Compulsory continuing medical education

Country: France
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1. Abstract

In 2002 the government decided that Continuing Medical Education (CME) will be compulsory for all physicians. The reform has been implemented progressively since then. Compulsory Continuing Medical Education (CCME) includes different types of programs which aim to maintain and improve doctors’ medical knowledge. Doctors are asked to participate in a number of educational programs/activities to obtain a specific certificate every five years.

2. Purpose of health policy or idea

After many decades of unsuccessful rhetorical policies trying to encourage doctors to participate in CME activities on a voluntary basis (see below "Origins of health policy idea"), CME became compulsory by law for all doctors in 2002 (law 2002-303 of the 4th of March 2002). The implementation has been stepwise.

Improving quality of care

The ultimate purpose of the Compulsory Continuing Medical Education (CCME) law was to improve the quality of care by maintaining or improving medical knowledge, and by increasing doctor’s compliance with evidence-based-medicine practice. The immediate objective was to improve doctor participation in CME programs.

The practical modalities of the CCME and the eligible programs are defined by two recent ministerial orders and a decree.

The programs which will be part of the CME are defined by an agreement between three different committees at the national level (one for doctors working in hospitals, one for self-employed doctors working in the ambulatory sector, one for salaried doctors), and a co-ordinating committee that consists of the representatives of physician unions, physician order, medical schools and CME associations. This committee will coordinate the activities of the three aforementioned committees and define common national priorities for continuous education (Ministerial orders of 26th of January 2004 and of 14th of April 2005, decree 2003-1077 of 14th of November 2004). Currently, these four national committees are effectively appointed, but the agreed CME institutions and the programs are not yet listed.

Different categories of CME courses

Each CME program is assigned a certain amount of credits (ministerial order of the 13 July, 2006). There are 4 categories of programs:
1. Collective CME courses, delivered by registered training institutions (seminars, professional meetings, CME training...). Participation in this type of CME courses generates 8 credits for one day course, 4 credits for evening or half day courses.

2. Individual CME supports such as teaching supports in paper or electronic form, reviews, books, telemedicine, e-education... For each registered CME journal/support program, the doctor can accumulate 4 credits with a maximum of 40 credits in 5 years. For non registered reviews a doctor can obtain 2 credits by review with a maximum of 10 credits in 5 years.

3. Education/research activities. This includes two types of activities:
   - participation in initial medical education (education, supervision of PhD, supervision of internship) and/or CME (education and training) and/or research project and publication;
   - participation in representative bodies (National/Regional/local council of physicians, CME associations, etc.) and in public interest duties for improving the quality and/or organization of care (prevention campaigns, etc.).

With these CME activities a doctor can accumulate 8 credits for one day of presence, 4 for one evening or half-day of presence, with a maximum of 50 in one category, 100 credits in all categories included, in 5 years.

4. Evaluation of professionals' practice (EPP) which is a form of medical audit (see Chevreul: Evaluation of professionals' practice, Health policy monitor, survey n°5, 2005). EPP aims to improve care quality by providing doctors a peer feedback on their pattern of practice. Participation in EPP became compulsory in 2004.

Doctors participating in these CME programmes are given points accordingly. In order to comply with the law, a doctor has to accumulate every 5 years 250 credits split up as follows: 150 credits in CME activities from categories 1 to 3 and 100 credits in activities from category 4. Credits are subject to a 20% bonus if the activities are linked to the priority topics defined by the national committee.

Regional committees were given the responsibility for validation and certification of doctors' compliance with the CCME for 5 years (decree 2006-650 of the 2nd of June 2006). However, these committees are not yet effectively in place because of financial problems.

If a physician does not comply with the law, the regional committee would have to inform the Medical Regional Order (deontological, ethical and regulatory body) six months after expiration of the legal delay. The Medical Regional Order would be responsible for proposing an education program which would help the physician to catch up with the continuing education. If the physician refuses to participate, then it would be legitimate to assume the Order could suspend a physician’s practice license but this is not explicit in the law. According to the president of the National Council of Physicians Order this will be the case only for recalcitrant physicians. Ultimately, it seems that the major incentive for doctors is the possibility of using the certificate as a quality label proving that they have gone through CME programmes.

Financing of CME

Currently the CME is financed by three sources:

1. Public funding: Up to 112 million € of which 103 million € come from national health insurance funds. NHI funds partly finance CME programmes and pay doctors allowances for participating in such programmes. Another 7 million € come from the state through tax reductions on physicians' income.

2. Private funding: About 22.5 million € come from direct and indirect contributions by physicians;

3. Private funding from the pharmaceutical industry which amounts to around 600 million €. The role the industry plays in CME is extremely diverse: it goes from financing to organising specific programs. CME programs organised by the pharmaceutical industry have been highly criticised for being marketing strategies rather than promotion of good practices. Currently, the place (or role) given to the pharmaceutical industry in developing CME has not been formally defined with a few exceptions. First to declare their CME activities and funding. Second to use international denomination instead of commercial name for drugs.
Main objectives
The first objective is to improve doctor participation in CME programs.

The ultimate aim is to improve the quality of care by maintaining or improving medical knowledge and physician's compliance with evidence-based-medicine.

Type of incentives
The major incentive for doctors is the possibility of using the certificate as a quality label proving that they have gone through CME programs.

Groups affected
Providers (physicians), payers (Ministry of Health, national health insurance funds, pharmaceutical industry), organizers (physician unions, Physician Order, continuing medical education associations)

3. Characteristics of this policy

<table>
<thead>
<tr>
<th>Degree of Innovation</th>
<th>traditional</th>
<th>innovative</th>
</tr>
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<tbody>
<tr>
<td>Degree of Controversy</td>
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<td>highly controversial</td>
</tr>
<tr>
<td>Structural or Systemic Impact</td>
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<td>fundamental</td>
</tr>
<tr>
<td>Public Visibility</td>
<td>very low</td>
<td>very high</td>
</tr>
<tr>
<td>Transferability</td>
<td>strongly system-dependent</td>
<td>system-neutral</td>
</tr>
</tbody>
</table>

4. Political and economic background

5. Purpose and process analysis

Origins of health policy idea
Low support for and participation in CME programs until 1996

Until the 1996 reforms by Juppe, even pronouncing the idea of compulsory continuous medical education was a big challenge. Furthermore, continuing medical education has been exclusively financed by the pharmaceutical industry in France and any tentative attempt to at least “partly” publicly finance CME has never been achieved.

As a consequence, only a small number of doctors has been participating in the CME activities (it is estimated that in
2005 only 20% of physicians working in the ambulatory sector participated in CME programs and CME programs were showing a lot of diversity in their contents as well as financing methods.

**CME becomes compulsory in 1996...**

The 1996 reform was a turn in the evolution of CME. It made CME compulsory for medical professionals and organised it uniformly. National and regional committees were set up to list and to certify programs that fulfil the relevant criteria to be accepted as CME programs. The reform has also proposed the creation of a new fund, which merges NHI funds and money raised from physician wage earners' income, managed by the government to oversee the organisation of CME.

**...but participation rate remains low**

However, all these measures did not improve doctors' participation in CME for many reasons. First of all, while the law stated that not going through CME can lead to sanctions, these sanctions were never defined. Second, a proper funding was never assured for an effective listing and certification of CME programs. Third, the NHI fund, not being able to control the decisions on what and who has to be financed with the the CME fund, refused to use this joint funding. As a consequence, the new fund has never been set up and the old financing system was re-installed.

**New legislation in 2002 tightening rules for participation in CME programs**

The Act on patient rights and the quality of care (Law 2002-303 of March 2002) was the second and a more determinant step for introducing CME. It confirmed that CME is compulsory for medical doctors and defined the modalities: participation in agreed CME programs, with an obligation to participate in evaluation of professionals' practices.

**Initiators of idea/main actors**

- Providers
- Payers
- Others

**Approach of idea**

The approach of the idea is described as: renewed: The concept of compulsory CME entered the political debate in 1996 (see “Origins of health policy idea”)

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**Stakeholder positions**

Physicians representatives (Unions or Medical Order) are very supportive but the position of individual physicians it is less clear.

Public payers (Ministry of Health, NHI funds) are very supportive of the concept of compulsory CME. However, public funding devolved to CCME still remains too modest and insufficient.

**Actors and positions**

Description of actors and their positions

- **Providers**
  - Physicians
    - very supportive
    - strongly opposed

- **Payers**
  - Ministry of Health
    - very supportive
    - strongly opposed
  - National health insurance funds
    - very supportive
    - strongly opposed
Influences in policy making and legislation

The reform of compulsory continuing medical education is directly conditioned by the legislative process which gradually abandoned any idea of formal sanctions for non-participation in CME programs and independence of funding from the pharmaceutical industry.

Legislative outcome

Actors and influence

Description of actors and their influence

Providers

Physicians
very strong

None

Payers

Ministry of Health
very strong

None

National health insurance funds
very strong

None

Pharmaceutical industry
very strong

None

Organizers

Continuing medical education associations
very strong

None

Physician unions
very strong

None

Physician Order
very strong

None

Positions and Influences at a glance

Adoption and implementation

CME institutions and programs are not yet defined

Although most of the decrees required to implement this law have been currently published, the legislative process still remains unachieved as the list of agreed institutions which would provide CME and the education programs are not defined yet. Moreover, the regional committee, which is a major actor in co-ordinating CME is not appointed.

Incentives for participation in CME instead of formal sanctions

It appears that the sanctions which were initially mentioned are finally abandoned, and will be replaced by a set of incentives. These incentives have not been defined yet, but the main one would be to authorise doctors to use a "CME label" proving that they have gone through CME programmes. Paying doctors an annual lump sum for participating in CME is also proposed as an option.

New funding mechanism still needs to be created

The NHI funds have the possibility to choose the programmes that they want to finance. A new single fund merging all other sources of funding will be created. However, it is not clearly defined yet how it would be managed and what the
methods of financing various committees are. At this stage, it is difficult to see the benefit of this new organisation compared with the previous one.

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**Monitoring and evaluation**

The success of this CME reform will be measured by each regional committee which will measure and provide an annual report on physician participation in CCME.

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### 6. Expected outcome

While it is too early to make an assessment of the outcome of this policy, we can point out the existing problems in implementing this complex framework:

1. **There is no solid structure of financing** CME. It is not clear yet how the regional committees will be funded. The institutional funding (134.5 million Euros, of which 112 million Euros will come from public funds and 22.5 million Euros from direct or indirect physician contributions) seems to be too modest and insufficient for counterbalancing the investment of the pharmaceutical industry in this field that amounts to 600 million Euros.

2. **There is a lack of transparency in defining eligible CME institutions and programs** with some obvious conflict of interest. Physician unions are well represented within the national committees for CME (which approve CME institutions and programs), even though they have developed their proper CME institutions and programs. The principle of independence of CME institutions from the pharmaceutical industry is finally not retained. While national committees claim that they are independent, many CME associations live on pharmaceutical industry funding.

3. **There is a lack of accountability in decisions concerning eligible CME programs** which are not always
coherent with public health priorities. There is strong competition between different stakeholders setting up CME programs (physician unions, not-for-profit associations, National Health Insurance funds). We estimate that there are at least 1200 different training institutions.

4. It is difficult to say how many physicians will participate in CME programs, as no formal sanctions for non-participation were set up.

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<thead>
<tr>
<th>Quality of Health Care Services</th>
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<tbody>
<tr>
<td>Level of Equity</td>
<td>system more equitable</td>
</tr>
<tr>
<td>Cost Efficiency</td>
<td>very high</td>
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</tbody>
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7. References

Sources of Information

For a historical and critical overview of CME see:


For a critical analysis of this framework see:

www.ladocumentationfrancaise.fr/rapports-publics/064000180/index.shtml

CME law, decree, ministerial order. Can be downloaded from the main association of CME website:
www.unaformec.org/reglementation/index.htm

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