

1. Reform of On-Call Duty Compensation

Since November 2025, an increase in on-call duty compensation has been implemented in public hospitals in order to standardize the system.

Previously, systems were highly heterogeneous, with regulations that were difficult to interpret. This gave hospital directors full discretion to decide whether or not to recognize working time during on-call duty, and to vary flat-rate payments and travel compensation.

The new regulations provide for several on-call duty packages (ranging from €70 to €280), depending on workload intensity, defined in particular by:

- the number of call-outs and phone calls,
- working hours (including late-night shifts),
- urgency of interventions,
- complexity of patient management,
- number of on-call duties per month.

However, this reform has often been misapplied by many institutions, which have adapted it to their own advantage—most often to the detriment of practitioners—by falsely claiming insufficient budget.

APH and SNPHARE have worked to inform practitioners and support them within their hospitals to ensure that the reform is properly and lawfully implemented.

One issue remains unresolved: the valuation of telemedicine work (phone calls, tele-expertise, interpretation of imaging, remote prescriptions, etc.), which is not included in the calculation of on-call working time. This contradicts the European Working Time Directive (2003).

2. Perinatal Care

The revision of the 1998 perinatal care decrees is currently underway, initiated by the Minister of Health, Ms. Rist, following concerns over maternal and infant morbidity and mortality in France.

The initial exclusion of anesthesiologists and intensivists from the steering committee triggered strong reactions from unions and scientific societies, which ultimately succeeded in being included.

A joint letter from all stakeholders in perinatal care was sent to the Directorate General for Healthcare Supply (DGOS), calling for the launch of a structured reform of perinatal care levels, based on three main priorities:



- **Definition of a viable and safe maternity unit**
With trained, complete, and stable medical and paramedical teams, and a level of activity sufficient to maintain skills, manage critical situations, and ensure continuity of care.
- **Graduation of care levels**
Including local monitoring and prevention, delivery in appropriately resourced centers, and strengthened cooperation through regional healthcare teams.
- **Development of territorial healthcare plans**
Adapted to demographic and epidemiological needs. Low-activity maternity units without stable teams are not considered an adequate response to quality and safety challenges.

3. Working Time and Physicians' Health

Several surveys have been conducted by SNPHARE on the working time of hospital practitioners in anesthesia and intensive care medicine.

These studies highlight a hospital system based on excessive physician workload, which has become the norm:

- 75% of practitioners exceed 48 working hours per week,
- A significant proportion exceed 60 hours per week,
- There is heavy reliance on additional working hours (overtime).

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- Highlights heterogeneous and unclear methods for calculating working time,
- Reports unrecognized or unpaid working hours,
- Notes the exclusion of on-call duty time from working time calculations.

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- Strong demand for shorter shifts,
- Need for improved work-life balance,
- Recognition of workload strain.

WHAT HEALTH

These findings reveal a worrying deterioration in hospital physicians' health:

- Chronic diseases (cardiovascular diseases, cancers),
- High levels of fatigue and stress,
- Lack of medical follow-up and inadequate occupational health services.



Healthcare workers' health remains a blind spot in public policy, despite its significant impact on the quality and safety of care. Work initiated under previous Ministers of Health is currently at a standstill.

The hospital system is under structural strain, relying on overworked and increasingly vulnerable professionals.

Based on these findings, APH and SNPHARE advocate for several major changes:

- Accurate hourly calculation of working time and its reduction to 39 hours per week,
- Reform of shifts in terms of duration and organization,
- Recognition of workload strain, particularly at the end of careers,
- Development of a structured policy for prevention and medical monitoring of physicians.

At the request of the Prime Minister, an investigation by the General Inspectorate of Social Affairs (IGAS) on physicians' working time (across all modes of practice) is currently underway, but has been poorly—or not at all—communicated by hospital administrations.

4. Reform of the Disciplinary System for Hospital Practitioners

The Ministry intends to align the disciplinary system for physicians (currently managed by the National Management Centre – CNG) with the procedures applied to civil servants in the hospital public service.

The proposal to transfer the initial levels of disciplinary sanctions to hospital directors (DG) and heads of medical committees (PCME), instead of an elected peer-based body, appears highly concerning—particularly because no local union-level oversight is *предусмотрен* by regulations, and because career management remains under the authority of the CNG.

APH and SNPHARE will closely monitor this high-risk issue, given the potential for arbitrary or biased decisions, while remaining firm and uncompromising on disciplinary matters affecting practitioners.
