

OECD Health at a Glance - How France Compares

**How high is health
spending?**

**What is the mix of
public and private
funding?**

**What are the
resources in the health
sector?**

**What is the health
status of the
population?**

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Introduction

This *Policy Brief* presents some of the key indicators contained in the second edition of the publication *Health at a Glance – OECD Indicators 2003*, with a focus on how France compares with other countries.

In many respects, France fares well among OECD countries in terms of indicators of the health status of its population and resources allocated to its health care system. The French population (and particularly French women) enjoys a relatively high life expectancy compared with the average across OECD countries. The French have a free choice of doctor, and can approach relatively easily both generalists and specialists. Also, the French health system has not generally experienced the problems of long waiting lists for certain treatments, as has been the case in several other OECD countries. The health care system in France is predominantly funded through public sources, but with services delivered by both the public and private sector. Universal access is provided to doctors and hospital services, with some co-payments for patients which vary depending on the type of services. Since the introduction of the Universal Health Coverage Law (Loi de la Couverture médicale universelle or CMU) in 2000, people with low income who are not covered by complementary insurance have access to doctors and hospitals free of charge. Overall, public satisfaction with the health care system in France has traditionally been much higher than in most other countries. However, health spending in France is relatively high in comparison with the OECD average. ■

How high is health spending?

Total health spending (public and private) accounted for 9.5% of GDP in France in 2001, about one percentage point higher than the average across OECD countries (Chart 1). However, health spending as a share of GDP remains lower in France than in the United States (which spent 13.9% of its GDP on health in 2001, the highest share among OECD countries), Switzerland, Germany and Canada.

France also ranks above the OECD average in terms of total health spending per capita. Here as well, health spending per capita in France remains well below the level in the United States. It is also lower than in several other European countries (for instance, Switzerland, Germany and the Netherlands) and Canada. Differences in health spending across countries may reflect differences in price, volume and quality of medical goods and services consumed.

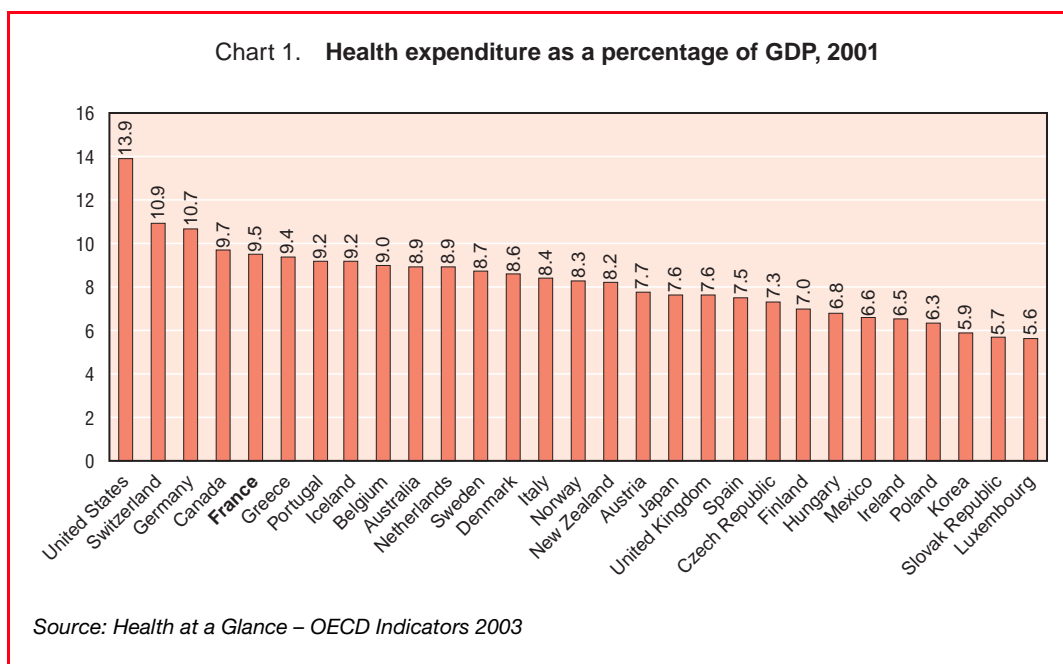
During the 1990s, health spending per capita in France increased, in real terms, by 2.2% per year on average, a growth rate lower than the OECD average over the same period. However, health expenditure in France started to rise again rapidly in 2000 and 2001, at a rate of 3.7% per year in real terms over these two years.

The rise in pharmaceutical spending has been one of the factors behind the overall increase in total health spending in France, as well as in several other OECD countries. Between 1990 and 2001, the share of total health expenditure spent on pharmaceuticals in France increased from 16.9% to 21%, one of the steepest increases among OECD countries (Chart 2). Only the United States spent more per capita than France on pharmaceuticals in 2001. Most OECD countries have been applying a mix of tools in order to control the rise in pharmaceutical expenditure over the past two decades. An increase in cost-sharing for pharmaceuticals has been a common feature. In France, as in other OECD countries, the number of non-reimbursed drugs has increased, mainly covering “comfort” drugs or those without proven therapeutic value. The degree of cost-sharing has also been increased for many other drugs. ■

What is the mix of public and private funding?

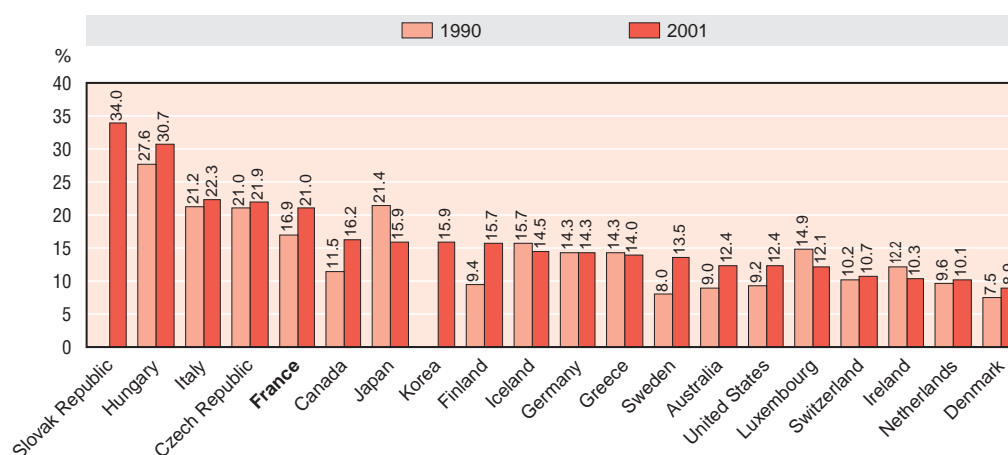
The source of funding for health care and, in particular, the optimal public/private mix, remains a matter for policy debate in most OECD countries.

The public sector continues to be the main source of health funding in all OECD countries, except the United States, Mexico and Korea. In France, 76% of



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Chart 2. Pharmaceutical expenditure as a percentage of total health expenditure, 1990 and 2001



Source: Health at a Glance – OECD Indicators 2003

health spending in 2001 was funded by public sources, slightly above the average of OECD countries. Among European countries, the share of public spending in France is higher than in countries such as Spain, Belgium and the Netherlands, but lower than in most Nordic countries (Denmark, Norway and Sweden).

Private sources accounted for the remaining 24% of health spending in France in 2001. Private insurance (including the *mutuelles* and complementary insurance) represented around 13% of total health spending, a larger share than in most other OECD countries, but a lower share than private insurance funding in the United States (35%) and the Netherlands (15%). The share of health spending paid directly by consumers accounted for about 10% of total health spending in France, a lower level than in most other OECD countries.

Pharmaceutical expenditure tends to be funded from private sources to a greater extent than inpatient and outpatient services, since co-payments tend to be higher on pharmaceuticals and a considerable portion of pharmaceuticals is not covered under public insurance schemes. In France, 66% of pharmaceutical spending was financed by the public sector in 2001, a higher share than the average in OECD countries. Between 1990 and 2001, the pub-

lic share of pharmaceutical expenditure decreased in several European countries (Germany, Italy, the Netherlands and Sweden), but increased in France as well as in Denmark, Australia and Canada. ■

What are the resources in the health sector?

Physicians and nurses remain the primary resource of any health system. In 2000, France had 3.3 practising physicians per 1 000 population, compared to the OECD average of 2.9 and much higher than the 2.0 recorded in the United Kingdom. There are however wide regional disparities in ambulatory care supply in France, with the density of doctors being highest in the area of Paris and in the Mediterranean region. Fewer numbers of doctors per capita can result in longer waiting times for both ambulatory and inpatient services, although the method of remuneration of doctors is also an important factor.

The proportion of female doctors has increased strongly over time in France as in most other OECD countries. In some countries (Finland, Poland and the Czech Republic), there are now more female doctors than males. In France, one doctor in four was a woman in 1985; this proportion increased to over one in three by 2000. The growing proportion of female doctors is important, not only because

some patients prefer to consult a woman doctor, but also because women may differ from men in how they participate in the medical workforce, for instance in their choice of specialties.

In addition, there were 6.7 nurses per 1 000 population in France in 2000, less than the average in OECD countries. It should be noted however that nursing assistants are not included in the figures for France, while they are in most other countries.

The diffusion of modern medical technologies is one of the main drivers of rising health expenditure in developed countries. For instance, the number of magnetic resonance imaging (MRI) units which are used to diagnose a wide range of diseases has more than tripled on average across OECD countries during the 1990s, rising from 1.7 per million population in 1990 to 6.5 in 2000. While the number of MRI

units has also increased in France, their number was lower in 2000 (2.6 per million population) than in most other OECD countries.

The number of acute care hospital beds in France was 4.2 per 1 000 population in 2000, a slightly higher number than the OECD average. As in most other OECD countries, the number of hospital beds per capita has fallen in France over the past 20 years (table 1). This decline has coincided with a reduction in the average length of stay in hospital and an increase in the number of day-surgery patients.

Although the average length of stay in hospital has decreased over time in OECD countries, there remain notable variations across countries. For instance, in France, the average length of stay for mothers following a normal delivery was about five days in 2000, while it was only two days in Canada,

Table 1 : Number of acute care beds per 1 000 population, 1980 to 2000

| | 1980 | 1985 | 1990 | 1995 | 2000 |
|---------------------------------|------------|------------|------------|------------|------------|
| Australia | 6.4 | 5.3 | 4.8 (1989) | 4.2 | 3.8 |
| Austria | -- | 7.4 | 7.0 | 6.6 | 6.2 |
| Belgium | 5.5 | 5.9 | 4.9 | 4.7 | -- |
| Canada ^a | 4.6 | 4.4 | 4.0 | 3.9 | 3.2 |
| Czech Republic | 8.6 | 8.6 | 8.5 | 7.2 | 6.6 |
| Denmark | 5.3 | 4.7 | 4.1 | 3.6 | 3.3 (1999) |
| Finland ^b | 4.9 | 4.8 | 4.3 | 4.0 | 2.4 |
| France | 6.2 | 5.7 | 5.2 | 4.6 | 4.2 |
| Germany | 7.7 | 7.6 | 7.5 | 6.9 | 6.4 |
| Greece | 4.7 | 4.2 | 4.0 | 4.0 | 4.0 (1999) |
| Hungary | 6.6 | 6.8 | 7.1 | 7.0 | 6.3 |
| Iceland | -- | -- | 4.3 | 3.7 | -- |
| Ireland | 4.3 | 4.2 | 3.3 | 3.2 | 3.0 |
| Italy | 7.9 | 7.0 | 6.2 | 5.5 | 4.3 |
| Japan | -- | -- | -- | -- | -- |
| Korea | -- | -- | 2.7 | 3.8 | 5.2 |
| Luxembourg | 7.4 | 7.5 | 7.0 | 7.4 | 6.7 |
| Mexico | | | 1.0 (1991) | 1.1 | 1.0 |
| Netherlands | 5.2 | 4.7 | 4.3 | 3.8 | 3.5 |
| New Zealand | -- | 8.7 (1986) | 8.0 | -- | -- |
| Norway | 5.2 | 4.7 | 3.8 | 3.3 | 3.1 |
| Poland | 5.6 | 5.7 | 6.3 | 5.8 | 5.1 |
| Portugal | 4.2 | 3.5 | 3.4 | 3.3 | 3.3 (1998) |
| Slovak Republic | -- | -- | -- | 6.5 (1996) | 5.9 |
| Spain | -- | 3.5 | 3.3 | 3.0 | 3.2 (1998) |
| Sweden | 5.1 | 4.6 | 4.1 | 3.0 | 2.4 |
| Switzerland | 7.2 | 6.8 | 6.5 | 5.5 | 4.1 |
| Turkey | 1.5 | 1.6 | 2.0 | 2.1 | 2.2 |
| United Kingdom | -- | -- | -- | 4.1 | 3.9 |
| United States | 4.4 | 4.2 | 3.7 | 3.3 | 2.9 |
| Average (20)^c | 5.7 | 5.3 | 5.0 | 4.6 | 4.0 |
| Median | 5.3 | 5.1 | 4.3 | 4.0 | 3.9 |

a. Break in time series in Canada in 1995. Before 1995, the Canadian figures represent beds in short-term units of all hospitals. Starting in 1995, they represent beds in short-stay hospitals; many of the short-stay hospitals also have long-term care beds.

b. Break in time series in Finland after 1995.

c. The average excludes: Austria, Belgium, Iceland, Japan, Korea, Mexico, New Zealand, Slovak Republic, Spain and United Kingdom.

Source: Health at a Glance – OECD Indicators 2003

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the United States and New Zealand. The average length of stay following acute myocardial infarction (AMI) was 7.5 days in France, higher than in the United States (5.7 days, the lowest among OECD countries), but lower than in Austria (15 days, the highest average length of stay).

The average length of stay in hospitals is often used as an indicator of efficiency in health systems since, all other things being equal, a shorter stay will reduce the cost per episode. However, length of stay should only be used with caution as an indicator of efficiency. Shorter stays tend to be more service intensive and more costly per day. Also, if the stay is too short, there may be an adverse effect on health outcomes or on the recovery of the patient. ■

What is the health status of the population?

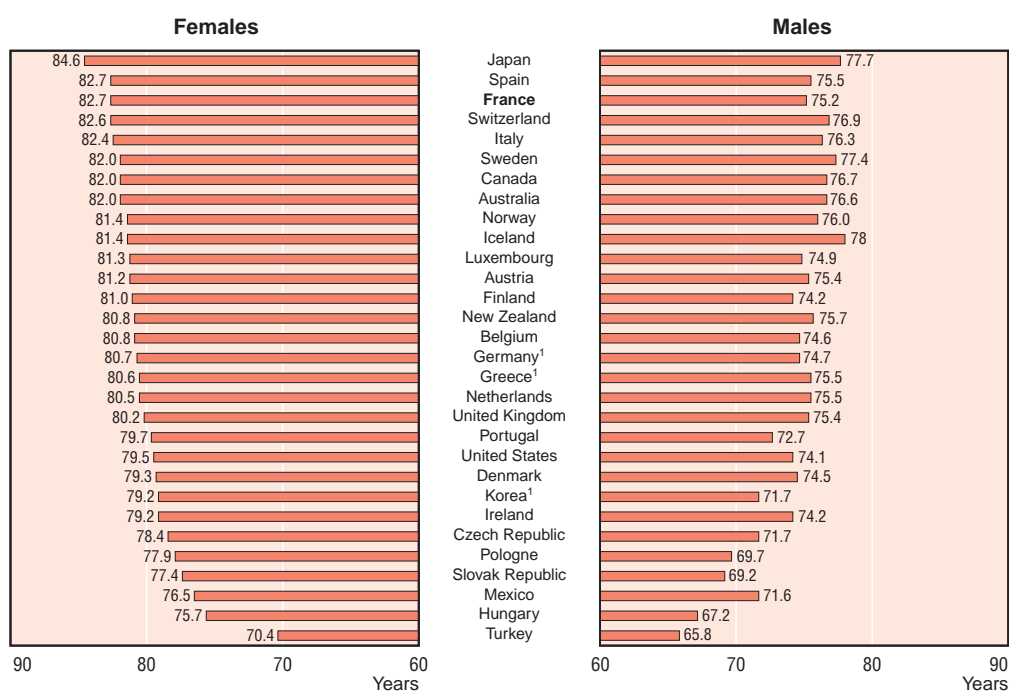
Most OECD countries have enjoyed large gains in life expectancy over the past 40 years. In France, life expectancy at birth increased by 8.7 years between 1960 and 2000, the same gain as registered on aver-

age across OECD countries. These improvements in longevity have been made possible by rising standards of living, public health interventions and progress in medical care. In 2000, life expectancy in France stood at 79 years, two years above the OECD average. Japan had the highest life expectancy among OECD countries, with 81.2 years, followed by Switzerland, Sweden and Iceland with life expectancy close to 80 years.

Interestingly, in France the gender gap in life expectancy at birth was 7.5 years, a much wider gap than in most other OECD countries (Chart 3). France ranks equal second with Spain in life expectancy at birth among women, but it ranks only fifteenth for men. This gap reflects at least partly the relatively high mortality rates among French men due to violent deaths (for instance, road traffic accidents and suicides) and to diseases associated with excessive tobacco and alcohol consumption.

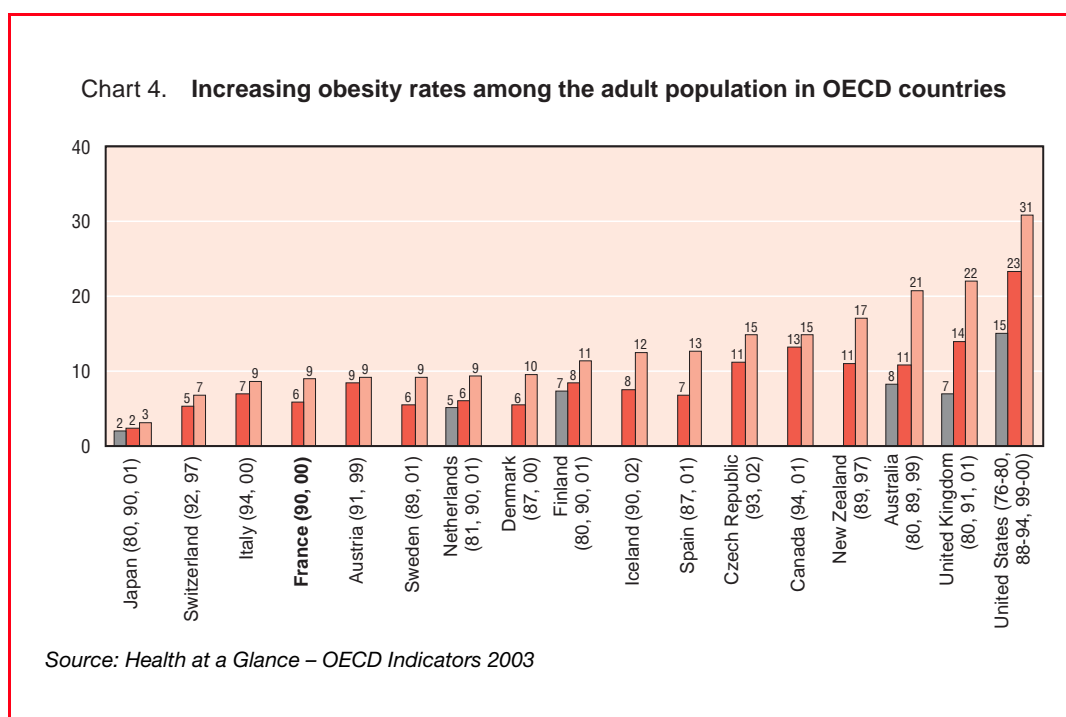
The life expectancy of people at age 65 has also been steadily improving over the past few decades in most OECD countries, including France. French

Chart 3. Life expectancy at birth, 2000



1. 1999.

Source: *Health at a Glance – OECD Indicators 2003*



women and men at age 65 can now expect to live an additional 21 and 17 years respectively, two years more than the OECD average in the case of women and one year more in the case of men. These gains in life expectancy at age 65 in France and in several other countries have been driven largely by a marked reduction in death rates from heart diseases and cerebrovascular diseases (stroke) among elderly people.

Regarding infant health, the infant mortality rate in France, as in other OECD countries, has fallen significantly over the past few decades, reflecting improvements in the living conditions of mothers and newborns as well as medical progress. The infant mortality rate in France stood at 4.6 deaths per 1 000 live births in 2000, below the OECD average. Among OECD countries, the infant mortality rate is lowest in Japan and in the Nordic countries (Iceland, Sweden, Finland and Norway). ■

What are the risk factors?

A number of risk factors affect the health status of populations in OECD countries, such as tobacco and alcohol consumption, and overweight and obesity problems.

Over the past two decades, the proportion of daily smokers among adults has declined in most OECD countries. In France, the proportion has fallen from 30% in 1980 to 27% in 2000, a slower decline than in most other OECD countries. This means that the proportion of smokers in France was lower than the OECD average in 1980, but it is now higher.

In all OECD countries except Sweden and Norway, smoking prevalence among men continues to be higher than among women, but in most countries smoking rates have declined more rapidly among men than among women since 1980. However, in France, the percentage of women who report smoking every day has actually increased over the past two decades. Finland, Norway and Spain are the only other countries to have experienced an increase in smoking rates among women between 1980 and 2000.

Alcohol consumption per capita has fallen in most OECD countries over the past few decades. In France, total alcohol consumption has fallen considerably since 1970, although it continues to be higher than the OECD average. In Sweden, one of the OECD countries with the lowest alcohol consumption per capita, strict controls on sales and high taxation have led to lower overall consumption, while in

France, as in Italy and Spain, the reduction in consumption has coincided with the introduction of tighter control measures, particularly with regard to advertising.

Obesity rates have increased in recent decades in all OECD countries for which trend data is available (Chart 4). However there remain notable differences in adult obesity rates across countries. In France, the obesity rate among adults (9% in 2000) remains much lower than in most other developed countries, although it is rising. Recent data from a survey carried out by SOFRES for the Institut Roche de l'Obésité, in collaboration with INSERM, suggest that the prevalence of obesity in France has increased to 11.3% in 2003, up from 8.2% in 1997 and 9.6% in 2000 based on similar surveys. Among OECD countries, obesity rates are highest in the United States (31% in 1999), the United Kingdom (22% in 2001) and Australia (21% in 1999). It should be noted however that the data for the United States, the United Kingdom and Australia are more

reliable and precise than those from other countries since they are based on health examinations where actual measures are taken of people's height and weight, while data for other countries are based on health interview surveys, which generally underestimate the real prevalence of obesity.

The time lag between the onset of obesity and increases in related chronic diseases (such as diabetes and asthma) suggest that the rise in obesity that has occurred in most OECD countries will have substantial implications for future incidence of health problems and related spending. ■

For more information

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For further reading

- **Health at a Glance – OECD Indicators, 2003**
ISBN: 92-64-10404-6, €23, 140p.
- **OECD Economic Surveys - France, 2003**
see the special chapter on public expenditure management
ISBN: 92-64-01485-3, €35, 188p.
- **OECD Health Data 2003, CD-ROM and User Guide** - ISBN: 92-64-10126-8
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