European Commission



State of Health in the EU

France

Country Health Profile 2021

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European Observatory on Health Systems and Policies
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The Country Health Profile series

The State of Health in the EU's Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policymakers and influencers with a means for mutual learning and voluntary exchange.

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Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated 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 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in September 2021, based on data available at the end of August 2021.

Demographic and socioeconomic context in France, 2020

Demographic factors	France	EU
Population size (mid-year estimates)	67 320 216	447 319 916
Share of population over age 65 (%)	20.4	20.6
Fertility rate[1] (2019)	1.9	1.5
Socioeconomic factors		
GDP per capita (EUR PPP[2])	31 091	29 801
Relative poverty rate[3] (%, 2019)	13.6	16.5
Unemployment rate (%)	8.0	7.1

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 60 % of median equivalised disposable income. Source: Eurostat database.

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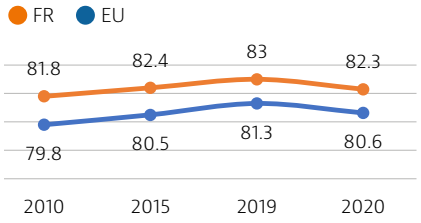
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1 Highlights

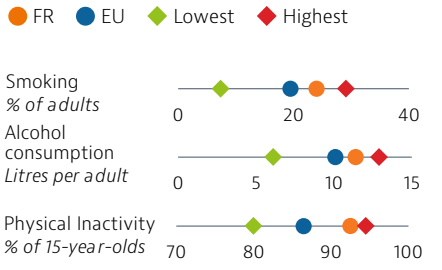
Life expectancy in France is among the highest in Europe, but it temporary fell in 2020 because of deaths due to COVID-19. While the French health system provides good access to high-quality care, COVID-19 highlighted important structural weaknesses, including low investment in prevention, public health and health workforce. The pandemic also stimulated many innovative practices that could be expanded to build a more resilient health care system.



Life expectancy at birth, years

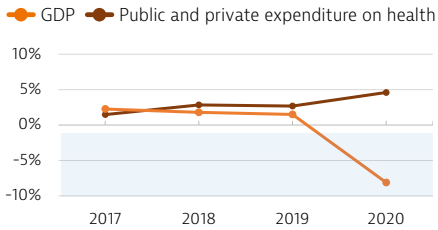
Health Status

Life expectancy in France in 2020 was almost two years higher than the EU average, but it fell by eight months because of deaths due to COVID-19. Even before the pandemic, gains in life expectancy had slowed considerably since 2010 compared with previous decades, partly due to increased mortality rates from influenza, pneumonia and other respiratory diseases among older people.



Risk factors

Behavioural risk factors for health are also major drivers of mortality in France. While tobacco consumption has fallen over the past two decades, almost one quarter of adults still smoked daily in 2019. Alcohol consumption has also decreased, but is still over 10 % higher than the EU average. More than 90 % of 15-year-olds reported not doing at least moderate physical activity each day in 2018 – the second highest share across the EU after Italy.



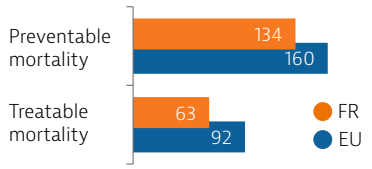
Annual change in nominal terms

Health system

Spending on health per capita and as a share of GDP has been greater in France than the EU average for many years. Until 2020, spending on health was growing at around the same rate as the economy, but it increased more rapidly in response to the COVID-19 pandemic, while GDP fell by 8 %.

Effectiveness

Mortality from preventable and treatable causes was lower in France than across the EU before the pandemic. However, France lagged behind some EU countries (Italy, Sweden, Spain) on preventable mortality, suggesting that more could be done to save lives by reducing risk factors for cancer and other leading causes of death.



Age-standardised mortality rate per 100 000 population, 2016

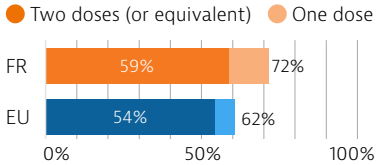
Accessibility

Access to health care is generally good in France, but it was hampered by COVID-19 in 2020. One in six people reported forgone care during the first 12 months of the pandemic; this is less than the EU average of 21 % but higher than in Germany (14 %). Growing use of teleconsultations helped maintain access to care during the various waves of the pandemic.



Resilience

France was among the EU countries hardest hit by the COVID-19 pandemic in numbers of cases and deaths relative to its population size. The country accelerated its COVID-19 vaccination campaign in early 2021. As of end of August 2021, nearly 60 % of the population was fully vaccinated (had received two doses or the equivalent).



Share of total population vaccinated against COVID-19 up to the end of August 2021

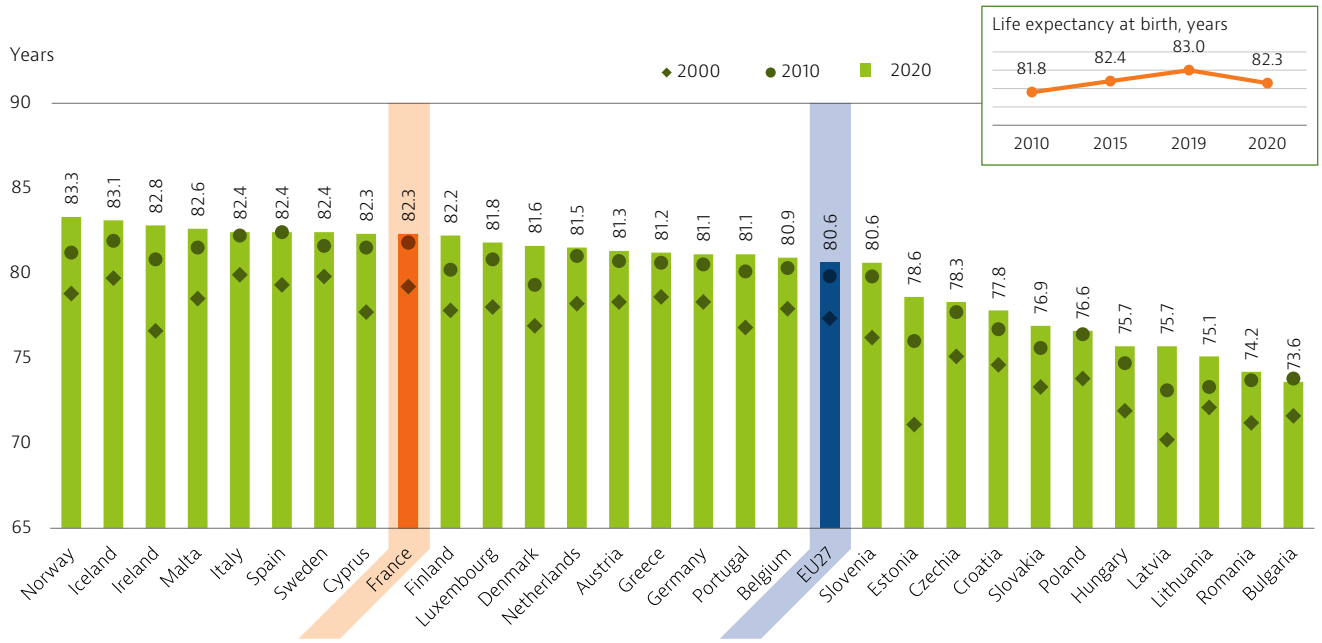
2 Health in France

Life expectancy is among the highest in the EU, but it fell temporarily in 2020 due to COVID-19

In 2020, life expectancy at birth in France stood at 82.3 years, almost two years higher than across the EU (Figure 1). It temporarily fell by eight months in 2020 because of deaths due to COVID-19 – the biggest reduction since 1945.

Even before the pandemic, gains in life expectancy in France, as in many other western European countries, had slowed considerably between 2010 and 2019. While the causes for this are not fully understood, it was partly related to an increase in mortality rates from influenza, pneumonia and other respiratory diseases among older people.

Figure 1. Life expectancy in France remains among the highest among EU countries



Note: The EU average is weighted. Data for Ireland refer to 2019.
Source: Eurostat database.

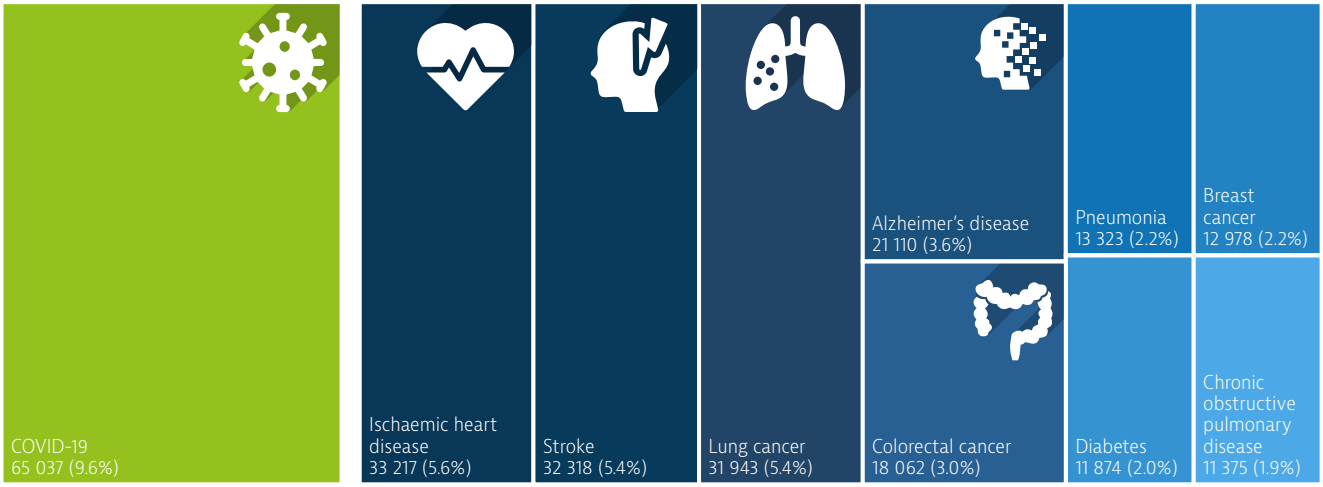
Ischaemic heart disease, stroke and lung cancer were the main causes of mortality, but COVID-19 accounted for many deaths in 2020

In 2016 (latest data available at the time of writing), cancer accounted for 30 % of all deaths in France, followed by circulatory diseases (24 %). Ischaemic heart disease (5.6 %) and stroke (5.4 %) were the leading disease-specific causes of death. Lung cancer was the most frequent cause of death by cancer (Figure 2).

In 2020, COVID-19 accounted for about 65 000 deaths in France (almost 10 % of all deaths). An additional 49 000 deaths were registered in the first eight months of 2021. By the end of August 2021, the mortality rate from COVID-19 was 7 % higher than across the EU (about 1 700 per million population compared with 1 590 in EU countries)[1].

1. *Excess mortality (defined as the number of deaths from all causes above what would have been expected based on the experience from previous years) is close to the number of COVID-19 deaths reported by France in 2020, validating the approach used to register COVID-19 deaths.*

Figure 2. Before the pandemic, ischaemic heart disease, stroke and lung cancer were the main causes of death



Note: The number and share of COVID-19 deaths refer to 2020, while the number and share of other causes refer to 2016. The size of the COVID-19 box is proportional to the size of the other main causes of death in 2016.
Sources: Eurostat (for causes of death in 2016); ECDC (for COVID-19 deaths in 2020, up to week 53).

Over 90 % of all deaths from COVID-19 in France were among people aged 65 and over (and 80% over 75 and over). The pandemic also disproportionately hit ethnic minorities and people living in deprived areas. During the first wave in March/April 2020, mortality rates in Seine-Saint-Denis (one of the poorest departments in France) more than doubled compared to those registered in March/April 2019 – a much higher increase than the 27 % increase observed nationally during the same period (INSEE, 2020).

Most French people reported good health, but nearly two in five have a chronic condition

In 2019, about two thirds of French adults reported being in good health – a proportion close to the EU average, according to EU-SILC survey. However, as in other countries, people on higher incomes are more likely to report being in good health: 72 % in the highest income quintile reported being in good health compared with 58 % in the lowest.

Nearly two in five French adults (38 %) reported having at least one chronic condition in 2019, a slightly higher proportion than the EU average. Many of these conditions increase the risk of severe complications from COVID-19.

Persistent COVID-19 symptoms have been reported by many people who contracted the virus

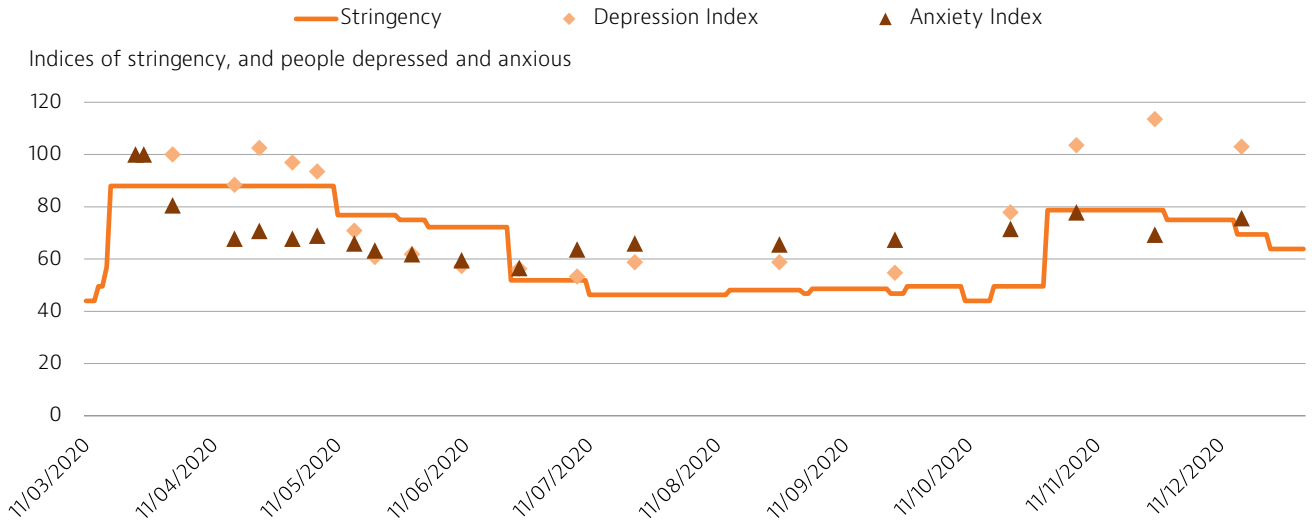
An emerging issue from the COVID-19 pandemic is the number of people who experience persistent ill health for a long period after contracting the virus. "Long COVID" is associated with a range of symptoms, including generalised chest and muscle pain, fatigue, shortness of breath, anxiety and cognitive dysfunction.

In France, around 60 % of patients hospitalised for COVID-19 had at least one COVID-19 symptom up to six months after infection, and 25 % had at least three symptoms (INSERM, 2021). The French health authorities issued clinical practice guidelines for multidisciplinary primary care teams, neurologists and physiotherapists assessing and managing long COVID.

The COVID-19 pandemic led to higher rates of mental distress

As in other EU countries, the mental health of many people in France deteriorated during the COVID-19 pandemic. The prevalence of anxiety and depression symptoms during the first wave in 2020 was double the rate in 2017. Higher rates of mental distress were also correlated with the stringency of policies to contain the pandemic during the first two waves. Anxiety and depression levels were highest between mid-March and early April 2020, falling around June-July 2020, then rising again during the second lockdown in October-December 2020 (Figure 3).

Figure 3. The lockdowns had a negative impact on mental health



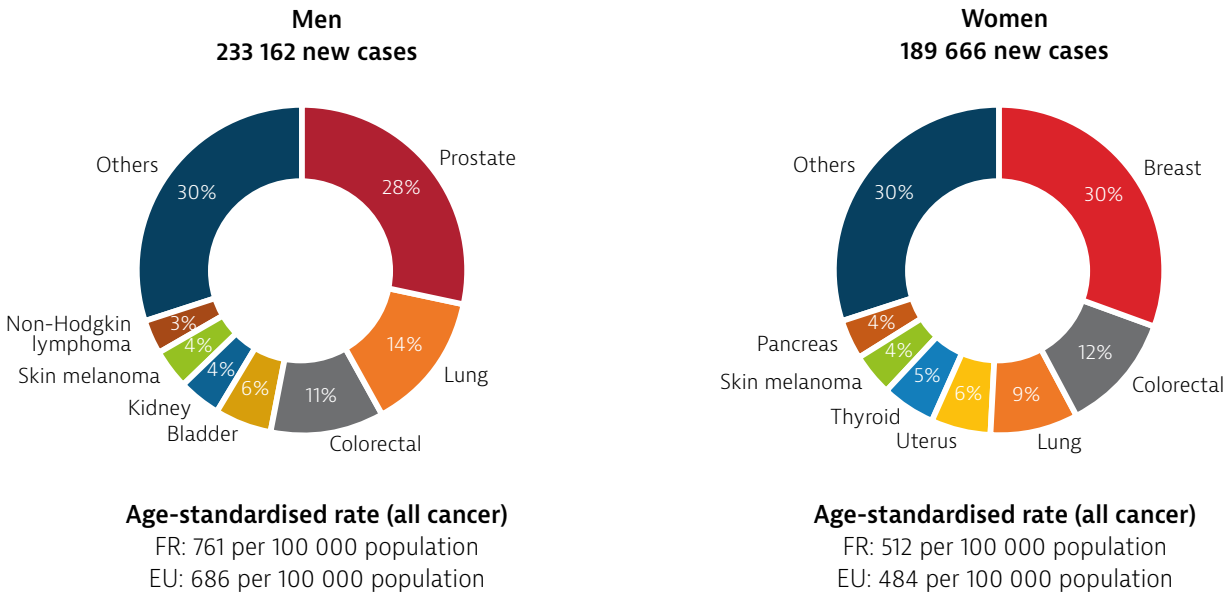
Note: The "stringency score" is based on the Oxford University/Blavatnik Stringency and Policy Index. The first point of the depression and anxiety index is assigned 100; each subsequent data point is defined in relation to this to provide a relative percentage change.
Source: Santé Publique France (2020a).

The burden of cancer in France is higher than the EU average

According to estimates from the Joint Research Centre based on incidence trends from previous years, in 2020, around 420 000 new cases of cancer were expected and about 185 000 people were expected to die of cancer, making it the leading cause of death[2].

Age-standardised incidence rates for all cancers were expected to be 10 % higher for men and 5 % higher for women than the EU averages. The main cancers among men were expected to be prostate, lung and colorectal, while among women breast is expected to be the leading cancer, followed by colorectal and lung (Figure 4). France has put in place several national plans over the past two decades to improve cancer prevention and care (see Section 5.1).

Figure 4. More than 400 000 people in France were expected to be diagnosed with cancer in 2020



Age-standardised rate (all cancer)
FR: 761 per 100 000 population
EU: 686 per 100 000 population

Age-standardised rate (all cancer)
FR: 512 per 100 000 population
EU: 484 per 100 000 population

Note: Uterus cancer does not include cancer of the cervix.
Source: ECIS – European Cancer Information System.

2. Based on national data sources, the French National Cancer Institute reports about 382 000 new cases of cancer in 2018 and about 157 000 cancer deaths (https://www.e-cancer.fr/Expertises-et-publications/Les-donnees-sur-les-cancers).

3 Risk factors

Behavioural and environmental risk factors are major drivers of mortality in France

Historically, France has lagged behind other western European countries in investing in health promotion and disease prevention. Around 33 % of all deaths in 2019 can be attributed to behavioural risk factors (lower than the EU average of 39 %) such as tobacco smoking, dietary risks, alcohol consumption and low physical activity. Air pollution in the form of fine particulate matter ($PM_{2.5}$) and ozone exposure alone also have a non-negligible impact of the number of deaths each year (Figure 5).

Figure 5. Tobacco, dietary risks and alcohol are major contributors to mortality in France



Note: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable intake, and high sugar-sweetened beverage consumption. Air pollution refers to exposure to $PM_{2.5}$ and ozone.
Source: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

Smoking and alcohol consumption among adults remain high

Smoking rates among adults in France have declined over the past two decades to 24 % in 2019, down from 30 % in 2000. However, they remain higher than in most EU countries (Figure 6).

Smoking rates among 15-year-olds have also decreased from 26 % in 2014, and aligned to the EU average of 18 % in 2018.

While alcohol consumption among adults decreased between 2000 and 2013, it has remained stable since 2013 and remained 13 % higher than the EU average in 2019. On a more positive note, the proportion of 15-year-olds who report having been drunk more than once decreased substantially from 19 % in 2002 to 13 % in 2018 – a lower value than in most other EU countries[3].

Obesity rates in France have increased but are not greater than in most EU countries

Based on self-reported data, the obesity rate among adults increased from 9 % in 2000 to 14 % in 2019 – a level lower than the EU average[4]. Overweight and obesity rates among 15-year-olds also increased to 14 % in 2018, but remain lower than in most EU countries[5].

As in other countries, poor nutrition is the main factor contributing to overweight and obesity. While the proportion of adults who report eating at least one portion of fruit or vegetables per day is higher than in most EU countries, in 2019 about 35 % of adults reported not eating any vegetables every day and 40 % not eating any fruit. About two thirds of 15-year-olds reported not eating any vegetables or fruit every day in 2018.

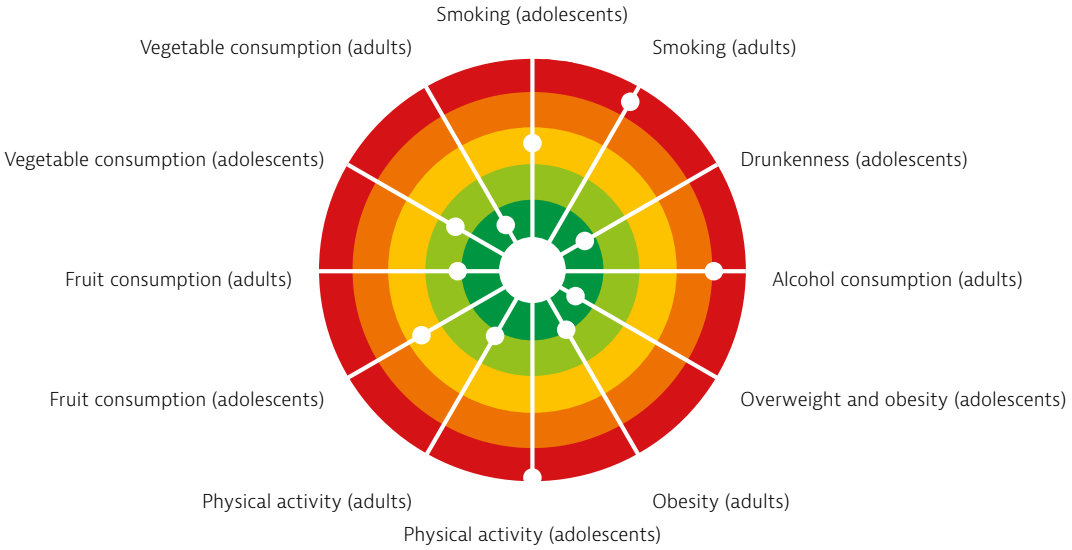
3. *Results from the 2017 French ESCAPAD survey, which covers mostly adolescents at age 17, also show a reduction in the proportion of teenagers who report heavy episodic drinking ("binge drinking"). However, the rate (44 % in 2017) is higher than the proportion of 15-year-olds who report having been drunk more than once from the 2018 HBSC survey used here.*
4. *Based on actual measurements of people's height and weight, obesity rates among adults are higher but remained stable at 17 % between 2006 and 2016.*
5. *The results from the 2016-17 national health survey in schools found that 18 % of 14- and 15-year-olds were overweight or obese.*

Physical activity among teenagers in France is among the lowest across EU countries

Low physical activity also contributes to overweight and obesity. The proportion of French teenagers who reported doing at least moderate physical activity each day was the second lowest across EU countries in 2018, after Italy. This is particularly the case among teenage girls: only 4 % of 15-year-old girls reported doing at least moderate physical activity compared with 11 % of boys.

On a more positive note, the proportion of French adults who report engaging in at least moderate physical activity each week compares well with other EU countries. Nevertheless, about 30 % of adults did not meet the WHO recommendation of at least 2.5 hours of moderate physical activity per week in 2014.

Figure 6. Smoking, alcohol and low physical activity are 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.
Sources: OECD calculations based on HBSC survey 2017-18 for adolescents indicators; EHIS 2014 for physical activity among adults, EHIS 2019 for obesity and fruit and vegetable consumption; and national sources for smoking and alcohol consumption among adults.

4 Health system

The French health system is centralised, with regional responsibilities

France's health system is based mainly on a social health insurance (SHI) system, with a traditionally strong role for the state. While regional health agencies have played a greater role in managing health care provision at the local level since 2009, SHI and central government have always played a strong role in organising the health system and determining its operating conditions. Over the past two decades, the state has also become more involved in controlling health expenditure funded by the SHI system by setting a national health spending target. The governance structures established to manage the COVID-19 pandemic were piloted at the national level (Box 1).

Health spending is higher in France than the EU average

Health spending in France accounted for 11.1 % of GDP in 2019, the highest share in the EU along with Germany and above the EU average of 9.9 %. On a per capita basis, health spending was the seventh highest across the EU, at EUR 3 645 in 2019 (Figure 7).

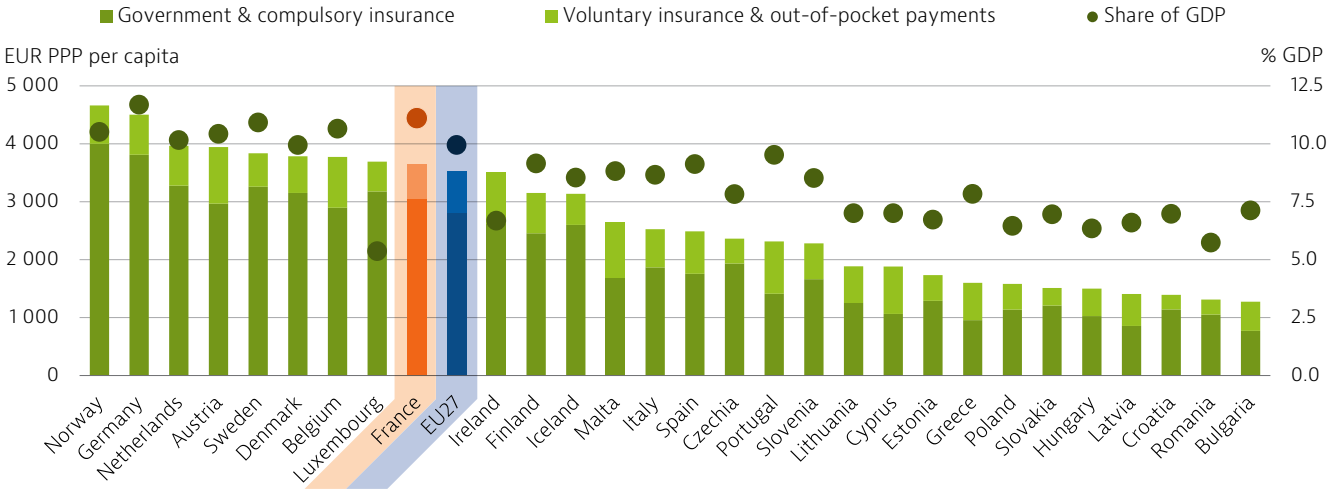
Box 1. The governance mechanisms to manage the COVID-19 pandemic were highly centralised

During the COVID-19 pandemic, France centralised policy-making at the national level through the National Defence and Security Council, a crisis management body established in 2008 composed of a selection of ministers and chaired by the President. Throughout the pandemic, the Council held regular weekly meetings to take key strategic decisions on how to manage the health crisis.

In addition, in March 2020 the government set up a special Scientific Council to provide transparent and independent scientific advice on public health measures to guide the policy-making process through the pandemic.

While this process was highly centralised, policy implementation required the involvement and coordination of the many players involved in the health system at the national, regional and local levels. The complex organisation structure between the Ministry of Health and other national agencies, and the need to strengthen coordination between regional health agencies and prefectural bodies, presented significant challenges in the early phase of the COVID-19 crisis in spring 2020, notably in mobilising greater testing and laboratory capacity (Pittet et al., 2021; Or et al., 2020).

Figure 7. Health spending in France is higher than in most EU countries



Note: The EU average is weighted.
Source: OECD Health Statistics 2021 (data refer to 2019, except for Malta 2018).

In 2019, public and private compulsory health insurance schemes funded 83.7 % of all health spending in France[6] – higher than the EU average of 79.7 %. The revenue for these schemes comes mainly from social security contributions paid by employers and employees, income taxes and additional sources such as taxes on tobacco and alcohol.

Since 1996, annual growth in SHI expenditure has been controlled by the national health spending target. It remained constant at around 2.5% growth per year in 2009-19, but grew by 9.5 % in 2020 due to additional spending related to the pandemic and the introduction of a new investment plan to strengthen public hospitals (see Box 2 and Section 5.3).

Box 2. The government provided substantial additional resources to support the health system's pandemic response

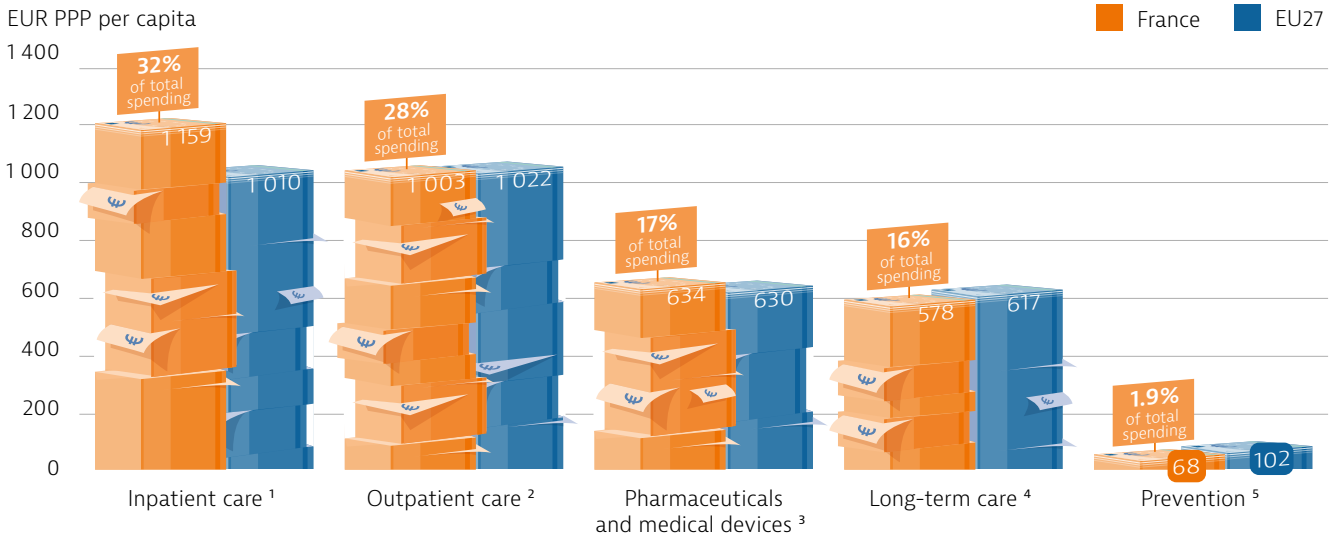
Health spending in response to the COVID-19 crisis and implementation of a new investment plan for hospitals ("Segur de la Santé", see Section 5.3) exceeded the initial national health spending target by almost EUR 14 billion in 2020 (around 7% of the initial target). These additional expenses included EUR 7 billion for hospitals and long-term care institutions, EUR 6.8 billion for ambulatory care (Ministère des solidarités et de la santé, 2021). While the growth rate in public spending on health had been contained to about 2.5 % per year in previous years, spending rose by 9.5 % in 2020.

6. Public insurance schemes funded 77 % of all health spending; private compulsory insurance covered another 6.7 %.

Inpatient and outpatient care make up most health spending

Inpatient care in public and private hospitals is the largest category of health spending, accounting for about 32 % of the total in 2019 – slightly higher than the EU average of 29 % (Figure 8). Around 28 % of health spending was allocated to outpatient care, including primary, specialist and dental care. Retail pharmaceuticals and medical devices made up almost one fifth of health spending, and long-term care (LTC) over one sixth. Spending on prevention accounted for less than 2 % of all health spending, a share lower than the 3 % EU average. However, as in other countries, this only includes spending dedicated to organised prevention programmes, resulting in an underestimation of real spending on prevention.

Figure 8. Most health spending is on inpatient and outpatient care, with little on prevention



Note: The costs of health system administration are not included. 1. Includes curative-rehabilitative care in hospital and other settings; 2. Includes home care and ancillary services (e.g. patient transportation); 3. Includes only the outpatient market; 4. Includes only the health component; 5. Includes only spending for organised prevention programmes. The EU average is weighted.
Sources: OECD Health Statistics 2021, Eurostat database (data refer to 2019).

French social health insurance covers the entire population

The SHI system offers coverage to the whole population based on residence through various compulsory schemes. The main fund (Caisse Nationale d'Assurance Maladie des Travailleurs Salariés, CNAMTS) covers 92 % of the population; the agricultural fund covers another 7 %. Other small funds (specific to certain professional categories, such as the national railway company) cover the remaining 1 %. There is also a fully state-funded scheme providing access to a specific benefits package (essential care) for undocumented migrants.

Nearly all the population (95 %) has complementary health insurance, mainly to cover co-payments and to attain better coverage for medical goods and services poorly covered by the SHI, such as dental and optical care (see Section 5.2).

France has achieved further progress towards universal health coverage

In 2015, the French parliament adopted a law that aimed to increase the universality of health coverage and the uniformity of protection across the sickness funds. One of the main achievements of this reform has been to ensure continuity of health coverage when people face a change in their professional or personal situation. For example, before its adoption, workers who changed jobs involving a change in sickness fund affiliation could face a coverage gap of several weeks.

Another important measure from this legislation consisted of integrating under their own name adults previously affiliated as dependents, making them full beneficiaries in a sickness fund. This is progress in the spirit of universality, particularly for non-working spouses. By the end of 2019, around 3.2 million people had been granted autonomous affiliation.

The number of doctors per population has remained stable and is now below the EU average

While the number of doctors has increased in most EU countries over the past decade, it has remained stable in France. As a result, it is well below the EU average, at 3.2 doctors per 1 000 population in 2019, compared with 3.9 across the EU. There are wide disparities in the density of doctors and other health professionals across regions, with some areas facing shortages.

Concerns are also rising that shortages of doctors, especially of GPs, may be exacerbated in the future, as a large proportion will retire in the next decade (see Section 5.2).

The number of nurses in France has increased from 7.9 per 1 000 population in 2008 to 11.1 in 2019 – above the EU average of 8.4. Following the COVID-19 pandemic, the government has taken some measures to increase the recruitment and retention of nurses in hospitals and other facilities (see Section 5.3).

5 Health system performance

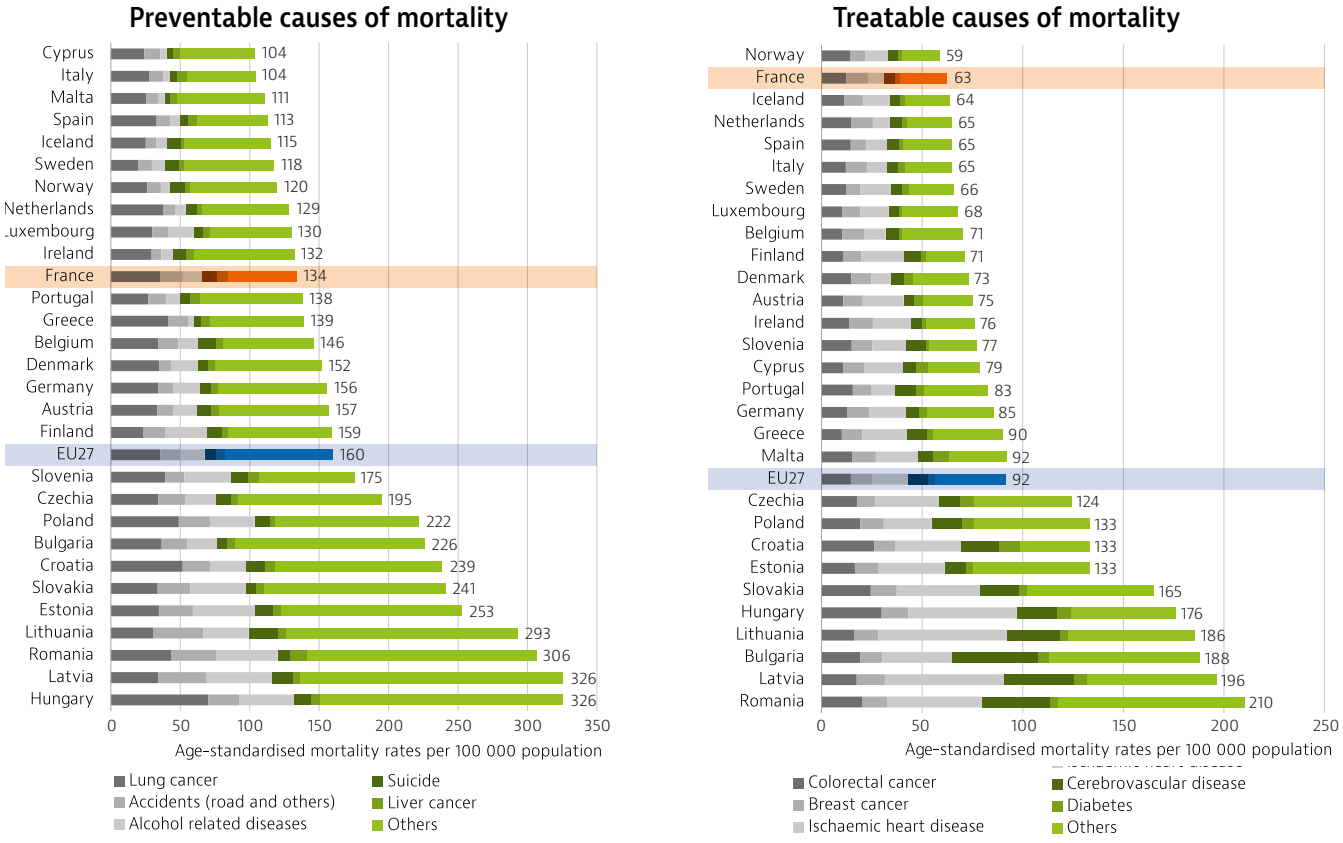
5.1 Effectiveness

France fares well on treatable and preventable causes of mortality compared to other EU countries

Treatable mortality rates in France were among the lowest among EU countries in 2016 (latest year available), well below the EU average. This indicates that the health system is effective in saving the lives of people with acute conditions (Figure 9). The leading causes of treatable mortality are colorectal cancer, ischaemic heart disease, breast cancer, stroke and pneumonia.

Preventable mortality is also lower than the EU average, but France lags behind countries such as Italy, Spain and Sweden. The leading causes of preventable mortality are lung cancer, accidents (road and others), alcohol-related deaths and suicide.

Figure 9. Preventable and treatable causes of mortality are lower than the EU average



Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Half of all deaths for some diseases (e.g. ischaemic heart disease and cerebrovascular disease) are attributed to preventable mortality; the other half are attributed to treatable causes. Both indicators refer to premature mortality (under age 75). The data are based on the revised OECD/Eurostat lists.
Source: Eurostat database (data refer to 2018, except for France 2016).

France's Health Strategy 2018-22 emphasises prevention, but investment remains modest

Prevention has traditionally been a neglected aspect of health policies in France. The priority of the National Health Strategy 2018-22 is to put greater focus on health promotion and prevention at all ages and across all socioeconomic groups through a wide range of interventions, although the budget allocated to the national plan for public health remains modest (EUR 400 million over five years).

Tobacco control policies have been effective, but there is room for further reductions in smoking rates

Since 2014, France has implemented national plans to reduce tobacco consumption with the aim of deterring young people from smoking and helping regular smokers to quit. These objectives were amplified through the 2018-22 National Plan Against Tobacco, which set an overarching goal of creating a "smoke-free generation" and a specific objective to reduce smoking rates to less than 5 % among young people born since 2014 by 2032.

The measures helped to reduce by 4.5 percentage points the proportion of adults who smoke daily between 2014 and 2019 (Santé Publique France, 2020b). According to the National Observatory on Drugs and Addictions, 3.4 million people were involved in smoking cessation activities in 2018 – a 25 % increase compared to 2017. France also implemented other policies, including better coverage of nicotine substitutes from 2018, several tax increases on tobacco, a public #MoisSansTabac campaign and creation of an app to help smokers quit.

France developed a nutritional logo to improve nutrition and tackle rising rates of obesity

In 2017, Santé Publique France developed an official "nutri-score" food label, which provides easy-to-understand information on the overall nutritional quality of food products to promote more healthy nutrition habits. Nearly 60 % of the population reported that they had modified aspects of their food purchasing behaviour with the help of the "nutri-score" in 2020, up from 43 % in 2019 (Santé Publique France, 2021a).



Influenza vaccination rates among elderly people increased by 10 percentage points in 2020-21

The COVID-19 pandemic raised the importance of increasing vaccination rates against seasonal influenza to minimise avoidable pressure on hospitals and avoid having both viruses spreading widely concurrently. The government ordered 30 % more flu vaccination shots in 2020-21 than in 2019-20, and sent personalised invitations to everyone in the target population, highlighting the vaccination's importance and benefits.

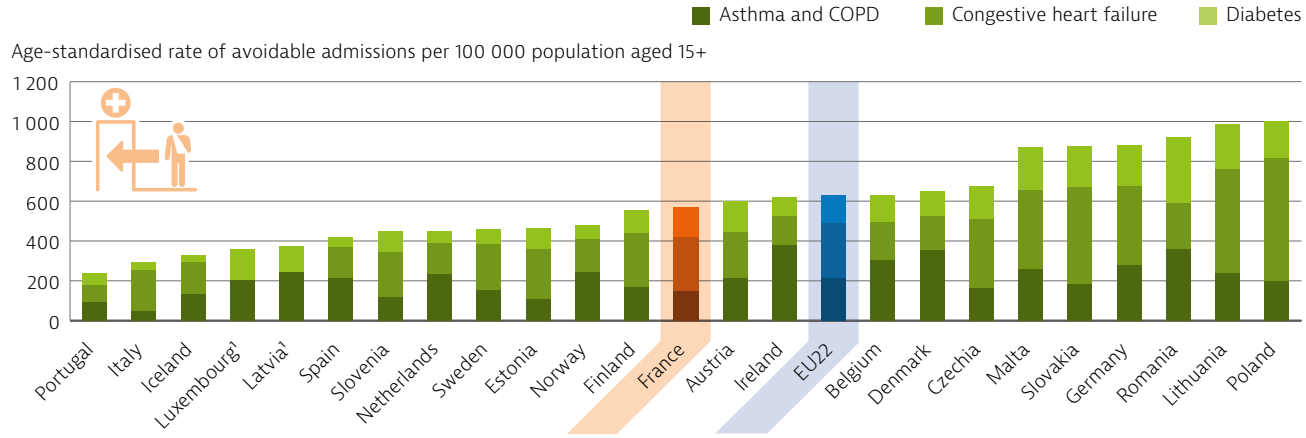
The 2020-21 campaign was a success: 60 % of people aged 65 and over were vaccinated compared to about 50 % in previous years. However, this is still below the vaccination target of 75 %.

Avoidable hospital admissions are lower than in many other EU countries

Many admissions to hospital for communicable or chronic diseases could be avoided through well-organised prevention and primary care interventions. While avoidable hospital admissions for asthma, chronic obstructive pulmonary disease (COPD) and congestive heart failure were lower in France than the EU average in 2019, admission rates for diabetes were 8 % higher (Figure 10).

Over the past two decades, measures to improve management of chronic conditions outside hospitals have produced positive results, generating efficiency gains. For example, a programme was launched in 2004 and extended in 2012 to improve management of diabetes and a few other chronic diseases, relying on co-operation between general practitioners (GPs) and trained nurses to diagnose and manage patients more effectively. In 2019, more than 700 nurses and 3 000 doctors participated in the programme. Evaluations found positive, albeit modest, results for patient care, with no reduction in the number of consultations with doctors but an increase in the size of the patient list, suggesting efficiency gains (Loussouarn et al., 2019).

Figure 10. Avoidable hospital admissions are lower than the EU average



Note: 1. Data for congestive heart failure are not available in Latvia and Luxembourg.
Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).

France launched the National Cancer Plan 2021-30 to improve cancer prevention and care

In February 2021, the National Cancer Plan 2021-30 was launched, with the goal of reducing the number of avoidable deaths from cancer by 50 000 per year. The Plan is structured around four key priorities: a) improving prevention and early diagnosis; b) improving the quality of life of cancer patients; c) increasing cancer survival among adults and children, particularly for cancers with low prognosis; d) ensuring that all population groups can benefit equally from progress in cancer care. Implementation is supported by funding of EUR 1.74 billion over five years – an increase of 20 % on the previous plan. The Plan is aligned with the overall priorities set out in the Europe's Beating Cancer Plan (European Commission, 2021).

The quality of cancer care has improved over recent decades through the introduction of multidisciplinary teams and cancer networks, greater use of clinical guidelines and more rapid access to innovative medicines. France compares well with other EU countries for five-year survival rates following common cancers (breast, colon, cervical, prostate and lung cancer) and childhood leukaemia, based on the most recent data available for people diagnosed in 2010-14 (Figure 11).

While better detection and treatment facilitated a rapid increase of five-year survival rates for patients with breast and colon cancer, progress has been slower for other cancers with poorer prognosis, such as lung cancer (Santé Publique France, 2021b).

Figure 11. France compares well with other EU countries on five-year cancer survival rates



Prostate cancer
France: 93 %
EU23: 87 %

Childhood leukaemia
France: 89 %
EU23: 85 %

Breast cancer
France: 87 %
EU23: 82 %

Cervical cancer
France: 65 %
EU23: 63 %

Colon cancer
France: 64 %
EU23: 60 %

Lung cancer
France: 17 %
EU23: 15 %

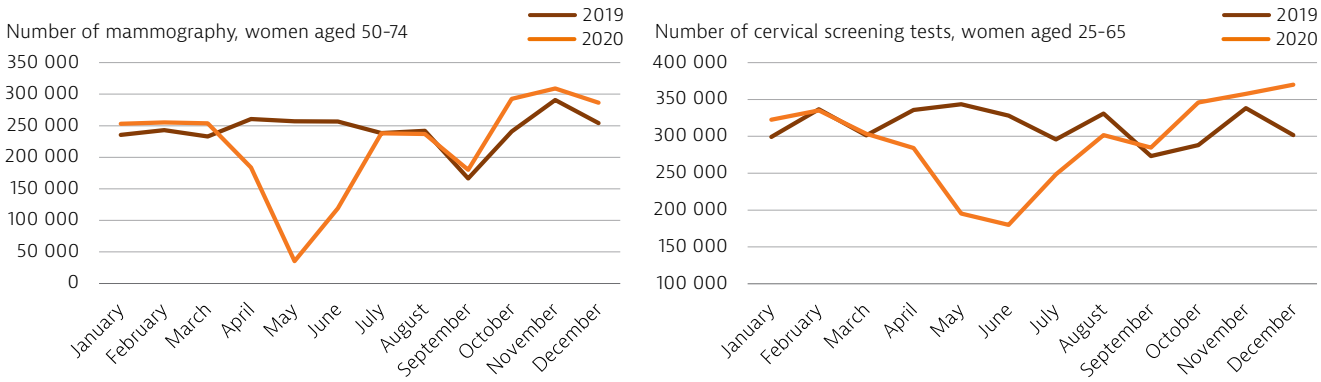
Note: Data refer to people diagnosed between 2010 and 2014. Childhood leukaemia refers to acute lymphoblastic cancer.
Source: CONCORD Programme, London School of Hygiene and Tropical Medicine.

The COVID-19 crisis had a detrimental impact on cancer screening programmes and treatment. As in other EU countries, screening for breast and cervical cancer fell sharply in France during the first lockdown (Figure 12). Across 2020, breast cancer screening fell by 14 %, while cervical cancer screening fell by 9 % compared to 2019 (Assurance Maladie, 2021).

In addition, elective cancer surgery fell by 34 % in April 2020 and 27 % in May 2020 compared to 2019 (Assurance Maladie, 2021), and was 6 % lower through 2020 than 2019. According to Unicancer[7], delayed cancer diagnosis and treatment during the first wave of the pandemic will result in excess mortality of between 1 000 and 6 000 patients in the coming years.

7. See http://www.unicancer.fr/actualites/groupe/unicancer-presente-les-conclusions-son-etude-relative-aux-retards-diagnostics-en-cancerologie-lies-c

Figure 12. The first lockdown in spring 2020 led to a sharp reduction in cancer screening



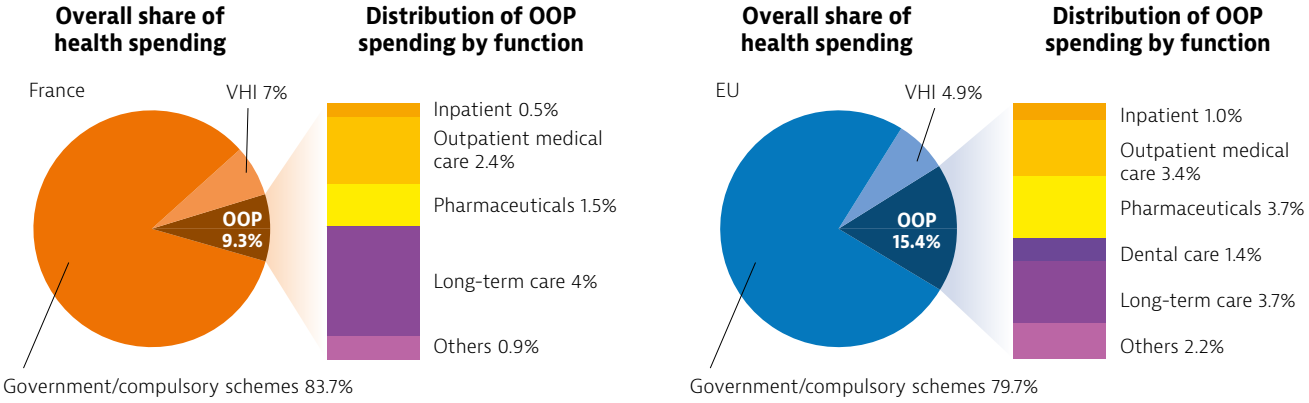
Source: Assurance Maladie (2021).

5.2 Accessibility

High public and private insurance coverage limits out-of-pocket health expenditure

France reports the lowest share of out-of-pocket (OOP) payments for health among all EU countries (9.3 % compared to a 15.4 % EU average; Figure 13) because public and private health insurance schemes cover most health spending. This is particularly the case under the scheme for people with chronic conditions, which covers all health-related costs linked to these conditions.

Figure 13. France has the lowest share of out-of-pocket expenditure in the EU



Note: The EU average is weighted. The share of voluntary health insurance (VHI) is lower than the figures reported by the Ministry of Health because it only includes the part of private health insurance that is voluntary.
Sources: OECD Health Statistics 2021, Eurostat database (data refer to 2019).

Unmet needs for medical care are low but concentrated in the lowest income group

Unmet needs for medical care due to cost, distance or waiting times are very low – reported by only 1.2 % of the population in 2019, based on the EU-SILC survey. However, there is inequality across income groups: about 2.4 % of people in the lowest income quintile reported going without medical care – the main reason being that it was too expensive – compared to 0.4 % in the highest.

Unmet needs are greater for services that are less comprehensively covered by the SHI, such as hearing aids, glasses and other eye products, and dental care. For example, 2.7 % of French people reported unmet needs for dental care in 2019, but this proportion was much greater in the lowest income quintile (6 %), mainly for financial reasons.

In 2018, the SHI introduced a plan to reduce forgone medical care by deploying health councillors to provide a personalised assistance programme to vulnerable patients.

The COVID-19 crisis and related containment measures limited access to health services in 2020. A survey carried out in February and March 2021 found that 16 % of the population reported having forgone a needed medical examination or treatment during the first 12 months of the pandemic. This was below the EU average of 21 % (Eurofound, 2021)[8].

8. *The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.*

New measures were introduced to reduce out-of-pocket payments on dental care, optical and hearing aids

The health care benefits package covers a broad range of goods and services, including hospital and outpatient care and all other services prescribed by doctors, such as pharmaceutical products, medical devices and medical transportation. However, the depth of coverage varies according to the goods and services.

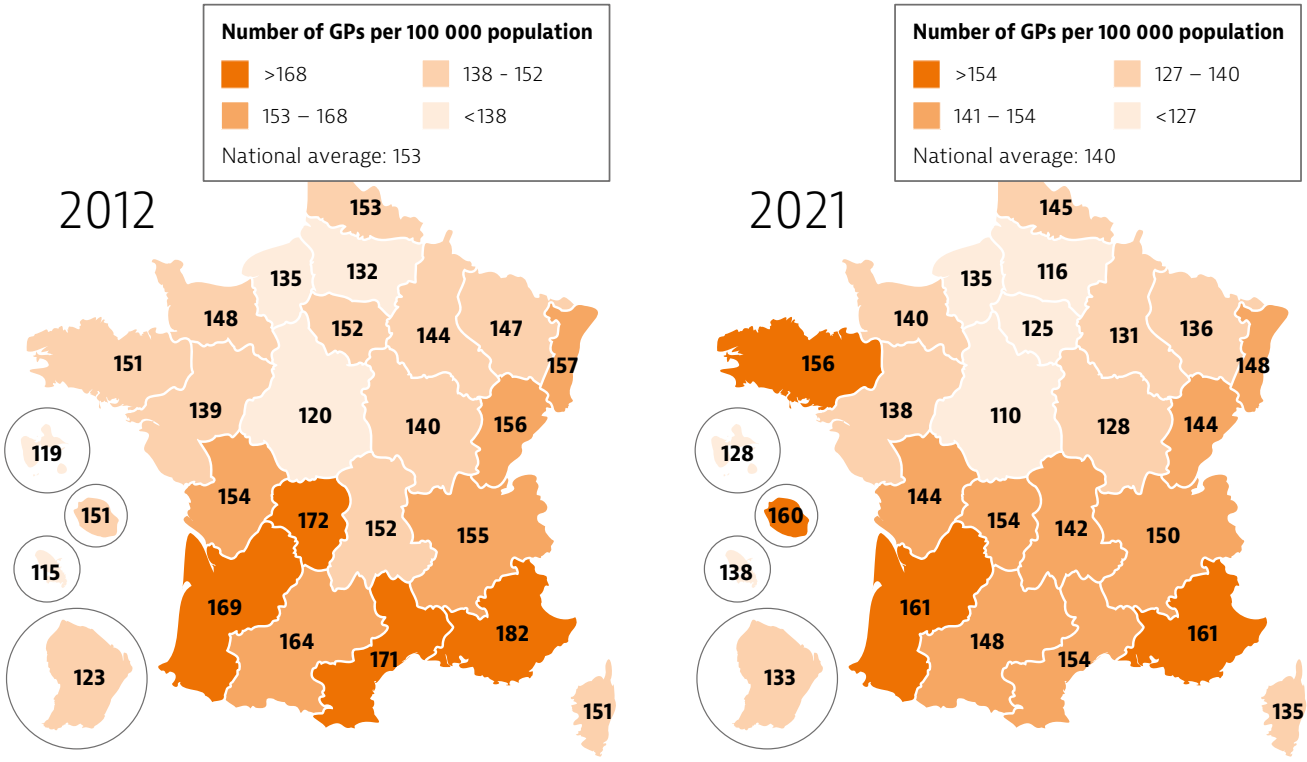
OOP payments can be substantial; for example, the SHI does not cover more than 95 % of expenditure on glasses and other eye products, 85 % on hearing aids and 65 % on dental care – mainly for prostheses. The complementary health insurance market has not compensated entirely for this limited coverage, leading to important levels of unmet medical needs for lower income groups. Since 2017, the government has taken a series of measures to reduce the financial burden from health expenditure. From January 2021, any patient with a complementary health insurance contract can now access a comprehensive benefits package for eye care, hearing aids and dental care without any form of co-payment.

There are wide disparities in the density of general practitioners across regions

As noted in Section 4, the overall number of doctors per 1 000 population in France is much lower than the EU average, and the total number fell by 5.6 % between 2012 and 2021. Combined with rising population, the density of GPs was reduced from 1.5 per 1 000 population in 2012 to 1.4 in 2021. While this reduction occurred in most regions, it was greater in some, and disparities increased (Figure 14).

Concerns about "medical deserts" have grown and may be exacerbated in the future as a large proportion of GPs will retire in the next decade. The proportion of people living in a region with a density of GPs 20 % lower than the national average increased from 1 % in 2012 to 4 % in 2021 (DREES, 2021).

Figure 14. The density of GPs fell in almost all regions in France between 2012 and 2021



Source: DREES (2021).

The authorities launched a number of initiatives to address these concerns, including offering financial support for doctors to set up practices, and various tax breaks. Since 2007, the main policy to tackle this issue has been to create multidisciplinary medical centres, enabling GPs and other health professionals to work in the same location. In 2020, a total of 1 612 such centres were registered, 30 % more than in 2017. Unfortunately, the most recent centres are in areas where access is not the most limited (Mutualité Française, 2020).

In addition, as part of the National Health Strategy 2018-22, from 2021 students in general practice are required to undertake at least six months of their last year of postgraduate training in ambulatory care settings, including medically underserved areas.

Engaging with medical students to increase access in deprived areas has been successful. Between 2010 and 2019, 2 696 access contracts were signed with students and residents. Under this scheme, students receive a monthly stipend during their training in exchange for a commitment to practise in areas identified by the regional health authorities for an equivalent period after graduation.

Task-sharing between doctors and other health professionals has received strong support

Improving access to primary care is also supported through France's National Health Strategy 2018-22, which aims to create 1 000 communities of health professionals by 2022. These coordinate outpatient health professionals across a territory, with the objective of improving patient-centred care and access. More than 500 communities were planned in 2020, but only 60 were operational at the end of the year (Assurance Maladie, 2020).

It is expected that these communities will lead to greater teamwork and task-sharing between doctors and other health professionals, which is currently limited. Legislation formalising the role of advanced practice nurses was passed in 2018: they provide greater support in the care of chronically ill patients and those with complex morbidities, working with GPs and specialists in primary care teams and other health and LTC settings. A first wave of 63 advanced practice nurses graduated in 2019, and another 1 695 advanced practice nurses are expected to graduate in 2022 (ONDPS, 2021). In addition, a new position of medical assistant was created to take on responsibility for non-medical tasks traditionally performed by GPs, such as creation of medical files, verification of vaccinations and screening, and sanitation of medical devices. The aim is to train and recruit 4 000 medical assistants by 2022 (as of September 2020, around 1 300 contracts had been signed).

COVID-19-related care is fully covered by the national health insurance funds

The health insurance funds cover costs linked to COVID-19 testing and treatment in full. As of April 2020, all tests (PCR and antigen) are entirely reimbursed, even without a prescription or symptoms. However, serological tests are only reimbursed with a physician's prescription. Medical consultations following a positive test and for contact tracing and vaccination are also fully reimbursed.

Various measures were set up to facilitate access to care for vulnerable groups during the pandemic. These include mechanisms to allow migrants to continue benefiting from state medical aid once their rights to it were due to expire.

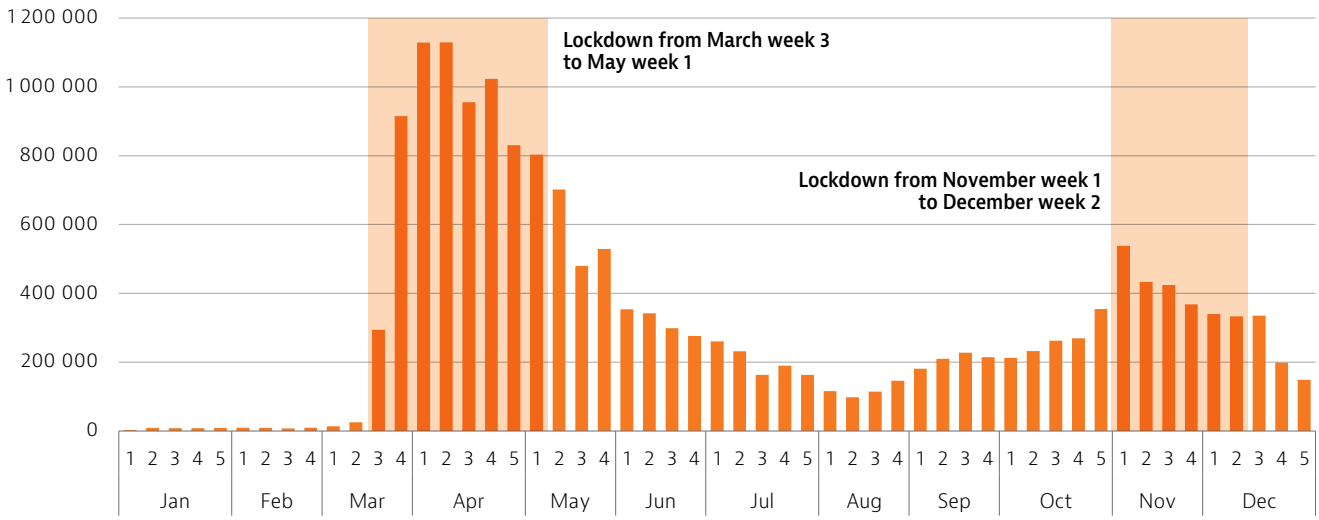
Access to health services was disrupted for non-COVID-19 patients in spring 2020

During the first wave of the pandemic, visits to doctors, ambulatory surgery and cancer diagnoses decreased because of the need to mobilise additional resources to respond to COVID-19 patients, and because people feared being infected. For example, billing data show that activity for specialists declined by 60 % and for GPs by 30 % during the first lockdown, compared to the same period in 2018 and 2019 (Assurance Maladie, 2020).

One solution to maintain access to care was wider adoption of telehealth services. The number of teleconsultations peaked at almost 1 million per week in April 2020, compared to around 10 000 per week before March 2020 (Figure 15). The number fell after the easing of the first lockdown in May/June 2020, but rose again from the end of October to mid-December 2020 during the second. New regulations were introduced to scale up telemedicine during the first wave of the pandemic: the conditions of entitlement and reimbursement were simplified to maintain continuity of care, and the cost was fully covered by the SHI. Physicians were allowed to use this mode of consultation without having to know the patient already. Teleconsultations were also made available to nurses for follow-up of COVID-19-infected patients confined at home.

Figure 15. The number of teleconsultations increased during the two lockdowns in 2020

Number of telecommunications per week, 2020



Source: Assurance Maladie (2020).

5.3 Resilience

This section on resilience focuses mainly on the impacts of and responses to the COVID-19 pandemic[9]. As noted in Section 2, the pandemic had a major impact on population health and mortality in France in 2020, as in most other EU countries. The measures taken to contain it led to a major contraction of the economy (French GDP fell by over 8 % in 2020), rising unemployment rates and poverty, with levels of economic activity not projected to return to their 2019 levels before 2022.

A broad set of containment measures was implemented to control the pandemic, with mixed success

The first cases of COVID-19 were identified in France at the end of January 2020. By the end of August 2021, 6.7 million people (about 10% of the population) had been diagnosed (confirmed through a laboratory test)[10]. The COVID-19 mortality rate to the end of August 2021 was 7% higher in France (1 700 deaths per million population) than across the EU (about 1 590).

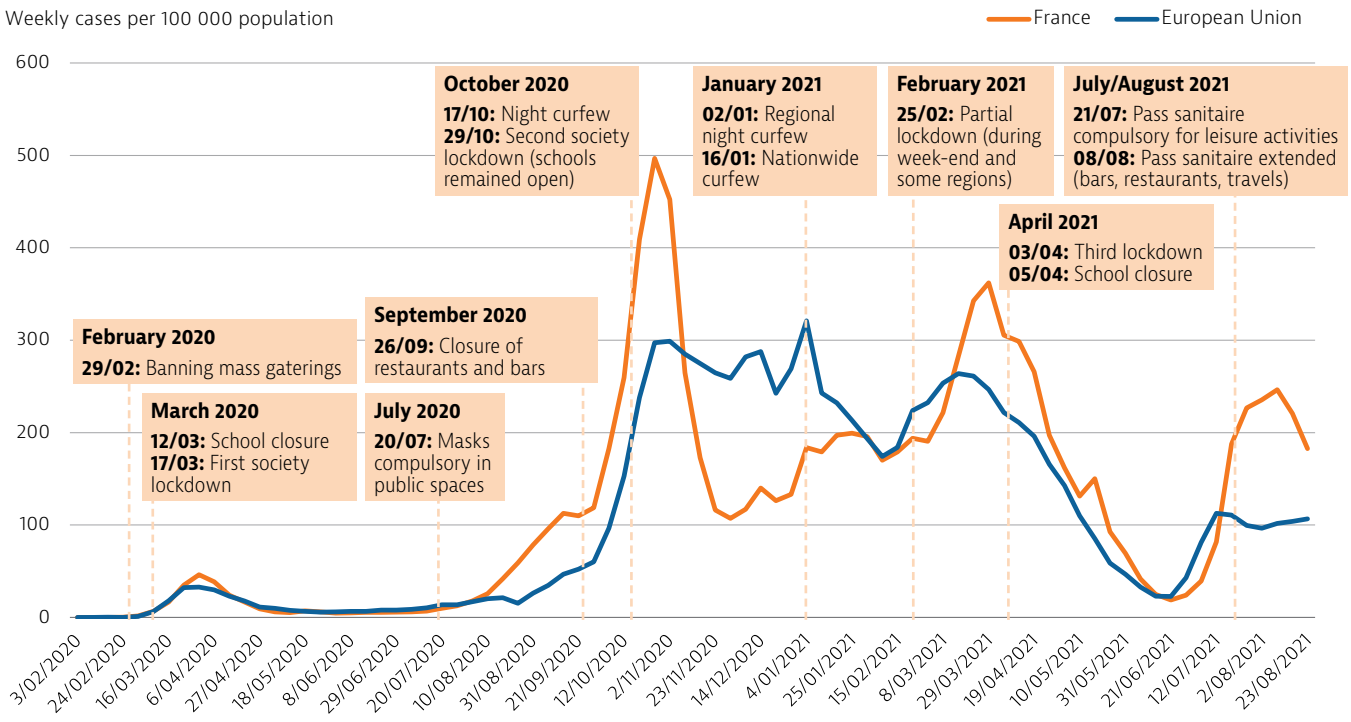
From late February 2020, France adopted a series of containment measures, first banning mass gatherings, then banning visits to LTC facilities. By mid-March 2020, the government had implemented a first full lockdown, which included the closure of schools and universities. These measures resulted in a sharp drop in the number of cases (Figure 16), although transmission was never entirely suppressed.

In early June 2020, containment measures were gradually loosened, which led to a slow but steady rise in the number of new cases during the summer. In response to this second wave, in autumn 2020, more limited and geographically targeted containment measures were initially adopted, followed by a second full lockdown at the end of October. While schools remained open this time, universities were closed and all classes given online, as in spring 2020.

The second lockdown was eased in mid-December 2020, raising concerns among epidemiologists that this would result in a rapid increase of COVID-19 cases following the Christmas holiday season. The number of cases started to rise slowly from January 2021, and France adopted a nationwide curfew, followed by a partial lockdown in February 2021 for the hardest-hit regions. These measures were not sufficient to control the steady rise in cases, and at the beginning of April 2021, the government implemented a third full lockdown that included the closure of schools for 3 weeks of which 2 weeks were already scheduled as school holidays. The third lockdown was accompanied by a sharp drop in the number of cases, but by end June 2021 the number of positive cases skyrocketed again because of the more transmissible Delta variant. France established the Pass Sanitaire, which was made compulsory by end of July 2021 for all leisure activities, later extended to bars, restaurants, and travels by train and plane in France (Figure 16).

9. In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (EU Expert Group on Health System Performance Assessment, 2020).
10. According to the Institut Pasteur, one fifth of the French population had been infected by the COVID-19 virus as of 22 March 2021.

Figure 16. France implemented three full lockdowns in 2020 and 2021 to contain virus transmission



Note: The number of COVID-19 cases in France and other countries was greatly underestimated during the first wave in spring 2020 due to more limited testing.
Sources: ECDC for COVID-19 cases and review of government policies (https://www.gouvernement.fr/info-coronavirus/les-actions-du-gouvernement).

Limited preparedness to respond to infectious disease led to shortcomings at the beginning of the outbreak

During the first wave of the pandemic, France faced a number of issues with containing the transmission of the virus. Logistical capacity to implement mass testing was limited due to a low number of accredited laboratories and lack of equipment (reagents, swabs). Overall, crisis preparedness before the pandemic was weak in laboratory capacity. Due to time-consuming bureaucratic procedures, the administration also took a long time to decide which tests would be used and to authorise research and other non-medical laboratories to carry out COVID-19 testing (Pittet et al., 2021).

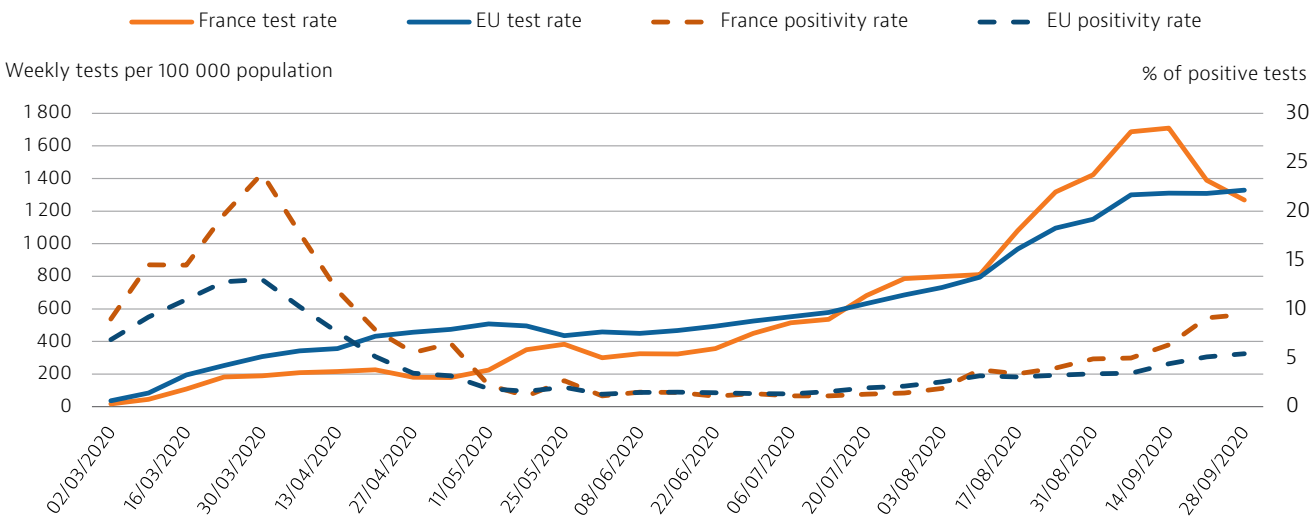
Furthermore, the national stockpile of facemasks was insufficient because hundreds of millions of masks purchased years earlier had reached their expiry date, and the stock had only been partly replenished in a context of tight budgetary constraints. As a result, government recommendations on mask-wearing were ambiguous at the beginning of the pandemic. Both these factors may explain why French people were late adopters of mask-wearing in spring 2020 compared with Germany, Italy and Spain. This gap was reduced by summer 2020. Wearing masks in all shops and enclosed public places was made compulsory on 20 July 2020 in France for everyone aged over 11.

The test, trace and isolate policy proved challenging during the early stage of the pandemic

France had limited capacity to promote mass testing at the beginning of the pandemic. The weekly number of tests performed was much lower than the EU average from March to May 2020. Testing was limited mainly to people with COVID-19 symptoms in hospitals, explaining the high positivity rates during that period (Figure 17). Only a small number of tests were carried out in the community during the first wave, limiting capacity to implement effective contact tracing and isolation policies. Testing capacity was gradually increased by mobilising greater laboratory capacity and more people to carry out the tests. Nonetheless, by the end of summer 2020, laboratories were still struggling with high demand, resulting in long waiting times both to be tested and to receive test results.

From September 2020, France introduced new rules for patient prioritisation in testing, established new testing centres and promoted use of new rapid antigenic tests. These efforts were successful: by the end of 2020, it was among the EU countries testing the most people.

Figure 17. France struggled to increase its testing capacity at the beginning of the crisis



Note: The EU average is weighted (the number of countries included in the average varies depending on the week).
Source: ECDC.

Partly as a consequence of low testing capacity in the early phase of the pandemic, France also experienced difficulties with contact tracing, because of a limited number of professional contact tracers and a failure to suppress transmission to a level that enables effective contact tracing. In addition, a low percentage of the population downloaded the first contact tracing application. This was launched in early June 2020 at the end of the first lockdown, but by October 2020, only 3 % of the population had downloaded it. The authorities released a new app, which gained relatively more support: as of March 2021, it had been downloaded by 20 % of the population. As with other COVID-19 tracing apps, its real capacity to facilitate contact tracing efforts remains to be demonstrated.

Management of isolation and quarantine was not strictly applied and controlled throughout the pandemic. People with confirmed COVID-19 were asked to self-isolate at home. If self-isolation was not possible, it was planned that people would isolate in dedicated hotels, but deployment of this plan remained very limited. To encourage greater compliance, the government simplified and extended the conditions to receive sick leave allowances in January 2021.

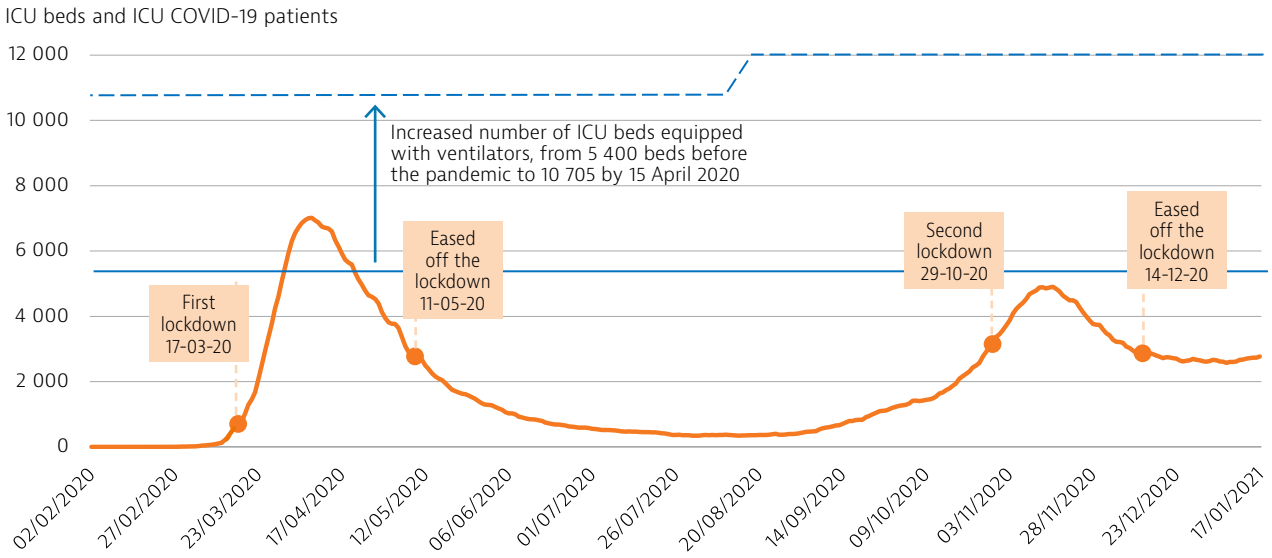
The pandemic put hospitals under severe strain, but mobilisation of additional resources was swift

The emergency hospital plan was activated on 13 March 2020 to mobilise additional human resources and equipment to respond to the pandemic. Although France had more hospital and intensive care unit (ICU) beds per population than many other EU countries before the outbreak, hospitals in some regions rapidly became overstretched during the first wave.

To manage the peak in demand for acute care, health workers and equipment were transferred to hospitals in regions with greater need. The military sector helped create field hospitals and additional ICU beds in the most severely affected regions, and some post-surgery wards in public and private hospitals were converted into ICUs. Through these measures, the number of ICU beds equipped with ventilators nearly doubled, from 5 400 before the pandemic to 10 700 by 15 April 2020 (DREES, 2021b). As a result, the number of COVID-19 patients in ICUs in spring 2020 did not exceed the overall bed capacity at the national level (Figure 18). Nonetheless, hospitals in some regions were overwhelmed, and patients had to be transferred to other regions or neighbouring countries (Germany, Switzerland and Luxembourg). By the end of August 2020, the potential ICU bed capacity was further increased to 12 000 (Ministère des solidarités et de la santé, 2020a).

France also successfully managed to mobilise additional staff to respond to the surge in demand for care in spring and autumn 2020, using a national platform to recruit volunteers, students in medical and nursing education programmes. The "health reserve", which was established in 2007 following the avian influenza epidemic, was also used to recruit inactive and retired health professionals. By early May 2020, more than 2 000 health workers and more than 2 000 LTC workers were mobilised to respond to the first wave (Ministère des solidarités et de la santé, 2020a). During the second wave, around 800 health workers were mobilised.

Figure 18. Mobilisation of additional ICU beds with ventilators helped to manage peaks in demand



Note: The orange line shows the daily number of COVID-19 patients in ICUs and does not include ICU admissions for other causes. The solid blue line is the initial bed capacity in ICUs before the pandemic. The dashed blue line shows the additional bed capacity mobilised during the pandemic.
Source: ECDC for patients (https://www.ecdc.europa.eu/en/publications-data/download-data-hospital-and-icu-admission-rates-and-current-occupancy-covid-19); DREES (2021b) for ICU beds.

COVID-19 response in nursing homes improved gradually, but structural issues persist in long-term care

The first wave of the pandemic disproportionately hit people living in LTC institutions. Between March and the end of May 2020, nearly half (49 %) of all COVID-19 deaths in France were among LTC residents. The COVID-19 emergency plan in LTC facilities was activated at the same time as the hospital plan (6 March 2020), but LTC facilities were particularly vulnerable because of a lack of protective equipment, testing and adequately trained personnel (Pittet et al., 2021; Milon et al., 2020).

Regional health agencies provided greater medical support to nursing homes, notably via additional health workers to increase testing and treatment, and by establishing a more integrated care network to support co-ordinated hospital admissions and proper follow-up after discharge. However, structural challenges such as the persistent lack of personnel and qualified medical staff caused by unattractive working conditions continue to affect the quality and safety of LTC services. In response, the government provided bonuses for care workers to reward them for their exceptional efforts during the first wave of the pandemic. Further, to improve recruitment and retention, all health workers in nursing homes and hospitals received a pay rise of EUR 183 per month in 2020, followed by another of between EUR 45 and EUR 450 per month by end 2021/early 2022, depending on job tenure.

Vaccine hesitancy sharply dropped following the start of the vaccination campaign

Following the approval of the first vaccines against COVID-19 in December 2020 and January 2021, the vaccination campaign started slowly in France but accelerated from February 2021 with the growing availability of doses. The target population groups were gradually widened, and several hundred immunisation centres were set up to enable mass vaccination. Besides GPs, pharmacists, nurses and other health workers were also allowed to administer vaccines.

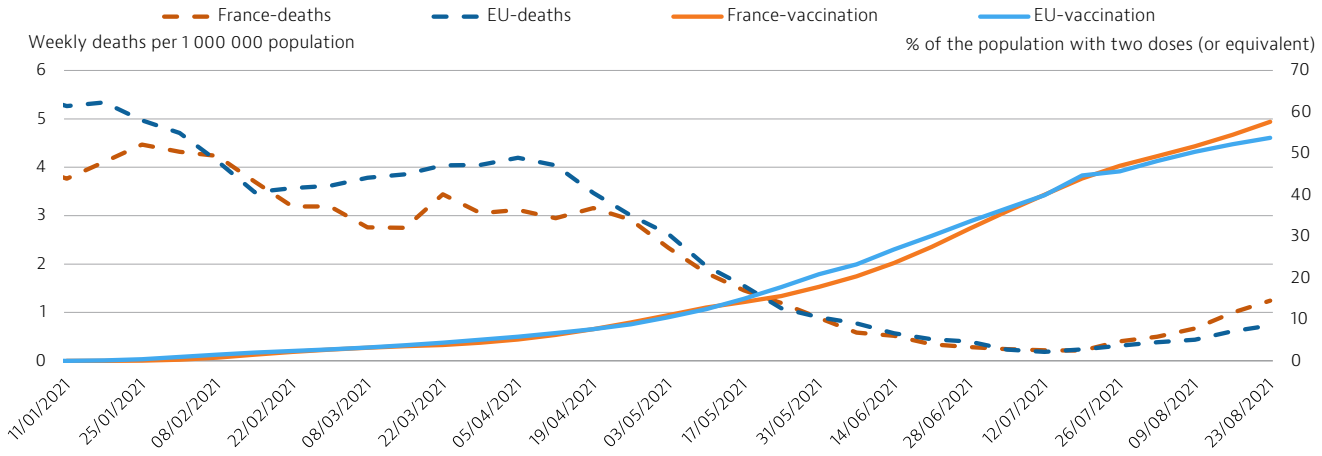
At the start of the vaccination campaign in early 2021, vaccine hesitancy was high in France, with one in two French people reporting in mid-January 2021 that they were not willing to get vaccinated. However, vaccine hesitancy declined sharply during the course of 2021, dropping to 23% of the French population reporting that they were not willing to get vaccinated by mid-August 2021. The implementation of the Pass Sanitaire during the summer 2021 provided a strong incentive for people who were not yet vaccinated to get their first and second doses if required in order to be able to access certain places and services.

The vaccination campaign among adolescents (12-17 years old) started in June 2021 with teenagers being able to get vaccinated with parent's consent. The campaign is continuing in the Fall 2021; 68 % of teenagers had received at least a first dose by early September 2021.

By the end of August 2021, 59 % of the population had received two doses (or the equivalent), a slightly higher proportion than the EU average (Figure 19).

The government announced a mandatory COVID-19 vaccination for health and long-term care workers from mid-September 2021 to ensure greater protection for patients. While around two thirds of health workers in hospitals and LTC facilities had already received two doses (or the equivalent) by the end of July 2021, this proportion reached only 43% among nursing aides and 42% among medical residents (Santé Publique France, 2021c). Those health and long term care workers not vaccinated by mid-September 2021 are no longer authorised to practise.

Figure 19. The percentage of the population who have received two doses of Covid-19 vaccine against COVID-19 was close to the EU average at the end of August 2021



Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).
Source: ECDC for COVID-19 cases and Our World in Data for vaccination rates.

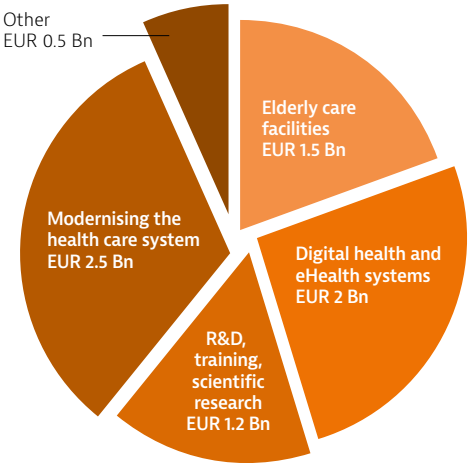
The government increased public spending on health to strengthen the health system

As noted in Section 4, the government greatly increased public spending on health in 2020 in response to the crisis – by 9.5 % compared with an average growth of 2.5 % per year in the previous decade. This is expected to grow by 4 % in 2021, including specific provisions for testing (EUR 2 billion), vaccination (EUR 1.5 billion) and purchasing masks (EUR 0.7 billion).

In July 2020, the government adopted an ambitious plan to strengthen public hospitals and increase investment in the health workforce. Resulting from numerous consultations with health workers and unions, the plan allocated an additional EUR 8.2 billion per year to increase recruitment and retention of health workers in hospitals and nursing homes. It also reaffirmed the ambition to restructure the public hospital network, improve coordination between ambulatory and hospital care, increase digitalisation of the health system and modernise the LTC sector (Ministère des solidarités et de la santé, 2020b).

The Recovery and Resilience Plan in France will support these investments. The proposed investments in health care, research and cohesion amount to EUR 7.7 billion, representing almost 20 % of total grants for France under the EU Recovery and Resilience Fund. Priority areas include modernisation of the health care system, greater investment in elderly care facilities, wider implementation of technological health and eHealth systems, and encouraging research and development, training and scientific research (Figure 20).

Figure 20. The Recovery and Resilience Plan is allocating EUR 7.7 billion to the health sector



Source: France Recovery and Resilience Plan (2021).

6 Key findings

- Life expectancy in France is among the highest in Europe, but it fell by eight months in 2020 because of deaths due to COVID-19 – the biggest drop since the Second World War. About 65 000 people died from COVID-19 in 2020, and another 49 000 in the first eight months of 2021.

- Behavioural risk factors for health – notably smoking, alcohol consumption and lack of physical activity – are major drivers of mortality, and risk factors such as obesity increase the risk of complications and deaths from COVID-19. Environmental factors like air pollution also result in several thousand deaths each year from circulatory diseases, respiratory diseases and some types of cancer.

- In recent years, between 380 000 and 420 000 new cases of cancer have been detected in France annually and between 157 000 and 185 000 people died from cancer each year, making it the leading cause of death. France compares well with other EU countries in survival rates following diagnosis of various cancers. The National Cancer Plan 2021-30 was introduced to reduce the number of avoidable deaths from cancer by 50 000 per year. The COVID-19 crisis had a negative impact on cancer screening and care, as services and interventions were disrupted during the lockdowns.

- In 2019, health spending accounted for 11.1 % of GDP – the highest share in the EU along with Germany. Public spending on health rose by 9.5 % in 2020 in response to the COVID-19 crisis, while GDP dropped by 8 %.

- The French health system provides good access to care, with low out-of-pocket payments. However, the pandemic and related containment measures limited access to health services in 2020, and one in six people reported forgone care during the first 12 months of the pandemic; this was lower than the EU average of 21 %, but higher than in Germany. To help maintain access to care, new regulations were introduced to scale up the use of telemedicine.

- Low numbers of general practitioners practising in underserved areas ("medical deserts") have been a concern over the past decade. The creation of territorial communities of health professionals is expected to help improve access to care, notably by fostering teamwork and task-shifting between doctors and other health professionals.

- France was among the EU countries hardest hit by COVID-19, with the number of cases and death rate slightly higher than the EU average between March 2020 and the end of August 2021. Many measures were implemented to try to contain virus transmission from the beginning of the outbreak, including three more or less strict lockdowns, with mixed success. France initially faced several shortcomings linked to weak pandemic preparation, limited testing capacity and coordination issues between national, regional and local governments, but the situation improved after the first couple of months.

- Additional resources were mobilised during the peaks of the pandemic to help overstretched hospitals and other parts of the health system. France managed to mobilise additional staff by using a national platform to recruit volunteers, students in medical and nursing education programmes and the "health reserve".

- As in other EU countries, the vaccination campaign against COVID-19 started at the end of December 2020. At the end of August 2021, nearly 60 % of the population had received two doses (or the equivalent), a slightly higher percentage than the EU average. The implementation of the Pass Sanitaire in the summer 2021 provided a strong incentive for people who were still hesitating to get vaccinated to get their first and second doses to be able to enjoy a normal life again.

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT		

European Commission

State of Health in the EU
Country Health Profile 2021

The Country Health Profiles are an important step in the European Commission's ongoing *State of Health in the EU* cycle of knowledge brokering, produced with the financial assistance of the European Union. The profiles 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, in cooperation with the European Commission.

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/EEA country. The aim is to create a means for mutual learning and voluntary exchange that can be used by policymakers and policy influencers alike.

Each country profile provides a short synthesis of:

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

The Commission is complementing the key findings of these country profiles with a Companion Report.

For more information see: ec.europa.eu/health/state

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