



France

Health system summary 2024

AUTHORS

Zeynep Or, Coralie Gandré, Anna-Veera Seppänen,
Cristina Hernández-Quevedo, Erin Webb, Morgane Michel,
Karine Chevreul

Anna Maresso (Series Editor)

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This Health system summary is based on the *France Health System Review* published in 2023 in the Health Systems in Transition (HiT) series. Health system summaries use a concise format to communicate central features of country health systems and analyse available evidence on the organization, financing and delivery of health care. They also provide insights into key reforms and the varied challenges testing the performance of the health system.

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How is the health system organized?

ORGANIZATION

The French health system is of a mixed type: it is structurally based on a social health insurance approach, but it shares National Health System goals reflected in the single public payer model, the importance of tax-based revenue for financing health care, strong state intervention and residency-based benefits. There is statutory health insurance (SHI), which currently covers almost 100% of the resident population under various schemes.

The leadership of health policy and regulation of the health care system is divided between the state

(parliament, government, and the Ministry of Health), SHI and, to a lesser extent, local authorities (*départements*).

The Ministry of Health (MoH) has substantial control over the health system, although at the regional level, the regional health authorities (*agences régionales de santé*, ARS) have public health and health care planning and financing responsibilities within their remit (Box 1).

The French health system is centralized, with regional decentralization of responsibilities

PLANNING

Responsibility for planning health system resources and capacity is shared by the MoH and the ARS. The goal of this partial devolution of the planning function is to

enable regional authorities to meet the health needs of local populations more appropriately.

PROVIDERS

The responsibility for delivery of care is shared among private, fee-for-service physicians and other health professionals, private for-profit hospitals, private non-profit hospitals, and public hospitals. Health care provision is highly fragmented in France, with a segmented approach to care organization and funding across

primary, secondary and long-term care. The system is hospital-centred, with many public and private hospital providers competing for patients, who have freedom of choice. Most providers are paid on the basis of statutory tariffs, which are either paid directly to the provider by the SHI or by patients who are later partly reimbursed.

BOX 1 | THE DISTRIBUTION OF RESPONSIBILITIES ACROSS ACTORS

Decentralization in France reflects a marked reluctance to reduce central control over policy and finance. It mainly comes in the form of deconcentration, i.e., where some administrative authority from central government offices is passed to locally based offices. The creation of the regional health agencies (ARS) in 2010 changed the regional landscape by merging seven regional institutions into a single regional entity traversing the traditional boundaries of health care, public health, and health and social care for older and disabled people.

The 18 ARS (13 in mainland France and 5 in the overseas territories) are responsible for ensuring that the provision of health care services meets the needs of the population by improving the coordination between the ambulatory and hospital sectors and health and social care sector services, while respecting national objectives for SHI spending.



How much is spent on health services?

FUNDING MECHANISMS

The SHI system in France is universal and provides a broad benefits basket. To ensure financial sustainability, sources of health funding have been extended beyond payroll contributions and diversified over the past decades. In 2021 only about 33% of revenues for the SHI came from employer and employee payroll contributions, while 24% came from the general social contribution (CSG), a basket of taxes applied to a household's broader range of income, and 33% from other taxes, of

which 20% came from VAT (HCFi-PS, 2021).

The national government introduced spending targets in 1997 and monitoring mechanisms for health insurance in 2010, both of which play an increasingly important role in managing costs by reducing the initial independence of the SHI in controlling health expenditure.

Spending targets play an increasing role in managing health expenditure

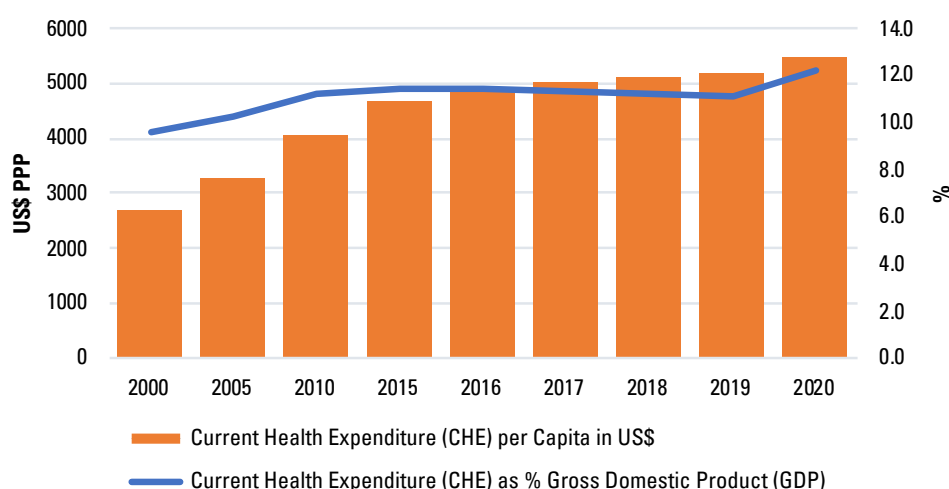
HEALTH EXPENDITURE

France spends a high proportion of its national income on health care: in 2020, 12.2% of GDP was spent on health care (Fig. 1), which was the third highest in the WHO European Region that year, after Germany (12.8%) and Armenia (12.2%). Spending on health as a share of GDP has been persistently higher in France than the EU average over the past 20 years. Per capita health expenditure in 2020 was also relatively high and exceeded both the EU and WHO European Region

averages (Fig. 2).

In 2020, about 79% of the current health expenditure was funded by public resources, according to national sources, mainly the SHI (73%) and the state (6%). Out-of-pocket (OOP) expenditure on health amounted to 8.8%. As cost sharing is required for most health services, the majority of the population purchases private complementary health insurance (CHI) which covered about 13% of health care costs in 2020 (DREES, 2023).

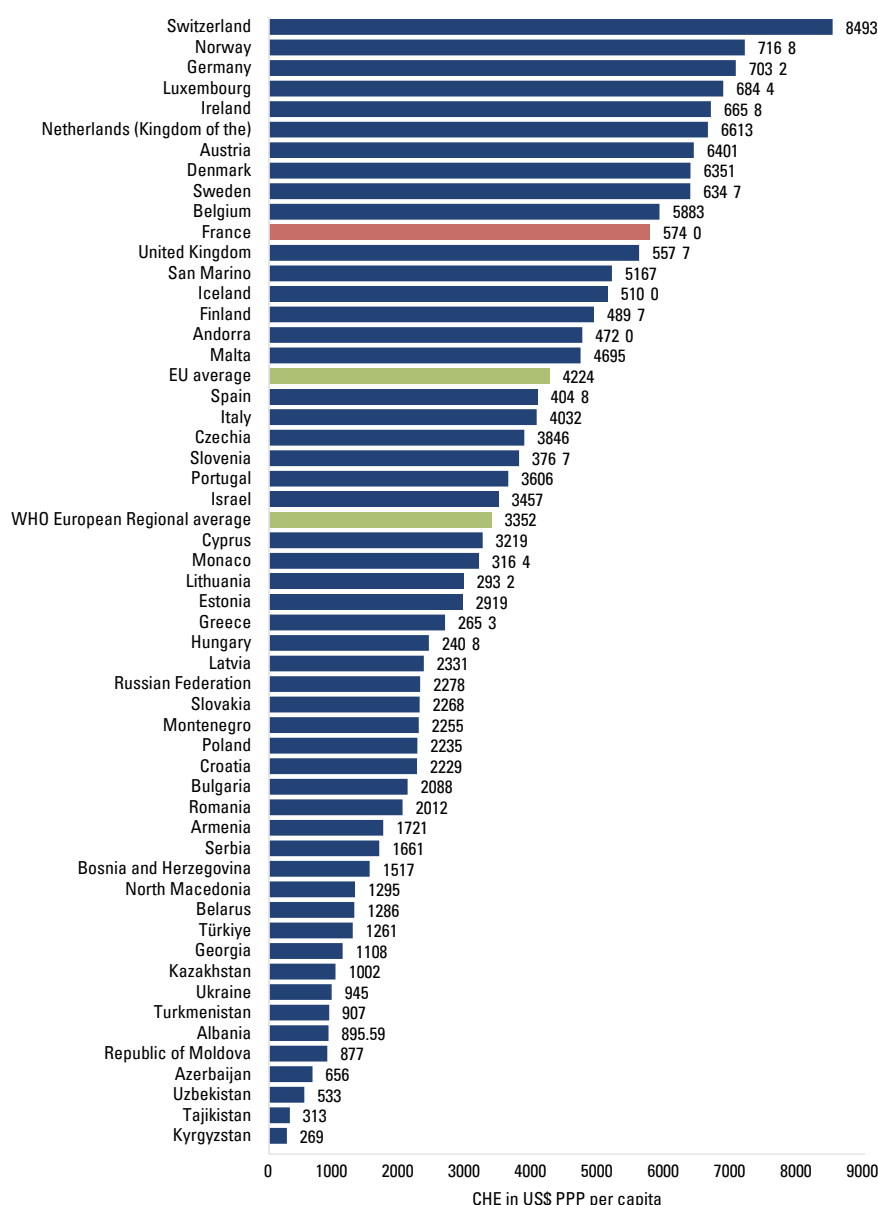
FIG. 1. TRENDS IN HEALTH EXPENDITURE, 2000–2020



Notes: The data presented in this figure vary slightly from those presented in Fig. 2 due to the different database used. PPP = purchasing power parity.

Sources: WHO, 2023; OECD, 2023.

FIG. 2. CURRENT HEALTH EXPENDITURE (US\$ PPP) PER CAPITA IN WHO EUROPEAN REGION COUNTRIES, 2020



Notes: Current health expenditure corresponds to the final consumption of health care goods and services consumed during each year, including curative, rehabilitative and long-term care, ancillary services and medical goods, prevention and public health services as well as health administration, but excluding spending on investment. Data for Albania are from 2018.

Source: WHO, 2023.

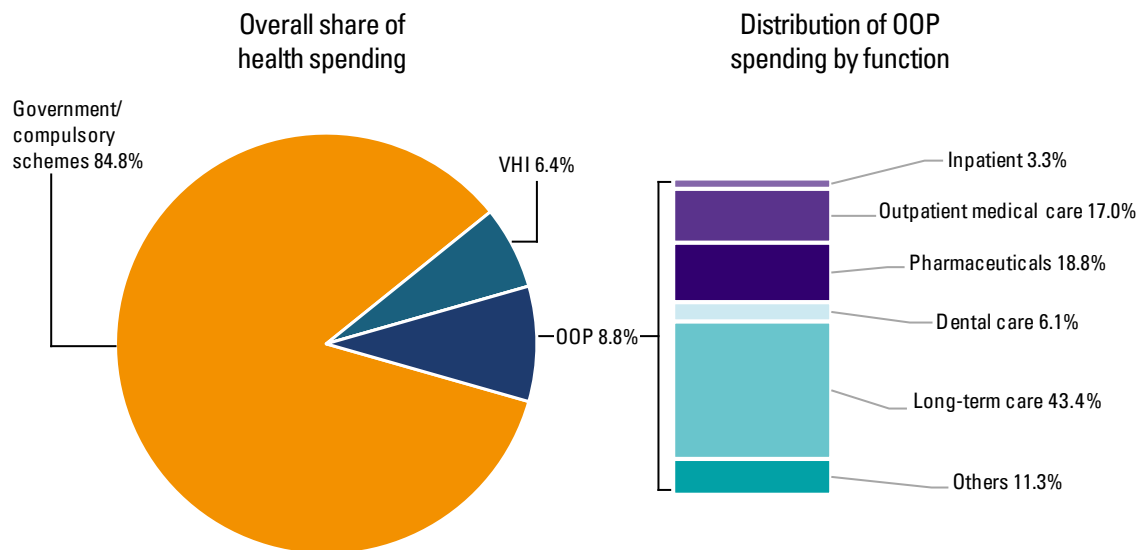
OUT-OF-POCKET PAYMENTS

Overall, the share of direct out-of-pocket (OOP) costs in current health expenditure has been stable and decreased slightly over the past decade, from 10% in 2010 to approximately 9% in 2020, which was below the EU average of 14 %. In 2020, the majority of OOP spending was on long-term care, followed by pharmaceuticals and therapeutic devices, and outpatient care (Fig. 3).

User charges are required for most health care goods and services in France. Primarily, patients are asked to

pay a proportion of the tariffs or the full price to be reimbursed later by the SHI and private CHI. Given the importance of cost sharing, protective mechanisms are in place to reduce the financial burden for vulnerable patients, such as those suffering from chronic illnesses, pregnant women or those with very low income, by increasing SHI and/or CHI coverage (see Section on Financial Protection).

FIG. 3. COMPOSITION OF OUT-OF-POCKET PAYMENTS IN FRANCE, 2020



Notes: VHI also includes other voluntary prepayment schemes. The EU average is weighted.

Sources: OECD Health Statistics (2023); Eurostat Database (data refer to 2021).

COVERAGE

Coverage is universal: all persons residing or working in France for at least 3 months are covered under SHI, which provides a comprehensive benefits basket and funds about 80% of health consumption expenditure. However, as mentioned, cost sharing is required for all essential services. In 2019, about 96% of the French population held private CHI to cover these co-payments. The reliance of the population on private complementary insurance to cover OOP costs leads to very low average

OOP payments, but raises concerns about solidarity, financial redistribution and efficiency in the health system (Box 2).

All SHI schemes provide access to the same benefits basket, which offers a wide range of medical services and goods. The benefits basket is defined through explicit positive lists/catalogues of covered services, medicines, and devices/equipment.

BOX 2 | WHAT ARE THE KEY GAPS IN COVERAGE?

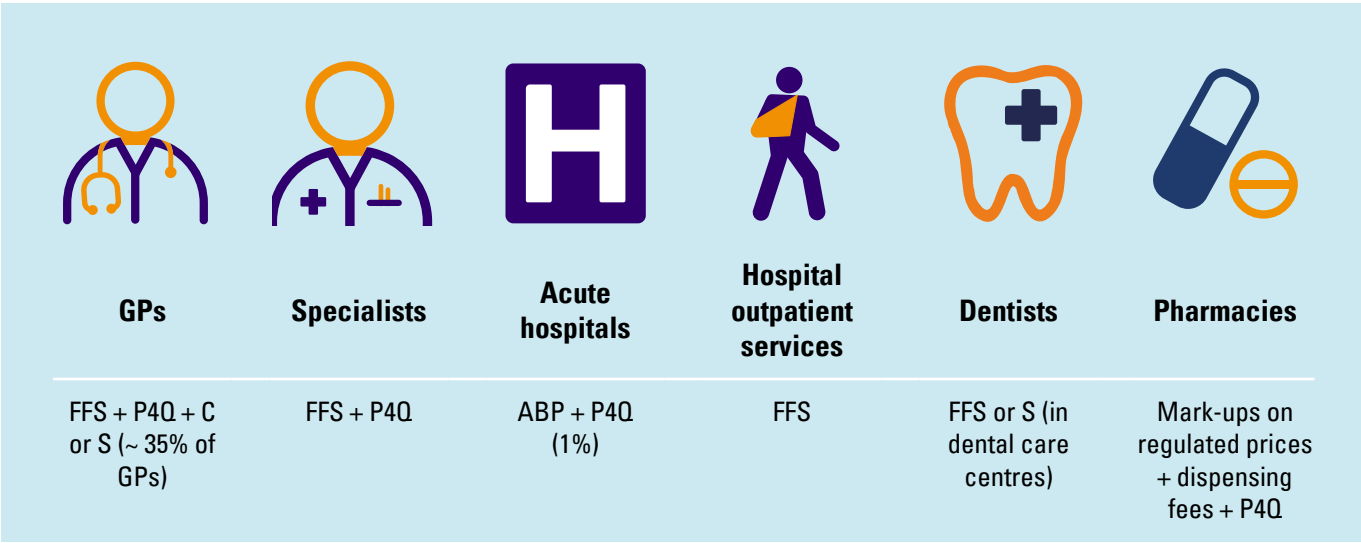
France has a SHI system which provides universal coverage for a broad basket of services. The benefits are almost the same for all insured, regardless of their scheme. However, the level of cost sharing imposed by the SHI for essential services means that most of the population buys complementary private health insurance (CHI) to reduce OOP payments. Despite the existence of protective schemes for vulnerable patients, such as those suffering from chronic illnesses, pregnant women or those with very low income, persons with the highest care needs (in particular, older individuals and those with multiple chronic conditions) have higher OOP payments. The generosity of CHI contracts varies widely, with the poorest and sickest populations more likely to have less advantageous contracts, and a higher share of their income spent on health care.

PAYING PROVIDERS

Most health care providers in France are paid based on volumes: fee-for service (FFS) for self-employed health workers and activity-based payments (ABP) in the acute hospital sector (Fig. 4). However, it is recognized that these types of payment contribute to increasing volumes of care without effectively improving quality and

coordination of care across settings. Therefore, in recent years new payment models have been implemented and piloted to encourage better quality, coordination and efficiency of care. There are also plans to reduce the share of ABP in hospital funding by 2025, by increasing the share of population-based and quality-based payments.

FIG. 4 PROVIDER PAYMENT MECHANISMS IN FRANCE



Notes: FFS : fee-for-service; S: salary; C: capitation; P4Q: pay for quality; ABP: activity-based payment.



What resources are available for the health system?

HEALTH PROFESSIONALS

France has a relatively low number of physicians per capita. In 2020 there were 318 practising physicians per 100 000 inhabitants, which is lower than the EU average (393 per 100 000 inhabitants), and lower than in Germany, Italy and Spain (Fig. 5). The number of nurses is relatively high, and at 1134 practising nurses per 100 000 inhabitants, their overall number in France is higher than the EU average (837 per 100 000), and also higher than in Italy and Spain, but lower than in Germany. The distribution of both physicians and nurses across sectors and regions is unequal. In addition, the role of nurses in health care provision is still restricted in

France compared with many other countries, with limited responsibility and career options, and this has only been evolving slowly.

In view of the anticipated shortage of health care professionals because of an ageing workforce and population, the number of trained health care workers has increased over time for most health care professions, although for some professionals, especially GPs, the pace of increase is considered insufficient to meet future needs.

The health workforce and capital resources remain unequally distributed

FIG. 5. PRACTISING NURSES AND PHYSICIANS PER 100 000 POPULATION, 2020



Notes: Latest available year for United Kingdom (UK) is 2018.

Source: Eurostat, 2022.

HEALTH INFRASTRUCTURE

At the end of 2019 there were 3008 hospitals in France. Of these facilities, 45% were public, 33% private for-profit and 22% private non-profit hospitals (*Établissements de santé privés d'intérêt collectif*, ESPIC). Among the total number of hospitals, 1834 were for post-acute and rehabilitation services (*Soins de suite et de réadaptation*, SSR) delivering short-term rehabilitation and medical support services, mainly after a hospitalization (DREES, 2021).

The number of inpatient beds has been decreasing over time in France (–5% between 2013 and 2019). The density of hospital beds has also been reduced (from 406 beds per 100 000 inhabitants in 2000 to 300 per 100 000 in 2019).

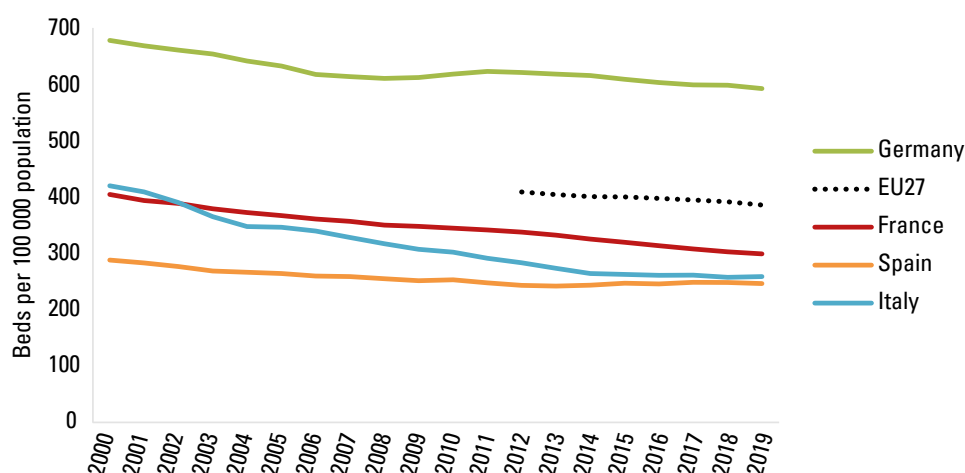
In 2019, the density of hospital beds was lower than the EU average (387 per 100 000 inhabitants) and lower than in Germany (595 per 100 000), but higher than in Spain and Italy (248 and 260 per 100 000, respectively) (Fig. 6). The decrease in bed density is explained by

several parallel trends in the hospital sector, including a significant increase in ambulatory hospitalizations, an increase in hospitalizations at home, mainly in perinatal and palliative care, and a reduction in the number of long-term care beds in hospitals due to the transfer of older patients to beds in medical residential nursing homes.

In 2019 there were 2885 major imaging units available in France; the majority were computed tomography (CT) (42%) and magnetic resonance imaging (MRI) scanners (36%). The density of both CT and MRI scanners in France is approximately half of that in Germany and Italy and lower than in Spain (Fig. 7). Most of the imaging equipment is in public facilities.

Public hospital investments have decreased over time: around 5% of the income of public hospitals was dedicated to investment in 2019, half of the percentage dedicated in 2009 (10%). A reduction in investment over the past decade has also been observed for private non-profit and private for-profit hospitals.

FIG. 6. BEDS IN ACUTE HOSPITALS PER 100 000 POPULATION IN FRANCE AND SELECTED COUNTRIES, 2000–2019



Source: Eurostat, 2022.

FIG. 7. MRI AND CT SCANNERS PER MILLION POPULATION IN FRANCE AND SELECTED COUNTRIES, 2019

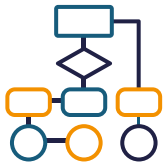
	 MRI scanners	 CT scanners
France	15.4	18.2
Germany	34.5 (2018)	35.3 (2018)
Italy	30.2	36.5
Spain	17.6	19.2

Sources: OECD, 2021a (MRI and CT scanners).

DISTRIBUTION OF HEALTH RESOURCES

There are significant geographical disparities in the distribution of health resources in France. Disparities are particularly strong for physicians since they are free to choose where they work, while other self-employed health professionals, including pharmacists, midwives, nurses and physiotherapists, are subject to a form of regulation to set up a new practice. The density of hospital beds also varies largely across French local authorities

(*départements*). To improve access to health resources for all, there has been heavy investment in eHealth, with both a national strategy for digital health, focusing on developing and implementing infrastructure, and a national strategy for eHealth, which aims to increase the availability of telemedicine and services to increase autonomy, and to help train health care professionals on these topics.



How are health services delivered?

PRIMARY AND AMBULATORY CARE

Primary care in France is provided by GPs and some medical specialists practising in ambulatory settings (for example, cardiologists, paediatricians, gynaecologists and ophthalmologists), as well as allied health professionals such as dentists, pharmacists, midwives, nurses and physiotherapists. A voluntary gatekeeping system has been in place since 2004; however, primary care providers have little connection with care providers in other sectors (Box 3) and are not very active in health promotion and disease prevention.

Specialized care in France is commonly referred to as care provided by physicians specialized in areas other than general medicine. The number of specialist physicians increased by 6% between 2012 and 2021, while the number of GPs per capita decreased by 6% during the same period, and the density is not expected to increase in the next few years.

Despite efforts to strengthen primary care, the system remains hospital-centered

BOX 3 | WHAT ARE THE KEY STRENGTHS AND WEAKNESSES OF PRIMARY CARE?

Limited available data suggest that satisfaction with primary care provided by GPs is relatively high in France, including with care quality (88%), communication of medical information (87%) and time spent with the GP (84%) (Castell & Dennevault, 2017) but there is no routine monitoring of patient experience in primary care within the French health care system. Financial accessibility of primary care services is facilitated by a universal health insurance system which offers free coverage for populations with low incomes (*Complémentaire santé solidaire*, C2S). One major weakness of the French primary care system is the strong reliance on self-employed physicians who are not integrated into multiprofessional care teams and who are weakly connected with care providers in other sectors. France has encouraged different forms of group practice in primary care settings with a dedicated funding model. Despite a slow take-off initially, the proportion of GPs practising in a group has increased steadily over the past decade: 69% of GPs were working in a group practice in 2022, compared with 54% in 2010 (Bergeat, Vergier and Verger, 2022).

Wide inequalities in the geographical distribution of GPs hinder equitable access to care. About 6% of the French population, mostly in the central region, live in areas where primary care supply is considered insufficient (Legendre, 2020), and up to 20% of the French population expressed difficulties in accessing at least one primary care provider and around 10% in accessing several professionals (Legendre, 2021).

HOSPITAL CARE

The inpatient hospital sector (acute and rehabilitative care, excluding long-term care facilities) in France represents a high share of GDP (2.7% in 2019) compared with most other OECD countries (ranging between 1.1 and 3.3%). In 2019 the Law on the organization and transformation of the health system introduced the concept of local hospitals (*Hôpitaux de proximité*):

public or private hospitals which are responsible for specific services shared with ambulatory structures and professionals within a given territory. They must be designated by the regional health agency and receive dedicated funding to ensure their missions. Ongoing efforts also target horizontal integration of care within the health system (Box 4).

Box 4 | ARE EFFORTS TO IMPROVE INTEGRATION OF CARE WORKING?

Several recent policies have aimed to increase local coordination between health care providers. These include the creation of local hospital groups (GHTs) and the development of local health professional communities (CPTS) incorporating hospital and primary care physicians, nurses and allied health and social care professionals. The GHTs were created in 2016 to pool certain functions (purchasing, information systems, training, etc.) and share resources across public hospitals working in the same territory. GHTs include a so-called support hospital, responsible for overseeing different functions and coordinating the collaboration between hospitals. However, currently, these groupings concern only public hospitals while half of surgeries are provided by private clinics.

Concerns have also been raised regarding the varying sizes and levels of medical integration of the GHTs, which risk the creation of monopolistic markets and reinforce hospital-centred care provision. New payment models, such as bundled payments or budgets for health teams, have been tested locally with the aim of improving care quality and efficiency through better collaboration and prevention. These pilots are expected to facilitate structural transformations in care delivery and bring forward a paradigm shift for health and social care providers to have a holistic and integrated approach to care. It is too early to predict whether they will bring the change hoped for.

PHARMACEUTICAL CARE

France is Europe's fourth largest pharmaceutical manufacturer, accounting for 3% of the global pharmaceutical market. In 2019 nearly 99 000 individuals were directly employed by pharmaceutical companies, mostly working in production (35%) and sales and marketing (23%).

There are three types of medication in France: over-the-counter (OTC) medicines for which a prescription is not required, medicines subject to mandatory prescription and medicines reserved for hospitals. Both OTC and prescription pharmaceuticals are dispensed exclusively through community pharmacies but there

is intense demand, especially from supermarkets, to extend OTC sales to other places. Online sale of OTC pharmaceuticals is allowed but only by registered community pharmacies. Accessibility of pharmaceuticals is high due to an extensive public benefits basket and a well distributed network of pharmacies. The SHI covers around 80% of pharmaceutical expenditures, which pays for prescription medicines based on their effectiveness. However, France has high volumes of pharmaceutical consumption, with an overuse of certain medicines such as antibiotics, and low generics utilization rates, despite multiple policies aimed at encouraging it.

MENTAL HEALTH CARE

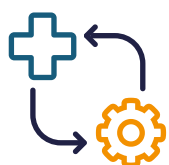
The French mental health system has historically been organized around public and private non-profit hospitals, which have had the main responsibility for providing mental health care (including outpatient care) to the population in administratively defined catchment areas. Mental health care provision remains hospital-centred, with a lack of both gradual care planning and an adequate supply of alternative structures in ambulatory

settings. Recent developments include the requirement for all hospitals providing psychiatric care to be part of a formal territorial network involving all mental health care providers at the local level. In addition, the SHI covers a limited number of consultations per year with a self-employed psychologist upon prescription by a physician, with stringent requirements and tariffs, which have led to limited uptake.

DENTAL CARE

Dental care in France is mainly provided by self-employed dentists (81% in 2021), with a few salaried dentists in hospitals (2% of all dentists) and in dental care centres (15% of all dentists) which are commonly run by private insurance companies. Patients have direct access to dental care and are free to choose their dentists. The

100% Santé reform has significantly improved dental care coverage since 2020: a selection of common dental care and dentures are now fully reimbursed by the SHI and all CHI, based on regulated prices. Overall, OOP costs for dental care remain low in France compared with other OECD countries.



What reforms are being pursued?

Recent reforms in France have focused on four main areas: improving financial access to care to avoid forgone care; improving physical access, particularly in underserved areas; strengthening prevention; and reforming payment methods for care providers (Box 5). Improving financial access to care has included full coverage by the SHI and all CHI, via the *100% Santé* reform in 2020 of OOP payments for common optical devices, dental care and hearing aids, as well as better coverage of mental health care by reimbursing psychologist visits under certain conditions. Improving physical access has meant increasing the number of training places for medical students, improving the territorial organization of health services, supporting task sharing, and forming new health professions to address workforce shortages (such as advanced nurse practitioners and medical assistants).

Measures for reinforcing preventive services in the health care system have included a change in medical education requiring all health care students to practice health promotion and prevention activities as part of their training. In addition, free prevention consultations for key age groups (teenagers for sexual issues, older people at retirement, etc.) are provided, as well as extended mandatory vaccination for children and facilitated access to vaccination through expanding the range of professionals who may perform it, including midwives and pharmacists. However, these measures have not been linked to a major increase in primary prevention funding.

In acute care, there has been increasing criticism of activity-based payment (ABP) as it provides incentives to increase the volume of hospitalizations and it is not adapted to the financing of chronic diseases or to collaborations with ambulatory care. Future reforms will reduce the share of ABP in hospital funding by introducing allocations based on the population served and quality of care.

In psychiatry, historical funding methods have introduced major territorial disparities, stifled innovation and, in the private sector, led to an increase in length of stay. In home hospitalization and post-acute and rehabilitation services the nomenclatures were ill-equipped to reflect activity. The My Health 2022 (*Ma santé 2022*) plan announced in 2018 contained multiple proposals to reform hospital funding, some of which are still being piloted. In July 2020 the *Ségur de la santé* reform package recommendations reinforced the need to decrease ABP within hospital funding.

Reforms, accelerated by the COVID-19 pandemic, also aim to improve the working conditions, remuneration and career paths of physicians and other health professionals working in hospitals and long-term care facilities (*Ségur de la santé*) which face persistent staff shortages.

Recent reforms have focused on enhancing access to health care

BOX 5 | KEY HEALTH SYSTEM REFORMS OVER THE PAST 10 YEARS

YEAR	REFORM
2016	Law for the modernization of the health care system: creation in the hospital sector of local hospital groups, and in the ambulatory sector of health territorial professional communities, primary care teams and territorial support platforms; creation of the advanced practice nurse
2017	Law for the financing of the SHI for 2018: increasing the number of mandatory vaccinations for children under 2 years of age from three to 11
2019	Law for the organization and transformation of the health care system: reform of medical studies; creation of proximity hospitals; creation of territorial health projects; extension of the right to carry out vaccinations to pharmacists and midwives
2020	100% Santé reform: for full coverage of optical devices, dental care and hearing aids by SHI and CHI
2021	Ségur de la santé reform: reform package for improving working conditions of 1.5 million health professionals in acute and long-term care facilities. Wages of all categories of health professionals increased between, on average, 15% and 20% as of October 2021.
2021	Law to improve the health care system through trust and simplification: increasing authorization to prescribe medications to midwives, physiotherapists, occupational therapists and speech therapists.



How is the health system performing?

HEALTH SYSTEM PERFORMANCE MONITORING AND INFORMATION SYSTEMS

Overall, France lacks a national health system performance assessment (HSPA) framework to monitor and evaluate health systems performance. Major quality indicators across care settings are not systematically monitored and publicly reported. While important progress has been made for collecting data on quality, in particular concerning safety of care in hospitals, most indicators are focused on processes.

There are several coexisting information systems in France. The main ones collect exhaustive information on the consumption of SHI-covered care by SHI beneficiaries for reimbursement claims both in the hospital

and the ambulatory care sectors (national health data system, SNDS). The Health Data Hub (*Plateforme des données de santé*) was set up in 2019 to enable researchers to easily access anonymized data hosted on a secure platform, in compliance with regulations and citizens' rights. It covers and allows linking data from the SNDS with other sources such as research cohorts, epidemiological and practice registers, etc.

Improving data availability for quality monitoring and regular evaluation of health system performance remain a challenge

ACCESSIBILITY AND FINANCIAL PROTECTION

Health care accessibility is high in France, with universal health insurance coverage and a broad and unitary benefits basket for all residents. Financial accessibility is supported by a state-funded insurance which avoids cost sharing for the poorest part of the population and for those with high health care needs. To reduce the burden of co-payments for the lowest income groups (individuals living 20% under the poverty limit), a state-funded complementary health insurance scheme (*Complémentaire santé solidaire*, C2S) allows 100% coverage of the costs of services and medicines included in the benefits basket (with no cost sharing). Persons with chronic illnesses can be included, upon medical criteria, in a long-term illness scheme (*Affection de longue durée*, ALD) which covers all costs related to their chronic condition. In 2019, this scheme included 12.5 million individuals (less than 20% of SHI beneficiaries), and about 60% of their health expenditures was reimbursed by the SHI (Adjerad and Courtejoie, 2021). Coverage is

also available to undocumented migrants under certain conditions.

Geographic accessibility to primary care remains a persistent problem for ensuring equal access to care. Physicians are free to decide where to establish their practice and are highly concentrated in urban and coastal areas. Financial incentives to attract physicians to underserved areas have had limited success, while the development of multidisciplinary group practices has shown promising results (Chevallard and Mousquès, 2021).

The level of estimated unmet care needs for medical examinations (due to cost, waiting time or travel distance) in 2021 was slightly higher in France (2.8%) compared with the EU average of 2% (Fig. 8). This may be partly due to the restrictions over the period 2020–2021 to contain the spread of the COVID-19 pandemic, which also increased the pressure on the health care system, as well as inequalities in geographic access to care.

HEALTH CARE QUALITY

France lacks a comprehensive assessment of the quality of care delivered in different care settings and there is no routine publication of data on care quality outside of the hospital sector (Box 6). The rare data available on primary care quality date from 2015 and include rates of avoidable hospital admissions, that is, admissions for causes that could be avoided if adequately followed up in primary care. The avoidable admission rates for congestive heart failure (CHF) and hypertension, as well as for diabetes, were very high compared with neighbouring countries (Germany, Spain and the United Kingdom) (Fig. 9). In contrast, the avoidable hospital

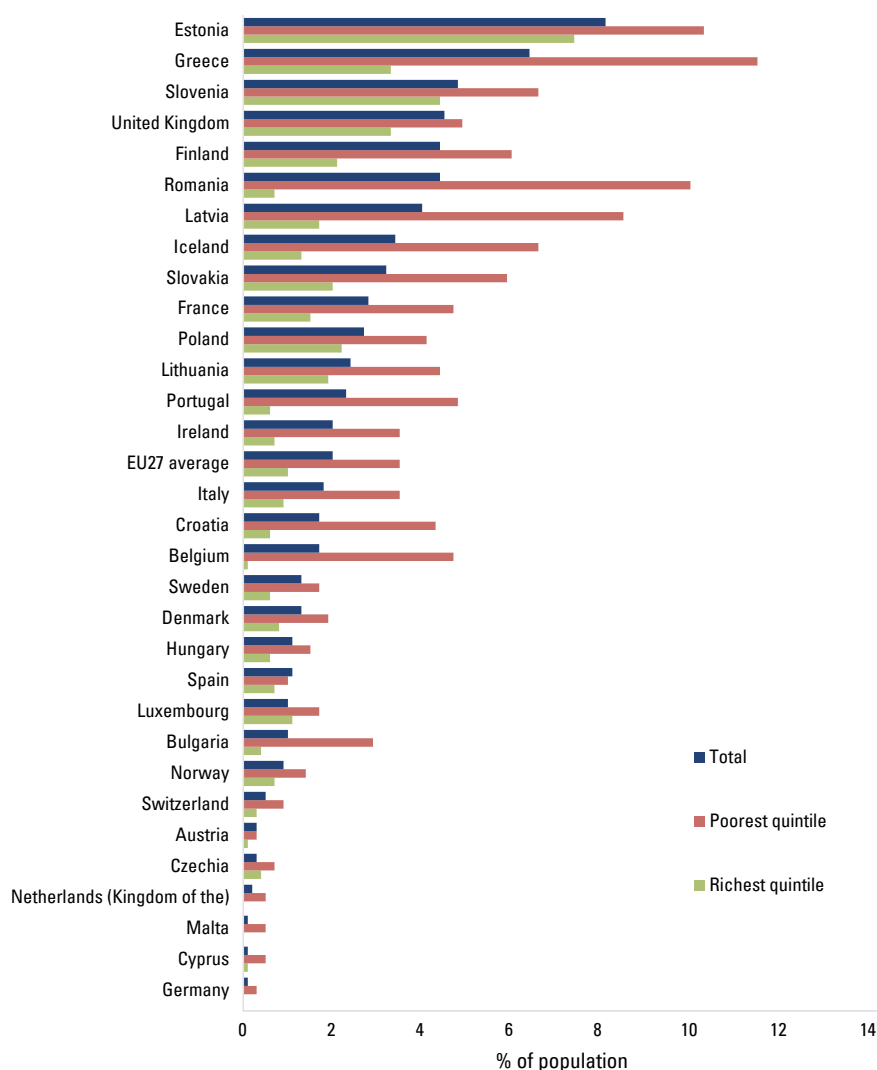
admission rates for asthma and chronic obstructive pulmonary disease (COPD) were lower in France than in neighbouring countries (Fig. 9).

Based on the latest data available from the OECD (from 2015), the quality of cardiovascular care appears to be rather good. France has relatively low mortality rates after hospitalization for acute myocardial infarction (AMI) (5.6 per 100 000 persons over 45 years old), haemorrhagic stroke (22.4 per 100 000) and ischaemic stroke (7.1 per 100 000) compared with other OECD countries, and in particular, neighbouring countries (Fig. 10).

BOX 6 | WHAT DO PATIENTS THINK OF THE CARE THEY RECEIVE?

In France patient experience surveys are scarce outside of acute hospital settings. A patient-reported experience and satisfaction survey (e-Satis) is mandatory for large acute care hospitals (over 500 patients annually) and optional for smaller ones. The 2019 survey included 1123 acute hospitals (representing 97% of all large and 35% of all smaller hospitals), 35% of all inpatient and 27% of all ambulatory surgery patients. The global satisfaction score was 73/100 for patients with an overnight stay, and less than half (47%) of hospitals were classified as having satisfactory ratings (74/100 or more). In terms of experience, care delivered by staff (attentive listening, pain management, respecting privacy, etc.) received the highest ratings by patients, while discharge organization and information on possible complications after discharge had the lowest.

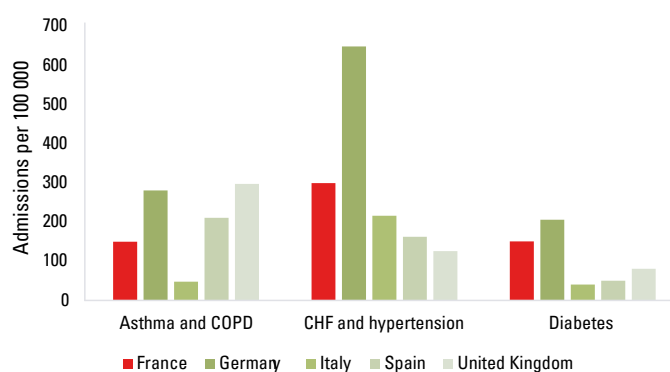
FIG. 8. UNMET NEEDS FOR A MEDICAL EXAMINATION (DUE TO COST, WAITING TIME OR TRAVEL DISTANCE), BY INCOME QUINTILE, EU/EEA COUNTRIES, 2021



Notes: Data for Norway, Slovakia and Switzerland data are from 2020; data for Iceland and United Kingdom data are from 2018.

Source: Eurostat, 2022.

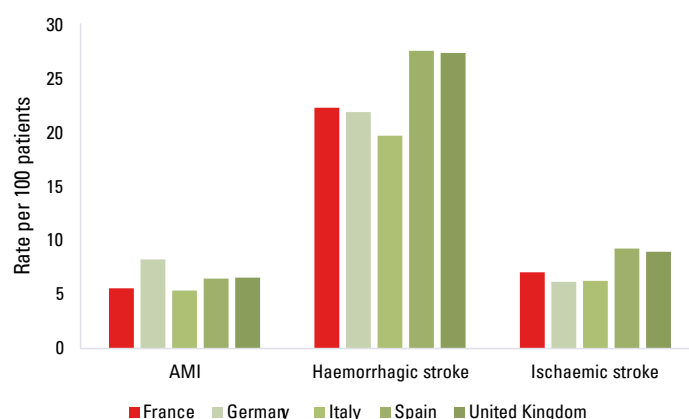
FIG. 9. AVOIDABLE HOSPITAL ADMISSION RATES FOR ASTHMA, CHRONIC OBSTRUCTIVE PULMONARY DISEASE, CONGESTIVE HEART FAILURE, HYPERTENSION AND DIABETES-RELATED COMPLICATIONS, 2019 OR LATEST AVAILABLE YEAR, FRANCE AND SELECTED COUNTRIES



Notes: Age-sex standardized rate per 100 000 population (15 years and older), 2019 or latest available year. Data for France are from 2015.

Source: OECD, 2021b.

FIG. 10. IN-HOSPITAL MORTALITY RATES (DEATHS WITHIN 30 DAYS OF ADMISSION) FOR ADMISSIONS FOLLOWING ACUTE MYOCARDIAL INFARCTION AND ISCHAEMIC STROKE, FRANCE AND SELECTED COUNTRIES



Notes: Age-sex standardized rate per 100 000 population (15 years and older), 2019 or latest available year. France – data for 2015.

Source: OECD, 2021b.

HEALTH SYSTEM OUTCOMES

France performs well in terms of all-cause mortality: 659 deaths per 100 000 inhabitants in 2019 compared with 770 per 100 000 inhabitants on average among OECD countries. Although life expectancy decreased by 8 months during the first year of the COVID-19 pandemic in 2020, it had almost attained pre-pandemic levels again in 2021, at 82.5 years. Infant mortality rates are also below the OECD average (3.8 deaths per 1000 live births compared with 4.2 in 2019) but above the EU average (3.4 deaths per 1000 live births), and there has been a slight increase in the past 10 years.

France has one of the lowest age-standardized rates for mortality due to treatable causes (that is, deaths that could have been avoided if the population had access

to timely and effective care) amongst EU countries with 62.1 per 100 000 inhabitants in 2017 (latest year available), which was significantly lower than the EU average of 92.1 per 100 000 (Fig. 11). France performs less well in terms of preventable mortality (deaths that could have been avoided with timely public health interventions focusing on the wider determinants of health such as lifestyle factors, socioeconomic status and environmental factors). France had 129.9 preventable deaths per 100 000 inhabitants in 2017 (latest year available), above Spain (110.0) and Italy (101.2), but below the EU average of 160.0 deaths per 100 000 inhabitants (Fig. 11; see also Box 7).

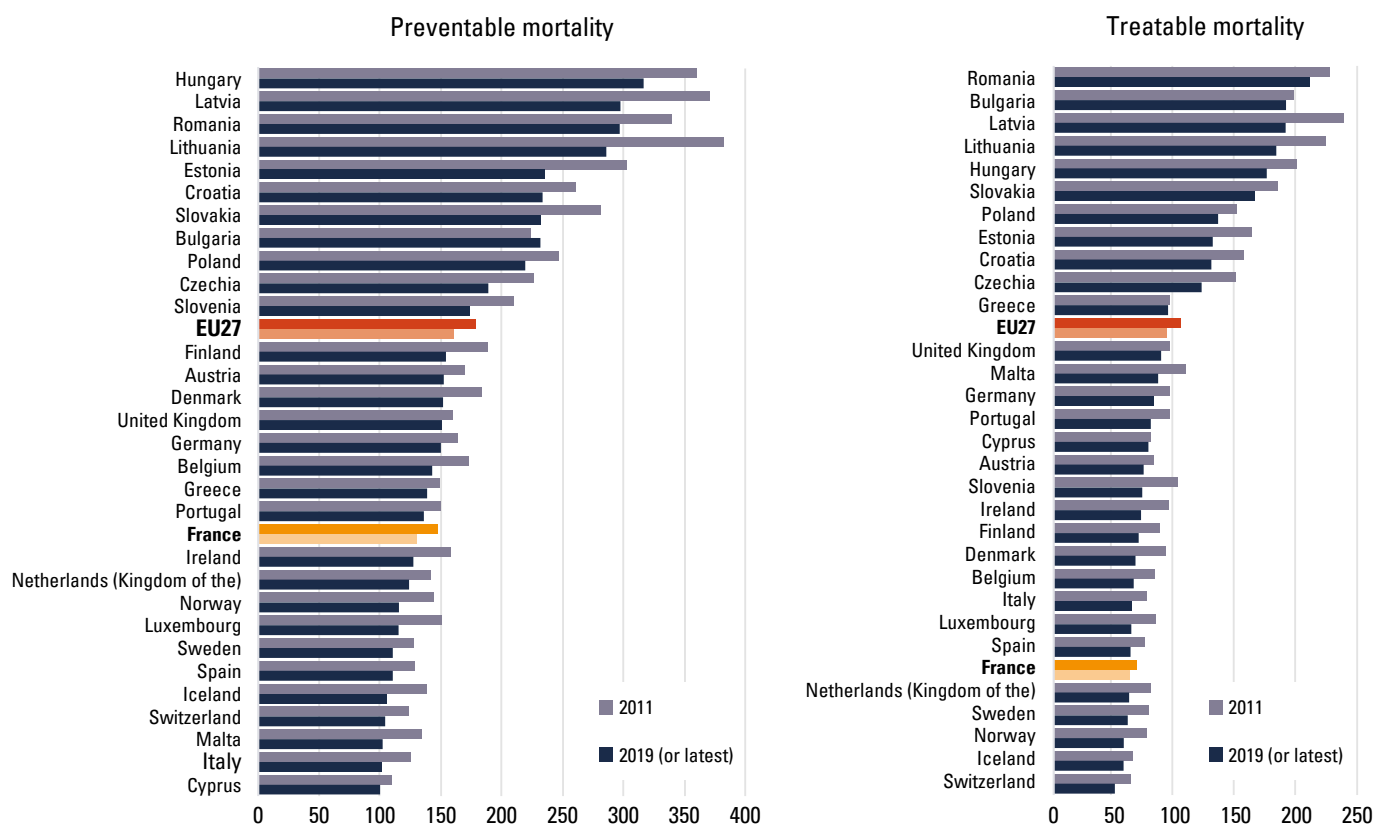
HEALTH SYSTEM EFFICIENCY

Although France devotes a high share of its GDP to health care, health expenditure per capita at the international level is lower than in several other EU and neighbouring countries. At the same time, levels of mortality from treatable causes are relatively very low. As an entry point for discussion, Fig. 12 shows that that given its expenditure levels, France has been able to secure good outcomes on this metric. For example, the United Kingdom, Belgium, Ireland and Denmark have higher treatable mortality rates while spending similar or higher amounts on health per capita.

France has significantly improved technical efficiency in the hospital sector in the past decade (2010–2020),

measured using classical indicators such as average length of stay in hospital, day-case surgery rates or hospital volume over hospital resources, and the country performs well internationally. In 2021 a relatively high proportion of surgical procedures, such as eye surgeries (95%), orthopaedic surgeries (53%) and digestive procedures (43%) were performed as day cases rather than inpatient procedures (Scansanté, 2021). While the percentage of ambulatory-based surgery has increased significantly over the past 5 years, there are significant variations across regions and hospitals. Measures have also been taken to improve the efficiency of pharmaceutical consumption and spending (Box 8).

FIG. 11. PREVENTABLE AND TREATABLE MORTALITY, 2011 AND 2019



Notes: Data are for 2011 and 2019 or latest available year. Data for France are from 2017; and from 2018 for Malta and the United Kingdom.

Source: Eurostat, 2022.

BOX 7 | ARE PUBLIC HEALTH INTERVENTIONS MAKING A DIFFERENCE?

In 2019, approximately one third of all deaths in France were related to behavioural risk factors such as smoking, alcohol consumption and diet. In 2018, the €1 increase in tax on cigarettes resulted in a 9% drop in sales. The public campaign #TobaccoFreeMonth (*#MoisSansTabac*), which has taken place each November since 2016, is also considered a success, with around 200 000 participants signing up to the campaign to support smoking cessation each year. Nevertheless, smoking rates remain high in France compared with the OECD average: 24% compared with 17% in 2019 (OECD, 2021a).

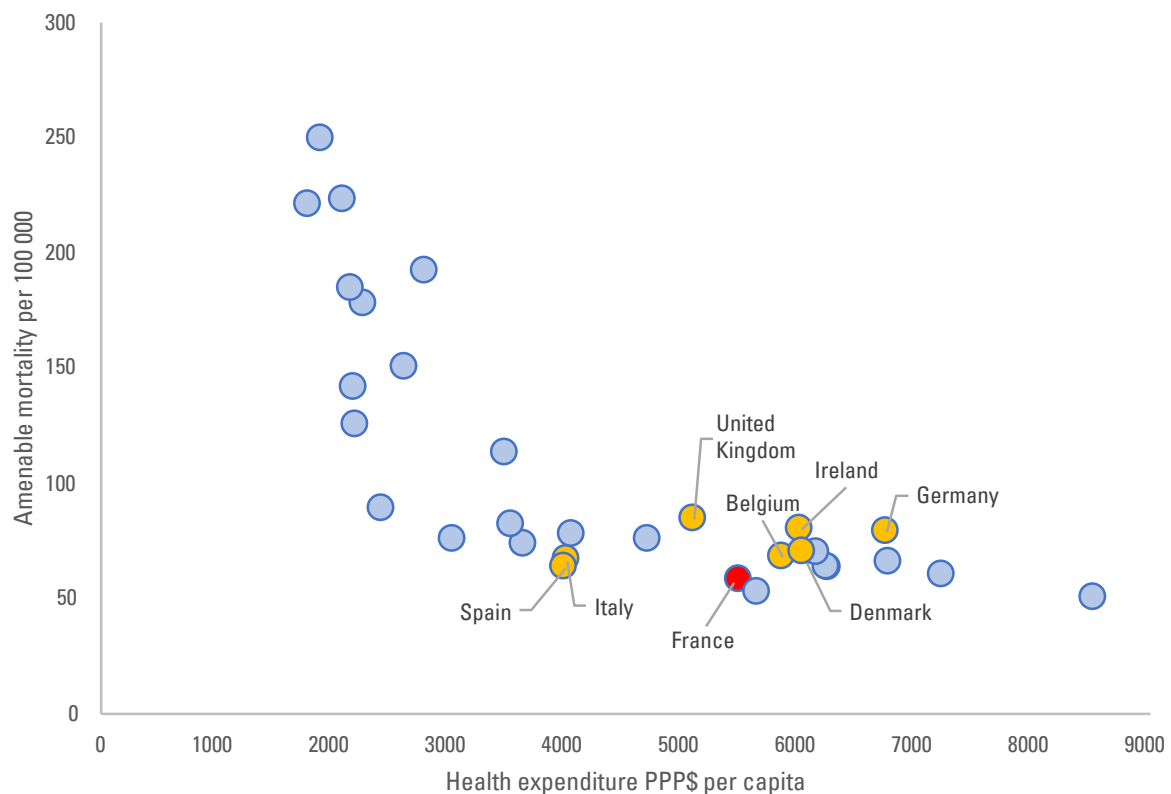
The rate of self-reported obesity and overweight among adults in France was 49% in 2019, which was lower than the OECD average of 56%. Although the proportion of overweight or obese 15-year-olds was also lower than the EU average in 2018 (14% compared with 19%), it has been steadily increasing (it was 12% in 2010). The nutritional labelling on food packaging (Nutri-Score) shows some promising results on food choices; out of 1001 surveyed people in 2020, 57% reported having changed their food purchasing behaviour thanks to the label. There are not many interventions encouraging physical activity for young people, including in school, while the share of French 15-year-olds who reported doing at least 1 hour of physical activity daily was the second lowest across EU countries in 2018 for both girls (4%) and boys (11%), compared with the EU-26 averages of 10% and 18%, respectively (OECD, 2020). In general, information on the efficacy of different prevention measures is limited in France due to lack of systematic evaluations.

BOX 8 | IS THERE WASTE IN PHARMACEUTICAL SPENDING?

Several policies are in place in France to reduce waste in pharmaceutical spending. They include delisting medicines with insufficient or low medical benefits; incentives for prescribing generic medicines; and efforts to reduce inappropriate prescription and overuse of certain medicines, such as antibiotics and proton pump inhibitors. While generics have enabled significant cost reductions (an estimated €3 billion in 2018 and more than €27 billion since 2000), their use remains limited compared with other European countries. Generics represented only 30% of the market volume of reimbursed pharmaceuticals in France in 2019 compared with 83% in Germany and 85% in the United Kingdom. This suggests that public funds currently spent on these pharmaceuticals could be more beneficially geared towards newer treatments.

There are also opportunities for improving prescription patterns as France still reports high rates of inadequate prescriptions. Despite national education campaigns and a dedicated objective to reduce antibiotic prescription rates by GPs in a pay-for-quality scheme, France reports higher rates of antibiotic prescriptions than the EU average. Moreover, in 2019 the volume of pharmaceutical consumption per capita was one of the highest among OECD countries. From 2022 onwards, pharmacies have been granted the possibility to dispense a few types of medicines by unit (instead of boxes) to reduce waste.

FIG. 12. TREATABLE MORTALITY PER 100 000 POPULATION VERSUS HEALTH EXPENDITURE PER CAPITA, FRANCE AND SELECTED COUNTRIES, 2019



Sources: WHO, 2023, 2022.



Summing up

The French health system is universal in terms of population covered and provides a generous benefits package combining a social health insurance system with a national health system approach. However, cost sharing is required for all essential services. Therefore, 96% of the population own a private complementary insurance to reduce OOP payments.

France promotes equity in access to health care through several regulatory tools and policies. However, the mix of public-private funding raises issues for equity of access and efficiency. Moreover, there are strong disparities in access by geographic areas and socioeconomic groups. While the number of most health workers has increased in the past decade, the number of GPs per capita in France has decreased, and this trend is expected to continue in the coming years. Persisting challenges in France include ensuring the sustainability of the health workforce, particularly to secure adequate numbers of health professionals in

medically underserved areas (rural and less affluent communities), and improving working conditions, remuneration and career prospects, especially for nurses, to support retention.

While the COVID-19 pandemic brought to light some structural weaknesses within the French health system, it has also provided opportunities for improving its performance and sustainability. These efforts should be supported by a systematic monitoring of outcomes through regular collection and reporting of quality indicators, particularly to compare across providers and across regions/territories. This will undoubtedly facilitate benchmarking of efficiency and care quality, which will also increase the capacity to identify both problem areas and good practices.

Future challenges for the health system include improving quality monitoring and regular evaluation of health system performance

POPULATION HEALTH CONTEXT

KEY MORTALITY AND HEALTH INDICATORS

Life expectancy (years) 2021	
Life expectancy at birth, total	82.5
Life expectancy at birth, male	79.3
Life expectancy at birth, female	85.4

Mortality (SDR per 100 000 population)	
All causes	829.6 ^a
Circulatory diseases	169.6 ^b
Malignant neoplasms	222.0 ^b
Communicable diseases	13.3 ^b
External causes of death	50.8 ^b
Infant mortality rate (per 1 000 live births)	3.6 ^c
Maternal mortality rate (per 100 000 live births) (modelled estimate)	4.5 ^d

Note: ^a 2017 data; ^b The latest data available are for the period 2015–2017; ^c 2021 data, ^d 2015 data.

Sources: Insee, 2018; CepiDc, 2022; Eurostat, 2022.

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