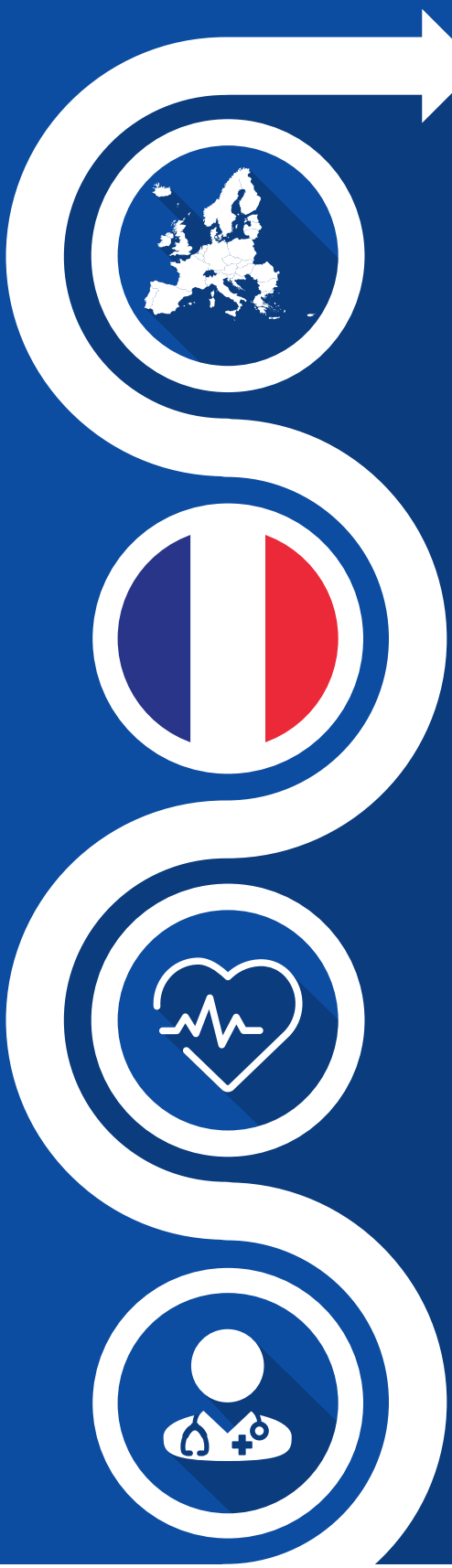
European Commission



State of Health in the EU

France

Country Health Profile 2019

OECD
BETTER POLICIES FOR BETTER LIVES

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.

The 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 the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Information.

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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 28 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in August 2019, based on data available in July 2019.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following URL into your Internet browser: http://www.oecd.org/health/Country-Health-Profiles-2019-France.xls

Demographic and socioeconomic context in France, 2017

Demographic factors	France	EU
Population size (mid-year estimates)	66 865 000	511 876 000
Share of population over age 65 (%)	19.3	19.4
Fertility rate[1]	1.9	1.6
Socioeconomic factors		
GDP per capita (EUR PPP[2])	31 200	30 000
Relative poverty rate[3] (%)	13.3	16.9
Unemployment rate (%)	9.4	7.6

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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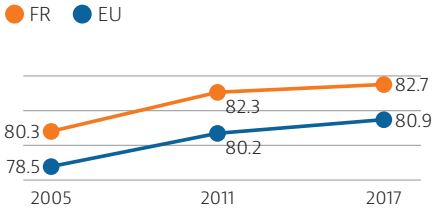
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1 Highlights

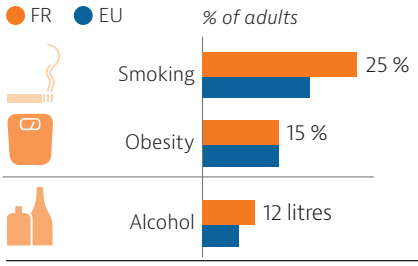
Life expectancy in France has historically been among the highest in Europe, but progress has slowed during the last decade, mainly because gains in longevity among older people have stalled. Large gaps in life expectancy persist by socioeconomic status, mostly linked to social, environmental and individual risk factors. The French health system generally provides good access to high-quality care, but the main challenges are strengthening prevention to improve health and reduce health inequalities and pursuing the transformation of the health system to better meet the needs of the growing number of people living with chronic conditions.



Life expectancy at birth, years

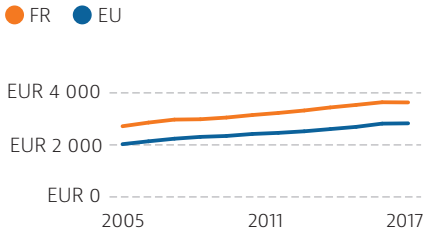
Health status

Life expectancy at birth reached 82.7 years in 2017, about two years above the EU average, and is the third highest among EU countries (after Spain and Italy). However, improvements in life expectancy have lessened since 2011 because the gains in old age have slowed down or even reversed in some years. At age 65, French people can expect to live more than half of their remaining years of life with some chronic diseases and disabilities.



Risk factors

One in four adults smoked daily in 2018, down from about one in three in 2000, but still above the EU average (19 %). Alcohol consumption per adult has also decreased but remained almost 20 % higher than the EU average in 2017. Over one in seven adults was obese in 2017, up from one in ten in 2000.



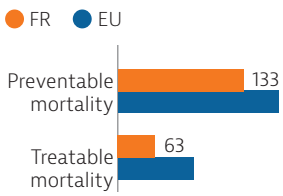
Per capita spending (EUR PPP)

Health system

Health spending in France has increased at a moderate rate over the last decade. In 2017, France spent EUR 3 626 per capita on health, about 25 % more than the EU average. Health spending accounted for over 11 % of GDP in 2017, the highest share in the EU along with Germany. Most health expenditure is publicly funded, but private complementary health insurance also plays an important role, explaining why the share of out-of-pocket spending is the lowest among EU countries.

Effectiveness

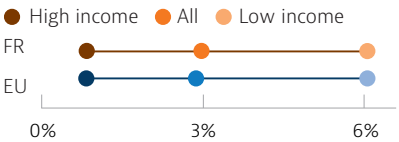
Mortality from treatable causes is among the lowest in EU countries, signalling that the health system performs well in saving people with acute conditions. On a less positive note, preventable mortality is higher than in many EU countries, but below the EU average.



Age-standardised mortality rate per 100 000 population, 2016

Accessibility

Access to health care is generally good, but unmet needs for services that are less covered, like dental care, are higher than for medical care. Access to doctors is limited in some rural and deprived areas, but numerous initiatives have been launched to mitigate these issues, including the creation of multidisciplinary practices and a greater role given to pharmacists and nurses.



% reporting unmet dental needs, 2017

Resilience



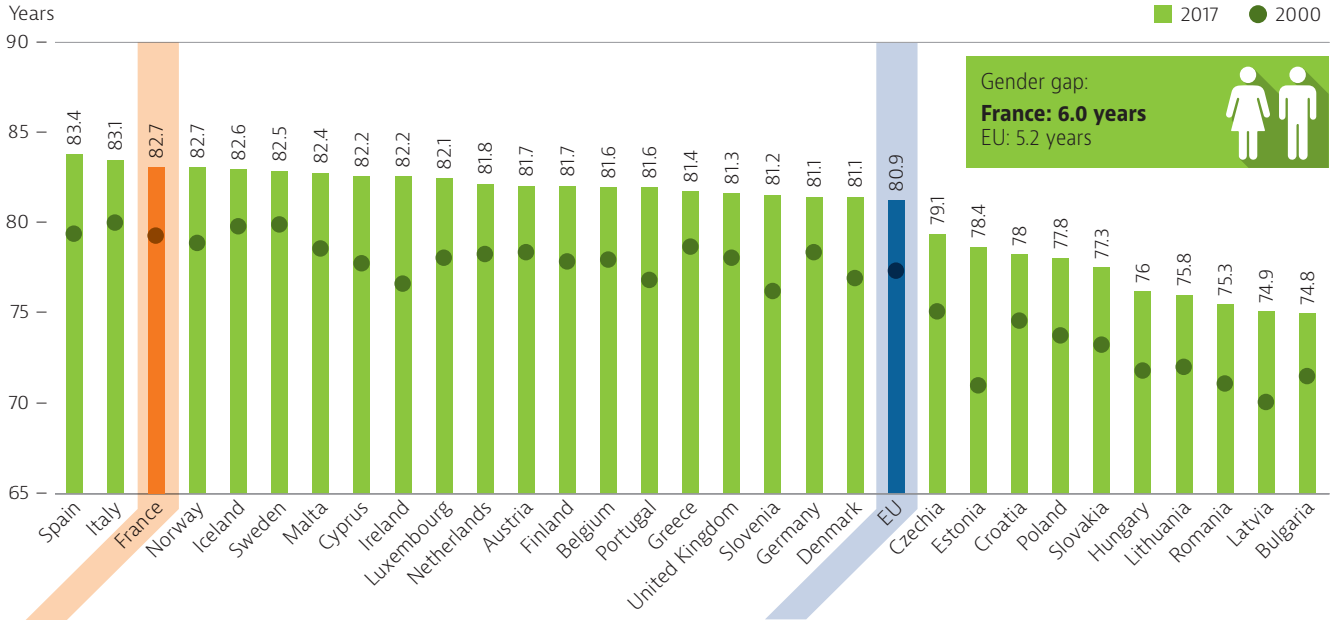
As in other EU countries, population ageing will continue to increase demands on health and long-term care in France and add budgetary pressures. Potential exists to improve population health outcomes by strengthening prevention policies, and to reduce demands on hospitals by promoting better care coordination outside hospital for people with chronic conditions.

2 Health in France

Life expectancy in France is among the highest in the EU, but large gender gaps persist

In 2017, life expectancy at birth in France stood at 82.7 years, the third highest in the EU after Spain and Italy (Figure 1). It is particularly high among women (second highest after Spain), while only the ninth highest among men. The gender gap in life expectancy in 2017 was 6 years, greater than the EU average and the highest among all western European countries. However, this gap has narrowed by about a year since 2010.

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



Source: Eurostat Database.

Gains in life expectancy have slowed during the last decade, especially among women

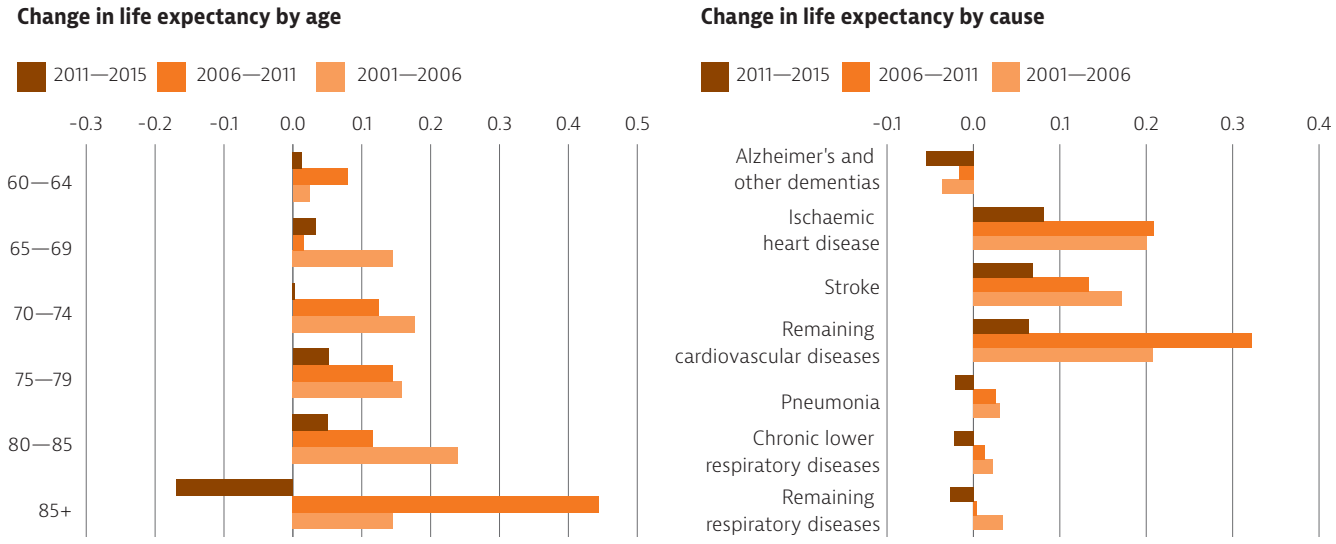
Although the life expectancy of French women is high, it increased by less than one year between 2010 and 2018, compared with about two years in the previous decade. The gains for French men also slowed to 1.5 years between 2010 and 2018, down from about three years in 2000-10. This slowdown has also been observed in the United Kingdom and several other EU countries (Raleigh, 2019).

In France, as in many other western European countries, the lessening of life expectancy gains during this decade is mainly due to a slowing of mortality rate reductions at older ages. There were even increases in mortality rates among the population aged 85 and over between 2011 and 2015, resulting in a reduction in life expectancy (Figure 2). Reductions in mortality rates from cardiovascular diseases slowed down and deaths related to Alzheimer's and other dementias increased between 2011 and 2015, as did mortality rates from pneumonia and other respiratory diseases.

Social inequalities in life expectancy are large

Inequalities in life expectancy in France are large not only by gender but also by socioeconomic status. Life expectancy for men with the lowest incomes is 13 years lower than for those with the highest incomes (Figure 3). The gap was 8 years among women (INSEE, 2018). This income gap in longevity can be explained at least partly by differences in education level and living standards, in exposure to risk factors and in access to health care.

Figure 2. The gains in life expectancy have slowed down mostly among elderly people



Source: Authors' calculations (based on Eurostat Database).

Figure 3. The income gap in life expectancy is about 13 years for men and 8 years for women



Note: High income is defined as the 5 % of people with the highest income; low income is defined as the 5 % with the lowest income.
Source: INSEE, 2018 (data refer to the period 2012-16).

Most French people report being in good health, but social disparities exist

In 2017, about two-thirds of the population reported being in good health, a proportion close to the EU average. However, as in other countries, people on higher incomes are more likely to report being in good health than those on lower incomes. In 2017, 73 % of the French population in the highest income quintile reported being in good health, compared with 63 % for those in the lowest. In comparison, the EU averages are 80 % and 61 %, respectively. A similar gradient is observed by education level.

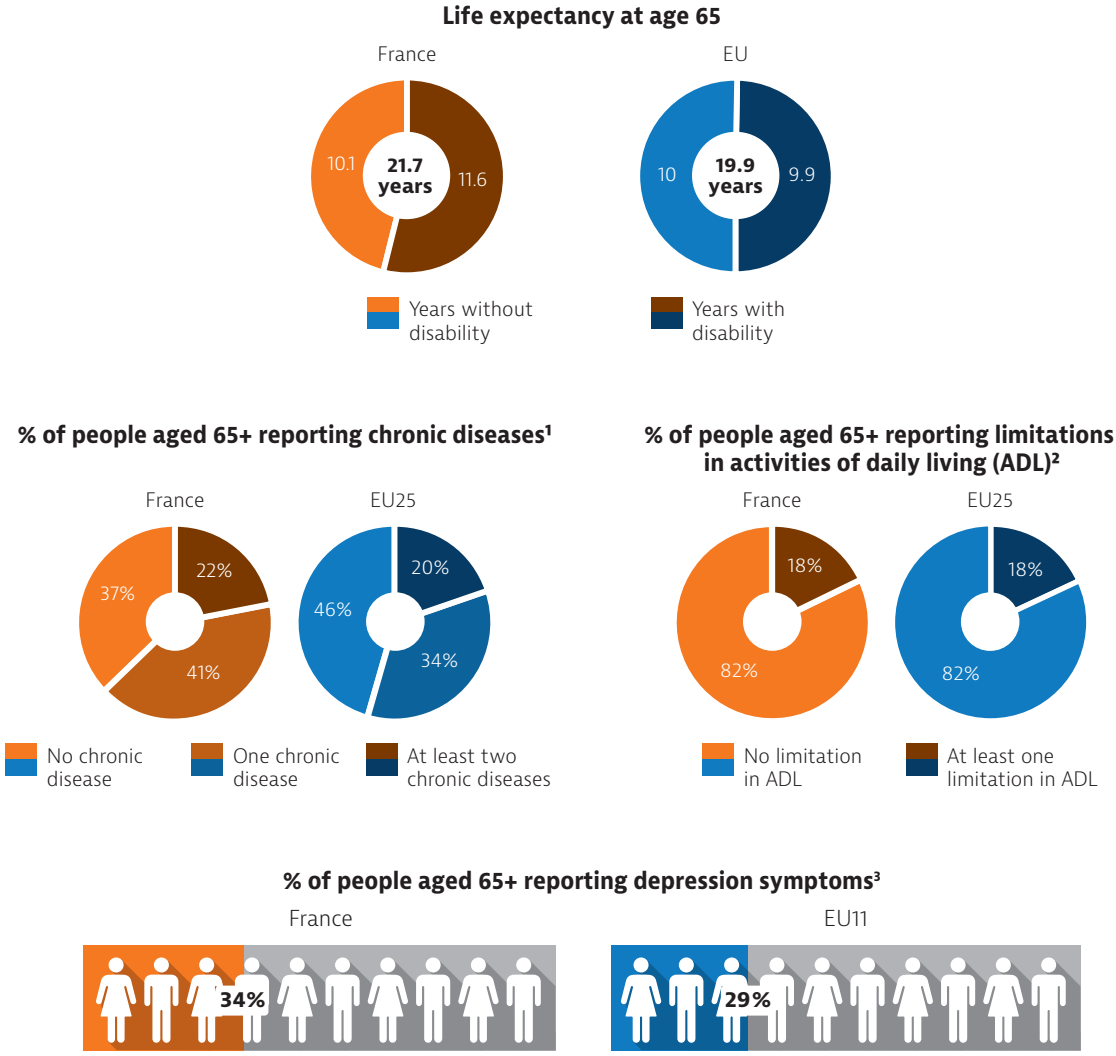
French people live longer than before, but not all remain healthy as they age

Older people make up a growing proportion of the French population. In 2017, one in five people in France was aged 65 and over, up from about one in seven in 1980, and this share is projected to increase to more than one in four by 2050.

The life expectancy of French people at age 65 has increased over the past decades, even if the gains have been smaller in recent years. In 2017, they could expect to live another 22 years, almost two years more than the EU average (Figure 4). While many people remain in good health as they get older, others have health conditions that may limit their activities. On average, French people at age 65 could expect to live another ten years free of disability in 2017, with the rest lived with some activity limitations.

More than three in five people aged 65 and over reported having at least one chronic condition in 2017, although this does not necessarily impede them from leading a normal life. Most people are able to continue to live independently in old age, but one in six people reported some limitations in basic activities of daily living such as dressing and eating that may require long-term care assistance. One in three people aged over 65 have some depression symptoms, a slightly higher percentage than the EU average.

Figure 4. Many years of life after age 65 are spent with chronic diseases and disabilities



Note: 1. Chronic diseases include heart attack, stroke, diabetes, Parkinson's disease, Alzheimer's disease and rheumatoid arthritis or osteoarthritis. 2. Basic activities of daily living include dressing, walking across a room, bathing or showering, eating, getting in or out of bed and using the toilet. 3. People are considered to have depression symptoms if they report more than three depression symptoms (out of 12 possible variables).
Source: Eurostat Database for life expectancy and healthy life years (data refer to 2017); SHARE survey for other indicators (data refer to 2017).

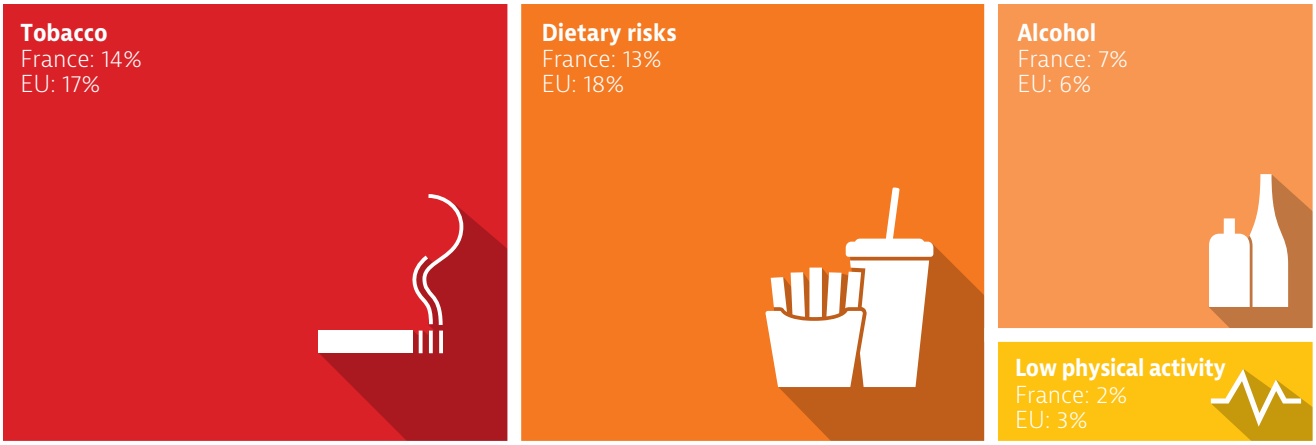
3 Risk factors

Behavioural risk factors are a major driver of mortality

Historically, France has lagged behind other western European countries in investing in health promotion and disease prevention. Around one-third of all deaths in 2017 can be attributed to behavioural risk factors, such as tobacco smoking, dietary risks, alcohol consumption and low physical activity (IHME, 2018; Figure 5).

Some 14 % (over 80 000) of all deaths can be attributed to tobacco smoking alone (including direct and second-hand smoking) in 2017. Dietary risks (including low fruit and vegetable intake, and high sugar and salt consumption) are estimated to account for about 13 % of all deaths in France, which is much lower than in the EU as a whole (18 %) but still amounts to 75 000 deaths. About 7 % (40 000) of all deaths can be attributed to alcohol consumption, while about 2 % (13 000) of all deaths are related to low physical activity.

Figure 5. Around one-third of all deaths in France can be attributed to behavioural risk factors



Note: The overall number of deaths (190 000) related to these risk factors is lower than the sum of each one taken individually (210 000), because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable consumption, and high sugar-sweetened beverages and salt consumption.
Source: IHME (2018), Global Health Data Exchange (estimates refer to 2017).

Smoking and alcohol consumption among adults remain high

Smoking rates among adults have declined over the past two decades to 25 % in 2018, down from 30 % in 2000. However, they remain higher than in most EU countries (Figure 6). Similarly, smoking rates among teenagers (15- and 16-year-olds) have come down slightly but remain higher than in most EU countries. This indicates that further progress is possible in tobacco control policies (see Section 5.1).

While alcohol consumption decreased between 2000 and 2012, it has stabilised since 2013 and is still almost 20 % higher than the EU average. The proportion of 15- and 16-year-olds who report binge drinking[1] is lower than in most EU countries: it came down from over 40 % in 2007 to about 30 % in 2015.[2]

Overweight and obesity rates in France are lower than in most EU countries

Based on self-reported data, obesity rates among adults in France increased from 9 % in 2000 to 15 % in 2017, and is about equal to the EU average.[3] Overweight and obesity rates among children aged 15 also increased slightly to reach 14 % in 2013-14, but remain lower than in most EU countries.[4]

In France 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 fruit or vegetable per day is higher in France than in most other EU countries, in 2017 about 30 % of adults reported not eating any vegetables every day and 40 % not eating any fruit.

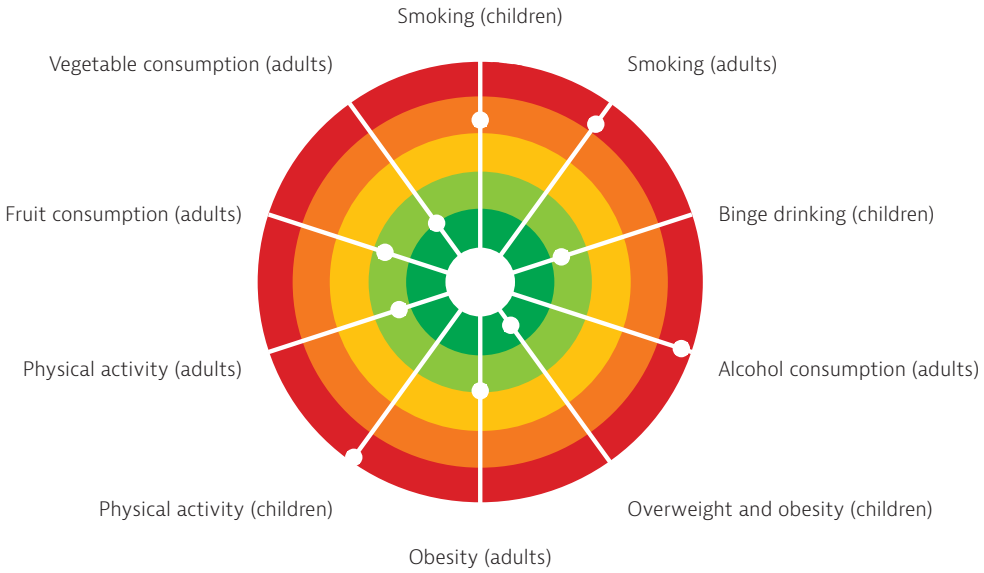
1: Binge drinking is defined as consuming five or more alcoholic drinks on a single occasion for adolescents.
2: More recent results from the 2017 French ESCAPAD survey also show a reduction in the proportion of adolescents who report binge drinking, but the rates are higher than in the 2015 European-wide ESPAD survey used here (44 % compared with 30 %).
3: Based on actual measurements of people's height and weight, obesity rates are higher but remained stable at 17 % between 2006 and 2016.
4: The results from the 2016-17 national health survey in school 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 2013-14, after Italy. This is particularly the case among teenage girls: only 6 % of 15-year-old girls reported doing at least moderate physical activity, a proportion more than twice as low as that among 15-year-old boys (14 %).

On a more positive note, the proportion of French adults who reported engaging in at least moderate physical activity each week compares better 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



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 ESPAD survey 2015 and HBSC survey 2013-14 for children indicators; and EU-SILC 2017, the French Health Barometer 2018, EHIS 2014 and OECD Health Statistics 2019 for adults indicators.

4 The health system

The French social insurance 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. The single-payer system increasingly relies on tax-based revenues to ensure the financial sustainability of health insurance funds. In the past two decades, the state has become more involved in controlling health expenditure funded by the SHI system. Since 2009, the regional health agencies have played an expanding role in managing health care provision at the local level.

The National Health Strategy 2018-22, adopted in 2017, sets ambitious goals covering both prevention and health care (Box 1).

Health spending is substantially higher than the EU average

Health spending as a share of GDP increased over the last decade from 10.3 % in 2007 to 11.3 % in 2017, the highest share in the EU along with Germany and well above the EU average of 9.8 % (Figure 7). However, France only comes in sixth place in terms of health spending per capita, at EUR 3 626 per capita in 2017 (adjusted for differences in purchasing power). While this is 25 % above the EU average (EUR 2 884), several countries such as Germany, Austria, Sweden, the Netherlands and Denmark spend more.

Box 1. The National Health Strategy 2018-22 aims to improve public health and health care

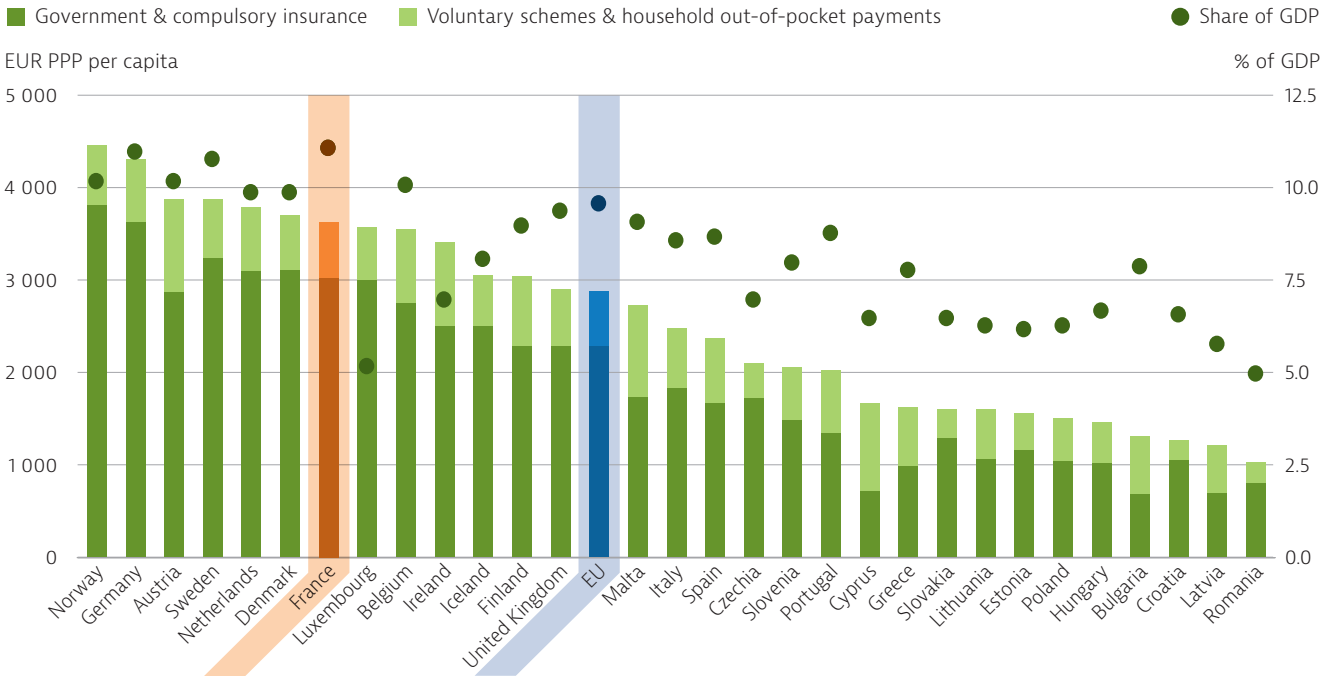
France's National Health Strategy 2018-22 provides a policy framework to improve public health and the health system, and to reduce health inequalities. It is structured around four main priorities:

- to place greater focus on health promotion and prevention policies throughout life and across all socioeconomic groups;
- to tackle social and geographical inequalities in access to health care;
- to ensure the quality, safety and appropriateness of health care;
- to break new ground in transforming the health system by reaffirming the role of its users.

This Strategy includes a series of measures, some of which are discussed in Section 5.

Source: Ministère des solidarités et de la santé (2017).

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

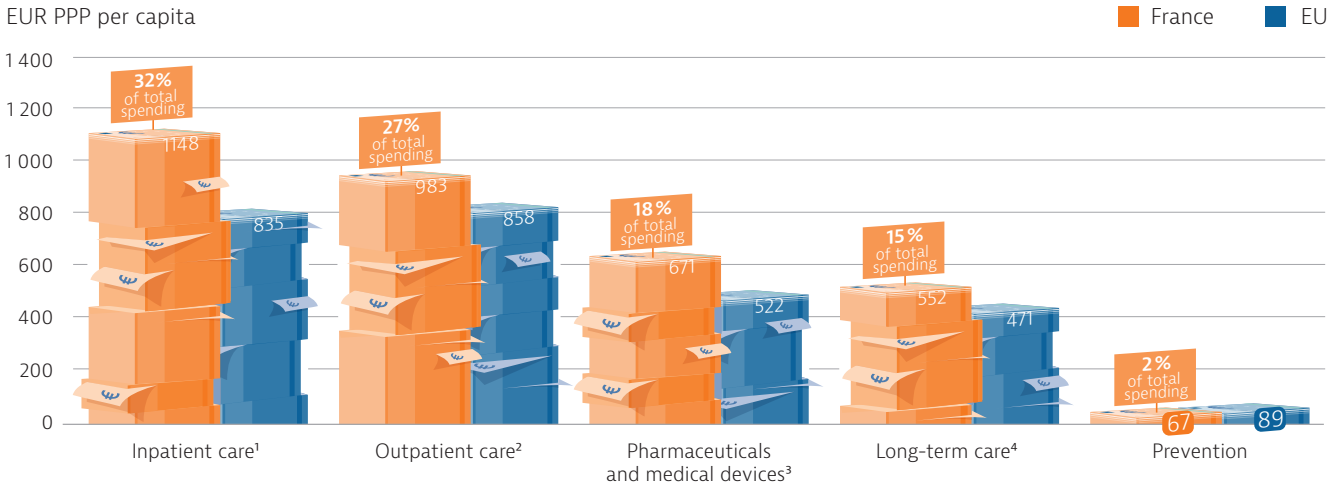


Source: OECD Health Statistics 2019 (data refer to 2017).

Inpatient and outpatient care make most of health spending in France

The largest category of health spending in France is inpatient care provided in public and private hospitals, which accounted for about one-third of all health spending in 2017, a share higher than the 29 % EU average (Figure 8). Over one-fourth of health spending was allocated to outpatient care, including primary care, specialist care and dental care. Retail pharmaceuticals and medical devices made almost one fifth of health spending, and long-term care over one seventh. Spending on prevention accounted for less than 2 % of all health spending, a share lower than the 3.1 % EU average, but this only includes spending dedicated to organised prevention programmes.

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



Note: Administration costs are not included. 1. Includes curative-rehabilitative care in hospital and other settings; 2. Includes home care; 3. Includes only the outpatient market; 4. Includes only the health component.
Sources: OECD Health Statistics 2019, Eurostat Database (data refer to 2017).

Universal health coverage is a high priority

The French SHI system covers virtually the entire population through various compulsory schemes. The main fund (*Caisse Nationale d'Assurance Maladie des Travailleurs Salariés*, CNAM) covers 92 % of the population and the agricultural fund covers 7 % of the population. Other small funds cover the remaining 1 %.

The 2000 Act on Universal Health Coverage (*Couverture Maladie Universelle*) changed the eligibility criteria for health insurance coverage from professional activity to residence to cover the small but growing share of uninsured people. In 2016, the PUMa (*Protection Universelle Maladie*) replaced the 2000 Act to eliminate gaps in coverage due to status change and to facilitate the administrative registration. There is also a fully state-funded scheme providing access to a standard benefit package for irregular immigrants.

The benefits package is broad, but with various cost-sharing arrangements

The French health care benefits package is broad in terms of the goods and services covered, including not only hospital and outpatient care but also pharmaceutical products, medical devices, medical transportation, mental care and dental care.

However, the depth of coverage varies depending on the goods and services. Co-payments are defined as a percentage of regulated prices and vary from 10 % of regular fees for hospital care to 30 % for doctor visits and 35-85 % for (approved) prescription medications.[5] Patients have to pay small deductibles for each doctor consultation, prescription drug and medical transportation, up to an annual limit. The degree of coverage is also fairly limited for optical products and dental prostheses, although there are plans to increase dental care coverage starting in 2020 (see Section 5.2). People with chronic diseases, pregnant women, victims of work accidents and people on very low incomes are exempt from all or most co-payments.

Health spending is mainly funded through public and compulsory insurance schemes

Public insurance schemes funded 78 % of all health spending in France in 2017 (up from 76 % a decade ago), while private compulsory insurance covered

5: Doctors who choose to practice in so-called 'Sector 2' are allowed to set their fees at higher levels than the statutory prices set for the majority of doctors practicing in 'Sector 1'. The difference between the fees and the statutory prices has to be paid either by patients themselves or their complementary health insurance.

another 5 %.[6] The revenues for these compulsory insurance schemes come mainly from social security contributions paid by employers and employees, other income taxes and additional sources such as taxes on tobacco and alcohol. Since 1996, annual growth in SHI expenditure has been controlled by a national objective known as ONDAM. The objective for 2019 is a growth rate of 2.5 %.

Private voluntary insurance plays an important role in France, accounting for about 7 % of total spending (compared to less than 4 % in the EU). Nearly all the population (95 %) has either a compulsory or voluntary health insurance, mainly to cover co-payments on health services, pharmaceuticals, eyeglasses and dental care. The remaining 9 % is paid directly out of pocket by households, the lowest share across EU countries and well below the EU average (about 16 %).

French people are encouraged to get a GP referral before consulting specialists

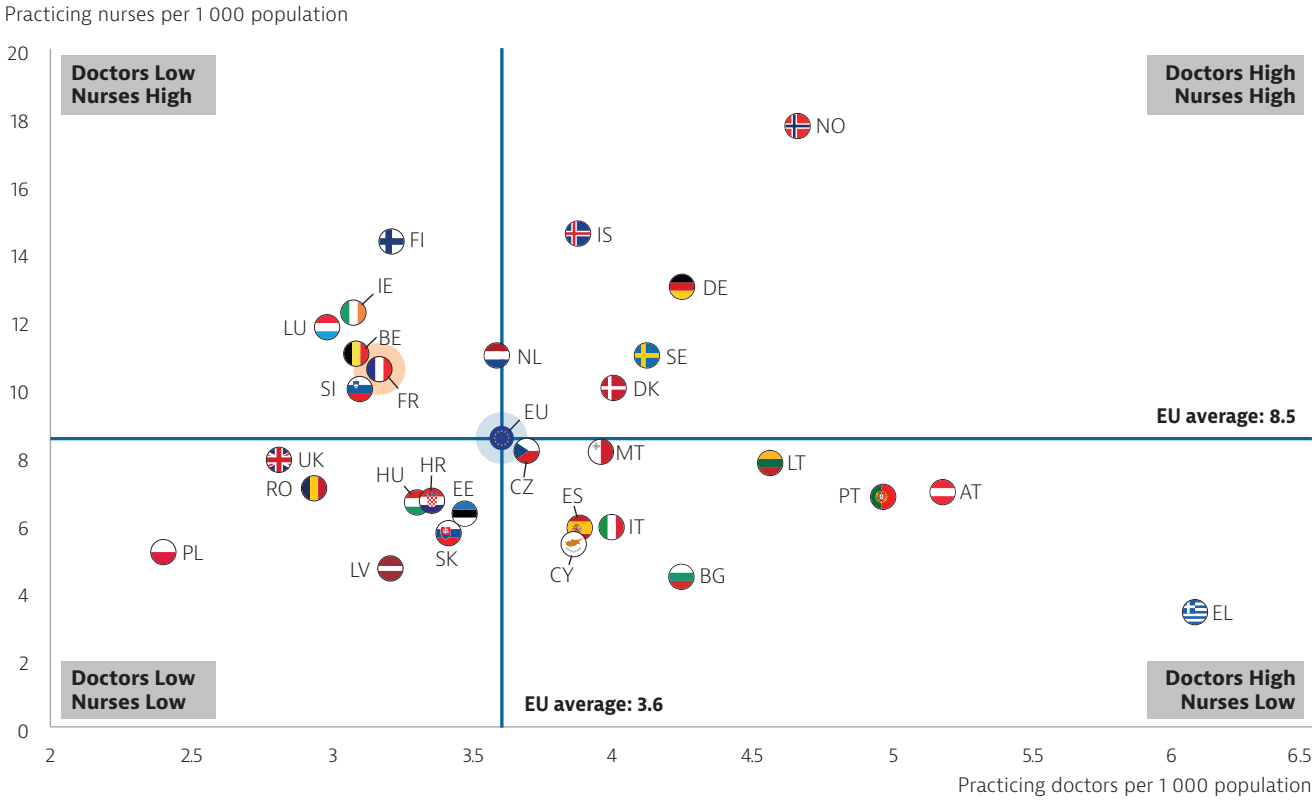
Primary care and specialist care outside hospitals are delivered mainly by self-employed doctors, dentists and medical auxiliaries (including nurses and physiotherapists) working in their own practices. Health professionals working in public hospitals and health centres are usually salaried staff. Since the 2004 Health Insurance Act, general practitioners (GPs) have been given a stronger role in the coordination of care through a semi-gatekeeping system (the 'preferred doctor scheme'). This provides financial incentives for people to visit their GP prior to consulting a specialist, although this appears to have had little impact on patient behaviour (Dumontet et al., 2017).

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

The number of doctors per population has remained fairly stable over the past decade, whereas it has increased in most other EU countries, so the number of doctors in France is now below the EU average. In 2017, there were 3.2 doctors per 1 000 population, compared with 3.6 for the EU average. The number of nurses per population has increased from 7.6 per 1 000 population in 2007 to 10.5 per 1 000 population in 2017, and is above the EU average (Figure 9).

However, there are wide disparities in the density of health professionals across regions, with some areas facing shortages. Concerns are also rising that the shortages of doctors may be exacerbated in the future, as a large share of doctors will retire in the next decade (see Section 5.2).

Figure 9. France has fewer doctors per capita than the EU average but 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 (data refer to 2017 or the nearest year).

6: This share is higher than the figures reported by the Ministry of Health because it includes funding through compulsory private complementary insurance.

5 Health system performance

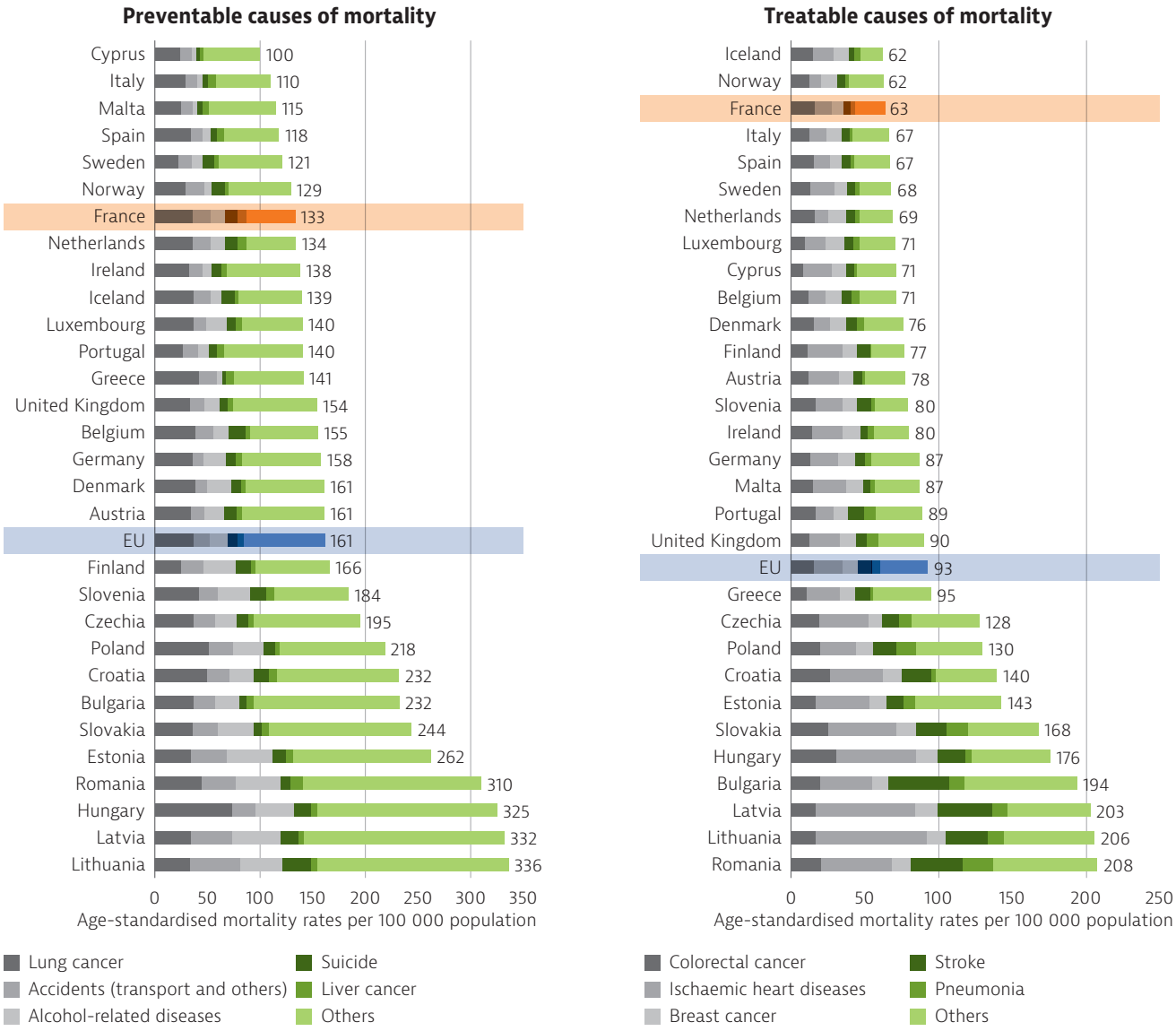
5.1. Effectiveness

France fares well on treatable causes of mortality but less so on preventable mortality

France fares very well in terms of mortality from treatable causes, indicating that the health system is effective in saving the lives of people with acute conditions (Figure 10). Treatable mortality rates were among the lowest in EU countries in 2016, and well below the EU average. The leading causes of treatable mortality in France are colorectal cancer, ischaemic heart disease, breast cancer, stroke and pneumonia.

On the other hand, preventable mortality lags behind leading countries such as Italy, Spain and Sweden, although it remains lower than the EU average. The leading causes of preventable mortality are lung cancer, accidents (road and others), alcohol-related deaths and suicide.

Figure 10. 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. Mortality from treatable (or amenable) causes is defined as death that can be mainly avoided through health care interventions, including screening and treatment. 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 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. In 2017, less than 2 % of all health expenditure was allocated to public health and disease prevention, a lower share than the EU average of 3.1 %. The first 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, but the budget allocated to the national plan for public health remains fairly modest (only EUR 400 million over five years).

Tobacco control policies have reduced smoking rates, but further progress is possible

In recent years, France has adopted a number of policies to prevent people from smoking and help smokers quit. These include a public campaign, *#MoisSansTabac*, run since 2016; the introduction of plain packaging in 2017; better coverage of substitutes since 2018; and creation of an app to help smokers quit (Box 2). In addition, a new fund was created in 2017 to prevent tobacco smoking, help smokers quit and finance research into tobacco policies (EUR 100 million in 2018). In 2018, the government also increased taxes on a pack of 20 cigarettes by nearly EUR 1 on average, contributing to a reduction in cigarettes sales of 9 % in that year. In 2019, taxes on tobacco increased further, by an average of 50-60 cents on a pack of 20 cigarettes.

Box 2. The Tobacco Info Service app helps smokers to stop smoking and avoid relapsing

Medical and public health practices supported by mobiles devices, or mHealth, are growing in France. They can be used to monitor, record, alert and communicate health information to people and professionals remotely. The SHI and Santé Publique France launched the Tobacco Info Service app in 2015 to offer a personalised solution for smokers who want to stop or avoid relapsing. The smoker receives personalised coaching and help to manage weight and stress with expert advice, and can watch videos on relaxation and positive visualisation via the app. A tobacco specialist can be contacted if needed. In 2017, the app was downloaded 110 000 times.

Recent alcohol-control policies are limited to raising public awareness of health risks

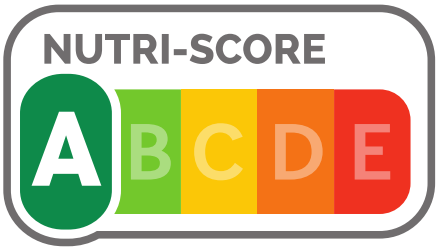
Historically, alcohol-control policies in France have mainly consisted of laws regulating alcohol sales, consumption and marketing, as well as taxes. One major milestone was the Évin Law in 1991, which introduced strict regulations on the advertisement of alcoholic drinks, forbidding it on all traditional media available to people aged under 18 (such as television). A 2009 law extended the legislation to websites targeting mainly young people and websites on sport, but online advertising of alcohol products on all other websites remained unregulated. Application of the Évin Law has been softened in recent years: in 2016, advertisement of alcohol products was allowed when it related to a region or to cultural heritage.

The level of taxation on alcohol products generally depends on their strength, with some exceptions – especially for wine. While taxes on beers and liquors were increased in 2012, France continues to impose lower levels of taxes on wine than most EU countries.

Recent measures to reduce consumption have focused primarily on raising public awareness of the health risks of excessive alcohol consumption through information campaigns targeting the media and health professionals. Health warnings on the risks during pregnancy are also expected to become more visible on alcohol products since 2019.

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

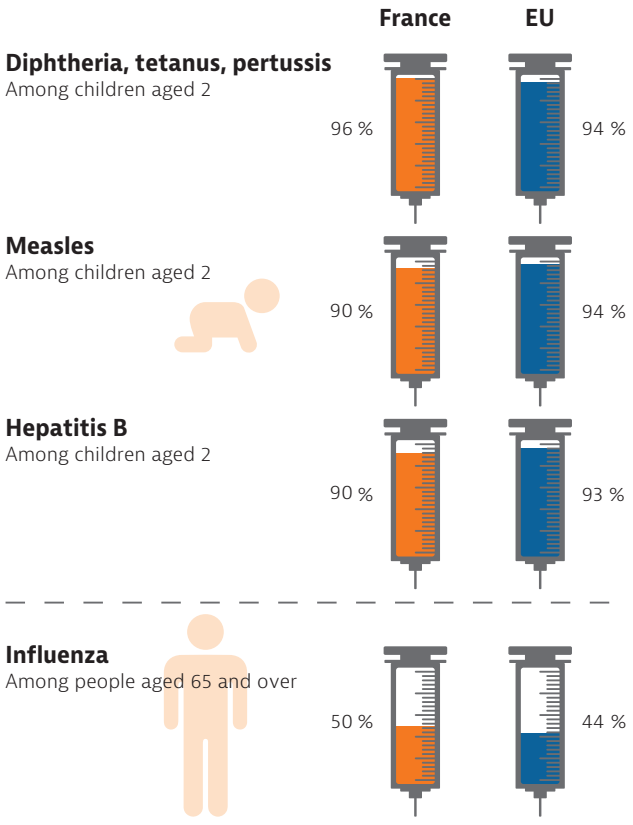
France also launched a number of initiatives to promote more healthy nutrition habits, notably by improving the information available to consumers. In 2017, Santé Publique France developed an official 'nutri-score' food label, which provides easy-to-understand information on the overall nutritional quality of food products. Implementation is on a voluntary basis: by July 2019, 140 producers and distributors had committed to putting the nutritional logo on their products (accounting for more than 20 % of the market share).



The number of mandatory vaccinations for children has increased

Until 2018, child vaccination rates were decreasing for several non-mandatory vaccines and did not reach the WHO target of 95 %, because of population concerns about vaccines' safety and usefulness. In January 2018, eight additional vaccines were made mandatory for children, in addition to the three already mandatory. The first evidence of the impact of this new policy shows that coverage for the first dose of these vaccinations has increased for babies born since then (Ministère des solidarités et de la santé, Santé Publique France, 2019). However, these recent increases are not reflected yet in the 2018 vaccination coverage of children aged 2, as the impact of the new mandatory vaccination policy had not been fully felt (Figure 11).

Figure 11. New mandatory vaccinations aim to increase childhood vaccination rates



Note: Data refer to the third dose for diphtheria, tetanus, pertussis and hepatitis B, and the first dose for measles.
Source: WHO/UNICEF Global Health Observatory Data Repository (data refer to 2018), OECD Health Statistics 2019 and Eurostat Database for people aged 65 and over (data refer to 2017 or nearest year).

Vaccination coverage against influenza among older people has decreased over the past decade, with coverage of only 50 % in 2017, well below the WHO target of 75 %. This reduction is partly due to misinformation and misperceptions about the safety and effectiveness of the flu vaccine. The Ministry of Health has launched several initiatives to improve flu vaccination coverage, including public information campaigns and allowing pharmacists to vaccinate older people and other people at risks (Box 3).

Box 3. Pharmacists are now allowed to provide vaccination against influenza

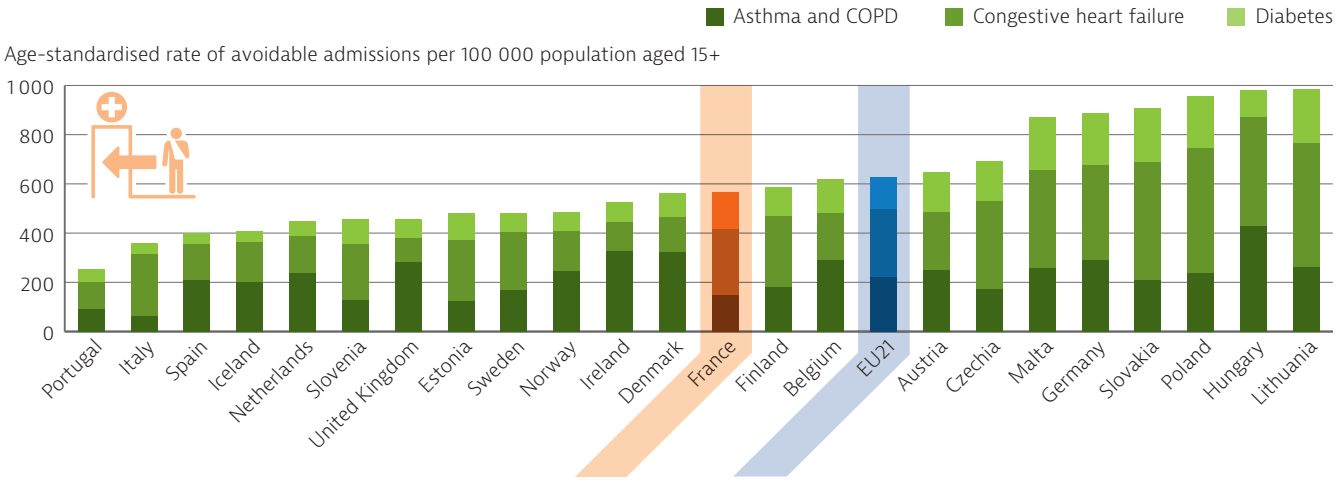
In 2017, a pilot project was implemented in two regions to extend the role of pharmacists in prevention, allowing them to vaccinate older people and other at-risk groups for whom flu vaccination is recommended. During the winter season 2017/2018, 160 000 flu vaccines were performed by about 5 000 participating pharmacists. In 2018, the pilot became more flexible, allowing participating pharmacists to vaccinate more people against influenza. Following the successful pilot project, since 2019, all pharmacists in France are allowed to vaccinate against influenza.

Avoidable hospital admissions for chronic conditions are higher than in many EU countries

For several communicable or chronic diseases admissions to hospital can be avoided through well-organised prevention and primary care interventions. While avoidable hospital admissions for some chronic diseases such as asthma and chronic obstructive pulmonary disease (COPD) are lower in France than the EU average (Figure 12), admission rates for diabetes are almost 20 % higher.

The *Asalée* programme was launched in 2004 and extended in 2012 to improve the management of diabetes and a few other chronic diseases. It relies on cooperation between GPs and trained nurses to diagnose and manage better patients with these chronic diseases. In 2017, 1 959 doctors and 533 nurses participated in the programme. An evaluation yielded positive but modest results on patient care and no reduction in the number of consultations with doctors (IRDES, 2018).

Figure 12. Hospital admissions that could be avoided are higher than in many EU countries



Source: OECD Health Statistics 2019 (data refer to 2017 or the nearest year, except for France 2015).

Cancer screening and care has improved in recent decades

France's Cancer Plan 2014-19 introduced a number of measures to reduce mortality from various cancers. One key initiative was an organised programme to promote cervical cancer screening, set up in 2018 and fully covered by the SHI, without any upfront payment requirement.

The quality of cancer care has also improved since the early 2000s through the introduction of multidisciplinary teams and cancer networks, greater use of clinical guidelines and more rapid access to innovative drugs. France compares well with other EU countries for five-year survival rates following diagnosis of breast, colon, prostate and lung cancer (Figure 13).

Figure 13. Five-year cancer survival rates are higher than the EU average



Prostate cancer
France: 93 %
EU26: 87 %

Breast cancer
France: 87 %
EU26: 83 %

Colon cancer
France: 64 %
EU26: 60 %

Lung cancer
France: 17 %
EU26: 15 %

Note: Data refer to people diagnosed between 2010 and 2014.
Source: CONCORD programme, London School of Hygiene and Tropical Medicine.

5.2. Accessibility

Unmet needs for medical care are generally low but can be an issue in low-income groups

Nearly everyone in France is covered by the public health insurance system, which covers the majority of costs for medical services provided in and outside hospitals. Unmet needs for medical care due to cost, distance or waiting times are very low, with only 1 % of the population reporting such unmet needs in 2017, based on the EU-SILC survey.[7] There is some variation across income groups: about 2 % of people in the lowest income quintile reported going without medical care for financial, distance or waiting time reasons, compared to only 0.3 % of people in the highest quintile.

Unmet needs are greater for services that are less comprehensively covered by the SHI, such as optical and hearing aids, mental care services and dental care. For example, slightly more than 3 % of French people reported some unmet needs for dental care in 2017, mainly for financial reasons. This proportion was much greater among people in the lowest income quintile (over 6 %). The main factor affecting such unmet needs is the absence of complementary health insurance (DREES & Santé Publique France, 2017).

The government aims to improve financial assistance to enable low-income households to acquire complementary health insurance. The introduction of a new complementary health insurance scheme in November 2019 should enable 11 million French citizens with a monthly income below EUR 991 to acquire a complementary health insurance for less than EUR 30 a month, regardless of their age.

New measures are expected to improve dental care coverage in 2020 and 2021

As noted in Section 4, the share of direct out-of-pocket (OOP) payments in total health spending in France is the lowest among EU countries. However, OOP payments can still be substantial for optical and hearing aids and dental care. The government has taken measures to reduce the financial burden on households to pay for these goods and services by negotiating with both industry and complementary health insurers. In addition, there are plans to increase public coverage for some goods and services, notably for dental care.

In 2018, the SHI and dentists reached an agreement to improve dental care coverage substantially from 2020. The agreement will see the prices of some dental prostheses capped, while the prices of preventive or routine dental care will increase. Over half of dental care spending should be fully covered by public or compulsory health insurance without any OOP payments by patients, while about 25 % of dental prostheses should have capped prices and continue to be partially covered. Dental care solely for aesthetic purposes will continue to be neither covered nor capped. These measures are expected to be gradually implemented in 2020 and 2021.

Concerns about shortages of doctors have prompted an increase of medical students

As noted in Section 4, the number of doctors per 1 000 population in France has remained stable over the past decade, but it is projected to decrease slightly in the coming years as the number of doctors expected to retire will exceed the number of newly trained doctors. More than 45 % of doctors in France in 2017 were aged 55 and over (including 13 % aged over 65), raising concerns that their retirement may exacerbate the shortage of doctors, especially of GPs.

In response to these concerns, the number of medical students admitted under the *numerus clausus* has increased substantially over the past decade, returning in 2017-18 to the level seen in the 1970s (Box 4). In 2019, the government announced a plan to abolish the *numerus clausus* policy. It also aims to increase the number of students admitted by 2020 by another 20 % and to provide greater flexibility to universities in the admission process (Gouvernement. fr, 2019).

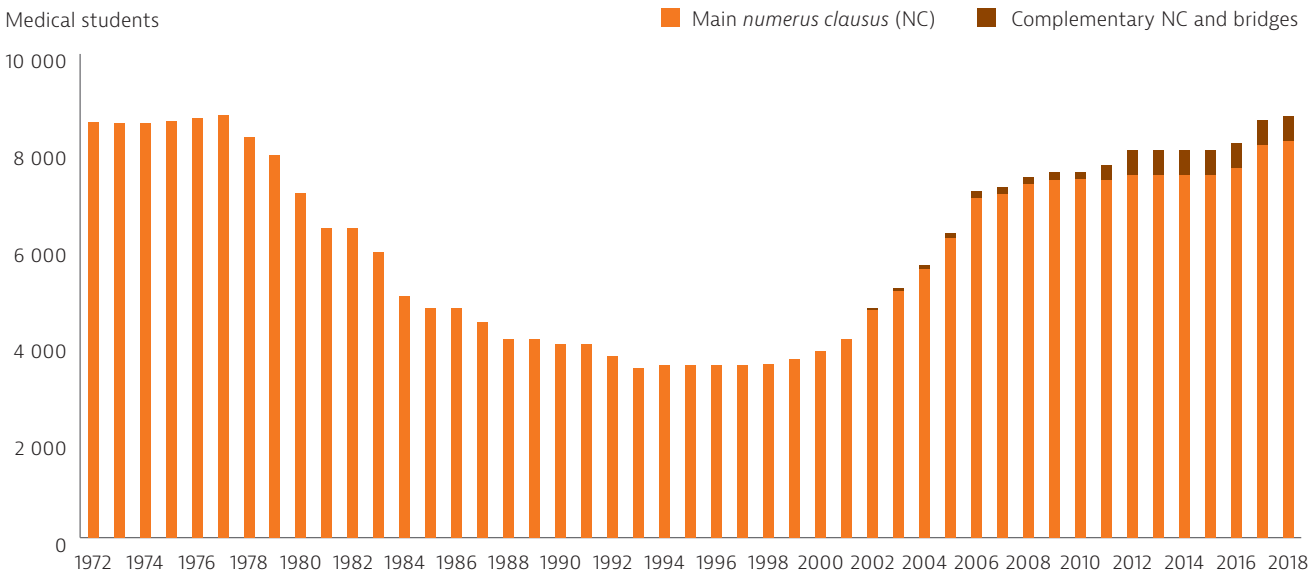
Box 4. The *numerus clausus* has fluctuated greatly over the past decades

Since the early 1970s, France has regulated the number of students admitted to medical schools through a *numerus clausus* policy. One objective of this policy was to match the number of medical students to hospitals' limited capacity to offer practical training places, as well as to control the number of doctors to avoid rapid increases in health expenditure in a system that was mainly based on fee-for-services. Since its introduction, the number of students admitted into medical education has reflected changing concerns about surpluses of doctors in the 1970s to 1990s and possible shortages since 2000 (Figure 14).

Since 2009, the *numerus clausus* has also aimed to address imbalances in the geographical distribution of doctors by using regional quotas for admissions, but with very limited success. Many medical graduates move on to pursue their postgraduate training in more urban, highly populated regions.

7: However, a national survey estimated that 27% of people chose to go without medical, dental and eye care in 2014-17, mostly for financial reasons. Women and single-parent families are more likely to forgo health care (CNAM, 2018).

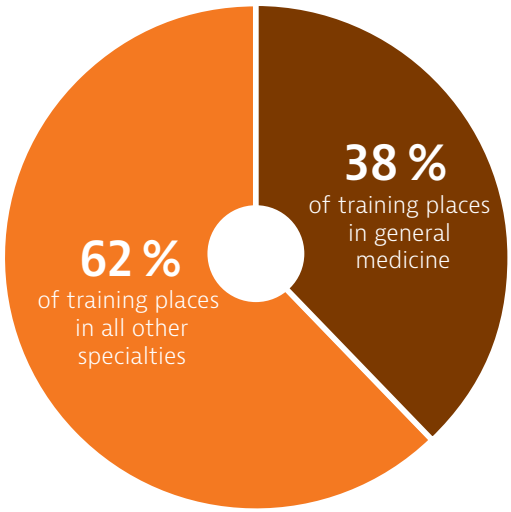
Figure 14. The evolution of the *numerus clausus* reflects changing concerns about surpluses and shortages of doctors



Source: ONDPS (2018).

About 40% of all new postgraduate training places in 2017 and 2018 were in general medicine to address concerns about shortages of GPs – a much higher proportion than in nearly all other EU countries (Figure 15). However, it remains a challenge to attract a sufficient number of new medical graduates to fill all the available training places given the lower remuneration and perceived prestige of general practice.

Figure 15. Almost 40 % of postgraduate places are in general medicine



Source: DREES (Centre national de gestion). Data refer to 2018.

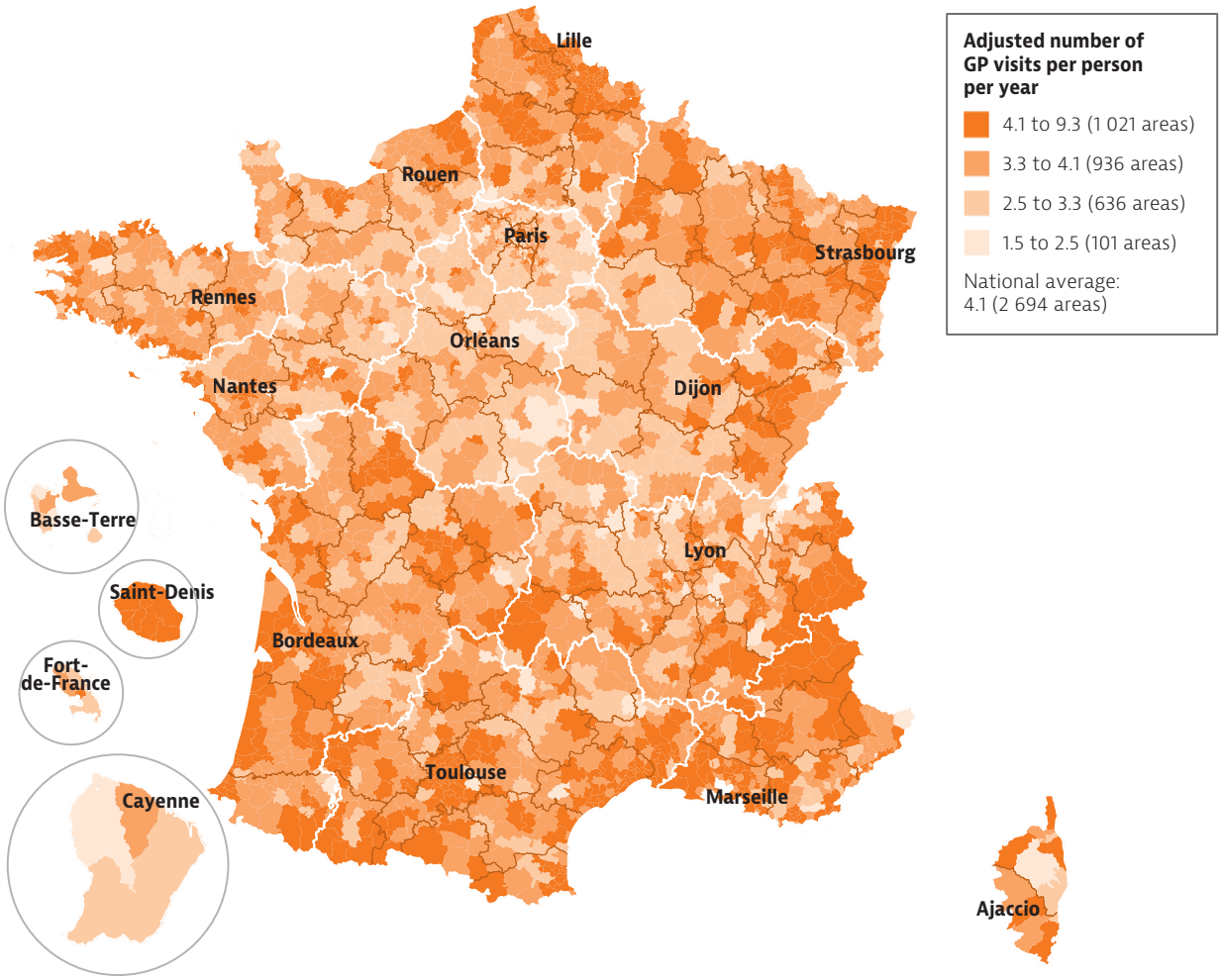
Access to doctors is a concern in some rural and deprived areas

An estimated 5.4 million people (8 % of the population) live in areas where access to GPs is potentially limited[8] (DREES, 2017). These so-called 'medical deserts' are located mainly in rural areas and in distant suburbs of small towns and big cities. They are mostly concentrated in the central and the northwest parts of France (Figure 16).

A series of initiatives has been taken over the past decade to address concerns about medical deserts, including financial support for doctors to set up their practices and various tax breaks. Since 2007, the main policy action to tackle this issue has been to create multidisciplinary medical homes to allow GPs and other health professionals to work in the same location to avoid working in solo practices. In 2017, 910 multidisciplinary medical homes were created and their number is expected to double by 2022. More recently, telemedicine options have also been encouraged (Section 5.3).

8: This estimate is based on the indicator 'Localised Potential Accessibility' (Accessibilité Potentielle Localisée).

Figure 16. An estimated 8 % of the French population live in areas with limited access to GPs



Note: Underserved areas are defined as those for which the number of GP visits per person per year, adjusted for the density of GPs, the distance to GP practices and population age structure, is below a threshold of 2.5
Sources: SNIIR-AM 2015, EGB 2013, CNAM-TS; populations by sex and age 2013, INSEE; calculations DREES.

Greater task-sharing between health professionals should help improve access to care

Improving access to primary care is also supported through expanding the roles of other health professionals working with GPs and making more efficient use of their skills. For over a decade, nurses have been allowed to vaccinate older people against influenza, and this right was extended to pharmacists starting in 2017 (see Box 3 above). Since February 2019, pharmacists can also renew pharmaceuticals prescribed for at least three months, even when the prescription has expired (e.g. treatments for hypertension and diabetes or contraception).

France's National Health Strategy 2018-22 also promotes more advanced roles for nurses to improve access to care, particularly in areas where there are relatively few doctors. The position of advanced practice nurses was legally created in 2018. It is expected that these nurses will be able to provide greater support in the care of chronically ill patients and those with complex morbidities, working in cooperation with GPs and specialists in primary care teams and other health and long-term care settings. Their tasks will include prevention and screening activities, prescription of complementary exams and renewal or adjustment of medical prescriptions.

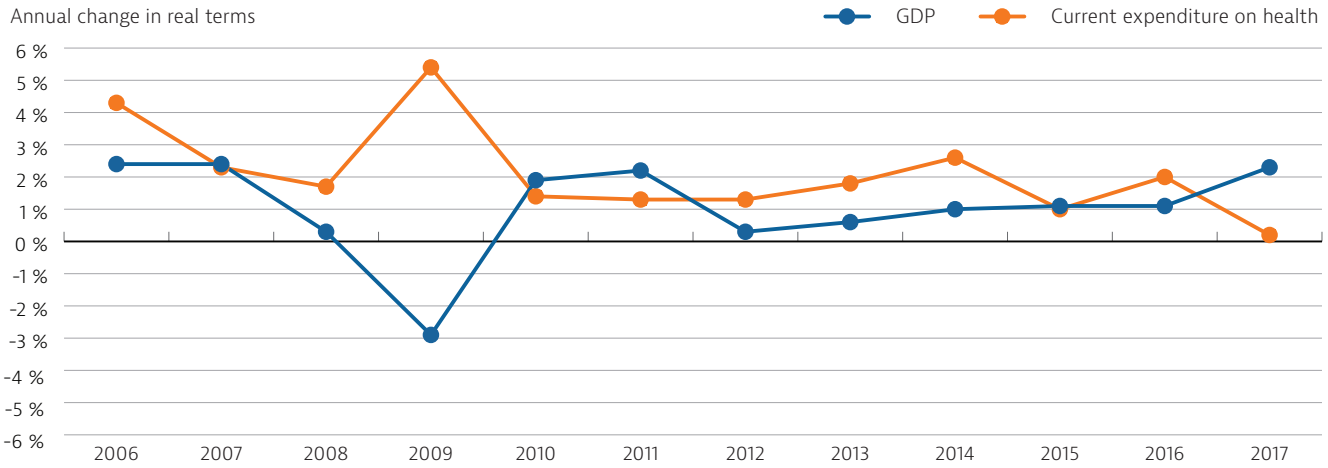
The Strategy further proposes creating a new position of medical assistant to take on responsibility for non-medical tasks traditionally performed by GPs (such as creation of medical files, verification of vaccinations and screenings and cleaning of medical devices). The goal is to free up GPs' time to focus more on clinical tasks. This new position mirrors one that exists in dental or ophthalmology practices in France, as well as in other countries. The objective is to have 4 000 medical assistants by 2022.

5.3. Resilience[9]

Health spending has grown in line with GDP in recent years

Following the economic crisis in 2009 and slow economic growth since then, health spending in France grew at a modest rate of 1.4 % per year in real terms between 2010 and 2017 (Figure 17). The health spending share of GDP remained relatively stable during that period, at around 11.3 %.

Figure 17. Health spending has grown in line with GDP on average since 2010



Source: OECD Health Statistics 2019; Eurostat Database.

Looking ahead, population ageing and modest economic growth are projected to add pressure to public spending on health and long-term care. According to the latest projections of the European Commission, public spending on health may increase by 0.4 percentage points of GDP between 2016 and 2070, but budgetary pressures are expected to be slightly greater on public spending for long-term care. The latest projections show a rise of 0.7 percentage points of GDP between 2016 and 2070, contributing to fiscal sustainability risks in the medium and long term (European Commission-EPC, 2018; Council of the European Union, 2019).

Further restructuring of the hospital sector is planned

The number of hospital beds and average length of stay in France have decreased over the past decade as the system has started to shift activities from inpatient to outpatient and ambulatory care, but they remain above the EU average (Figure 18).

The National Health Strategy 2018-22 proposes further restructuration of the hospital sector that would include a new category of 'proximity' hospitals. These would focus on providing low-technical level care, such as general medicine, geriatrics, rehabilitation, chronic disease management, technical support (medical imaging, biology), mobile care and eHealth, including telemedicine. It is expected that about 500 to 600 public hospitals (i.e. 35-45 %) will become proximity hospitals.

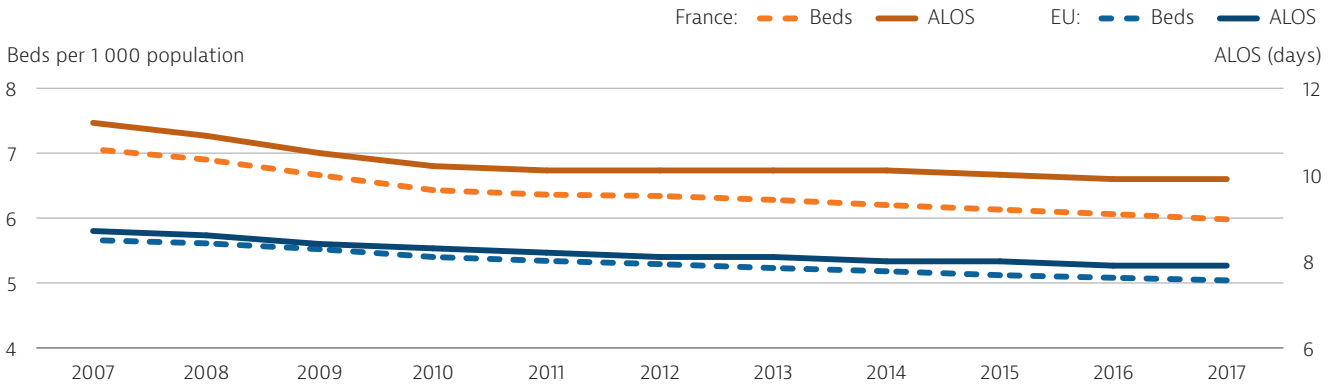
Greater care coordination is promoted through reforms in delivery models

Over the past 15 years, a number of reforms and initiatives have been launched to promote greater care coordination and multidisciplinary and group practices in primary care. One recent initiative is the establishment of territorial health professional communities since 2016, which aim to promote greater interaction and cooperation between GPs, specialists and other health professionals at the local level. These are designed to enable health workers to organise their activities around shared objectives, without necessarily working in the same setting. Their development will also be supported by the use of common digital tools, such as shared electronic medical records. These communities can obtain dedicated funding from regional health agencies to improve care coordination and quality.

As of 2019, 200 territorial health professional communities have been established or are in development. The objective is to increase their number to 1 000 across all regions in France by 2022.

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

Figure 18. The number of hospital beds and average length of stay remain higher than EU average



Source: Eurostat Database.

Recent initiatives have been launched to promote more appropriate care

There is widespread recognition that many activities and procedures in the French health system are not useful and bring little benefit to patients. The overuse of some of these procedures were illustrated in the 2016 atlas of medical practice variations, which reviewed the often large and unexplained variations in the use of ten frequently used surgical procedures (Le Bail & Or, 2016). Since 2016, each regional health agency has to provide a four-year action plan describing planned improvements in appropriateness of care, targeting the medical practice variations identified in the 2016 atlas.

In addition, since 2015, a range of measures have been taken to identify extreme unjustified medical practice variations in hospitals, based mainly on the hospital IT system. Hospitals identified as atypical have to sign a contract with their regional health agency and the SHI that guides the implementation of measures to improve appropriateness of care.

The SHI also encourages more appropriate care in primary care, especially since the introduction of payments based on public health objectives and control measures if the volumes of prescribed pharmaceuticals are well above the local area average in 2012.

The Ministry of Health recently proposed further reforms to payment methods to put less focus on activity-based payments (Box 5).

France has tried to strike a balance between access and affordability of new medicines

The government has pursued a number of initiatives over the past decades to balance access and affordability goals in the coverage of new medicines. Since 1994, an early access scheme called Temporary Utilisation Authorisation (ATU) has sped up and facilitated the introduction of promising pharmaceuticals covering unmet needs. It allows medicines that are not yet formally approved to be temporarily reimbursed and provided to specific patients, including during the negotiation phase with the national regulatory authority.

Box 5. The government proposes new reforms to payment methods to put less emphasis on activity-based payments

The French health system still relies mainly on activity-based payments (fee-for-services for doctor consultations and diagnostic-related group payments for hospital services). While these payment methods create incentives to increase the quantity of care provided, they do not necessarily promote care coordination or reward quality and appropriateness.

Recent government proposals are designed to experiment new payment methods in primary care and hospital to better respond to the growing burden of chronic diseases by providing greater financial incentives for care coordination and quality and giving less weight to activity-based payments. Starting in 2020, a selection of hospitals will test replacing the current activity-based payment system for hip and knee replacement and colectomy with an episode-based bundled payment system. Similarly, some primary care centres will be paid on a capitation basis and incentives towards local care integration will also be introduced. All these initiatives draw from international best practices.

Source: Ministère des solidarités et de la santé (2019).

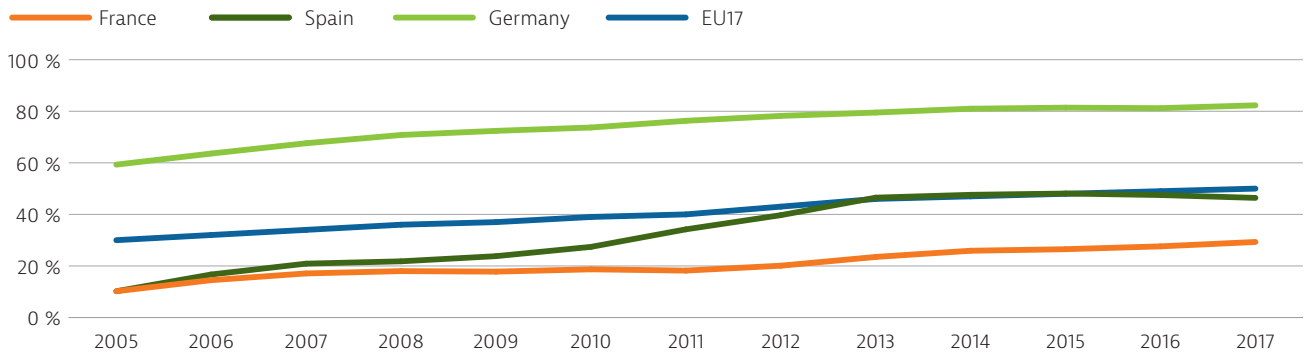
In contrast to the pricing system for reimbursed pharmaceuticals, until 2017 manufacturers could charge any price for medicines provided via the ATU programme, and only had to reimburse the difference between the price negotiated and the ATU price. Since then, reimbursement offered by the SHI fund for medicines provided through the ATU scheme is capped at EUR 10 000 per patient per year if the company's pre-tax sales for this product are above EUR 30 million per year in France. This regulation was introduced to better control pharmaceutical expenditure for new very expensive medicines.

Some measures promote greater use of generics, with mixed success

To reduce pharmaceutical spending, the Ministry of Health has also implemented a series of measures to promote greater use of generics, including by introducing financial incentives to encourage pharmacists to sell generics rather than originator products. In 2009, France also introduced incentives for GPs to prescribe generics through pay-for-performance schemes. 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. In 2015, mandatory international non-proprietary name prescribing was implemented, although this obligation is not yet fully applied in practice.

These policies, associated with patent expiries of several blockbusters, contributed to an increase in the generic market share from about 20 % in 2011 to 30 % in 2017 (Figure 19). However, this remains below the EU average, in part because France restricts the categories of pharmaceuticals for which generic substitution and competition are permitted.

Figure 19. The generic market share has increased but remains lower than in many EU countries



Note: Data refer to the share of generics in volume.
Source: OECD Health Statistics 2019.

The development of eHealth and telemedicine has been strongly encouraged

eHealth, and in particular the use of electronic medical records (EMRs) and telemedicine, has grown rapidly in recent years, after a few 'false starts'. EMRs were initially launched in 2004 to facilitate collaboration between various health professionals and patients but became operational in a few settings only in 2011 and more widely available in all settings in 2018. By mid-2019, over 6.4 million people (about 10 % of the population) had an EMR.

Telemedicine was legally defined in 2009, but the numerous pilot projects launched over the last decade were limited in scope. However, in 2018, the SHI defined the price and insurance coverage of teleconsultation and tele-expertise. The price for a teleconsultation is the same price as a face-to-face consultation, hence being covered like a traditional consultation. These teleconsultation activities have grown quickly, with about 50 companies currently in the market, but concerns have emerged rapidly about ensuring that the teleconsultations remain activities performed by the regular local health professionals rather than by national platforms without any links to local health professionals and their network.

France aims to reaffirm the role of patients in the health system

One of the four main priorities of the National Health Strategy 2018-22 is to reaffirm the role of patients and their experiences in the transformation of the health system. To collect more information from patients' point of view, a national health survey has included a series of questions about patient-reported experience (PREMs) since 2018, while outcome measures (PROMs) are still in development. The results of this survey will be used to provide feedback to health care providers.

6 Key findings

- Life expectancy in France remains one of the highest in the EU, but progress has slowed in recent years and there remain large disparities by socioeconomic status. As in other EU countries, many years of life after age 65 are spent with some chronic diseases and disabilities.

- Public health and prevention policies have traditionally been neglected in France. As part of the National Health Strategy 2018-22, the government has allocated EUR 400 million over five years to support prevention programmes across all ages. Some policies have already had a positive impact in reducing important risk factors: smoking rates and alcohol consumption have fallen over the past decade, yet remain above the EU average. To improve nutrition and reduce obesity, a 'nutri-score' food label was developed in 2017 to help people make healthier choices.

- In response to falling vaccination rates among children, the government made a further eight vaccinations mandatory in 2018 (for a total of 11 mandatory vaccinations). Public awareness campaigns were also launched to restore public trust in the benefits of vaccination. Preliminary evidence suggests that these measures have successfully led to an increase in childhood vaccination rates.

- In 2017, France spent more than 11 % of its GDP on health, the highest share among EU countries along with Germany. On a per capita basis, health spending in France was the sixth highest in the EU. Public insurance schemes funded 78 % of all health spending, while private compulsory insurance covered another 5 %. Unmet needs for medical care are generally low, but they are higher for services less covered by public insurance, such as optical and hearing aids and dental care.

- There are concerns about growing shortages of doctors, as 45 % of all doctors are aged 55 and over. In response, the number of students admitted to medical schools has been increased and will be increased further by 20 % by 2020. The government also plans to abolish the rigid *numerus clausus* policy and exam determining entry into medical education and to give more flexibility to universities in the student admission process.

- Medically underserved areas ('medical deserts') are a concern in France. Up to 8 % of the population live in areas where access to doctors is potentially limited, mainly in rural and deprived areas. A series of measures has been taken over the past decade to promote the recruitment and retention of doctors in underserved areas, including financial incentives for doctors to set up their practice in these areas and the creation of multidisciplinary medical homes, which the government wants to double between 2017 and 2022.

- Recent measures have also been taken to expand the roles of some health professionals, with the aim to improve access to care. Nurses and pharmacists are now allowed to administer flu vaccinations to older people and other at-risk groups, nurses can play a greater role in the management of chronic diseases such as diabetes, and a new medical assistant role to reduce general practitioners' administrative workload has been introduced.

- Since 2016, the government has been providing support to expand inter-professional networks, which aim to strengthen coordination between primary care providers and specialists and to improve care for the growing number of people living with chronic conditions. The goal is to multiply by five the number of these local networks by 2022.

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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	United Kingdom	UK

European Commission

State of Health in the EU
Country Health Profile 2019

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

Please cite this publication as: OECD/European Observatory on Health Systems and Policies (2019), *France: Country Health Profile 2019, State of Health in the EU*, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels.

ISBN 9789264484078 (PDF)
Series: State of Health in the EU
SSN 25227041 (online)

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European Observatory on Health Systems and Policies
a partnership hosted by WHO