, regarding the more value of such a new education.

The reasons are mainly because of no official NP position exists, both in the law and on the field, then absolutely no new salary or compensation are suggested with these new competences including more responsibilities.

When a French nurse with 10 years of practice has an average of salary of 25 000 euros per year, an Ontario one will have a minimum of 50 000 euros. NP salary is around 75 000 euros per year with 10 years experience.

According to these facts, French nurses do not feel the need to increase their competences as long as the NP role will not be recognized both professionally and financially.

Why learning a new job which does not exists and gets the same low salary?

4.5 The French specificity

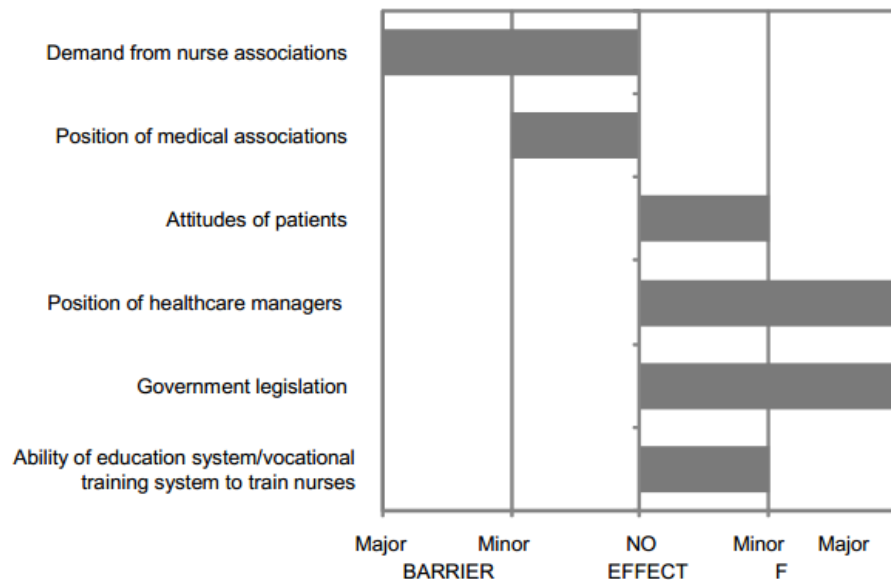
France has the particularity to transfer its Primary Care services into GPs and RNs self employed and protected by the law as “totally independent”.

If this system does not allows fast reactivity when any willing to modify the Primary Care organization, it ensures an independency of health professionals, meaning their ability to discuss health reforms and protect population’s values.

Implementing a NP position in the “liberal” Primary Care Model in France means keep the cultural values that both citizens and health professionals are attached to.

The resistance to change is strong in any organization’s modification, and transfers some Ontario specificity – like the possibility for GPs to hire NPs- will make more resistances than positive attitudes.

Graph 2: Main facilitators or barriers to development of advanced practice nursing, France



Source: Ministry of Health’s response to OECD questionnaire (2009)

Keeping the French current organization and implementing self-employed NPs to both better coordinate and educate patients seems the most pragmatic solution.

However, some issues must be solved before this NP role creation:

- Willingness to go toward this solution by the French Government, meaning modifying the Public Health Code to create such a new position and define scope of practice.
- Creation of a PhD nurse education program to train more NP lecturers. The future NPs students at university should be trained by skilled professionals. A new book of competences should be performed based on the new scope of practice. The

current PHC nurses should have a bridge making easier and faster the NP diploma delivery regarding their competences in advanced practices.

- Modification of the National PHC Nurse Convention, adding some specific NPs financials returns.
- Improve the development of “Maisons de Santé”, French Primary Care Centers with the specificity to not employ any health professional but sharing the same infrastructure and organization⁴⁹.

⁴⁹ Article L. 6323-3, [Fédération des Maisons et Pôles de Santé](#)

5 Conclusion

“The humanity will be able to access to an acceptable level of cares in 2000 if we use more efficiently and completely the worldwide resources⁵⁰”.

If this declaration about the primary cares access sounds, unfortunately, as still an actuality, the OECD countries like France and Canada -Ontario- made different choices, often due to their own culture, specificities and history.

However the main challenges in France in the next few years might change its healthcare organization. The inspiration with other countries solutions might be necessary in order to better adapt the system to the demographical issues, both for physicians and populations. The willingness to improve a system considerate as unique, as well as its organization than its financial model, starts from a cultural change. It means acceptance for physicians to delegate some medical acts and for nurses to extend their competences.

The politics being under pressure in a critical economy context by all groups of lobbying, once again the battle of rationality for public health decisions will occur in both Senate and Congress, with the risk of delaying the necessary modification to the healthcare system.

But, as the former Canadian –Ontario- Ministry of Health Georges Smitherman said about the Healthcare System during a private meeting in July 2012, *“After 6 years passed in the highest seat of the supreme healthcare organization, the more I go deep in the healthcare field, the less I see a System”*.

However Ontario and France are not so far away each other. They both have a National Health Insurance, a strong public health care offer, same goals and, at the end of the day, share some similar values.

France did colonize Canada a few centuries ago, bringing with people some principles of nursing values. Around 400 years later, Canada made its own choice to improve nurses' competences to better solve some public health challenges such as access to care. Finally this “simple” decision built a complete different primary health care model.

So sometimes small differences make big differences. Because if “Nurse” in Canadian means “who takes care of children” as mentioned in the introduction, it also comes from of “nourrice”.

A french word.

But sometimes, small differences are very small.

⁵⁰ [Declaration of Alma-Ata](#) in 1978, WHO.

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EHMBA Class of: 2011-2012		
Extending the Ontario's Nurse Practitioner role in the French liberal Primary Health Care model: potential interest?		
University partnership : ESCP Europe, LSE, Mailman School of Public Health		
<p>Abstract :</p> <p>The French Primary Health Care model is based on a liberal system, with a strong domination by General Physicians due to its historical context. However France must faces to a critical public health challenge which is the shortage of physician to come and the population rising and ageing. Ontario in Canada already decided to adapt its organization by improving nurses' competences with the Nurse Practitioner role and make them participate more in the diagnostic and prescription fields, allowing a better coordination between healthcare professionals, key for a better primary care. The international literature studied a lot those experiences and potential return on investments, both financially and qualitatively. This paper synthesized them and gives a potential solution for France to improve its efficiency by respecting its context and specificities.</p>		
<p>Key words :</p> <p>Nurse Practitioner, Canada Ontario, France, Primary Health Care System, medical demography, public health challenges, nursing role.</p>		
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