France: new government, new focus on medical deserts?

A few reflections come to mind on reading *The Lancet Public Health*'s editorial (June, 2017)[1] on the impact of the French presidential election on public health in France. As members of the medical field, we applaud the nomination of a respected medical doctor as Minister of Health. This nomination has generated hope for a new management style—one that will hopefully be closer to and address the real concerns of people working in the health sector, and those that they serve. It has also raised our expectations of the public health agenda, which we hope will concentrate on the real issues at hand, rather than stagnate in the purely technocratic, economic, or ideological impasse that has often been a feature under previous governments. The choice of *The Lancet Public Health* to highlight Agnès Buzyn's nomination is therefore very welcome.

However, a reader unfamiliar with the public health panorama in France might conclude that alcoholism is the foremost issue for public health. Alcoholism is indeed a major concern, particularly for young people, and an issue which, along with other types of addiction, should not be neglected. Yet public health in France has another more pressing problem, itself a source of the inequities mentioned in the editorial:[1] the decreasing coverage of large parts of the territory by medical practitioners, in a process of so-called medical desertification. According to the 2015 Atlas of Medical Demography by the French Order of Medical Doctors,[2] the number of retired physicians increased by 75·1% between 2006 and 2015, but the number of active practitioners grew by only 1·2%, with an unequal distribution of this trend between and within regions, leading to some areas becoming so-called medical deserts, with low densities of practitioners. In that context, a growing proportion of practitioners maintain some activity post-retirement. This long-standing process is tightly linked to two issues: a completely unrealistic and mainly cost containment-driven policy to limit the number of general practitioners, specialists, and paramedical personnel who are trained in medical schools; and the progressive closure of local care structures for the benefit of larger urban medical centres, with higher costs and a much more impersonal approach to care. In this context, patients are reduced to two choices: either travel much further for regular care, or rely on emergency services, generating additional inefficiencies.

This trend, if not addressed, will define the preventive and curative services that are the basis of the French public health system. As a cardiologist practising in a rural department and a public health specialist with ties to that same region, we are first-hand witnesses of this dilemma. So, in a country where medical studies are done in free public universities and therefore financed by the French people, is it not time to reflect on a post-diploma policy that balances the distribution of private and public medical practices in urban and rural areas for the benefit of the whole population? Let us hope that the new government will be willing and able to put in place the reforms many times evoked but never enforced by its predecessors. The French population has many expectations in that regard.

We declare no competing interests.

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1 The Lancet Public Health. France: new government, new opportunities for public health. *Lancet Public Health* 2017; **2:** e247.

2 Conseil National de l'Ordre des Médecins. Atlas de la Démographie Médicale en France. 2015. https://www.conseil-national.medecin.fr/sites/default/files/atlas_national_de_la_demographie_medicale_2015.pdf (accessed June 21, 2016).

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