

Doctors' working hours

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SUMMARY

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SUMMARY

The Prime Minister has tasked the General Inspectorate of Social Affairs and the General Inspectorate of Finance with conducting a review of working hours for doctors in private practice and in hospitals.

In accordance with the terms of reference, the purpose of this report is:

- ◆ to identify all available data sources that can be used to estimate doctors' working hours;
- ◆ to provide an overview of current knowledge regarding doctors' working hours in private practice and in hospitals, trends in these hours, and the effectiveness of measures designed to optimise them;
- ◆ to provide objective evidence regarding the links between working hours and private practice among doctors in private practice;
- ◆ to analyse the organisation of working hours in public hospitals, from the perspective of compliance and management.

The concept of doctors' working hours encompasses several dimensions for which no precise definition—whether legal or academic—has been established. In this report, medical working hours or doctors' working hours are defined as the total professional time devoted by doctors to the performance of their duties, whether this involves time spent directly with patients in a clinical setting (consultations, visits, technical procedures), indirect clinical time spent managing the patient's care outside of consultations (coordination with other healthcare professionals, analysis of results and maintenance of medical records, communication with the family, etc.) and non-clinical time that is not linked to a specific patient but is inherent to medical practice, whether in private practice or within a healthcare facility (training, research, administrative tasks, supervision, etc.).

'Medical time', on the other hand, refers to the proportion of available clinical time contributed by all doctors within the same organisation or geographical area. Medical time depends on two factors: the individual time of each doctor and the number of practising doctors. Whilst the latter figure is regularly monitored, both at the level of healthcare institutions and at national level by the public authorities, doctors' working hours are currently neither known nor monitored.

Existing data do not, in fact, allow for a complete picture of doctors' working time, including all its clinical and non-clinical components, nor do they take into account all the different ways in which doctors practise (self-employed, salaried, or a combination of both).

The main focus of the task force's work was to assess, within the current organisation of the healthcare system, what information was available regarding doctors' working hours, adopting a distinct approach for the private sector and for practice within public hospitals. In the private sector, working hours are determined by the doctor's individual organisational choices and are largely reflected in private practice billing records. In the public hospital sector, doctors' working hours form part of a collective system, governed by a body of regulations and managed by the hospitals' management.

To carry out its work, the task force drew on an in-depth analysis of activity data for private practitioners (analysis of reimbursement data from the National Health Data System), focusing on general practitioners as well as seven other specialities selected on the basis of differences in clinical practices, the proportion of female practitioners, age and the sectors covered by contractual agreements. The task force also drew on hospital activity data (the DNUM's 'Diamant' database).

It utilised the results of three surveys which it designed and which were conducted respectively amongst the management of public healthcare establishments (230 responses from a sample of 284 questionnaires sent out); amongst doctors at these same establishments (14,725 responses); and amongst private practitioners in the seven selected medical specialities (1,560 responses).

In addition to the qualitative interviews it conducted, notably with organisations representing doctors and hospital governing bodies, the task force also carried out site visits to three hospital establishments (the Hospices Civils de Lyon, the Tourcoing Hospital Centre, and the AP-HP's Paris Saclay University Hospital Group).

However, due to a lack of sufficient data, the task force was unable to analyse the working hours of salaried doctors in the private sector (both for-profit and not-for-profit). Nor was it able to conduct an in-depth analysis of the effects on working hours of the measures put in place to facilitate care pathways (sharing and delegating tasks to other healthcare professionals, coordinated practice, etc.).

Furthermore, the report focuses solely on the issue of working hours and changes in doctors' workload, and examines the question of remuneration and its link to working hours only in passing, as this issue alone would have required extensive investigations which the task force was unable to carry out within the time allocated to it.

Similarly, the task force chose to focus its analysis primarily on clinical time and its organisation, given its direct impact on the time available for medical practice, and did not explore the issue of non-clinical time, except to attempt to estimate its proportion using the available data and surveys conducted by the task force.

Following its work, the task force has drawn four conclusions:

- ◆ there is currently no database or monitoring tools enabling the public authorities to gain a precise understanding of doctors' working hours, their composition, and to measure how they have changed;
- ◆ existing self-reported surveys, as well as the task force's analysis of statistical data, show a decline in the working hours of self-employed doctors, with this trend being more pronounced amongst general practitioners over the past fifteen years or so. The trend towards a younger and more female workforce is having an impact on the proportion of total clinical time, even though, in the medium term, the difference between women and men is tending to disappear;
- ◆ mixed practice – that is, dividing one's work between private practice and salaried employment – is growing significantly and is expected to continue, driven by the appeal of salaried employment (in the public or private sector) and the desire for a varied role. However, the available data do not allow us to measure the trends in this phenomenon or its impact on working hours, as it is not possible to track the full scope of a single doctor's work;

- ♦ in public hospitals, regulations are not systematically enforced and the management of doctors' working time is underdeveloped. Over the last five years, hospital productivity per doctor has fallen, whilst the number of doctors has risen, as have expenditure on schemes to compensate for the shortfall in doctors' working time (overtime, use of locum doctors), particularly in hospitals that are less attractive than university hospitals, which can use these schemes as a means of attracting staff.

It should also be emphasised that whilst these developments do have an impact on access to healthcare, they are nevertheless only one aspect of the current pressures on healthcare provision. Apart from changes in doctors' attitudes to work, the issue of the regional organisation of healthcare provision has implications for work organisation, particularly in public hospitals.