

# Evaluation of the plan for preserving antibiotic efficacy 2007-2010

## Summary

February 2011

In France, overall antibiotic consumption fell between 2000 and 2008 but rose in 2009. Although the French policy for preserving antibiotic efficacy is considered exemplary in Europe, French consumption – in outpatient contexts – remains one of the highest in Europe. Antibiotic resistance trends in France vary depending on the bacterial species and class of antibiotics. It is highly likely that some changes in bacterial ecology towards lower resistance can be attributed to the plans of action for preserving antibiotic efficacy undertaken since 2001.

In October 2010, the French Ministry for Health asked the follow-up committee for the second antibiotic plan of action “*to suggest actions, without awaiting publication of the 3<sup>rd</sup> plan, which can be taken immediately*” given the 2009 increase in antibiotic consumption and the emergence of new multi-resistant bacteria to virtually all existing antibiotics. This, in fact, answers the question of the opportunity of a third plan of action and is in line with the publicly expressed consensus among experts to the French Directorate-General for Health (DGS).

With the speeding-up of the ministerial agenda, the French High Council for Public Health (HCSP) aimed to complete its evaluation of the second French program for preserving antibiotic efficacy as swiftly as possible. Initial observations and recommendations were presented to the follow-up committee and to the French DGS at the end of November 2010. These were then finalised and organised into five principles and recommendations.

**Principle 1: put together and implement a 3<sup>rd</sup> plan with all stakeholders**

Private-practising doctors, and GPs in particular, are hardly involved in the follow-up committee’s work – when they are in fact the primary prescribers. It is crucial that the involvement of these professionals and the people who consult them is ensured through their participation from the plan outset.

**Principle 2: put together and implement a 3<sup>rd</sup> plan of action from an evidence-based strategic analysis shared by all stakeholders**

The outcomes of the plans are real but fragile or partial and the resources are limited. An approach based on the best evidence available (from research and practices) is therefore essential. This should also pinpoint what is preventing the desired changes from taking place and identify opportunities for change.

**Principle 3: a 3<sup>rd</sup> plan of action whose objectives and resources need aligning**

It would be preferable to identify and quantify the resources that could be attributed to the 3<sup>rd</sup> plan as soon as possible so that the funds available match the objectives set, and the funding targeted on specific, attributed actions to ensure the highest effectiveness.

**Principle 4: a 3<sup>rd</sup> plan of action steered by the DGS from the outset**

Based on work done by expert committees, *ad hoc* groups as well as agencies and other relevant organisations, the DGS must be in charge of defining the political orientations and the objectives which, after ministerial decision, will form the public plan. The different stakeholders should be fully involved within the framework provided by this steering and work out actions that are decided together. Once the plan has been adopted, the DGS' role – beyond the regulatory and legal aspects within its remit – should mainly be one of overseeing, communicating and monitoring implementation of the plan.

**Principle 5: a 3<sup>rd</sup> plan of action including an evaluation method for steering during implementation**

To optimise the plan for preserving antibiotic efficacy, the DGS should produce an annual activity report indicating which actions are under way, who is the supervisor and effector and who is the sponsor, enabling the obstacles and success stories to be analysed and the necessary adjustments to be proposed.

**Recommendation 1: a 3<sup>rd</sup> plan of action combining health safety and public health**

Infections to the most resistant bacteria can spread and cause a local outbreak in hospital where they will be identified and treated. Close attention must therefore be paid to hospital infections. However, preserving antibiotic efficacy above all requires promoting proper use of these medicinal products which, for the most part, are prescribed by GPs to outpatients.

**Recommendation 2: a more restricted plan of action**

The 3<sup>rd</sup> plan should focus on a few federating themes and therefore, based on the previous principles, only adopt a limited number of priorities with, for each, a few actions carefully defined and precisely described for which the operational go-betweens and implementation means have been identified and are available.

**Recommendation 3: complete the current information system to turn it into an effective tool for assessing proper use**

Major efforts have been taken in terms of information collection. There is still room for improvement, however, to obtain better information about resistance trends in outpatient antibiotic use and regional disparities, as well as to make surveillance organisation more efficient and allow for the plan to be properly monitored and steered. Information systems at the service of professionals would also be worth developing.

**Recommendation 4: maintain coordinated actions targeting prescribers and consumers to conduct us to change behaviour and define by turning to human and social sciences, research in management and on health services for support**

The development of research in human and social sciences, management and on the health services should be encouraged to identify effective measures that stakeholders in charge of patients should adopt. Likewise, promote these aspects so that the research that emerges in general medicine forms a promising course of action.

## **Recommendation 5: identify the components of the French health system that would be worth “activating”**

### **The medicinal product policy**

It is expected that a dynamic approach to the tools of the medicinal product policy will be adopted. This particularly concerns pharmaceutical regulations, warning and surveillance systems of adverse effects, cross-checking data from the French health insurance system and existing processes in the event of prescription volumes of a given medicinal product exceeding the expected volumes when it is admitted for reimbursement, as well as support measures for pharmaceutical research (concerted European action). Close coordination between the diverse competent organisations for proper antibiotic use should be encouraged.

### **Medical training**

In terms of initial training, the actions should work towards meeting a more general training objective in prescribing and not prescribing medicinal products. To ensure the effectiveness of post-university training schemes, the French DGS should take account of determining factors of the professionals' choices. It could also give priority to actions by turning to the French Federation for Infectious Diseases, scientific societies of general medicine and independent associations of vocational training – particularly GPs' ones.

### **Regionalisation of the health system and policy**

The Regional Health Agencies (ARS) will have to manage implementation of the actions tabled under the 3<sup>rd</sup> plan. Due to regional variations – both in terms of antibiotic consumption and resistance – it would be appropriate for each ARS to draw up a work plan in keeping with the national plan, but which has been tailored to the regional situation. Through this method of structuring, it will also be possible to jointly organise the proximity response to prescribers as well as the expertise, epidemiological watch and coordination needs. This delegation to ARS should obviously go hand in hand with close steering by the DGS.