

# State of Health in the EU France

Country Health Profile 2017

## The Country Health Profile series

The *State of Health in the EU* profiles provide a concise and policy-relevant overview of health and health systems in the EU Member States, emphasising the particular characteristics and challenges in each country. They are designed to support the efforts of Member States in their evidence-based policy making.

The Country Health Profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by Member States and the Health Systems and Policy Monitor network.

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## Data and information sources

The data and information in these Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated in June 2017 to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 28 Member States unless otherwise noted.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following StatLinks into your Internet browser:  
<http://dx.doi.org/10.1787/888933593532>

## Demographic and socioeconomic context in France, 2015

	France	EU
Demographic factors	Population size (thousands)	509 394
	Share of population over age 65 (%)	18.9
	Fertility rate <sup>1</sup>	1.6
Socioeconomic factors	GDP per capita (EUR PPP <sup>2</sup> )	28 900
	Relative poverty rate <sup>3</sup> (%)	10.8
	Unemployment rate (%)	9.4

1. Number of children born per woman aged 15–49.

2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.

3. Percentage of persons living with less than 50 % of median equivalised disposable income.

Source: Eurostat Database.

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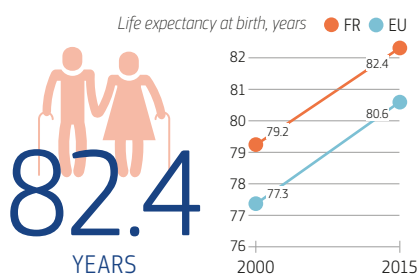
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# 1 Highlights

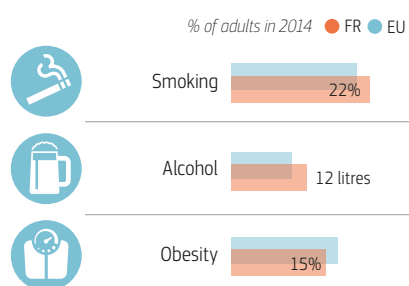
The health status of the population in France is good and life expectancy continues to increase, but there are substantial disparities by gender and socioeconomic status. The French health system generally provides good access to high-quality care, but further improvements require greater emphasis on prevention and continuing the transformation of the system to better serve growing numbers of people living with chronic conditions.

## Health status



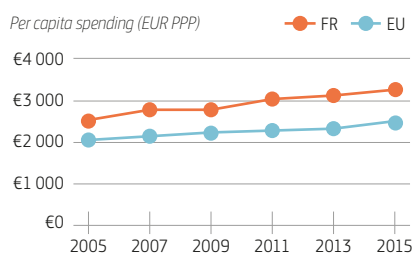
Life expectancy at birth in France reached 82.4 years in 2015, up from 79.2 years in 2000, and is one of the highest among EU countries. These gains have been driven mainly by reductions in mortality rates after the age of 65. At age 65, women on average live an additional 23.5 years, including 10.7 years disability free, for men 19.4 years and 9.8 years respectively.

## Risk factors



In 2014, 22% of French adults smoked tobacco every day, down from 27% in 2000, but still above the EU average. Overall alcohol consumption per adult has also decreased, but remains higher than the EU average. About 15% of adults in France were obese in 2014, up from 9% in 2000. Overweight and obesity among 15-year-old adolescents has also increased to 14% in 2013-14, up from 11% in 2001-02. Regular physical activity among adolescents is lower than in most other EU countries, notably among girls.

## Health system

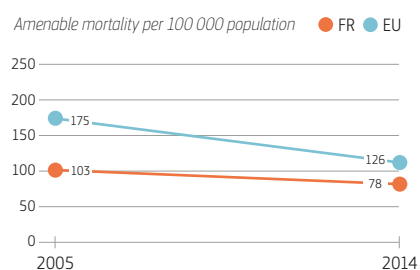


Health spending in France is higher than in most other EU countries, with health expenditure reaching EUR 3 382 per capita in 2015, compared to the EU average of EUR 2 797. This is equivalent to 11.1% of GDP, also well above the EU average of 9.9%. Because over three-quarters of health expenditure is publicly funded and complementary health insurance plays an important role, the share of out-of-pocket spending is the lowest among EU countries.

## Health system performance

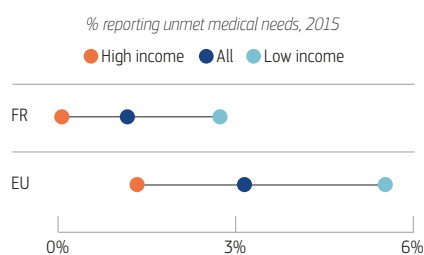
### Effectiveness

Amenable mortality in France is among the lowest in EU countries. More people survive life-threatening conditions such as heart attack, stroke and different cancers.



### Access

Access to health care is generally good, and unmet care needs remain low in comparison with EU average, even if disparities across income groups exist. One persisting challenge is to address regional disparities in access to care.



### Resilience

The modernisation and streamlining of the hospital sector are under way, but the challenges are to strengthen prevention, primary care and care coordination. Another challenge is to promote a more appropriate use of pharmaceuticals and balance access and affordability considerations in the coverage of innovative medicines.



## 2 Health in France

### Life expectancy in France is among the highest in the EU

France has the third highest life expectancy among all EU countries (after Spain and Italy), with life expectancy at birth reaching 82.4 years in 2015, nearly two years above the EU average (80.6 years) (Figure 1). The life expectancy in France increased by more than three years between 2000 and 2015.<sup>1</sup>

### There is a strong gender and socioeconomic gap in life expectancy

The gender gap in life expectancy in France is higher than in most other EU countries, and women lived more than six years longer than men in 2015. However, the gender gap in healthy life years is much smaller as women live a greater proportion of their lives with some disabilities.<sup>2</sup> At age 65, only 45% of the remaining years of life for French women on average are lived without disabilities (10.7 years out of 23.5 years in remaining life expectancy), while this proportion is about half among men (9.8 years out of 19.4 years of life expectancy).

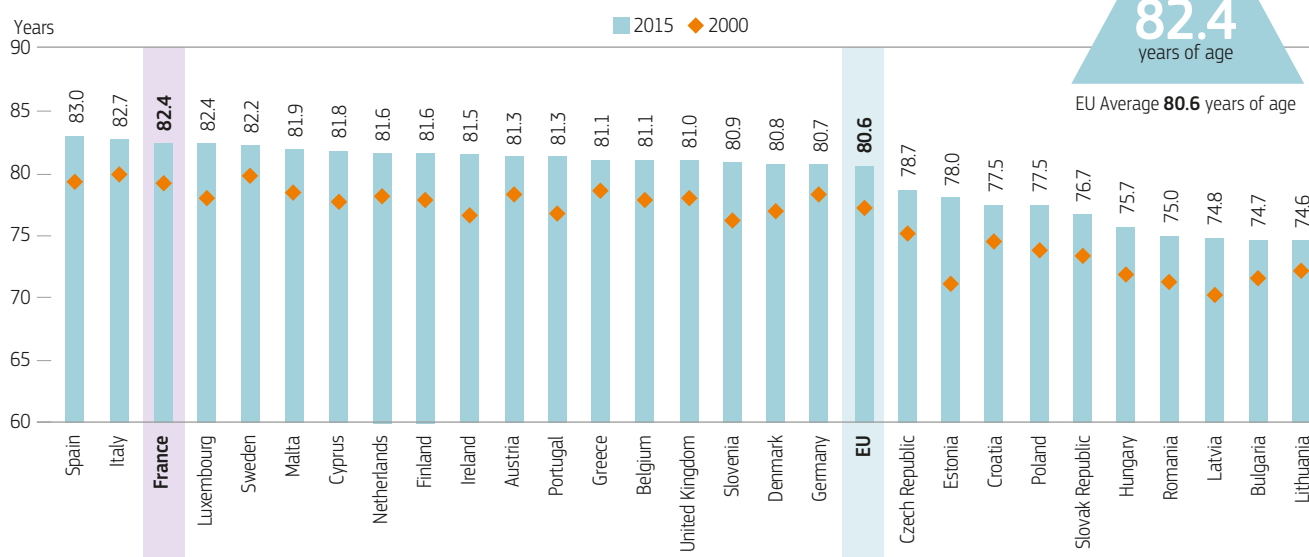
There are also large disparities in mortality and life expectancy attributable to preventable causes across socioeconomic groups, particularly among men. Life expectancy at age 35 for men in lower occupational categories is more than 6 years shorter than for men in higher occupational groups (Blanpain, 2016).

### Cancer is the main cause of death in France, followed by deaths from cardiovascular diseases

Cancer is the leading cause of death in France, accounting for 28.5% of all deaths in 2014, followed by cardiovascular diseases, which accounted for 25%. However, there are gender differences (Figure 2): 33% of all deaths among men were related to cancer, while this proportion was lower among women (24%). Cardiovascular diseases accounted for the greatest share of female deaths (27%).

Looking at trends in more specific causes of death, heart diseases (ischaemic and other) are the main causes of death, but the

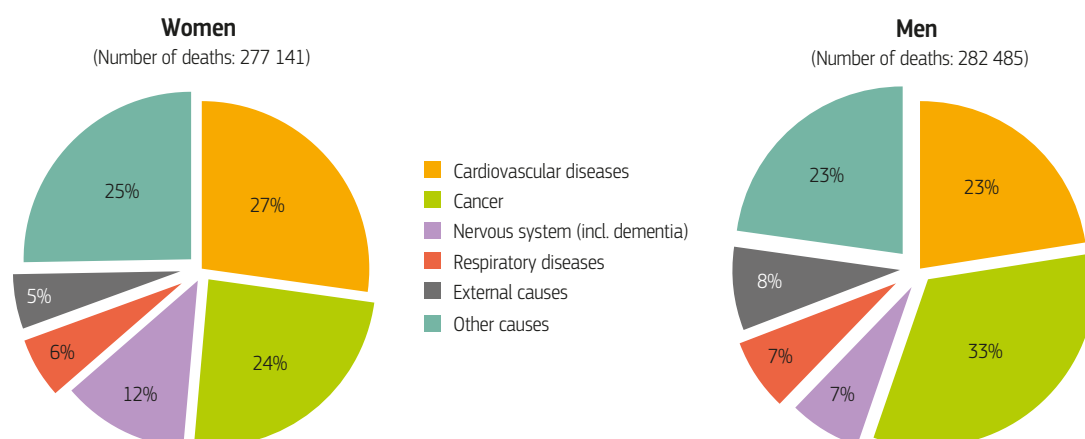
**Figure 1. The French population enjoys the third highest life expectancy at birth in the EU**



Source: Eurostat Database.

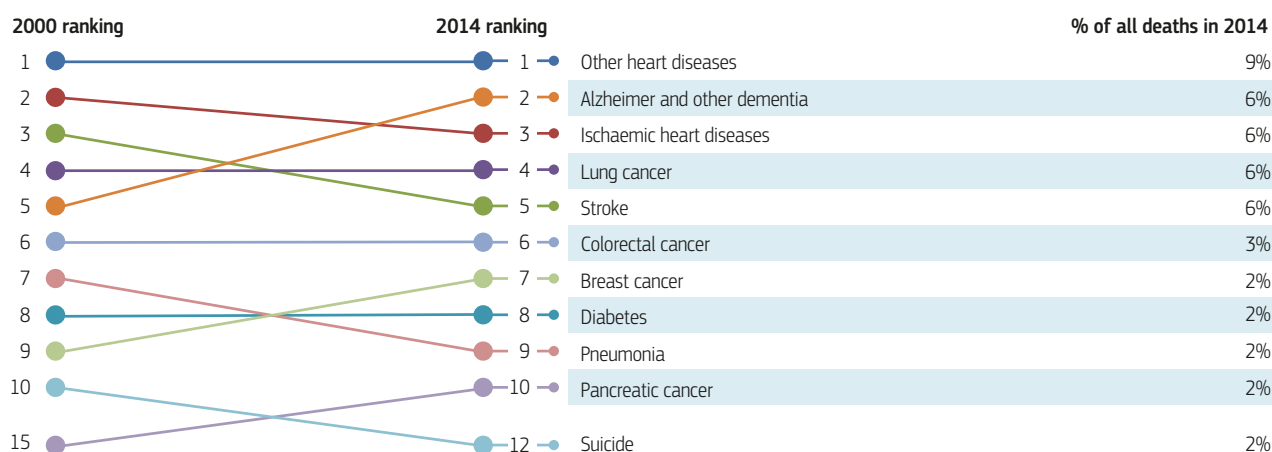
1. For the first time in many years, life expectancy came down in 2015 compared to 2014 (by 0.5 year). This reduction was driven mainly by an increase in mortality among elderly people due to an exceptionally long epidemic of flu and some exceptional weather fluctuations (Bellamy and Beaumel, 2016). However, life expectancy at birth and at 65 increased again in 2016.

2. 'Healthy life years' measures the number of years that people can expect to live free of disability at different ages.

**Figure 2. Cancer and cardiovascular diseases are the leading causes of death in France**

**Note:** The data are presented by broad ICD chapter. Dementia was added to the nervous system diseases' chapter to include it with Alzheimer's disease (the main form of dementia).

**Source:** Eurostat Database (data refer to 2014).

**Figure 3. Deaths from Alzheimer's disease and other dementias have risen rapidly in France**

**Source:** Eurostat Database.

number of deaths due to Alzheimer's disease and other dementias has increased rapidly since 2000 (Figure 3), a rise linked to population ageing, better diagnosis, lack of effective treatments and changes in coding practices. Lung cancer continues to be the main cause of cancer death, reflecting the long-term consequences of high smoking rates (although smoking rates have come down since 2000 – see Section 3). Following lung cancer, colorectal, breast and pancreatic cancer were the main causes of cancer death in France in 2014.

## Musculoskeletal problems, mental health problems and other chronic conditions account for a large share of disability-adjusted life years

In addition to the burden of disease caused by cardiovascular diseases, lung cancer and dementias, musculoskeletal disorders

(including low back and neck pain), and mental health disorders (including depression) are also some of the leading determinants of disability-adjusted life years<sup>3</sup> (DALYs) in France (IHME, 2016).

In the 2014 European Health Interview Survey (EHIS), one in seven people in France reported living with hypertension, one in eleven live with asthma, and one in ten live with diabetes. There are wide disparities in the prevalence of these chronic diseases by education level. People with the lowest level of education are more than twice as likely to live with hypertension, and nearly twice as likely to live with depression, asthma or other chronic respiratory diseases, as those with the highest level of education.<sup>4</sup>

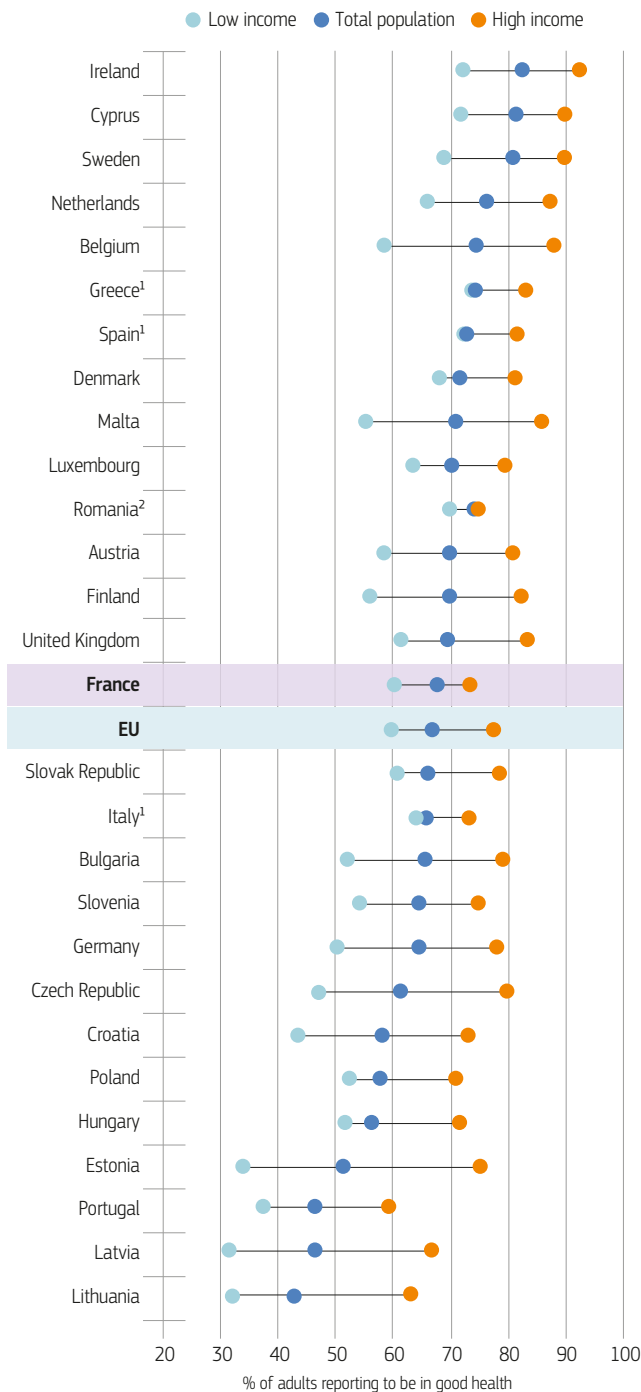
3. DALY is an indicator used to estimate the total number of years lost due to specific diseases and risk factors. One DALY equals one year of healthy life lost (IHME).

4. Inequalities by education may partially be attributed to the higher proportion of older people with lower educational levels; however, this alone does not account for all socioeconomic disparities.

## Most of the French population report being in good health

More than two-thirds (68%) of the French population report being in good health, close to the EU average. However, while 73% of people in the highest income quintile report being in good health, only 60% of people in the lowest income quintile do so (Figure 4).

**Figure 4. Most people in France report to be in good health, but there are disparities by income group**



1. The shares for the total population and the low-income population are roughly the same.  
2. The shares for the total population and the high-income population are roughly the same.

Source: Eurostat Database, based on EU-SILC (data refer to 2015).

## 3 Risk factors

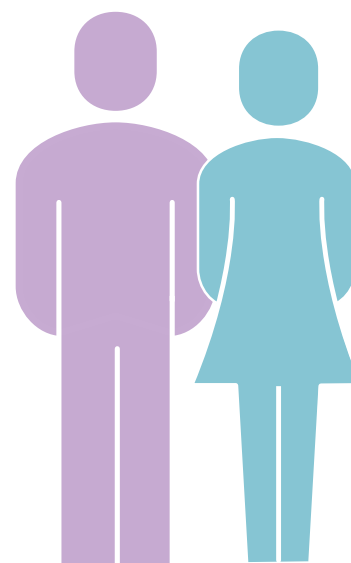
### Unhealthy lifestyles account for one quarter of the overall burden of disease

Based on IHME estimations, around 25% of the overall burden of disease in France in 2015 (measured in terms of DALYs) could be attributed to behavioural risk factors. Smoking (9.7%), dietary risks (8.2%), alcohol use (5.3%), and lack of physical activity (2.0%) contributed the most to DALYs in 2015 (IHME, 2016).

### Smoking and alcohol consumption in France remain higher than the EU average

While smoking rates and alcohol consumption have generally come down since 2000, there is still room for further progress. In 2014, 22% of French adults were still smoking daily, down from 27% in 2000 but still above the rate in most EU countries (Figure 5).<sup>5</sup>

Of particular concern are smoking rates among 15-year-old girls and boys in France. In 2014, nearly one in five 15-year-old adolescents in France reported to smoke daily, well above the EU average of one in seven. France has taken further steps to strengthen its tobacco control policy in recent years (see Section 5.1).



5. Based on another more recent survey (2016 Health Barometer), the proportion of people aged 15-75 smoking daily in France was higher, at 28.7% in 2016, and it only came down slightly from 30.0% in 2000.

Alcohol consumption among adults remains a major public health issue in France, although consumption levels have come down since 2000. On average, French adults consumed almost 12 litres of alcohol in 2015, down from nearly 14 in 2000, but still more than the EU average (10 litres). While the proportion of 15-year-olds reporting to have been drunk at least twice in their life is lower than in most other EU countries, one in six reported such repeated excessive alcohol consumption in 2013-14.

### Overweight and obesity have risen but remain lower than in most other EU countries

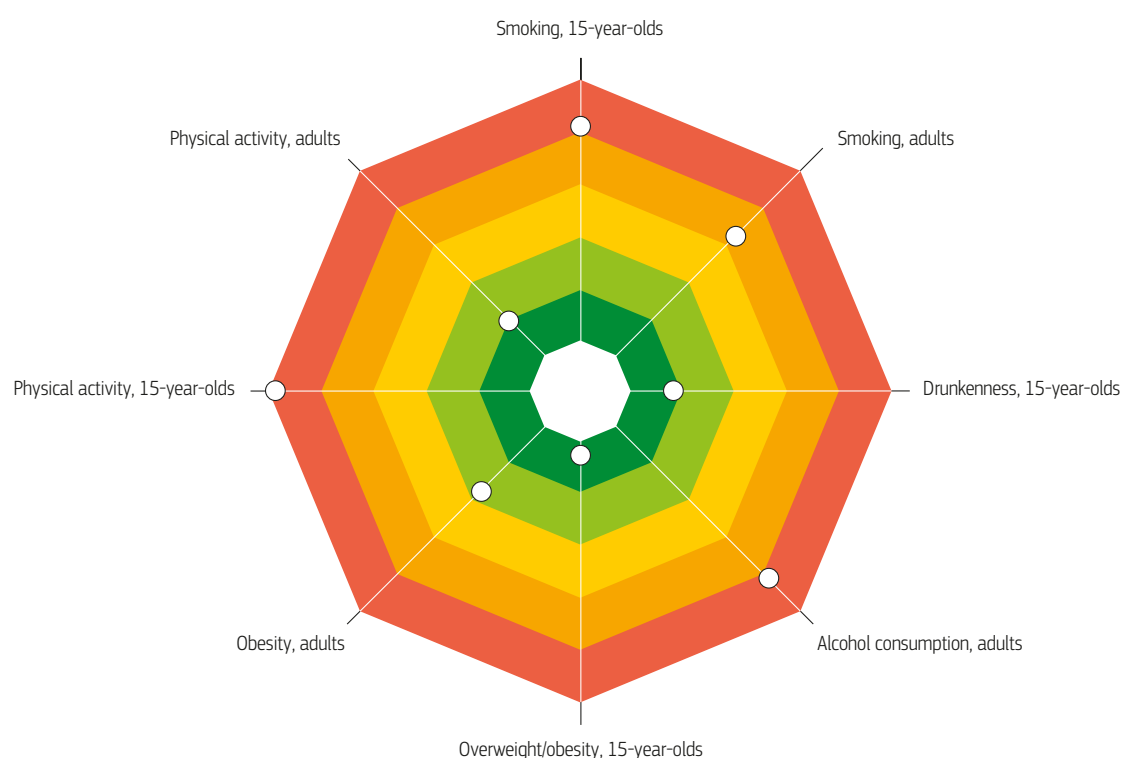
Overweight and obesity problems among children and adults represent a growing public health issue in France. More than one in seven adults is now obese (15% in 2014), up from one in eleven in 2000 (9%), and 14% of 15-year-old adolescents were overweight or obese in 2013-14, compared to 11% in 2001-02.

Regular physical activity among adolescents is particularly low in France, notably among girls. In 2013-14, only 6% of 15-year-old girls reported doing regular physical activity, compared with 10% on average in the EU. The proportion among 15-year-old boys was 14% in France compared with 20% on average in EU countries.

### Unhealthy behaviours are more prevalent among disadvantaged groups

As in other EU countries, the distribution of many behavioural risk factors to health in France follows a social gradient, with the highest prevalence among people with low education or income. For example, obesity rates among adults are two times greater among the lowest educated than the highest educated. The prevalence of smoking is also much greater among people who haven't completed their high school education than those with a tertiary education. This social distribution of risk factors contributes to the observed inequalities in health status.

**Figure 5. Smoking and alcohol consumption remain important public health issues in France**



**Note:** The closer the dot is to the centre the better the country performs compared to other EU countries. No country is in the white 'target area' as there is room for progress in all countries in all areas.

**Source:** OECD calculations based on Eurostat Database (EHIS in or around 2014), OECD Health Statistics and HBSC survey in 2013-14. (Chart design: Laboratorio MeS).

## 4 The health system

### Governance of the French social insurance system is centralised

The French financing system is based on social insurance, with a stronger role for the state than is usually the case in such systems. The responsibility for the management of the health system is split between the state and social health insurance (SHI). Since the mid-1990s, reforms have devolved power from the national to the regional level, in particular for planning. Following the 2009 Hospital, Patients, Health and Territories (HPST) Act, most existing regional regulatory institutions were merged into single regional health agencies (*Agences régionales de santé, ARS*), to facilitate and spread national governance at a local level and ensure that health care provision meets the needs of the population (Chevreul et al., 2015).

### Health spending per capita in France is 20% higher than the EU average

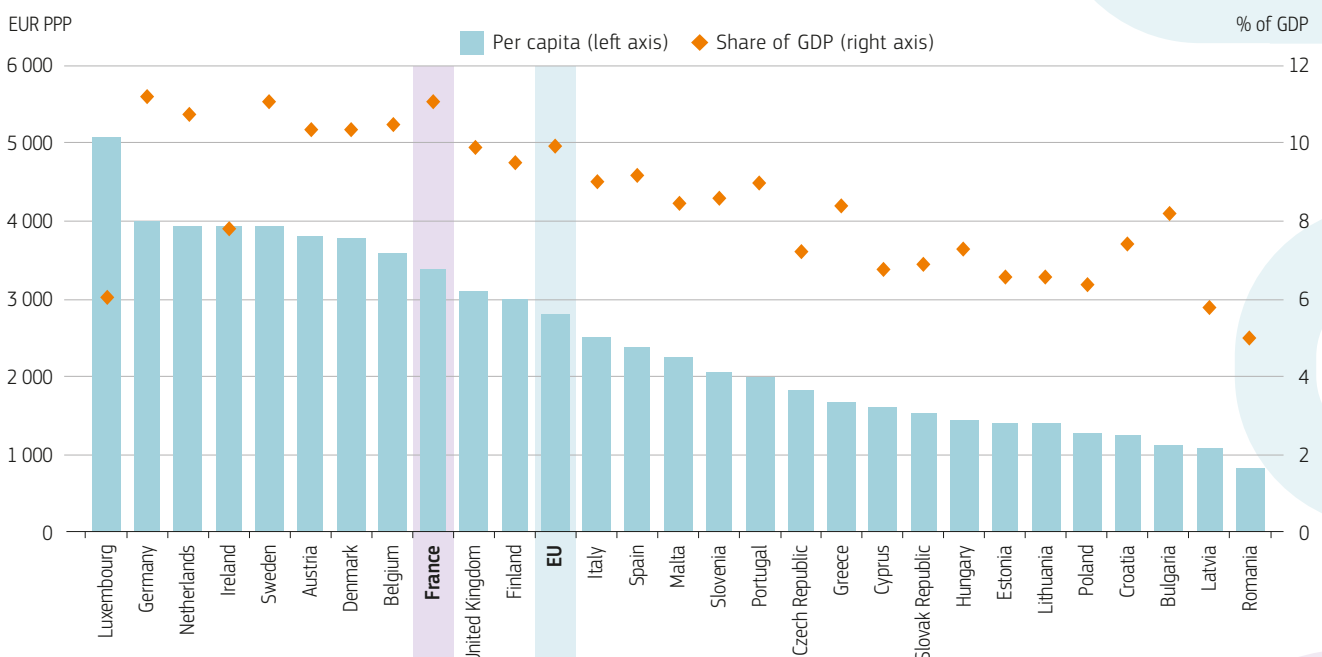
France ranked ninth among EU countries in health expenditure per capita in 2015 (EUR 3 342 per capita, adjusted for purchasing power parity). However, as a proportion of GDP, health spending in France was the second highest (after Germany) with 11.1% of GDP allocated to health (Figure 6). Health expenditure in France has grown at a moderate rate over the past decade. Nonetheless,

because health spending has grown faster than the economy, the health spending share of GDP has increased by almost one percentage point since 2005.

Over three-quarters of total health expenditure is publicly funded (79%), primarily through social health insurance (SHI). SHI is mainly funded from income-based contributions from employers and tax payers. Additional revenues come from specific taxes, such as taxes on tobacco and alcohol and on pharmaceutical companies. Since 1996, SHI annual expenditure has been controlled by a national objective for health insurance expenditure (known as ONDAM).

Complementary (voluntary) health insurance plays an important role in France. It provides complementary insurance for co-payments and better coverage for medical goods and services poorly covered by SHI (e.g. eyeglasses and dental care). It finances approximately 14% of total health expenditure and covers about 95% of the population. Among those insured, one in ten is covered by a publicly funded complementary coverage known as '*Couverture maladie universelle complémentaire*' (CMUC). The remaining out-of-pocket payments paid directly by patients account for only 7% of total health expenditure, the lowest share across EU countries and well below the EU average (15%).

**Figure 6. Health spending in France is higher than in most other EU countries**



Source: OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database (data refer to 2015).



## Nearly all the population is covered by social health insurance

All legal residents are covered by SHI, an entitlement of the wider social security system. Set up in 1945, the SHI scheme initially offered coverage based on professional activity and was contingent on contributions. The scheme has always been administered by a number of non-competing health insurance funds catering to different segments of the labour market. The main fund (*Caisse Nationale d'Assurance Maladie des Travailleurs Salariés*, CNAMTS) covers 91% of the population. The two other sizeable funds cover self-employed people (*Régime Social des travailleurs Indépendants*, RSI) and agricultural workers (*Mutualité Sociale Agricole*, MSA).

In 2000, the Universal Health Coverage (*Couverture Maladie Universelle*, CMU) Act changed the public insurance entitlement criterion from professional activity to residence. This allowed a small but growing share of the population to benefit from the same rights as the rest of the population. In 2016, this mechanism was generalized and simplified to become the Puma (*Protection Universelle Maladie*). Around 3.8% of the population now draw their social health insurance coverage from their residency status.

## The benefits package is broad, but the depth of coverage varies by type of services

The French health care basket is relatively broad in terms of goods and services covered. Medical goods and services covered include hospital care and treatment delivered in public and private institutions, outpatient care provided by GPs, specialists, dentists and midwives and all other services prescribed by doctors (diagnostic and medical procedures, laboratory tests, pharmaceutical products, medical appliances and health care related transport).

However, the depth of coverage varies depending on the goods and services (Box 1). It is fairly limited for eyeglasses and contact lenses and dental prostheses, with a substantial part of the cost left to patients or their complementary health insurance. The SHI also does not cover extra-billing amounts over the statutory tariffs.<sup>6</sup>

### BOX 1. PUBLIC COVERAGE FOR HOSPITAL CARE, OUTPATIENT CARE AND PHARMACEUTICALS

The coverage rate for hospital care is generally 80%, but increases up to 100% in a number of cases (e.g. people with long-term conditions and maternity cases). Whatever the level of coverage, most patients must pay a flat-rate catering fee (*forfait journalier*) of EUR 18 per day for hospital accommodation (this fee is expected to increase to EUR 20 starting in 2018).

For outpatient care provided by self-employed health professionals, the coverage rate ranges from 70% of the statutory tariff for consultations with doctors and dentists to 60% for services provided by medical auxiliaries and laboratory tests. However, the coverage of a doctor's visit can vary according to the 'preferred doctor' scheme (set up to support coordinated care pathways). Under this scheme, patients are requested to register with the doctor of their choice (most often a general practitioner), whom they should see to obtain a referral to a specialist. The coverage rate of patients who directly access specialists (or other general practitioners) outside of the coordinated care pathways falls to 30%.

The coverage rate for pharmaceuticals is generally set at 65%, but it can range from 100% for non-substitutable or expensive drugs to 15% for drugs that have been assessed as having low effectiveness (based on *Service Médical Rendu*).

Patients with long-term conditions (*Affections de Longue Durée*) are exempted of co-payments for all treatments related to this condition.

**Source:** Chevreur et al. (2015)

There are also deductibles, which are usually not covered by complementary health insurance, to reduce overconsumption and patient demand. Since 2005, patients must pay EUR 1 for every physician visit and biomedical analysis, EUR 0.50 for each paramedical procedure and EUR 2 for each medical transport. There is an annual ceiling of EUR 50 for each of these types of care. Exemptions from user charges apply in most cases for pregnant women, people with chronic conditions and victims of work accidents.

6. Doctors practising in 'Sector 2' (the sector where fees are set freely) are allowed to set their fees at higher levels than the statutory tariffs under the social security system, and these higher fees have to be paid either by patients themselves or their complementary health insurance. To limit such extra-billing, some provisions were introduced in the global agreement between the public health insurance system and physicians' unions in October 2012, so that these Sector 2 doctors would be incentivised to sign a voluntary contract restraining these extra-billing practices (Chevreur et al., 2015).

## The geographic distribution of doctors and other health professionals is unequal

Even if the number of doctors per capita in France has remained relatively stable over the past 10 years, it is now slightly lower than the EU average (3.3 doctors per 1 000 population in France compared with 3.6 doctors for the EU average in 2015). The number of nurses per capita has increased and is now slightly higher than the EU average (9.9 nurses per 1 000 population in France compared with 8.4 for the EU average in 2015), as shown in Figure 7.

However, there are wide disparities in the density of health professionals across regions in France, in particular for specialist doctors, with the density being two times greater in some regions than in others (Ministry of Solidarity and Health, 2016).

## The number of hospital beds has been reduced, but remains above the EU average

The number of hospital beds in France declined by more than 15% in absolute terms since 2000, but still remains above the EU average (6.1 per 1 000 population in 2015 compared to 5.1 for the EU average). There has been a reduction in all types of beds. Acute care beds came down by 12.5%. The most substantial reduction was for long-term care beds in hospital. These declined by over 60% between 2000 and 2015 through their transformation into nursing

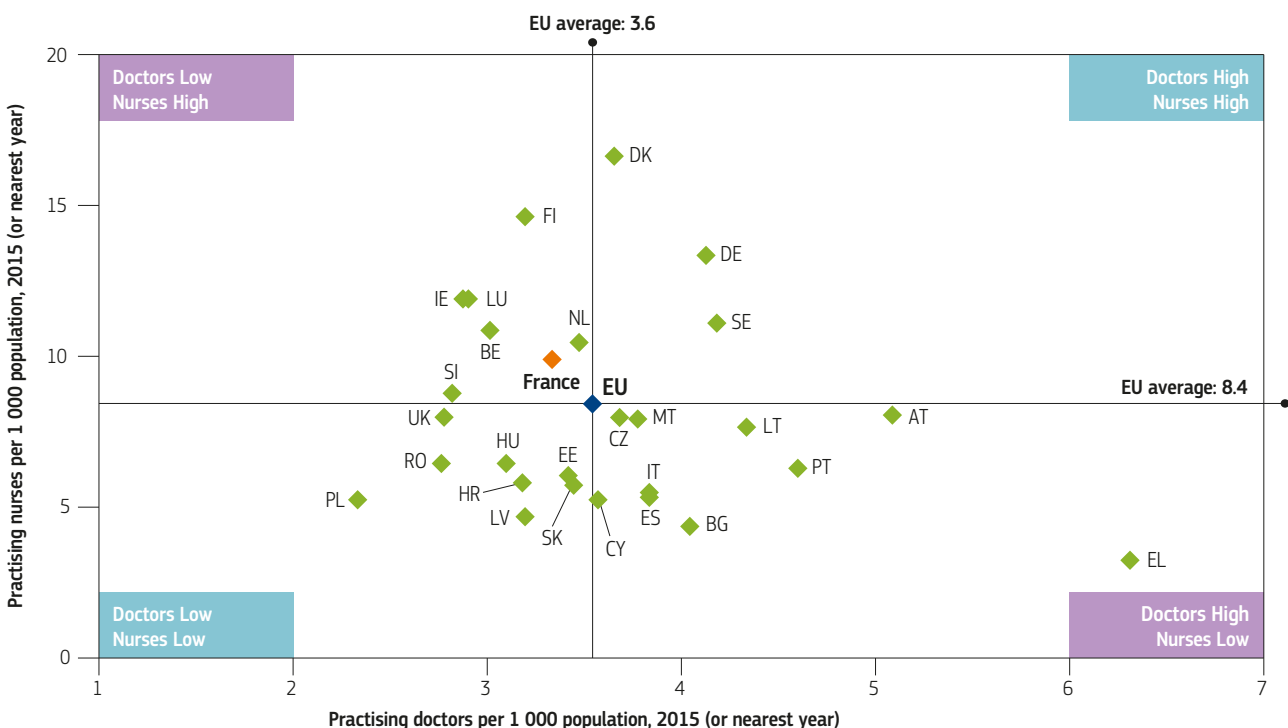
homes, considered to be a more appropriate response to the needs of frail elderly populations. Psychiatric care beds also diminished (by over 8%) as a result of the French deinstitutionalisation policy and a reorientation towards more community-based mental health facilities.

## The role of GPs in care coordination has been strengthened

Primary and secondary ambulatory care is provided mainly by self-employed doctors and medical auxiliaries (including nurses and physiotherapists) working in their own practices, and, to a lesser extent, by salaried staff working in health centres and hospitals. GPs have taken on a major role in the coordination of care through a semi-gatekeeping system (called 'the preferred doctor scheme'). This provides incentives to people to visit their GP prior to consulting a specialist (see Box 1).

Various initiatives have sought to address the lack of coordination and continuity of care in the health system. These include the gatekeeping structure developed under the 2004 Health Insurance Act to promote care coordination and provider networks to offer multidisciplinary care to patients with complex needs. Recently, care pathways have been developed for patients with chronic diseases (see Section 5.1) and for patients over 75 years of age at risk of dependency. The 2016 Health Reform Law aims to develop some Territorial Hospital Groups to improve cooperation between hospitals within a defined geographic area (see Section 5.3).

**Figure 7. France has fewer doctors per capita than the EU average but slightly more nurses**



**Note:** In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors (e.g. of around 30% in Portugal). In Austria and Greece, the number of nurses is underestimated as it only includes those working in hospital.

**Source:** Eurostat Database.

## 5 Performance of the health system

### 5.1 EFFECTIVENESS

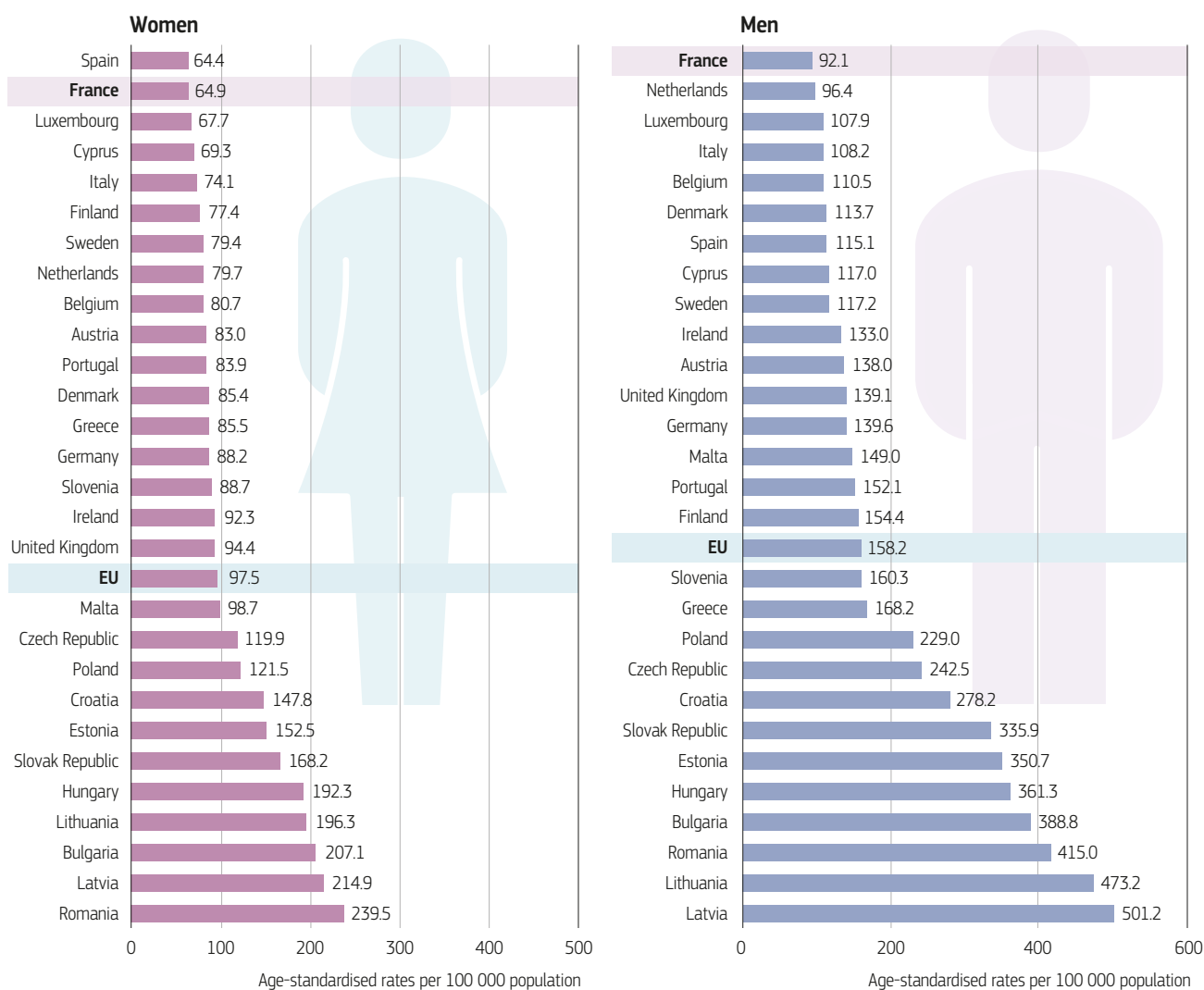
#### Low amenable mortality points to good performance of the health care system in treating people with acute conditions

Mortality amenable to health care is relatively low in France due mainly to low mortality rates from ischaemic heart diseases and stroke.<sup>7</sup> In 2014, France had the lowest rates of amenable mortality among men and the second lowest rate (after Spain) among women (Figure 8).

#### More people survive heart attack and stroke

The quality of acute care for life-threatening conditions, such as heart attack (acute myocardial infarction or AMI) and stroke has improved in France over the past ten years, and fewer people die after being admitted for these conditions than across the EU on average (Figure 9). These improvements reflect a number of changes including more rapid treatment of patients before their transportation to the hospital, and the development of specialised units to treat heart attack and stroke (OECD, 2015).

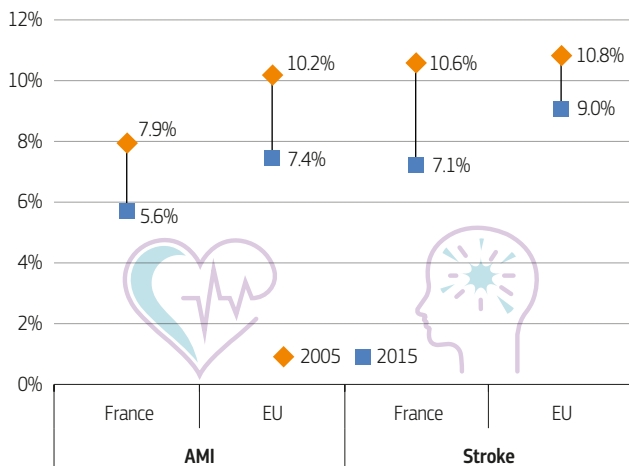
Figure 8. Amenable mortality rates in France are among the best in the EU



Source: Eurostat Database (data refer to 2014).

7. Amenable mortality is defined as premature deaths that could have been avoided through timely and effective health care.

**Figure 9. In-hospital case fatality rates following heart attack (AMI) and stroke decreased in France**



**Note:** These data are based on admission data and have been age-sex standardised to the 2010 OECD population aged 45+ admitted to hospital for heart attack (AMI) and ischemic stroke. The EU average is based on the unweighted average of 22 countries with data available in 2005 and 2015 (or nearest year).

**Source:** OECD Health Statistics 2017.

## Cancer care is also generally good

France ranks favourably compared with other EU countries with regards to five-year survival following diagnosis for breast, cervical, colon and rectal cancers. Since the early 2000s, the quality of cancer care has improved through the introduction of multidisciplinary team and cancer networks, the greater use of clinical guidelines and more rapid access to innovative drugs.

The current Cancer Plan (which is the third one) was allocated a budget of EUR 1.5 billion over the period 2014-19, and focuses on prevention, early diagnosis, access to quality care, innovations and more patient-centred care. The Plan also aims to tackle inequalities in cancer incidence and cancer outcomes. The governance of cancer care has been also strengthened through the establishment of an independent body (*Institut National du Cancer*, National Cancer Institute) which is responsible for overseeing the overall implementation of cancer control, allocating resources to achieve specific objectives, and monitoring and evaluating progress.

## New care models are emerging to improve the management of chronic diseases

New care models are gradually emerging in France to improve care coordination and quality for patients with chronic diseases. For example, disease management programmes have been introduced for diabetes and asthma patients. In addition, self-employed GPs now may receive a pay-for-performance (P4P) bonus (*Rémunération sur Objectifs de Santé Publique*, Payment for achieving public health objectives) that comes on top of the fee-for-service system. This bonus payment incentivises better care for chronic patients and accounted for 4.1% of total GP payments in 2014.

Care pathways have been introduced for several chronic diseases, including Parkinson's disease, chronic kidney disease, congestive heart failure and diabetes. The overarching objective of all these initiatives is to help physicians to deal better with acute episodes and to postpone the progression of the disease by improving care practice, care coordination and fostering patient involvement in care through therapeutic patient education (Chevreul et al., 2015).

## Preventable deaths from alcohol and transport accidents have been reduced

Alcohol-related and transport accident deaths have been reduced substantially in France since 2000, but still several thousands of people die each year of alcohol-related deaths<sup>8</sup> and about 3 460 people died in road traffic accidents in 2016. More than two decades ago, the French government adopted some alcohol control policies such as tight regulations on the promotion of alcoholic beverages (*la loi Évin* initially adopted in 1991). However, some of these measures have been reversed, and France continues to have lower levels of alcohol taxes, especially for wine, compared to other European countries, although taxes on beer and liquor have been increased in recent years. A number of policies have also been adopted in recent years to reduce the number of deaths from road traffic accidents, including lower speed limits and lower alcohol thresholds for drivers, in particular for young drivers.

## Tobacco control policies continue to be strengthened

To achieve the target of reducing tobacco smoking by at least 10% between 2014 and 2019 (Ministry of Social Affairs and Health, 2014), a national programme against tobacco addiction has been set which aims at preventing young people from starting to smoke, helping smokers to quit and acting on the tobacco economy. A number of policies have been adopted, including a massive national campaign directed to smokers and the introduction of plain packaging since 1 January 2017 (as in Australia, the United Kingdom and Ireland). A lump sum of EUR 150 per year is also available to smokers for using smoking cessation products since late 2016, and a broad range of health professionals (e.g. nurses, dentists, physiotherapists) are allowed to prescribe treatments.

In December 2016, a decree laid the foundations for the creation of a new fund for tobacco control and the 2017 Social Security Finance Act created a new social contribution which will collect

8. The Eurostat database reports that 7 800 people died from alcohol-related diseases in 2014 (excluding injuries and other violent deaths), but the most recent estimate used by the French Ministry of Health (which include such alcohol-related injuries and violent deaths) is that alcohol consumption is responsible for 49 000 deaths each year (Ministry of Solidarity and Health, 2017).

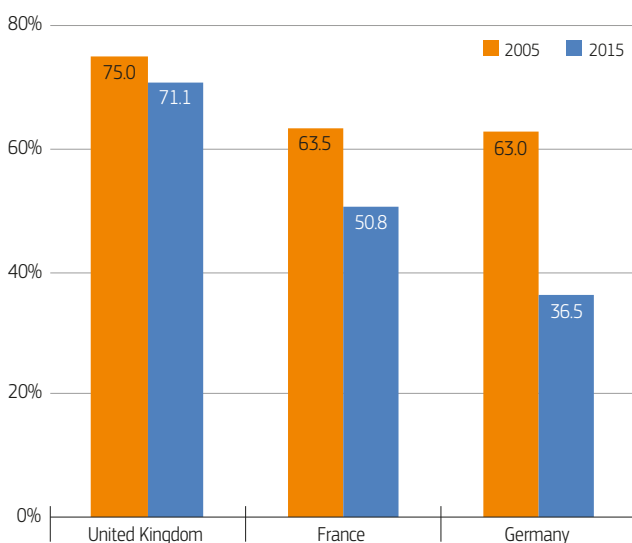
revenues directly from tobacco distributors yielding a total amount estimated at EUR 130 million per year. This new fund will support actions in four priority areas: prevention, smoking cessation, reducing social inequalities and evaluation and research.

## Immunisation coverage can be increased

Immunisation coverage for certain types of vaccines among children and elderly people is relatively low in France compared with other EU countries. For example, the immunisation rate of French children against measles (first dose) was only around 90% in 2015 (while most EU countries had a rate of 95% or higher), while vaccination against Hepatitis B was even lower at 83% (compared with an EU average of about 95%). The French Ministry of Health plans to increase the number of compulsory vaccinations among children from three to eleven, including measles and Hepatitis B which are only recommended under the current policy.

The vaccination rate against influenza among elderly people came down over the past decade in France as in other countries like Germany. Whereas nearly two-thirds of people aged over 65 in France were vaccinated against influenza in 2005, this proportion fell to about half only in 2015 (Figure 10). This reduction moved France away from achieving the target of 75% vaccination coverage of this population group set by both WHO and a 2009 EU Council Recommendation. The recent authorisation for pharmacists to vaccinate people against influenza, initially as part of pilot projects, is designed to facilitate access to this vaccination among older people and other populations at risk.

**Figure 10. Vaccination against influenza among people aged over 65 declined over the past decade**



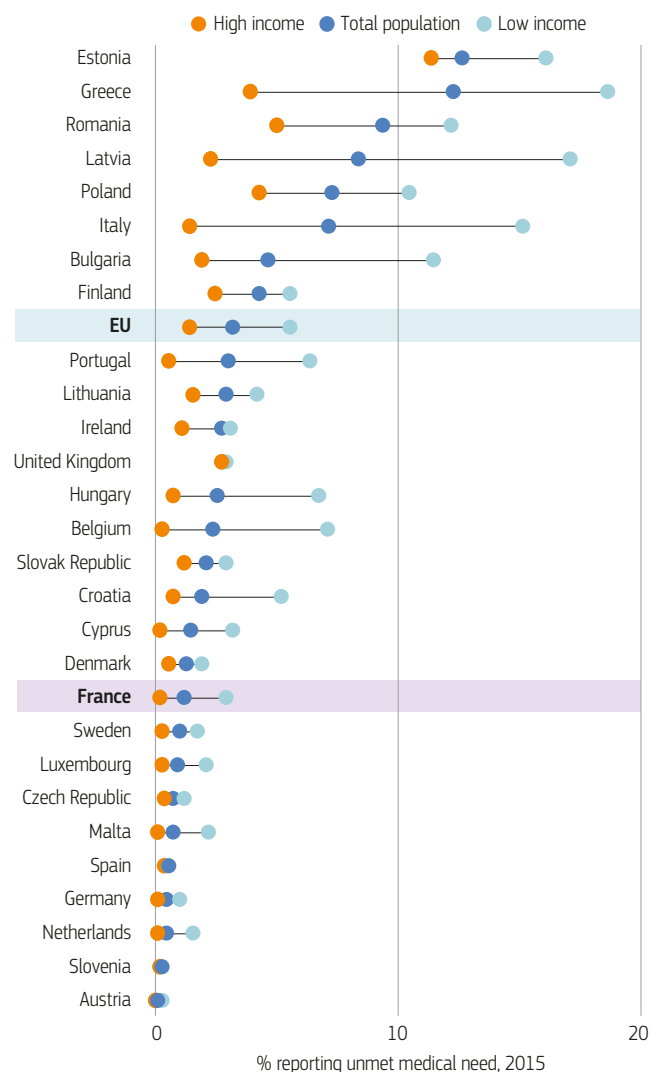
Source: OECD Health Statistics 2017.

## 5.2. ACCESSIBILITY

### Unmet needs are particularly high for dental and eye care, and among low-income groups

As described in Section 4, the French social health insurance provides quasi universal coverage, with 99.9% of the population covered in 2015. Based on the 2015 wave of the EU-SILC survey, only 1.2% of the French population reported some unmet needs for medical care for financial reasons, geographic reasons or waiting times, a much lower proportion than the EU average (3.2%). However, there are some variations across income groups: about 3% of people in the lowest income group reported going without medical care for financial, geographic or waiting time reasons, compared to close to zero (0.2%) among people in the highest income group (Figure 11).

**Figure 11. French people report low level of unmet need for medical care, but there are disparities by income group**

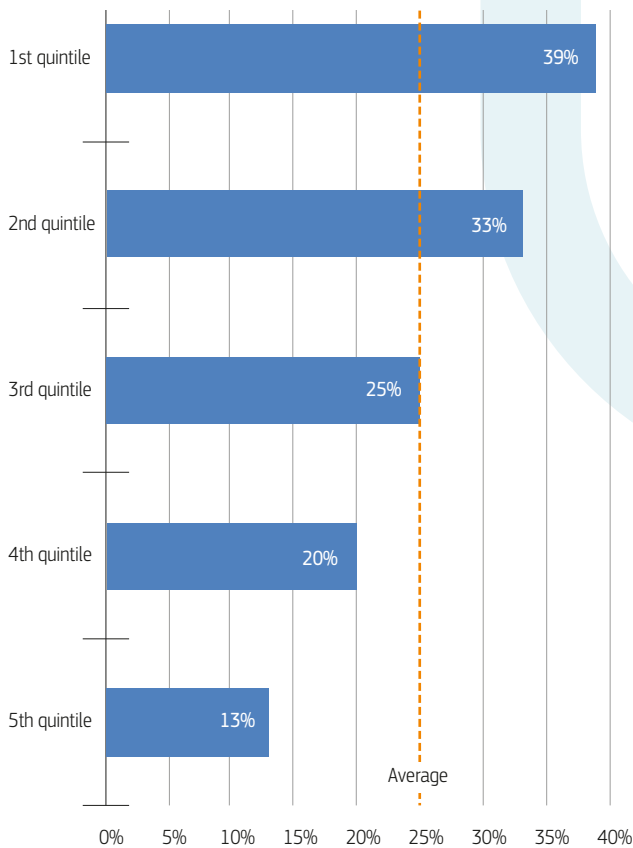


Note: The data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.

Source: Eurostat Database, based on EU-SILC (data refer to 2015).

Results from the national Survey on Health and Social Protection show that a much greater percentage of the French population report some unmet needs for financial reasons when the range of services include not only medical care, but also dental care, eye care and other care. One quarter of the population reported such unmet needs in 2014 (Figure 12). Most of these unmet needs relate to dental and eye care. The proportion of unmet needs among people with low income is three times higher (39%) than among people with high income (13%). The main factor affecting these unmet needs is the absence of a complementary health insurance (DREES and Santé Publique France, 2017).

**Figure 12. One quarter of the French population report unmet needs for a broader array of care, mainly for dental and eye care**



**Note:** These rates refer to the proportion of the population reporting unmet needs for dental care, eye care, doctor consultations, medical examinations or other care, for financial reasons over the last 12 months.

**Source:** ESPS 2014 (DREES-IRDES).

### Out-of-pocket payments are low on average, but higher for people without complementary health insurance

As noted in Section 4, the share of health expenditure paid out of pocket in France was only 7% in 2015, the lowest among all EU countries. However, this average masks variations in public coverage across different types of services and populations. While

more than 90% of hospital expenditure was publicly financed in 2015, the proportion was 67% for ambulatory care. For the vast majority of the population, which does not benefit from statutory exemptions of co-payments due to chronic diseases, the actual coverage of outpatient care was only about 50%. Out-of-pocket payments can thus be fairly substantial for people who do not have complementary health insurance (or good complementary insurance).

### Direct payments at the point of use is a financial barrier that is being removed

In France, patients have traditionally paid for the health services they receive in ambulatory care at the point of use and are then reimbursed by the social health insurance and their complementary health insurance. This payment upfront can constitute a financial barrier to access to care for certain population groups. For this reason, the initiative has been taken to generalise third-party payment at the point of use (as in many other countries like Germany, Austria and the Netherlands), so that any upfront payment would no longer be required. The generalisation of third-party payment at the point of use, initially planned for the end of 2017, has been postponed to the coming years.

### A series of measures have been taken to improve access to care in underserved areas

As already noted, there are large disparities in the distribution of doctors and other health professionals in France across regions. These disparities mainly result from the freedom of self-employed doctors to establish their practice where they wish.

The Ministry of Health launched in 2012 and 2015 two 'Health Territory Pacts' to promote the recruitment and retention of doctors and other health workers in underserved regions. These Pacts include a series of measures to facilitate the establishment of young doctors in underserved areas and to improve their working conditions. New multidisciplinary medical homes, allowing physicians and other health professionals to work in the same location, began to be set up in 2007, and their number is expected to double by 2022. Furthermore, the promotion of telemedicine and transfers of competences from doctors to other health care providers will be reinforced (see Section 5.3).

A public service commitment contract (*'contrat d'engagement de service public'*) is also offered to medical and dentistry students and residents who receive a monthly allowance during their studies in return for a commitment to work afterwards in an underserved area. Also for nurses, midwives and other health professions, some financial and other incentives have been introduced to encourage them to settle in underserved areas.

### 5.3. RESILIENCE<sup>9</sup>

#### A shift towards ambulatory care has begun since 2000

The reduction in the number of hospital beds since at least 2000 is one indication that France is attempting to rely less on inpatient hospital care than in the past. It was accompanied by a reduction in length of stay in hospital (Figure 13). This reduction in average length of stay was supported in recent years by the expansion of the 'hospitalisation at home' programme (known as *Programme d'Accompagnement du Retour à Domicile*, PRADO), which started in 2010 in maternity care and extended since to orthopaedics and some cardiac care.

Encouraging the development of ambulatory surgery has also been a stated priority over the past two decades, but progress has not been as rapid as in other countries. For instance, the share of cataract surgery (the most frequent surgical procedure in France) performed on a same day basis has increased from 32% in 2000 to 89% in 2014, narrowing the gap with many countries in Europe where nearly all cataract surgeries have been performed

9. Resilience refers to health systems' capacity to adapt effectively to changing environments, sudden shocks or crises.

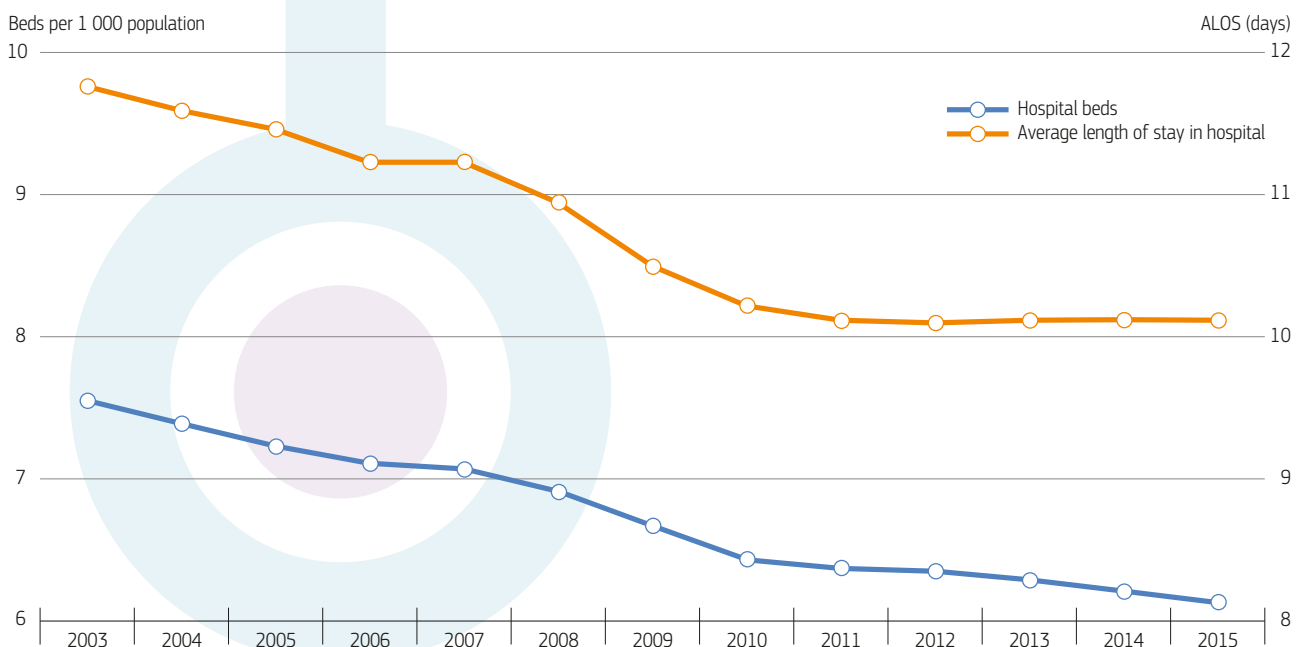
as day surgery for a long time. Nonetheless, further progress can be achieved for many other surgical interventions such as tonsillectomies, when these interventions are actually required.

The 2016 Health Reform Law plans the development of Territorial Health Professional Communities (*Communautés Professionnelles Territoriales de Santé*) to promote multidisciplinary teams of health and social care professionals to improve care coordination for people with chronic conditions.

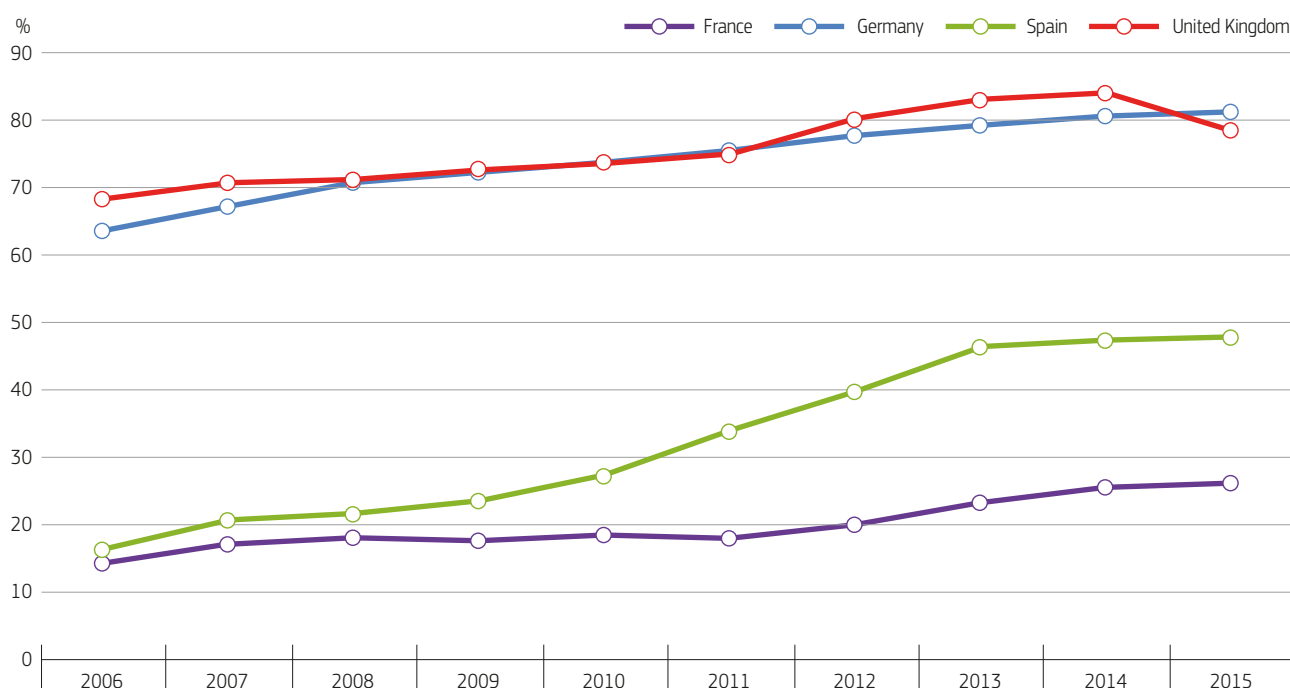
#### Efficiency gains in pharmaceutical spending have been achieved, but better managing access to high-cost medicines is an important challenge

France has taken a series of measures in recent years to promote greater efficiency in pharmaceutical spending and to free up resources to enable access to new high-cost medicines deemed to offer good patient outcomes. The reimbursement rates for pharmaceutical drugs are increasingly based on the assessment of their effectiveness. While there continues to be no or low cost-sharing for prescribed drugs that are highly effective, cost-sharing has been increased for less effective drugs.

**Figure 13. The number of hospital beds and average length of stay declined**



Source: OECD Health Statistics 2017.

**Figure 14. The share of the generic market in France has increased, but remains lower than in many EU countries**

**Note:** These data refer to the share of generics in volume of consumption (not in value).

**Source:** OECD Health Statistics 2017.

A number of measures were taken to incentivise generic prescribing and purchasing. Since 2010, patients who refuse a generic substitution proposed by the pharmacist have to pay upfront for all prescribed medicines and seek reimbursement later from the SHI. A pay-for-performance (P4P) scheme was introduced in 2009 to reward physicians for generic prescriptions, and since 2015 International Non-proprietary Names (INN) prescribing is mandatory (although this obligation is not respected yet in practice in many cases).

These policies, associated with patent expiries of several blockbusters, have contributed to a notable increase in the generic market share over the past decade. Between 2006 and 2015, the generic market share in volume nearly doubled in France, rising from 14.5% to 26.5%. However, this share remains below the EU average and far below the share in countries such as the United Kingdom, Germany and Spain (Figure 14). Part of the reason for the relatively low penetration is that France opens fewer categories of drugs to generic substitution and competition. The 2017 National Action Plan for the promotion of generics aims at increasing the generic market share by a further five percentage points by 2018 (CNAM, 2016).

France has also launched a number of initiatives to reduce antibiotic consumption as part of a broader strategy to tackle antimicrobial resistance (Box 2).

## BOX 2. NATIONAL STRATEGY TO ADDRESS ANTIMICROBIAL RESISTANCE

Antimicrobial resistance (AMR) is a major public health issue in France. High levels of AMR have been observed over the last 15 years for the majority of bacteria under surveillance by the European Centre for Disease Prevention and Control (ECDC, 2017). This situation is fuelled by the fact that France has the second highest level of consumption of antibiotics per population in Europe.

According to the French National Agency for Public Health, around 150 000 people develop an infection due to a resistant bacteria each year, which causes 12 500 deaths. In January 2015, the Ministry of Health established a special working group on AMR involving more than 100 experts from a variety of sectors. The working group produced a series of recommendations including the need to raise awareness among health professionals and the general public on the threats of AMR and the need for a more appropriate use of antibiotics, to support more R&D on AMR, and to strengthen existing monitoring systems. A national interdisciplinary plan has been put in place to achieve these objectives based on a One-Health approach (i.e. taking into account the health needs of humans, animals and the environment).

**Source:** ECDC (2017)



Identifying appropriate targets for the diffusion of new high-cost medicines remains a challenge in France. Like other countries, providing access to all the population to new hepatitis C drugs has been a challenge in France in the first months. On the other hand, France provides a wide access to new treatments. It explicitly exempts orphan medicines from economic evaluation, as long as their budget impact during the first two years on the market does not exceed EUR 20 million. France is also one of the few countries to provide public funding for a 'temporary authorisation for use' (ATU) scheme that grants patients early access to promising medicines before final approval. Expenditure growth in some therapeutic areas such as oncology continues to be a concern, as escalating expenditure may not be matched by commensurate health gains.

### Addressing health workforce challenges through better planning and innovative approaches in underserved areas

Based on the most recent projections from the Ministry of Social Affairs and Health, the number of doctors should remain relatively stable between 2016 and 2019, and then start to rise again in 2020, reflecting the moderate increase in the *numerus clausus*

between 2007 and 2015. Taking into account population growth, the density of doctors is expected to fall slightly between 2015 and 2021 (from 3.3 to 3.2 doctors per 1 000 population), before rising again to come back to its 2015 level by 2028. In terms of composition, the number of generalists is expected to grow less rapidly than the number of specialists, mainly because most foreign-trained doctors migrating to France are specialists (Bachelet and Anguis, 2017).

In response to concerns that the supply of doctors may not keep up with growing demands, the Minister of Social Affairs and Health announced in 2017 an increase of 6% in the *numerus clausus* for entry in medical schools (which, in France, applies to students entering their second year of medical education). This increase in the *numerus clausus* (which was not taken into account in recent projections) will become effective in 2017 and increases will be greater for medical schools located in regions deemed to be in shortages.

Extending further the roles of nurses and pharmacists, as in the case of immunisations, is also seen as a solution to improve access, particularly in underserved areas where the number of GPs is decreasing.



## 6 Key findings

- The French health system generally provides good quality care and significantly contributes to improving the population health. Life expectancy in France is among the highest in EU countries and amenable mortality rates are among the lowest, due in part to low and declining mortality from cardiovascular diseases. The French population generally has good access to care, even though a non-negligible proportion of the population reports some unmet needs for financial reasons, particularly for dental care and eye care.
- Health spending as a share of GDP is the second highest amongst EU countries (after Germany), with 11.1% of the French GDP allocated to health in 2015, but ranks ninth in per capita terms. Looking ahead, health spending as a share of GDP is projected to continue to increase in the coming years due to population ageing and the diffusion of new technologies.
- In France, 79% of health expenditure is publicly funded, which is similar to the EU average. Because complementary private health insurance plays a more important role than in other countries, the share of direct out-of-pocket payments by households is the lowest among EU countries. There have, nevertheless, been growing concerns with rising levels of out-of-pocket payments, particularly among people who do not have a (good) complementary health insurance.
- Beyond financial barriers, another important challenge is to address persisting disparities in the geographic distribution of doctors and other health professionals. To address this problem, the French Ministry of Health has taken a series of measures to promote the recruitment and retention of doctors and other health workers in underserved regions.
- In response to the broader concern about a possible shortage of doctors, the Ministry of Health announced in 2017 an increase of 6% in the *numerus clausus* for entry in medical schools, to be implemented as of September 2017. One challenge will be to maintain an appropriate balance between generalists and specialists. Some innovative measures have been undertaken to extend further the roles of other health professionals, such as nurses and pharmacists, to improve access to services particularly in underserved areas.
- One of the main challenges of the French health system is to continue its transformation from a system that was predominantly focussed on providing acute care in hospital to a system that is more geared towards responding to the needs of ageing populations and growing numbers of people living with chronic conditions. Some progress has been achieved in strengthening primary care and developing new care coordination models for people with chronic diseases such as diabetes and asthma, but further progress is possible.
- Strengthening public health and prevention policies may also reduce pressures on the health system and reduce social inequalities in health. Tobacco smoking and alcohol consumption continue to be important public health issues in France, and rising obesity rates and lack of physical activity particularly among young people also pose growing health risks. Even though tobacco smoking and alcohol consumption have been reduced over the past decade, they still remain higher than the EU average, with a significant social gradient.



# Key sources

Chevreur, K. et al. (2015), "France: Health System Review", *Health Systems in Transition*, Vol. 17(3), pp. 1–218.

OECD/EU (2016), *Health at a Glance: Europe 2016: State of Health in the EU Cycle*, OECD Publishing, Paris, <http://dx.doi.org/10.1787/9789264265592-en>.

## References

Bachelet, M. and M. Anguis (2017), "Les médecins d'ici à 2040: une population plus jeune, plus féminisée et plus souvent salariée", *Études et Résultats*, DREES, May.

Bellamy, V. and C. Beaumel (2016), *Bilan démographique 2015*, INSEE, January.

Blanpain, N. (2016), "Les hommes cadres vivent toujours 6 ans de plus que les hommes ouvriers", *INSEE Première*, February.

CNAM (2016), *Améliorer la qualité du système de santé et maîtriser les dépenses : Proposition de l'Assurance Maladie pour 2017*, 7 juillet 2016.

DREES et Santé publique France (2017), *L'état de santé de la population en France – Rapport 2017*.

ECDC (2017), *Antimicrobial Resistance Surveillance in Europe 2015*, Annual Report of the European Antimicrobial Resistance Surveillance Network (EARS-Net).

IHME (2016), "Global Health Data Exchange", Institute for Health Metrics and Evaluation, available at <http://ghdx.healthdata.org/gbd-results-tool>.

Ministry of Social Affairs and Health (2014), "Cancer Plan 2014–2019, Objective 10, National Smoking Reduction Programme 2014–2019", [http://social-sante.gouv.fr/IMG/pdf/pnrt2014-2019\\_uk.pdf](http://social-sante.gouv.fr/IMG/pdf/pnrt2014-2019_uk.pdf).

Ministry of Solidarity and Health (2016), "Numbers of Doctors and Nurses Per Capita", DREES, <http://www.data.drees.sante.gouv.fr>.

Ministry of Solidarity and Health (2017), *L'addiction à l'alcool*, 24 March 2017.

OECD (2015), *Cardiovascular Disease and Diabetes: Policies for Better Health and Quality of Care*, OECD Publishing, Paris, <http://dx.doi.org/10.1787/9789264233010-en>.

OECD (2016), *Better Ways to Pay for Health Care*, OECD Publishing, Paris, <http://dx.doi.org/10.1787/9789264258211-en>.

## Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Malta	MT	Slovenia	SI
Belgium	BE	Estonia	EE	Ireland	IE	Netherlands	NL	Spain	ES
Bulgaria	BG	Finland	FI	Italy	IT	Poland	PL	Sweden	SE
Croatia	HR	France	FR	Latvia	LV	Portugal	PT	United Kingdom	UK
Cyprus	CY	Germany	DE	Lithuania	LT	Romania	RO		
Czech Republic	CZ	Greece	EL	Luxembourg	LU	Slovak Republic	SK		



# State of Health in the EU

## Country Health Profile 2017

The Country Health Profiles are an important step in the European Commission's two-year *State of Health in the EU* cycle and are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies. This series was co-ordinated by the Commission and produced with the financial assistance of the European Union.

The concise, policy relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU Member State. The aim is to create a means for mutual learning and voluntary exchange that supports the efforts of Member States in their evidence-based policy making.

Each Country Health Profile provides a short synthesis of:

- health status
- the determinants of health, focussing on behavioural risk factors
- the organisation of the health system
- the effectiveness, accessibility and resilience of the health system

This is the first series of biennial country profiles, published in November 2017. The Commission is complementing the key findings of these country profiles with a Companion Report.

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