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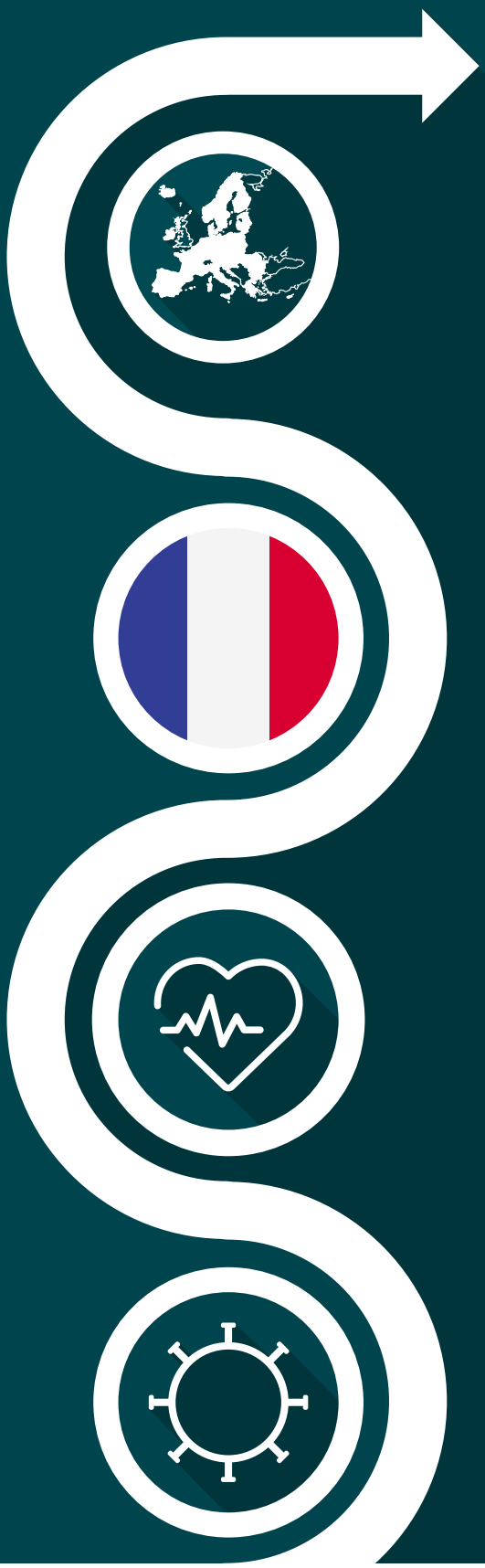

State of Health in the EU

France

Country Health Profile 2023

OECD
BETTER POLICIES FOR BETTER LIVES

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

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 policy makers and influencers with a means for mutual learning and voluntary exchange. For the first time since the series began, the 2023 edition of the Country Health Profiles introduces a special section dedicated to mental health.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in co-operation 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 Systems Performance Assessment (HSPA).

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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 finalised in September 2023, based on data that were accessible as of the first half of September 2023.

Demographic and socioeconomic context in France, 2022

Demographic factors	France	EU
Population size	67 871 925	446 735 291
Share of population over age 65 (%)	21.0	21.1
Fertility rate[1] (2021)	1.8	1.5
Socioeconomic factors		
GDP per capita (EUR PPP[2])	35 769	35 219
Relative poverty rate[3] (%)	15.6	16.5
Unemployment rate (%)	7.3	6.2

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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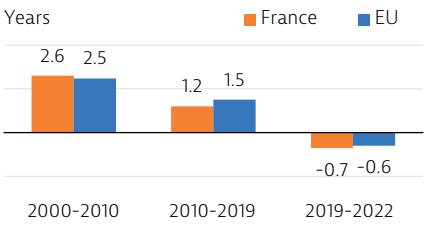
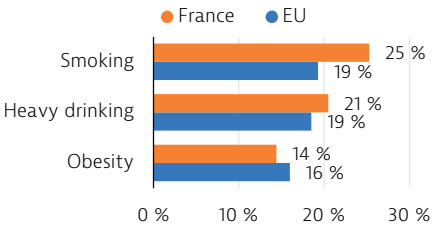
1 Highlights



Changes in life expectancy at birth

Health Status

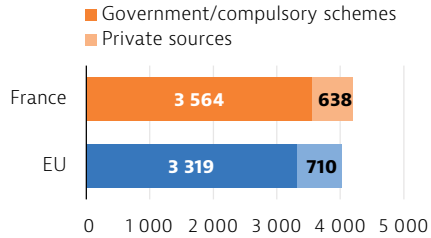
Life expectancy in France exceeded the EU average by over 1.5 years in 2022, even though it fell by more than half a year between 2019 and 2022 – mainly due to COVID-19, bad flu seasons and heatwaves. Even before the pandemic, gains in life expectancy had slowed considerably between 2010 and 2019. The gender gap in life expectancy remains large, with men living on average nearly 6 years less than women.



% of adult population

Risk Factors

Behavioural risk factors are major drivers of mortality in France, accounting for about one third of all deaths in 2019. One quarter of adults still smoked daily in 2021 – much more than the EU average. While overall alcohol consumption has decreased, more than one in five adults reported regular heavy drinking in 2019. Obesity rates, although lower than the EU average, have gone up: one in seven adults were obese in 2019.



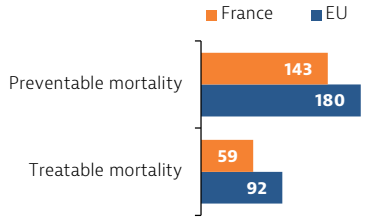
EUR PPP per capita, 2021

Health System

Health spending per capita in France is only slightly higher than the EU average. Adjusted for differences in purchasing power, it reached about EUR 4 200 in 2021 compared to an EU average of EUR 4 030. As a share of GDP, health spending reached 12.3 % of GDP in 2021 – the second highest share in the EU after Germany – and more than 1 percentage point higher than before the pandemic.

Effectiveness

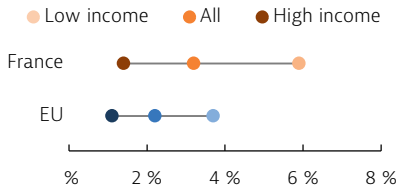
Mortality from preventable and treatable causes was lower in France than across the EU. However, France lagged behind some EU countries (including Sweden and Italy) on preventable mortality, suggesting that more could be done to save lives by reducing risk factors for cancer and other leading causes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



Age-standardised mortality rate per 100 000 population, 2020

Accessibility

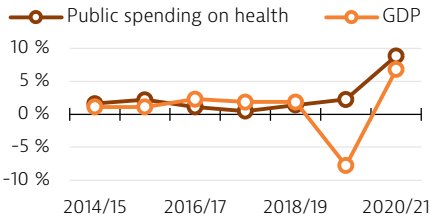
Access to healthcare is generally good, though shortages of general practitioners in underserved areas hinder access to primary care. Unmet needs are also greater for services that are less covered by public insurance, like dental care, although public coverage for dental care has improved since 2021. During the pandemic, growing use of teleconsultations helped to maintain access to care.



% reporting unmet medical care needs, 2022

Resilience

During the first two years of the pandemic, public spending on health outpaced GDP, particularly in 2020, when it started to increase more rapidly than in previous years while GDP fell sharply. The surge in public spending on health in 2021 was driven by direct costs related to COVID-19 and a catch-up in healthcare activities disrupted in 2020.



Annual change in real terms

Mental Health

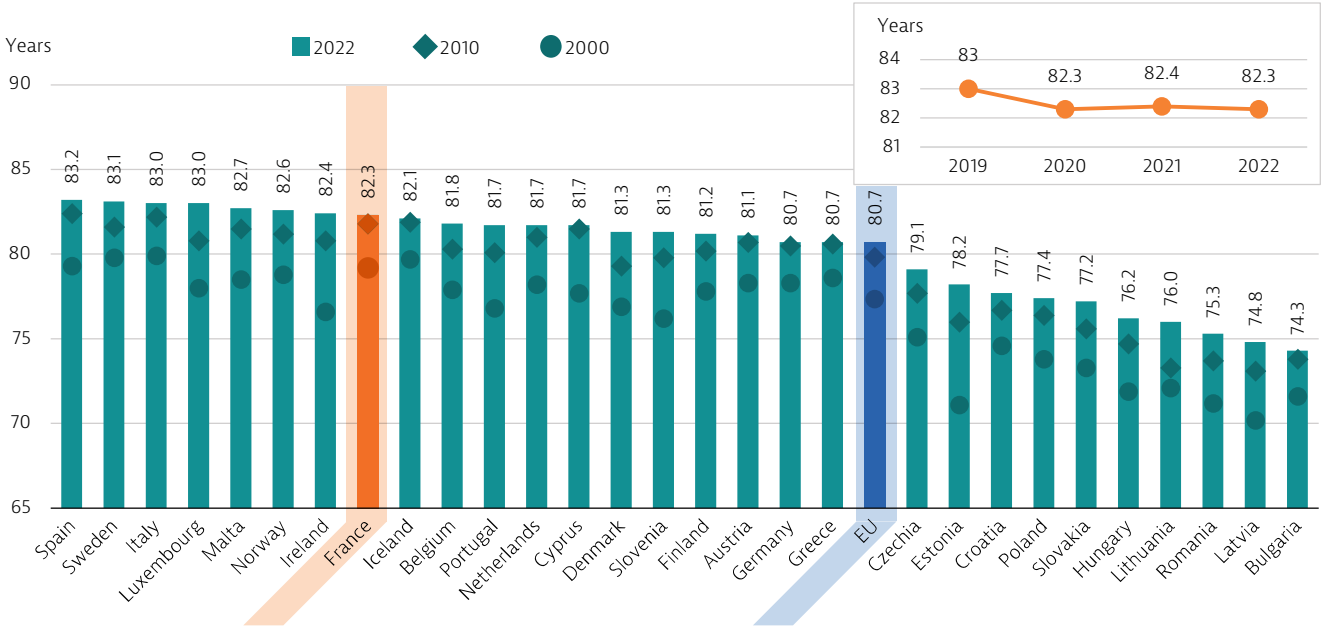
The burden of mental ill-health is estimated to be slightly higher in France than the EU average. Depression is among the most common mental health issues, and women and people on lower incomes are more likely to report depression. Despite improved public coverage of psychotherapy since 2022, challenges persist in the availability and coordination of care for those with mild-to-moderate disorders.

2 Health in France

Life expectancy is well above the EU average, despite a significant drop since 2020

In 2022, life expectancy at birth in France stood at 82.3 years, which is more than 1.5 years higher than the average across the EU (Figure 1). It fell by 0.7 years in 2020 due to COVID-19 deaths – the biggest reduction since 1945 – and remained at the lower level in 2021 and 2022.

Figure 1. Despite the reduction since 2020, life expectancy in France remains above the EU average



Notes: The EU average is weighted. The 2022 data are provisional estimates from Eurostat that may be different from national data and may be subject to revision. Data for Ireland refer to 2021.
Source: Eurostat Database.

As in other European countries, in France women tend to have a longer life expectancy than men. In 2022, French women could expect to live to 85.2 years – 5.8 years longer than men (79.4 years). This gender gap is greater than the EU average (5.4 years).

Cancer, circulatory diseases and COVID-19 were the main causes of death in 2020

In 2020, the leading causes of death in France were cancer, circulatory diseases (such as stroke and ischaemic heart diseases) and COVID-19 (Figure 2). During the first year of the pandemic, COVID-19 accounted for about 69 000 deaths – over 10 % of all deaths – making it the third leading cause. Nearly 60 % of COVID-19 deaths in 2020 were among people aged 85 and over, which was the highest proportion among EU countries. The pandemic also disproportionately hit ethnic minority groups and people living in deprived areas.

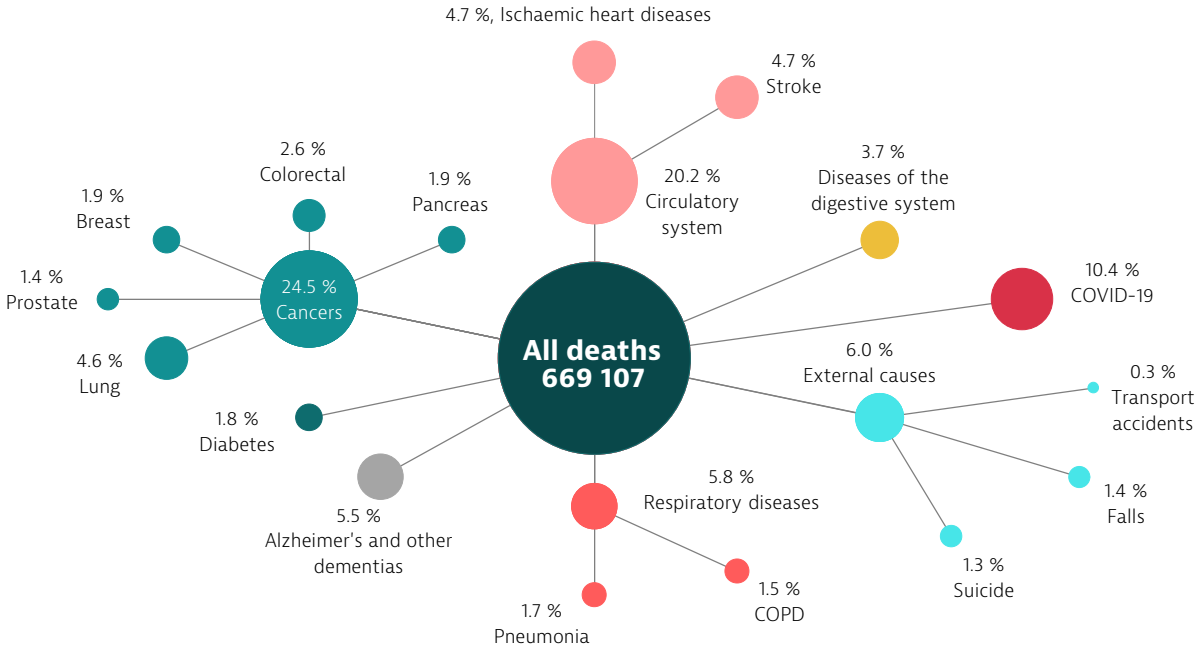
The broader indicator of excess mortality shows that the overall number of deaths in France in 2020, 2021 and 2022 was substantially higher than in the previous five years (Figure 3).

In 2020 and 2021, excess mortality was driven mainly by COVID-19 mortality. This was much less the case in 2022, when other factors including two bad flu seasons (one in March/April and another in December) and three heatwaves in the summer resulted in excess mortality (INSEE, 2023).

Women live a greater portion of their lives after age 65 with activity limitations

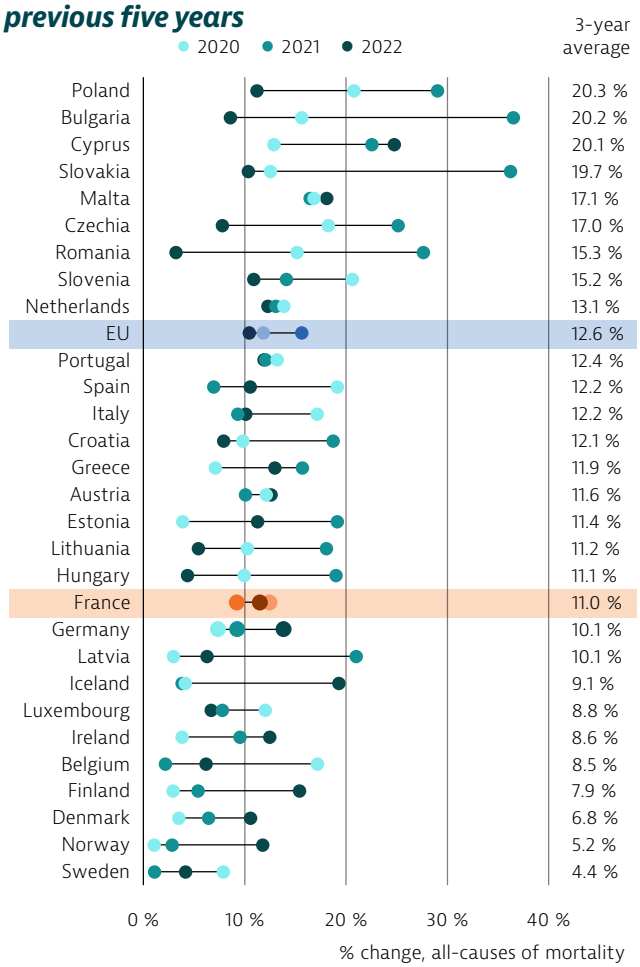
As a result of rising life expectancy, a fertility rate below replacement level and the ageing baby-boom generation, older people are making up a growing proportion of the French population. In 2020, 20 % of people in France were aged 65 and over, up from about 14 % in 1990, and this share is projected to increase to 28 % by 2050.

Figure 2. COVID-19 was one of the leading causes of death in France in 2020



Note: COPD refers to chronic obstructive pulmonary disease.
Source: Eurostat Database (data refer to 2020).

Figure 3. Excess mortality in France was at least 9 % higher in 2020, 2021 and 2022 than in the previous five years



Note: Excess mortality is defined as the number of deaths from all causes exceeding the average annual number of deaths in the five years preceding the pandemic (2015-19).
Source: OECD Health Statistics based on Eurostat mortality data.

In 2020, women aged 65 could expect to live another 23.1 years (over 2 years above the EU average), while men could expect to live another 19 years (nearly 2 years above the EU average) (Figure 4). For women, about half of this additional time is lived without disabilities and activity limitations, while for men the proportion is slightly greater. Hence, the gender gap in the number of healthy life years after 65 is much smaller than the gap in life expectancy.

An equal proportion of French men and women aged 65 and over reported having more than one chronic condition in 2020 (46 %) based on the SHARE survey. This was higher than the EU average, especially for men. However, a higher proportion of women in France reported having limitations in daily activities (31 % compared to 25 % of men), as in other EU countries.

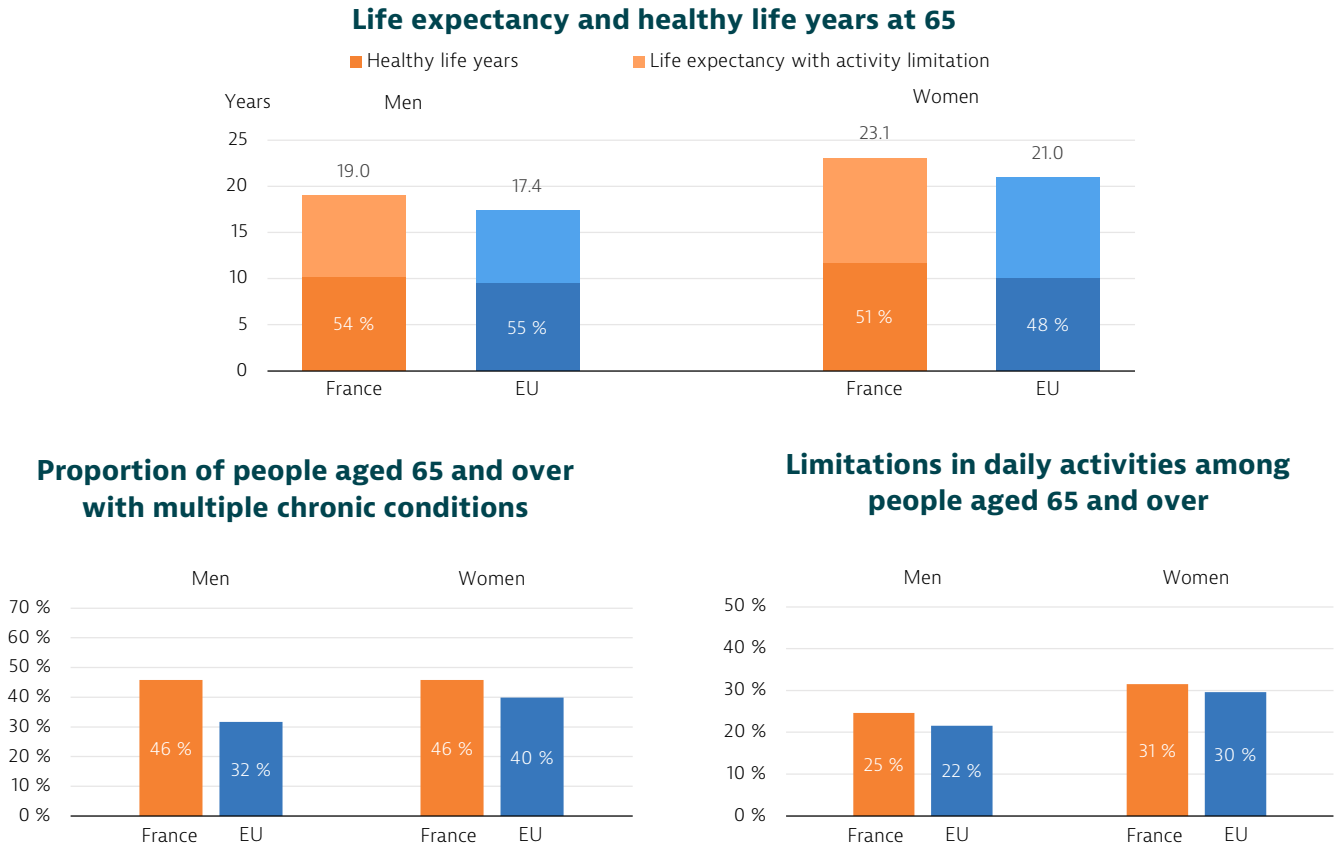
The burden of cancer in France is high

According to estimates from the Joint Research Centre, more than 435 000 new cases of cancer were expected in 2022. Men are more likely than women to be diagnosed with cancer (Figure 5).[1] The leading cancers among men are prostate, lung and colorectal cancer, while among women the leading cancers are breast, colorectal and lung cancer. According to the National Cancer Institute, the total number of new cases has doubled since 1990. This rise is mainly attributed to increases

1 *According to the French National Cancer Institute, the estimated number of cancer cases are even higher among men and lower among women than the estimates from the Joint Research Centre.*

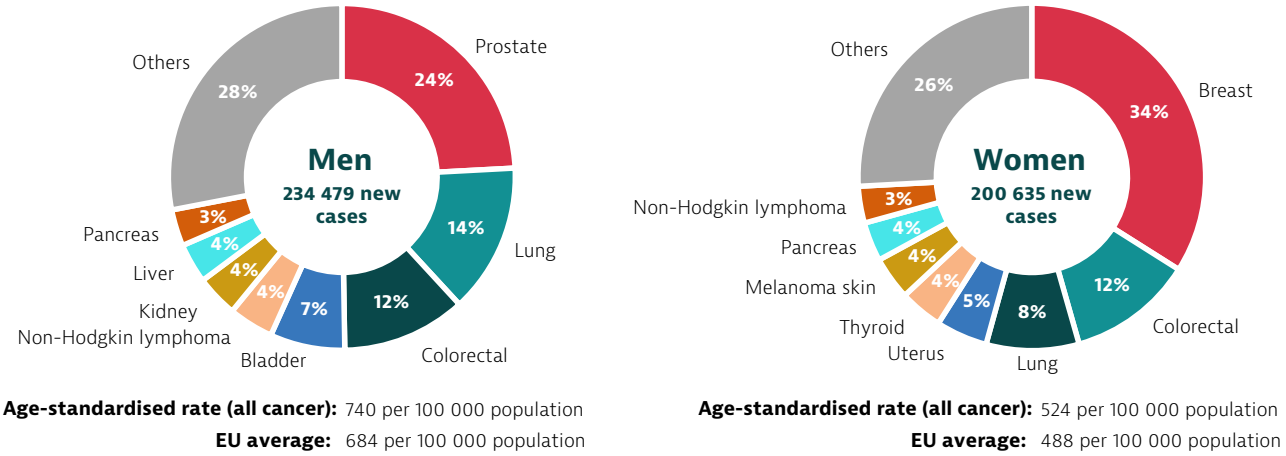
in population size and population ageing and, to a lesser extent, to an increase in cancer risk. France has put in place several national plans over the past two decades to improve cancer prevention and care (see Section 5.1).

Figure 4. More older people in France report having chronic conditions than the EU average



Sources: Eurostat Database (for life expectancy and healthy life years) and SHARE survey wave 8 (for chronic conditions and limitations in daily activities). Data refer to 2020.

Figure 5. More than 435 000 cancer cases in France were expected to be diagnosed in 2022



Age-standardised rate (all cancer): 740 per 100 000 population
EU average: 684 per 100 000 population

Age-standardised rate (all cancer): 524 per 100 000 population
EU average: 488 per 100 000 population

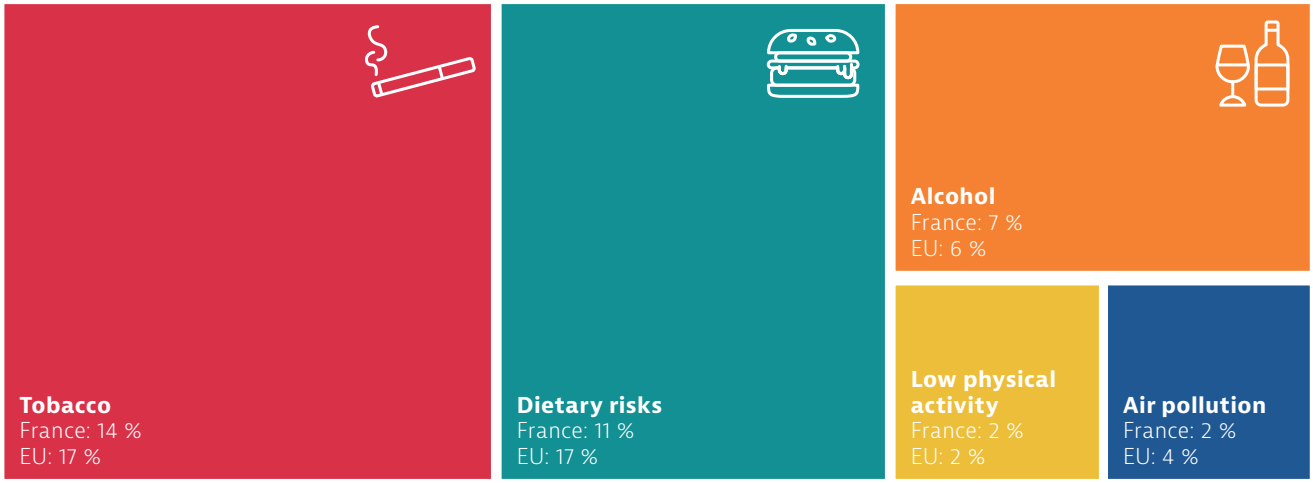
Notes: Non-melanoma skin cancer is excluded; uterus cancer does not include cancer of the cervix.
Source: ECIS – European Cancer Information System.

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 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 on the number of deaths each year (Figure 6).

Figure 6. Tobacco, dietary risks and alcohol are major contributors to mortality in France



Notes: 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 heavy drinking rates among adults remain high

Smoking rates among adults in France have declined over the past two decade, from 30 % in 2010 to just over 25 % in 2020, and remained stable in 2021. However, they are still higher than in most EU countries (Figure 7). While more French men than women smoke (28 % compared to 23 %), the rate among women is the highest across EU countries. More positively, regular smoking among 15-year-olds has reduced over the past decade (to 12 %) and was below the EU average (17 %) in 2022.

More than one in five adults (21 %) reported heavy drinking in 2019 – a proportion higher than in most EU countries.[2] Overall alcohol consumption among adults has decreased since 2000, but remained 6 % higher than the EU average in 2021. On a more positive note, the proportion of 15-year-olds who report having been drunk more than once decreased substantially over the past decade. from 22 % in 2010 to 13 % in 2022 – a lower proportion than in most other EU countries.

Obesity rates in France have increased but are lower than in most EU countries

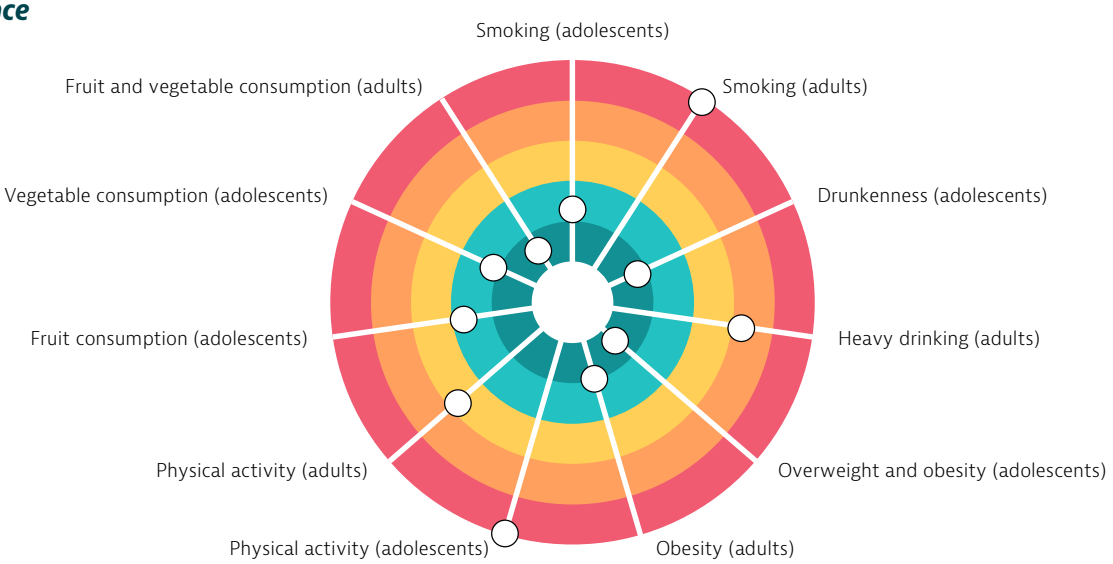
Based on self-reported data, the obesity rate among adults increased from 9 % in 2000 to 14 % in 2019 – a level that remains lower than the EU average.[3] The obesity rate is almost twice as high among adults with lower than higher education levels. Overweight and obesity rates among 15-year-olds also increased from 10 % in 2010 to 16 % in 2022, but also remain lower than in most EU countries.

Poor nutrition is the main factor contributing to overweight and obesity. While the proportion of adults who report eating at least five portions of fruit or vegetables per day is higher than in most EU countries, it was only 20 % in 2019. About two thirds of 15-year-olds reported not eating any fruit or vegetables every day in 2022.

2 *Heavy drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults.*

3 *Based on actual measurements of people's height and weight, obesity rates among adults are higher but fell slightly from 17 % in 2006 to 16 % in 2017.*

Figure 7. Smoking and alcohol consumption among adults are still important public health issues in France



Notes: 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 2022 for adolescents indicators; and EHIS 2019 for adults indicators (except smoking among adults, which comes from a 2021 national survey).

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

Low physical activity levels also contribute 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 2022, after Italy. This is particularly the case among teenage girls: only 6 % of 15-year-old girls reported doing at least moderate physical activity compared to 15 % of boys. Further, only 27 % of adults spent at least 150 minutes a week doing moderate physical activity in 2019 – a proportion lower than in many other countries.

4 The health system

The French health system is centralised, with some responsibilities devolved to regions

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 provision of healthcare – and especially hospital care – at the local level since 2009, SHI and central government play 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.

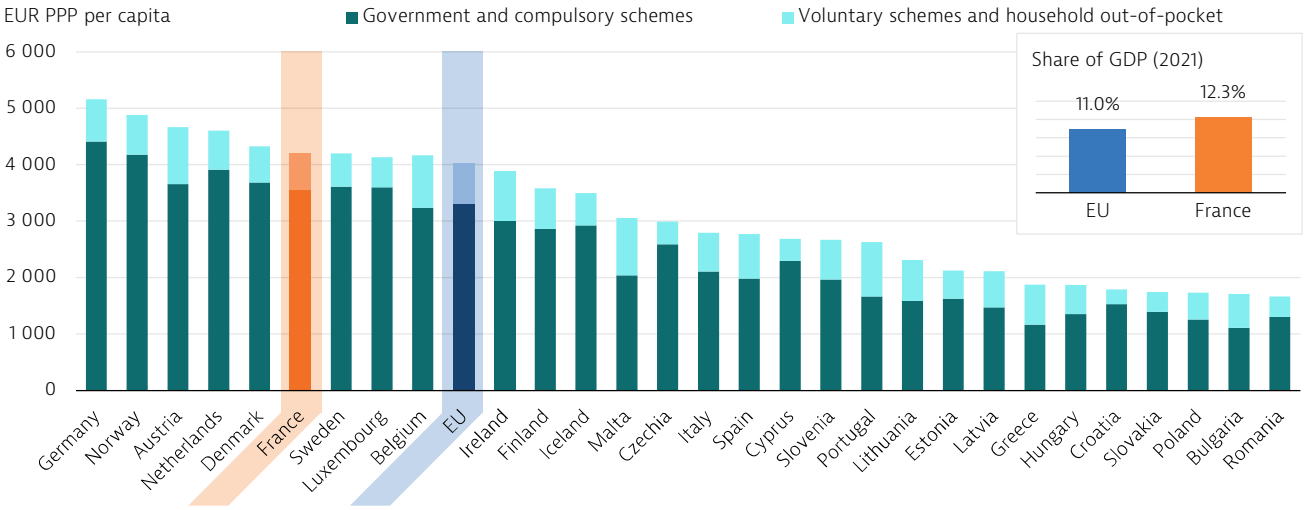
Health spending is higher in France than the EU average

Health spending in France accounted for 12.3 % of GDP in 2021, which was the second highest share in the EU after Germany and above the EU average of 11.0 %. This was the highest level recorded in France, and more than 1 percentage point higher than before the pandemic, driven mainly by the substantial increase in public spending on health during the first two years of the pandemic.[4]

In 2021, French health spending per capita was the fifth highest across the EU, at EUR 4 202 (adjusted for differences in purchasing power) compared to the EU average of EUR 4 030 (Figure 8).

4 *In 2022, health spending as a share of GDP fell slightly to 11.9 % as economic growth outpaced the growth in health spending (DREES, 2023a).*

Figure 8. France's health expenditure per capita is higher than in most EU countries, but substantially lower than in Germany



Note: The EU average is weighted.
Source: OECD Health Statistics (data refer to 2021, except Malta (2020)).

Since 1996, annual growth in SHI expenditure has been controlled by national health spending targets. However, the COVID-19 pandemic added substantial expenditure to the health budget (Box 1). Public spending on health in real terms grew by 2.3 % in 2020 and by 8.9 % in 2021, before coming back to a growth rate of about 2 % in 2022 according to the latest national estimates (DREES, 2023a).

France spends nearly the same amount on inpatient and outpatient care

Outpatient care (including primary care, specialist and dental care) and inpatient care are the two largest categories of health spending, accounting for 28 % and 27 % of the total in 2021 (Figure 9). Retail pharmaceuticals and medical devices also took up a considerable share of health resources, at 19 % of health spending, while long-term care made up 16 %.

Spending on prevention increased greatly during the pandemic and accounted for 5.5 % of all health expenditure in 2021. It fell in 2022, although it remained above the usual level of about 3 % before the pandemic (DREES, 2023a).

French social health insurance covers the entire population

The SHI system offers coverage to the whole population based on residence through various compulsory schemes. Revenue for healthcare comes from social security contributions, earmarked income taxes, value-added taxes and other sources such as tobacco and alcohol taxes.

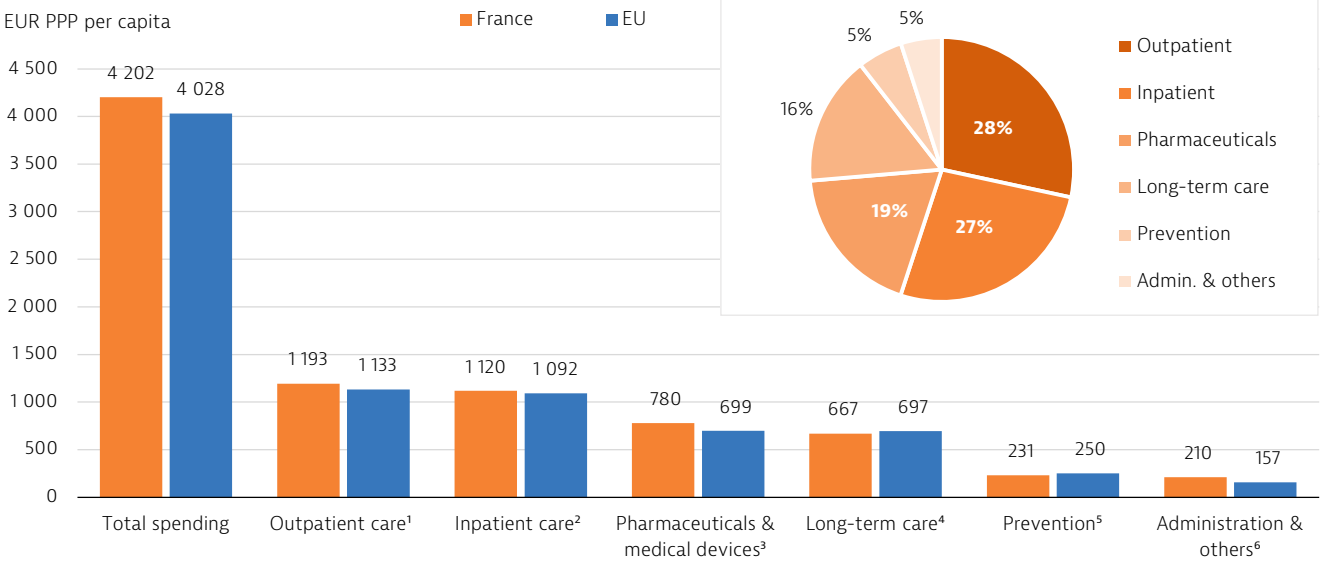
Box 1. The COVID-19 pandemic had a large impact on health spending in France

The government provided substantial additional resources to support the health system's pandemic response. In 2020, the additional cost linked to the COVID-19 pandemic was estimated at EUR 18 billion (Comité d'alerte sur l'évolution des dépenses d'assurance maladie, 2022). This includes direct expenditure such as the cost of masks, personal protective equipment and tests, additional costs of recruiting staff in hospitals and nursing homes, and exceptional bonuses. It also includes indirect expenditure such as derogatory sickness allowances – such as payments to people who were unable to work due to lockdown measures and support for self-employed health professionals who lost income due to reduced activity. Additional health insurance expenditure, with continuing deployment of measures against COVID-19 (including testing and vaccination), was estimated at EUR 17.4 billion in 2021 and EUR 11.7 billion in 2022 (Comité d'alerte sur l'évolution des dépenses d'assurance maladie, 2023).

Note: Other calculations based on a different scope of healthcare found that the additional costs linked to the pandemic reached EUR 14.8 billion in 2020 (DREES, 2022a).

Nearly everyone (95 %) has complementary health insurance, mainly to cover copayments and to attain better coverage for medical goods and services that are poorly covered by the SHI system, such as dental and optical care (although since 2021 public coverage for dental and optical care has improved substantially (see Section 5.2)). In 2021, public and private compulsory complementary

Figure 9. Most health spending is on inpatient and outpatient care



Notes: 1. Includes home care and ancillary services (e.g. patient transportation); 2. Includes curative-rehabilitative care in hospital and other settings; 3. Includes only the outpatient market; 4. Includes only the health component; 5. Includes only spending for organised prevention programmes; 6. Includes health system governance and administration and other spending. The EU average is weighted.
Source: OECD Health Statistics (data refer to 2021, except Malta (2020)).

health insurance schemes funded 85 % of all health spending in France – higher than the EU average of 81 %.[5]

The number of inpatient hospital beds in France has declined consistently since 2000s

In 2021, France had 5.7 hospital beds per 1 000 population, which was lower than the rate in Germany (7.8 per 1 000) but higher than the EU average (4.8 per 1 000). The persistent reduction in the overall number of beds in hospitals since 2000s is related to several trends: a decrease in inpatient bed numbers; a significant increase in ambulatory hospitalisations (contributing to a sharp decline in the length of stay after surgery in hospitals); an increase in home hospitalisation, mainly in perinatal and palliative care; and a decrease in numbers of long-term care beds in hospitals, linked to the development of nursing homes for older people.

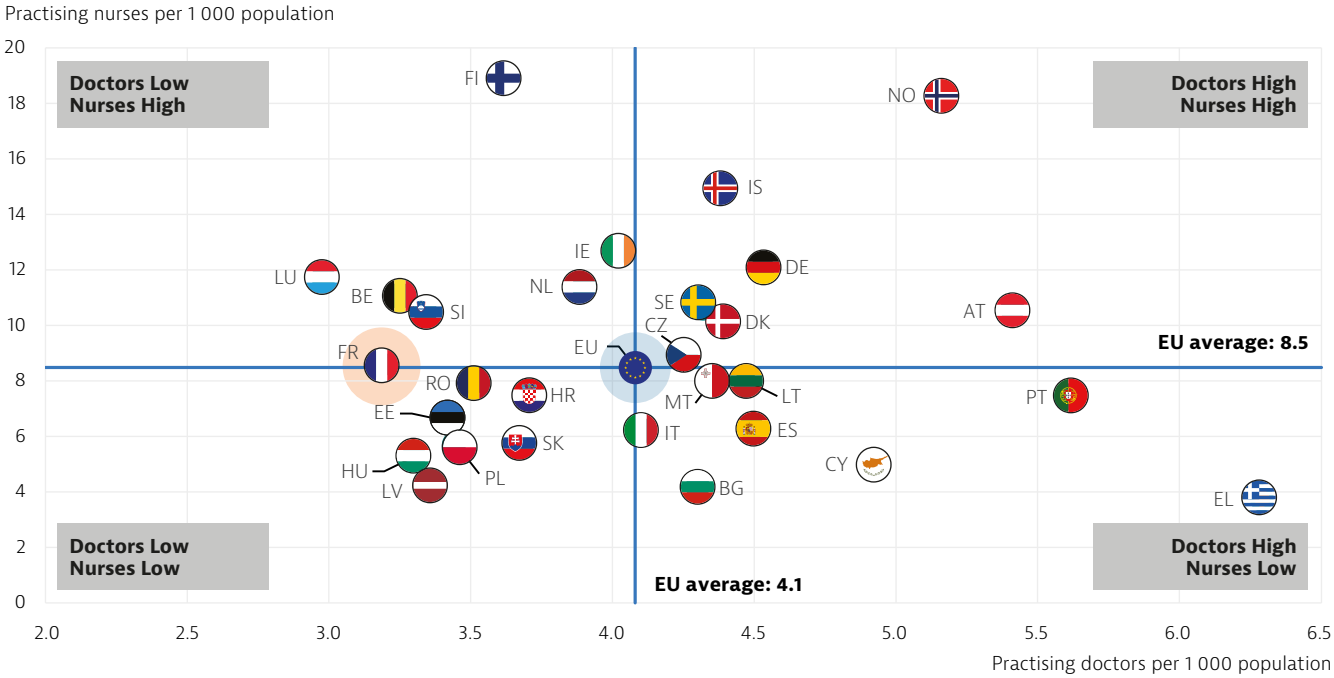
The density of doctors is below the EU average, while the density of nurses is close to average

While the number of doctors per population has increased in most EU countries over the past decade, it has remained stable in France. As a result, it is now well below the EU average, with 3.2 doctors per 1 000 population in 2021, compared to 4.1 per 1 000 across the EU (Figure 10). The share of general practitioners (GPs) has reduced over time, resulting in growing shortages of GPs in certain regions. The government has taken measures to address these "medical deserts" (see Section 5.2).

The number of practising nurses in France in 2021 (8.6 per 1 000 population) was close to the EU average (8.5 per 1 000). Since the pandemic, the government has implemented measures to attract and retain nurses in hospitals and to promote more advanced roles of nurses in primary care (see Section 5.2).

5 *In France, all employers in the private sector must offer their employees cover with a private complementary health insurance that is financed by employers and employees.*

Figure 10. The number of doctors per 1 000 population is lower than the EU average, while the number of nurses is close to the average



Notes: The EU average is unweighted. Data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Greece, the number of nurses is underestimated as it only includes those working in hospitals.
Source: Eurostat Database (data refer to 2021 or the nearest available year).

5 Performance of the health system

5.1 Effectiveness

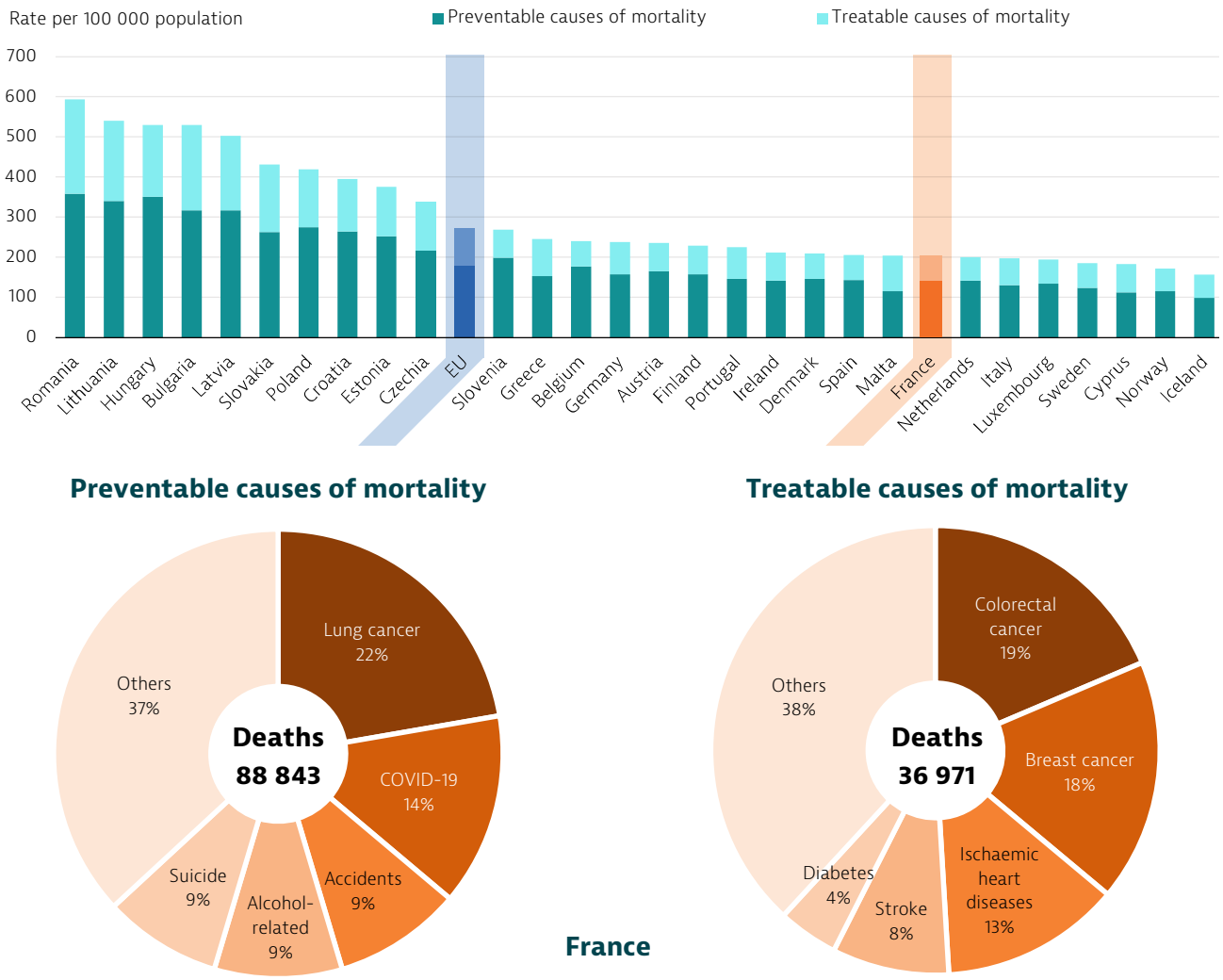
France fares well on treatable and preventable causes of mortality compared to other EU countries

Avoidable mortality rates in France were among the lowest in the EU in 2020, and well below the EU average (Figure 11). France fares particularly well on treatable causes of mortality, indicating that the health system is very effective in saving the lives of people with acute conditions. Preventable causes of mortality are also lower than the EU average, but France lags behind countries such as Iceland, Norway, Sweden and Italy. Part of this difference was due to a greater number of deaths from COVID-19 in France during the first year of the pandemic.

A range of measures have been adopted to reduce tobacco smoking, but there is room for further reductions

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 people born since 2014 by 2032. 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. The measures taken between 2016 and 2020, if maintained, are expected to save an estimated EUR 578 million per year between 2023 and 2050, with a return on investment of EUR 4 for each EUR 1 invested in these initial measures (OECD, 2023). From 2023, the price of tobacco products is pegged to inflation, and the price of a pack of cigarettes is expected to reach EUR 11 in January 2024. A forthcoming National Plan Against Tobacco is expected to prohibit the use of e-cigarettes in response to their growing popularity among young people.

Figure 11. France fared better than most EU countries on avoidable mortality in 2020

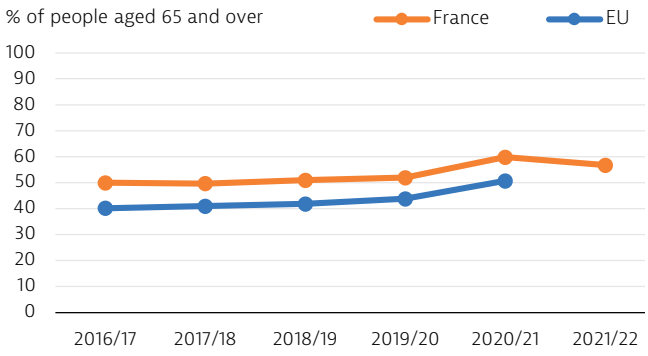


Notes: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through healthcare interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths from some diseases (e.g. ischaemic heart disease, stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting of the same death.
Source: Eurostat Database (data refer to 2020).

Influenza vaccination rates among older people have increased sharply since 2020

The COVID-19 pandemic raised the importance of increasing vaccination rates against influenza to minimise avoidable pressure on hospitals. The government launched public awareness campaigns in 2020-21 to encourage people at risk to get vaccinated as soon as possible. Nearly 60 % of people aged 65 and over were vaccinated compared to about 50 % in previous years (Figure 12). However, the 2021-22 vaccination campaign was slightly less successful, with a coverage rate of 57 %, which remains far below the WHO-recommended target of 75 %.

Figure 12. Influenza vaccination rates among older people have increased substantially during the pandemic



Sources: OECD Health Statistics and Eurostat Database.

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

The National Cancer Plan 2021-30 was launched in February 2021, 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: improving prevention and early diagnosis; improving the quality of life of cancer patients; increasing cancer survival among adults and children, particularly for cancers with low prognosis; and ensuring that all population groups can benefit equally from progress in cancer care. It is aligned with the overall priorities set out in the Europe's Beating Cancer Plan, and implementation is supported by funding of EUR 1.74 billion over five years – an increase of 20 % on the previous plan. About 80 % of the planned actions were launched during its first two years (Ministère de la Santé et de la Prévention, 2022).

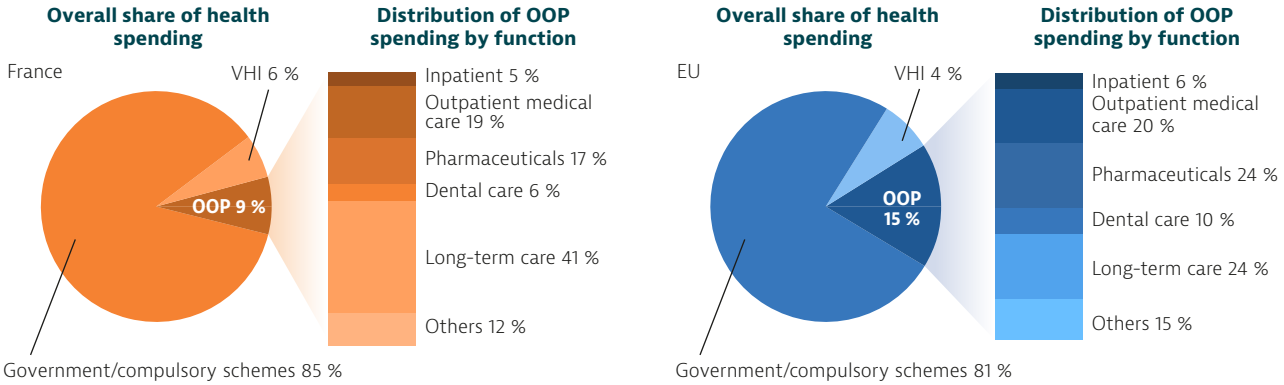
5.2 Accessibility

France has the lowest share of out-of-pocket health expenditure among all EU countries

France reports the lowest share, with Luxembourg, of out-of-pocket (OOP) payments for health among all EU countries (9 % compared to a 15 % EU average) because most of the population have private health insurance to cover cost sharing imposed by the public scheme (Figure 13). Public schemes, such as the one for people with chronic conditions, also cover all health costs linked to these conditions.

The largest part of OOP expenditure is spent on the health component of long-term care (41 %). According to insurers, about 7.4 million French people subscribe to a private long-term care insurance scheme for themselves or relatives (France Assureurs, 2022), but this does not prevent significant OOP spending for most people.

Figure 13. High public and private insurance coverage limits out-of-pocket health expenditure



Notes: 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 2023; Eurostat Database (data refer to 2021).

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

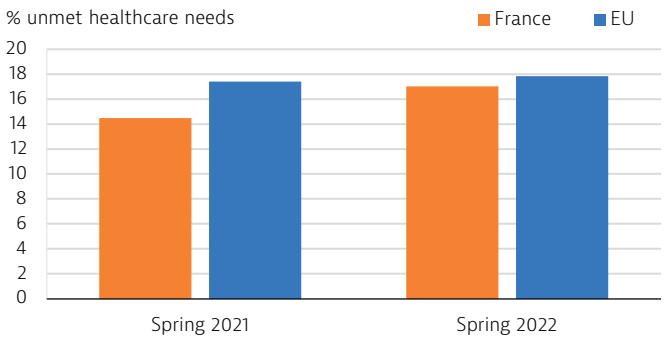
Unmet needs for medical care due to costs, distance to travel or waiting times were very low in France in 2022 according to the EU-SILC survey (3.2 % among all adults). However, there is inequality across income groups: 5.9 % of people in the lowest income quintile reported going without medical care – mostly because it was perceived as too expensive – compared to 1.4 % in the highest quintile.

Unmet needs are greater for services that are less comprehensively covered by the SHI, such as hearing aids, vision aids and dental care. For example, 6.1 % of French people reported unmet needs for dental care in 2021, but this proportion was much greater in the lowest income quintile (10.9 %), mainly for financial reasons. Since 2021, any patient with a complementary health insurance contract can access a core benefits package that covers 100 % of the costs for eye care, hearing aids and dental care without any form of copayment.

The COVID-19 pandemic and related containment measures limited access to health services. Eurofound surveys carried out in spring 2021 and spring 2022 found that 14 % and 17 % of the population reported having current unmet healthcare needs (Figure 14). Nevertheless, these proportions were below the EU averages.[6]

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

Figure 14. Unmet healthcare needs in spring 2021 and spring 2022 were below the EU averages

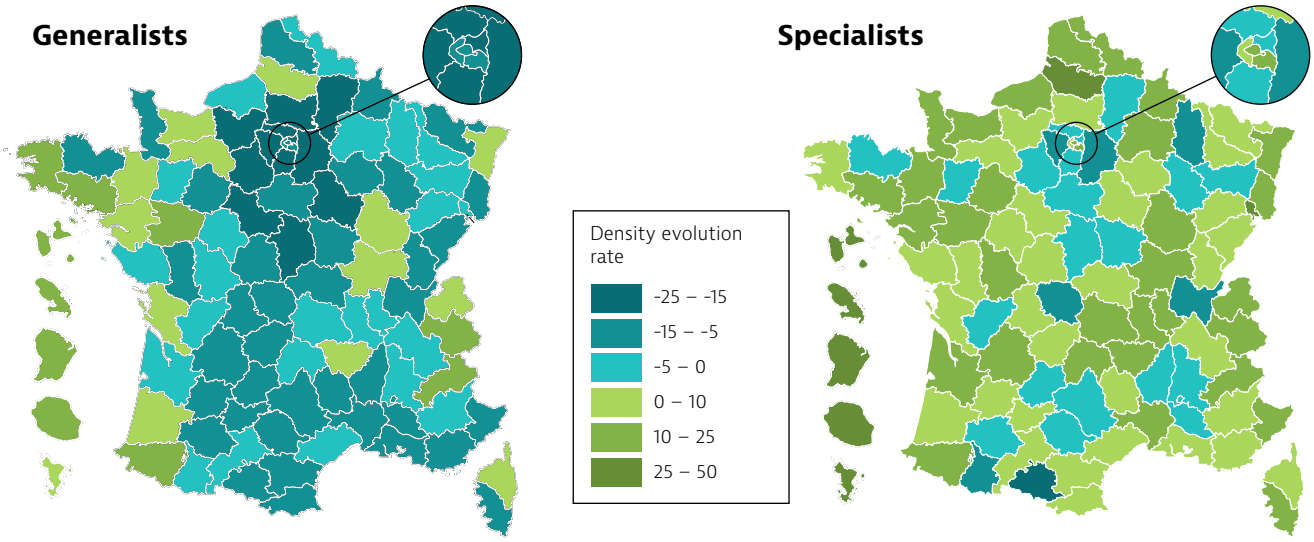


Note: The EU average is weighted.
Source: Eurofound's Living, working and COVID-19 e-survey.

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 has remained stable over the past decade. This masks a change in the composition of the French medical workforce: the number of specialists has increased but the number of GPs has decreased. When combined with population growth, the density of GPs fell by 8 % between 2012 and 2022. While this reduction occurred in most regions, it was greater in some – mainly in those surrounding Paris (Figure 15). By contrast, the density of specialists increased at least slightly in most regions.

Figure 15. The density of GPs fell in almost all regions in France between 2012 and 2022



Source: Ministère des Solidarités (2023), Rapport d'évaluation des politiques de sécurité sociale - Maladie.

An estimated 6 % of the population of France lived in areas where access to GPs was potentially limited in 2018 (DREES, 2020). These "medical deserts" are located mainly in rural areas and in distant suburbs of small towns and big cities, mostly concentrated in the central and the northwest parts of France.

Concerns about underserved areas may be exacerbated in the future as a large proportion of GPs are approaching or already beyond standard retirement age. The main drivers of the choice of practice location of GPs are related to their social and geographic backgrounds (e.g. physicians who practice in rural areas often tend to have had a rural upbringing) and to lifestyle choices, including educational facilities for children and employment opportunities for spouses. The working conditions and environment also play an important role. Financial considerations usually play a more minor role (DREES, 2021).

Successive governments have launched initiatives over the past 15 years to address concerns about medical deserts, including monthly stipends for medical students and interns who agree to practise for a minimum duration in underserved areas, financial support for doctors to set up practices in such areas, and various tax breaks. Since 2007, the main policy to tackle this issue has been to create multidisciplinary health centres and homes, enabling GPs and other primary healthcare providers to work in the same location. In 2022, a total of 2 773 such centres and homes were registered.

In addition, the number of medical students increased sharply between 2016 and 2020, and is expected to rise by a further 20 % over 2021-25 compared to 2016-20. Since 2017, 40 % of postgraduate internship positions have been allocated to general medicine. From September 2023, students in general practice also have to undertake one additional year of postgraduate

training in ambulatory care settings, and are encouraged to do it in underserved areas.

In the short term, various strategies are used to address the shortage of doctors, including the growing use of interim doctors (Box 2). However, a 2023 law aims to limit the use of interim doctors and other staff in hospital by capping daily compensation, although some hospitals are adapting by offering alternative contracts to circumvent the new compensation ceilings.

Box 2. The growing number of interim doctors generates costs and tensions

According to the National Medical Association, over a quarter of newly trained doctors opted for an interim activity in 2021, up from only one fifth in 2008. Overall, the number of interim doctors increased by 55 % over the past decade (from about 10 100 in 2012 to 15 600 in 2022). Interim activities are generally much better paid, and the administrative tasks are usually lighter than those of regular doctors. According to the Ministry of Health, the cost of interim activities for public hospitals nearly tripled in the years before the pandemic, from EUR 500 million in 2013 to EUR 1 424 million in 2018.

Sources: National Medical Association (2022), Atlas de la démographie médicale en France. [Atlas of medical demography in France.]; Ministère de la Santé et de la Prévention (2022), Projet de loi de financement de la sécurité sociale pour 2023. [Social Security Financing Bill for 2023.]

Task sharing between doctors and other health professionals has received support

France encourages access to primary care through communities of health professionals. These aim to coordinate outpatient health professionals across a territory, with the objective of improving patient-centred care and access. In 2022, about 400 communities were operational or in preparation – up from 60 in 2020.

In 2018, legislation formalised the role of advanced practice nurses, who provide greater support in the care of chronically ill patients and those with complex morbidities. They must work with GPs and specialists in primary care teams and other health settings. Nearly 1 000 advanced practice nurses were registered in 2021. Key factors that enable them to perform their roles successfully include the willingness of doctors to cooperate, the type of autonomy sought by the nurses, and the local availability of doctors (IRDES, 2023).

A new law adopted in April 2023 aims to facilitate access to advance practice nurses and widen the scope of their competences. Those working in multidisciplinary group practices can be consulted by patients without a doctor's referral, and can also prescribe some medications and other health products.

A new position of medical assistant was also created in 2019 to take on responsibility for non-medical tasks traditionally performed by GPs. In 2022, there were over 3 500 medical assistants. This is estimated to have freed up the time for GPs working with these assistants to care for 10 % more patients (Assurance Maladie, 2022). The government aims to reach 10 000 medical assistants by December 2024.

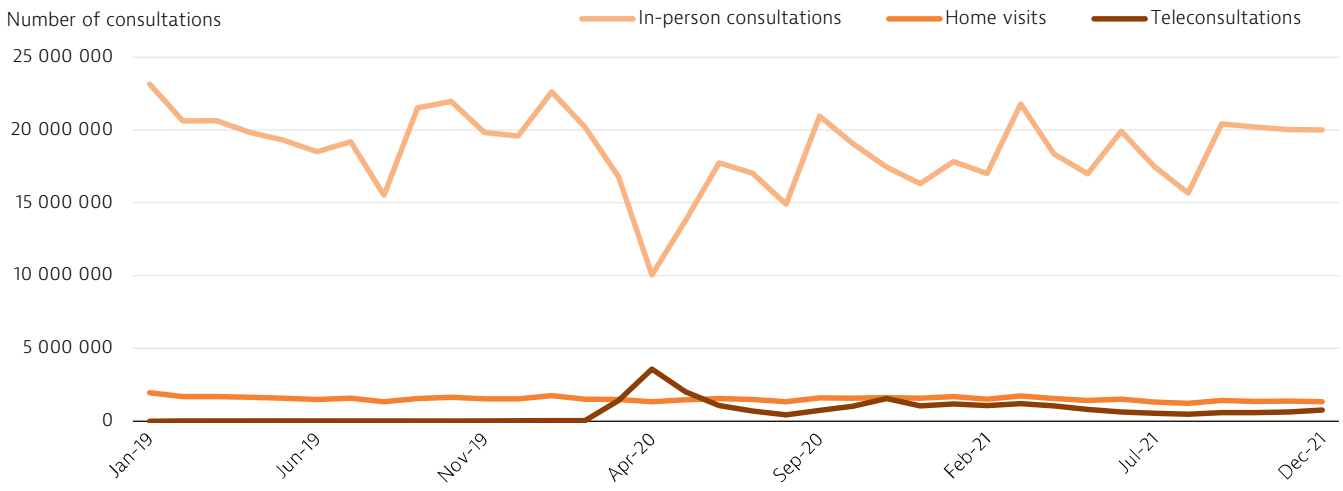
The number of teleconsultations has increased slightly since 2020

Telehealth services can be a complementary solution to maintain or improve access to care, and these proved particularly useful during the peaks of the pandemic and lockdown periods. New regulations were introduced to scale up telemedicine during the first wave of the COVID-19 pandemic in March 2020. Conditions of entitlement and reimbursement were simplified, and the cost was exceptionally fully covered by the SHI. Physicians were allowed to use this mode of consultation without having to know the patient beforehand.

Since 2022, teleconsultations are covered and reimbursed by the SHI at the same rate as in-person consultations (70 %) – marking a return to the pre-pandemic reimbursement level. Self-employed doctors are allowed to conduct up to 20 % of their activity through teleconsultations.

While the number of teleconsultations peaked at almost 1 million per week during the first lockdown in April 2020, it fell when confinement measures were lifted. In 2020, about 6 % of all consultations and visits of non-salaried GPs were through teleconsultations, but this share declined to 4 % in 2021 (Figure 16). Younger GPs and those practising in urban areas devoted a larger part of their activities to teleconsultations. Similarly, patients using teleconsultations were typically younger, living in urban areas and have higher incomes than those who use in-person consultations. Nonetheless, one in three GPs believed that teleconsultations can be a solution for patients living in underserved areas (DREES, 2022b).

Figure 16. Teleconsultations with GPs reached a peak during the first lockdown in spring 2020, but fell afterwards



Source: DREES (2022b).

5.3 Resilience

The COVID-19 pandemic has proved to be the most significant disruption to health systems in recent decades. It has shed light on the vulnerabilities and challenges within countries' emergency preparedness strategies and on their ability to provide healthcare services to their populations. In response to the enduring effects of the pandemic – as well as other recent crises, such as cost-of-living pressures and the impact of conflicts like the war against Ukraine – countries are implementing policies to mitigate the ongoing impacts on service delivery, invest in health system recovery and resilience,[7] improve critical areas of the health sector and fortify their preparedness for future shocks.

Following a huge drop in 2020, hospital admissions in France remained below pre-pandemic levels in 2021

France's hospital care capacity is considerably greater than that in most other EU countries. In 2019, the overall number of hospital beds was nearly 20 % greater than the EU average. Hospital admission and discharge rates were greater than the EU averages, and the occupancy rate of acute care beds was also higher.

To address the sudden increase in demand for acute care caused by the virus, in 2020 France rapidly scaled up its intensive care unit capacity by more than doubling the number of intensive care beds during the first six months of the pandemic, and provided temporary authorisations related to sharing material and human resources. At the same time, large volumes of non-urgent hospital services were postponed to create a buffer of excess resources (beds, staff and equipment) and reduce the risk of hospital outbreaks. The effects of these disruptions in non-COVID-19 care are partly reflected in the substantial reductions in hospital discharges (-13 %) and acute care bed occupancy rates (-8 %) in 2020 (Figure 17).

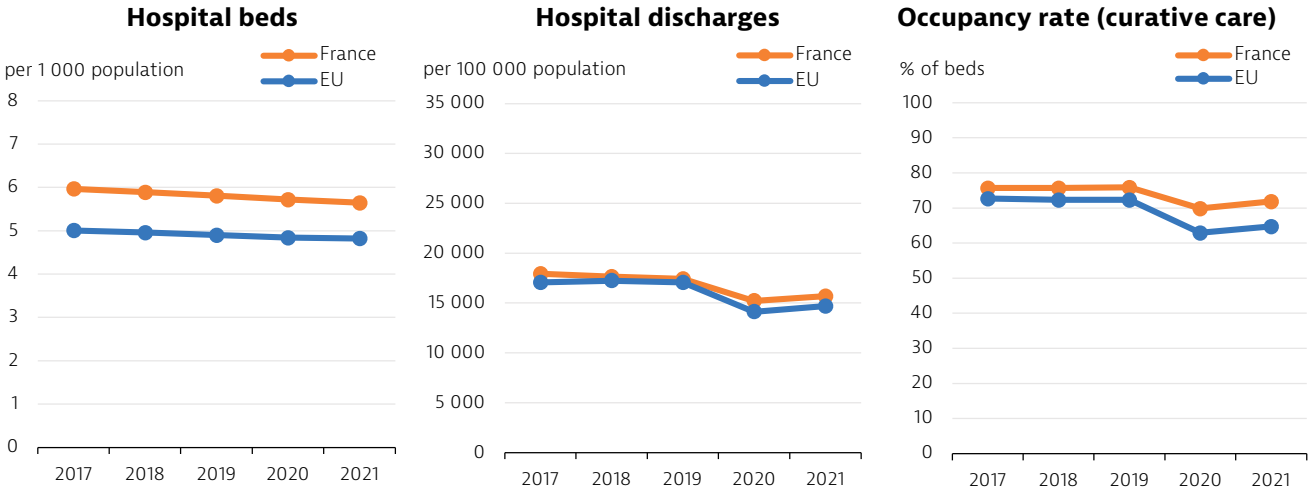
The number of hospitals discharges increased slightly In 2021, although it remained lower than in 2019. The number of inpatient stays decreased by 11 % compared to 2019, but it was partly offset by a higher number of day surgery procedures (up by 6 %) that do not require overnight stays (DREES, 2023b).

Elective surgical procedures fell significantly in 2020, but rebounded in 2021

Following the intermittent suspension of elective surgical procedures during the peaks of the pandemic in 2020, as in other EU countries, France saw a significant reduction in the volumes of non-urgent procedures in 2020. The numbers of hip replacements fell by 12 %, knee replacements by 22 % and breast surgery procedures by 6 % (Figure 18). These declines were similar to those observed across the EU. In 2021, the volume of these procedures rose by over 10 % compared to 2020. The number of breast cancer surgical procedures exceeded those in the pre-pandemic years, while the number of hip and knee replacements returned close to pre-pandemic levels.

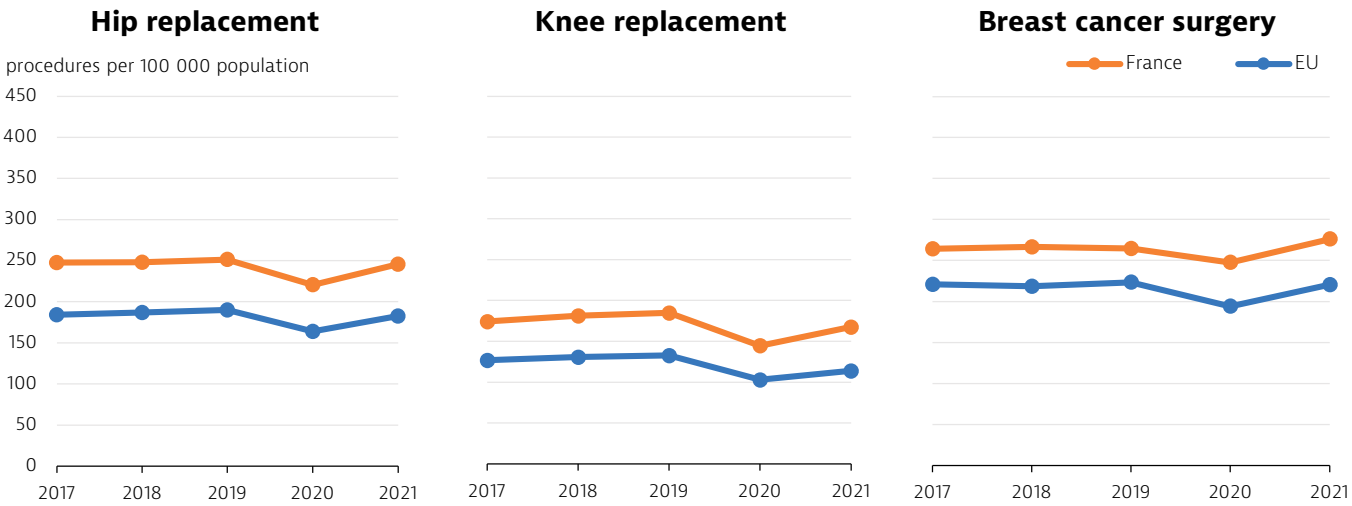
7 *In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (EU Expert Group on Health Systems Performance Assessment, 2020).*

Figure 17. Hospital discharges and occupancy rates fell substantially in 2020 and increased slightly in 2021



Note: The EU average is unweighted.
Sources: OECD Health Statistics 2023; Eurostat Database.

Figure 18. The numbers of hip and knee replacements and breast surgical procedures fell sharply in 2020 but rebounded in 2021



Note: The EU average is unweighted.
Source: OECD Health Statistics 2023.

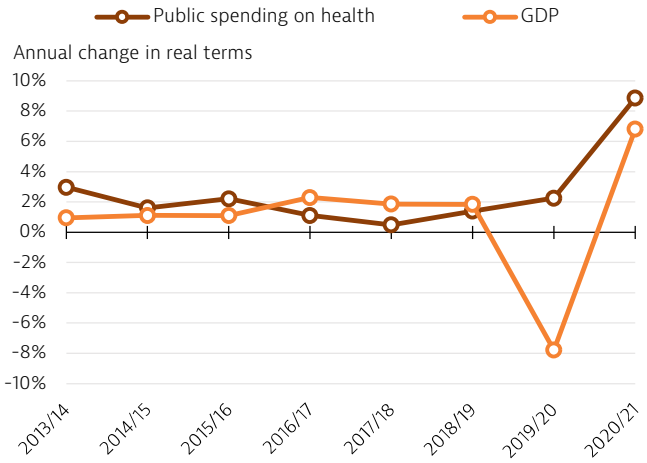
France's COVID-19 response led to a large rise in public spending on health

Between 2016 and 2019, public spending on health in France grew at a moderate rate in constant terms – a rate slightly lower than GDP growth (Figure 19). The pandemic severely disrupted this pattern. Public spending on health increased by 2.3 % in 2020 in real terms, while GDP fell sharply by 7.8 %. In the second year of the pandemic, public spending on health increased sharply by nearly 9 % in 2021, largely driven by a catch-up effect following the disruption in healthcare activities caused by the lockdown measures in 2020, as well as the cost of the COVID-19 testing and vaccination campaigns. National estimates for 2022 indicate that public spending on health returned close to its long-term trend, with a growth rate of 2.0 % in real terms (DREES, 2023a).

New investments in health will receive European support

In 2021, the government moved to the second step of an ambitious plan to strengthen public hospitals and increase investment in the health workforce. This plan allocated an additional EUR 19 billion over 10 years to restore the financial capacity of public hospitals, improve coordination between ambulatory and hospital care, increase digitalisation of the health system and modernise the long-term care sector (Gouvernement de la

Figure 19. The pandemic resulted in large increases in public spending on health, particularly in 2021

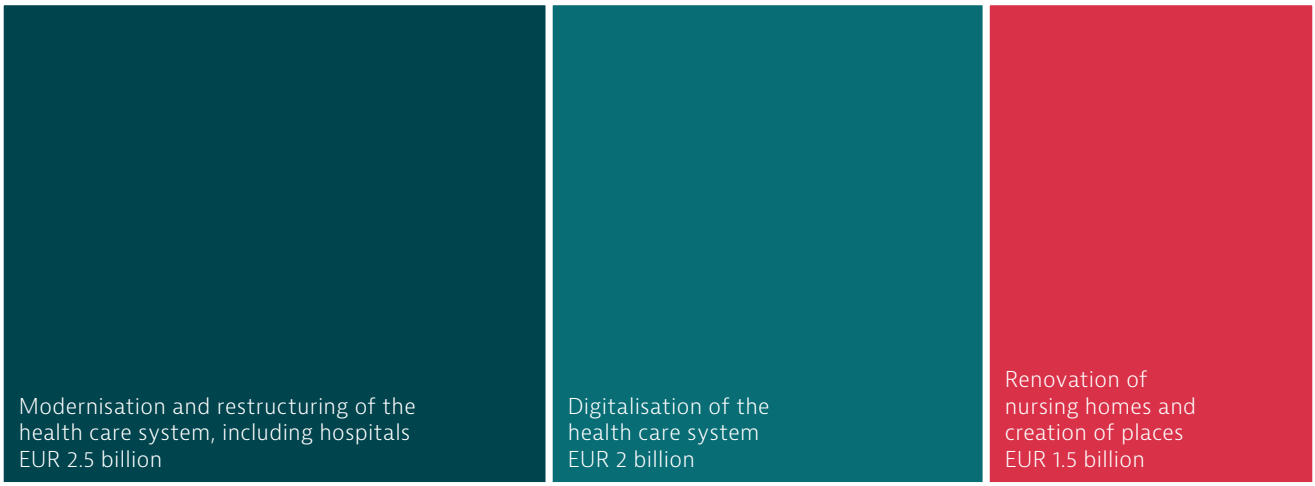


Source: OECD Health Statistics 2023.

France, 2021). The plan also includes significant pay rises that aim to increase recruitment and retention, especially for nurses. Nurses and nursing aides are expected to see their night shift pay increased by 25 % compared to daytime rates, and the allowance for working on Sundays and holidays raised by 20 %, starting in 2024.

France's Recovery and Resilience Plan – a key pillar of the EU's response to the COVID-19 crisis – will provide additional support to new investments in the health system. The proposed investments in health amount to EUR 4.5 billion over 2021-26, representing about 11 % of total grants for France under the EU Recovery and Resilience Fund. About EUR 2.5 billion will be invested to modernise the healthcare system including hospitals, and EUR 2 billion will be allocated to pursue digitalisation of the healthcare system, including investments in national infrastructure, digital medical records, secure exchange of data and digital skills training of health professionals. Another EUR 1.5 billion will be allocated to renovate nursing homes and create additional places (Figure 20). A small amount (EUR 2.9 million) will be allocated to suicide prevention programmes.

Figure 20. The Recovery and Resilience Plan aims to modernise and digitalise the health system, and improve capacity in nursing homes



Notes: These figures refer to the revised Recovery and Resilience Plan as of September 2023. Some elements have been grouped together to improve the chart's readability.
Source: European Commission – Recovery and Resilience Scoreboard.

These investments will be complemented by the rollout of the EU Cohesion Policy 2021-27 programming, through which France is set to invest a total of EUR 428 million in its health system. About 60 % of this amount will be co-financed by the EU. EUR 348 million from the European Regional Development Fund (ERDF) will be used for development of health infrastructure, e-health services and applications. An additional EUR 80 million from the European Social Fund Plus (ESF+) will finance various measures to improve the accessibility, quality and resilience of health services, prioritising workforce development and reducing access barriers for vulnerable groups

To supplement investments in digital health specifically, the government launched the Digital Health Acceleration Strategy in 2021. Supported by a budget of EUR 734 million from the France 2030 investment plan, the Strategy was conceived to catalyse innovation within the digital health sector, promoting development and adoption of cutting-edge digital technologies and bolstering the competitiveness of French companies in the global digital health landscape.

More broadly, one of the future challenges for the health system will be to improve the monitoring of costs, quality and outcomes in the hospital sector and other parts of the system to allow regular evaluation of performance (Or et al., 2023).

The pandemic and recent misconduct underlined structural issues in long-term care

The pandemic brought increased attention to the shortcomings of the long-term care sector in France. Structural challenges such as the fragmentation of the sector and the persistent lack of staff caused by unattractive working conditions affect the quantity, quality and safety of long-term care services. These structural challenges hindered the response to the pandemic. 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 in October 2021, depending on job tenure.

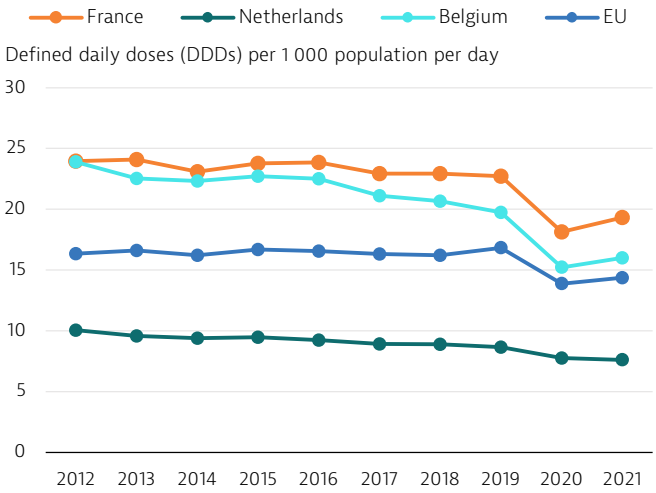
In addition, highly publicised misconduct involving some French private long-term care facilities emerged in 2020 and led to calls for better quality practices and stricter control. The misconduct was related to allegations of inadequate care and mistreatment of older residents, including insufficient staffing levels, very poor hygiene and nutrition, lack of proper medical care, abusive treatment and misuse of public funding. In response, the authorities ordered that all 7 500 long-term care facilities in France would be inspected within two years. A new decree also obliges all facilities to be more transparent about their services and the management of the sums billed to residents. Related financial penalties were also increased substantially. A national online platform for reporting abuse in nursing homes is also being developed. Nevertheless, no information is publicly available on the quality of nursing homes. In France, as in many other EU countries, there has been a lack of quality monitoring in long-term care.

Reducing the risks of other public health threats: France's efforts to tackle antimicrobial resistance

Antimicrobial resistance (AMR) is a major public health concern in the EU, with estimates of about 35 000 deaths due to antibiotic-resistant infections (ECDC, 2022) and healthcare-associated costs of around EUR 1.1 billion per year (OECD/ECDC, 2019). Antibiotic overprescription and overuse in humans are major contributors to the development of antibiotic-resistant bacteria.

France's antibiotic use in community settings (excluding hospitals) remained well above the EU average in 2021 (Figure 21), following a very modest reduction in the years before the pandemic. As in other EU countries, antibiotic use fell sharply (by 20 %) in France between 2019 and 2020. This decline can be at least partly attributed to reduced infections and hospitalisations due to pandemic-related measures. In 2021, the number of antibiotic prescriptions went up by 6 %, particularly in the last quarter of the year.

Figure 21. COVID-19 caused a significant reduction in antibiotic consumption



Notes: The EU average is unweighted. The data only cover consumption in the community (not in hospital).
Source: ECDC ESAC-Net

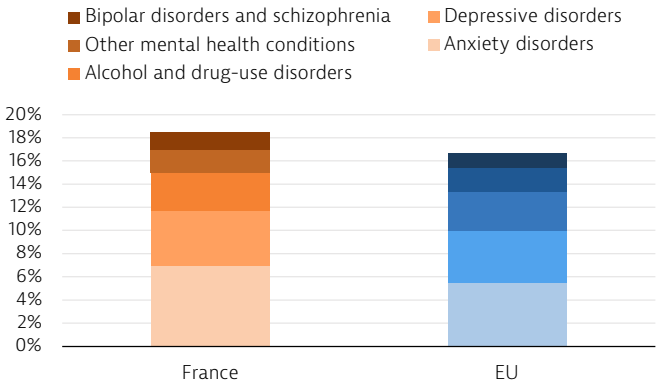
In the last decade, France's efforts to reduce the risk of AMR have focused on raising public awareness about antibiotic resistance and promoting responsible prescription and use of antibiotics among health professionals and patients. The recent National Prevention Plan 2022-25 on Infections and AMR outlines nine sets of actions that aim to ensure a comprehensive and cohesive approach among patients, health professionals and other health stakeholders.

6 Spotlight on mental health

The burden of mental health issues is heavy in France

Although there are significant gaps in information about the prevalence of mental health problems in France, the available evidence suggests that mental health issues affect more than 10 million French people every year. According to the latest IHME estimates, about 18 % of people had a mental health issue in France in 2019 – a slightly higher proportion than the EU average of 17 % (Figure 22). The most common mental disorders in France are anxiety disorders (7 % of the population), followed by depressive disorders (5 %). An estimated 3 % of the population have alcohol and drug-use disorders. Severe mental health conditions such as bipolar disorders and schizophrenia affect about 1 % of the population.

Figure 22. More than one in six people had a mental health issue in 2019

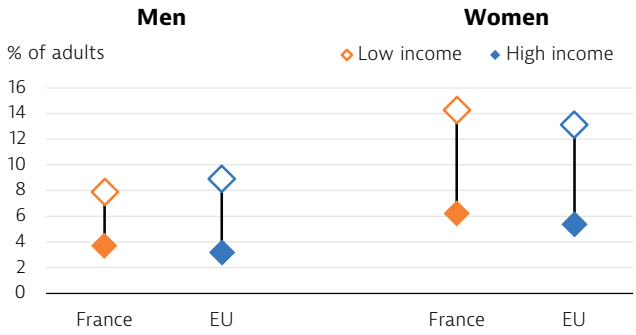


Note: The EU average is unweighted.
Source: IHME (data refer to 2019).

Several mental illnesses are more common among women in France, including anxiety, depressive and bipolar disorders. Some of these gender gaps may be due to a greater propensity of women to report these problems. However, one exception is alcohol and drug-use disorders, which are reported more frequently by men than women in France, as in other countries.

The socioeconomic disparity in self-reported depression is substantial. In France, as in other EU countries, people on lower incomes are more likely to report depression: about 8 % of men and 14 % of women in the lowest income quintile reported depression compared to only 4 % of men and 6 % of women in the highest quintile in 2019 (Figure 23). People who are employed typically report lower levels of depression than those who are unemployed, and people with mental health disorders are more prone to unemployment.

Figure 23. People on low incomes are twice as likely to report depression as those on high incomes



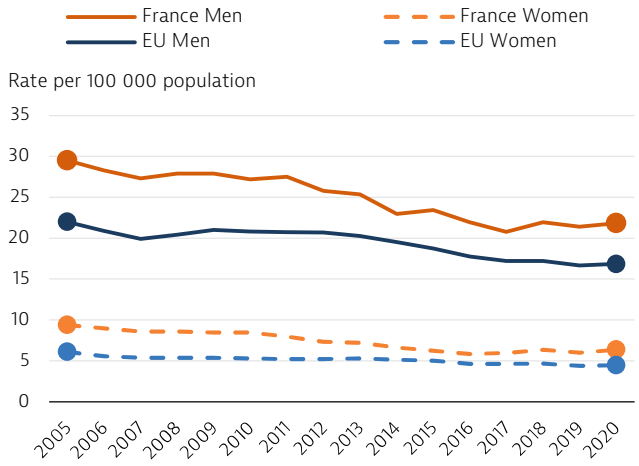
Note: High income refers to people in the top income quintile (20 % of the population with the highest income), whereas low income refers to people in the bottom income quintile (20 % of the population with the lowest income).
Source: Eurostat Database (based on EHIS 2019).

The number of suicides in France declined overall between 2005 and 2020, but remained above the EU average. As in other EU countries, about three quarters of the 9 000 deaths by suicide in 2020 in France were among men (Figure 24). However, the gender gap in suicide attempts is reversed, because women often use less lethal methods. Among the 68 500 French people who were hospitalised for suicide attempts in 2020, the rate was about 40 % greater for women than men (National Suicide Observatory, 2022).

The mental healthcare system remains hospital-centric and oriented towards severe mental health disorders

In the 2000s, France aimed to move beyond a traditional focus on psychiatry for mental health. Since then, mental health policies have aimed to promote a community-based approach, and to put greater emphasis on managing symptoms rather than attempting to cure illnesses. Because of the growing number of health and social care providers involved, a 2016 law reorganised the mental healthcare system around territorial projects to promote greater coordination of care among the various providers, with unknown effects to date. In 2020, fewer than 15 % of the 2 million people who received mental healthcare in a facility were hospitalised with overnight stays. However, 75 % of psychiatric care beds were still located in specialised psychiatric hospitals, limiting the integration of psychiatry into the general healthcare system (Coldefy & Gandré, 2022). Overall, the public mental healthcare system

Figure 24. Suicide rates have decreased in France since 2005, but remain above the EU averages



Notes: Since 2018, death certificates in France have incorporated a dedicated checkbox explicitly indicating suicide, resulting in higher reporting. This change in data reporting limits the comparability of data before and after that year. It is therefore premature to draw any firm conclusions on trends since 2018.
Source: Eurostat Database.

remains hospital-centric, with very long waiting times for access, and is focused mainly on severe disorders (Gandré et al., 2019).

The pandemic exacerbated mental health problems and led to stronger awareness of the importance of such issues and mental healthcare. In 2021, a wide consultation on mental health and psychiatry supported the government in defining three priorities: better information and prevention; more community-based mental healthcare and outreach activities; and more investment in research (Coldefy & Gandré, 2022).

Issues of access to appropriate treatment persist for people with mild-to-moderate mental health disorders

Mild-to-moderate mental health conditions form the bulk of mental health issues (e.g. depression and anxiety disorders). In practice, in France, mild-to-moderate mental health conditions are typically managed by GPs through drug treatments and referrals to psychotherapy. While psychotherapy is recommended as a first-line treatment, a prescription of antidepressant drugs alone is typically not, as these drugs come with numerous side-effects (Gandré et al., 2019). However, the most recent data available show that nearly half of patients with a mild-to-moderate depression were only prescribed drugs by GPs without a referral to psychotherapy in 2011 (Dumesnil et al., 2016).

The use of drugs to treat anxiety and depression increased substantially in 2020 and 2021, especially during the lockdowns, when more people reported mild-to-moderate mental health symptoms. The SHI covers these drugs, while psychotherapy conducted by self-employed psychologists was not generally covered until 2022.

During the pandemic, the SHI started to cover psychotherapy provided by psychologists for some at-risk population groups (such as students), and this coverage was extended in April 2022 to the whole population aged over 3, under certain conditions. The main condition is that a doctor must first provide a referral based on a defined set of mild-to-moderate mental health disorders. Public coverage includes a maximum of eight sessions per year (at a cost of up to EUR 40 for the first session and up to EUR 30 for the remaining seven sessions). However, many psychologists disagreed about both the compulsory doctor referral and the coverage level, and only 7 % had signed an agreement with the SHI to provide such psychotherapy by 2023.

A new reform of psychiatric hospital care funding encourages outpatient care and aims to reduce geographical inequalities

Until 2022, public and not-for-profit private hospitals providing psychiatric care received a fixed annual budget provided by regional health authorities, while for-profit clinics received activity-based funding, with day tariffs defined for each type of care provided. For public and not-for-profit private hospitals, the set budget did not factor in either cost–effectiveness and appropriateness of care provided to patients or changes over time in local mental health needs, resulting in inequalities in access within and across regions. For for-profit clinics, the low tariff for day cases provided strong incentives for inpatient care and long stays.

A reform of funding of psychiatric hospital care implemented in 2022 aims to encourage outpatient care and shorter hospital stays, reduce inequalities within and across regions, and harmonise financing schemes across public, not-for-profit and for-profit facilities. This reform combines various financing mechanisms, with about 85 % of funding allocated based on indicators of local population care needs in the public and not-for-profit sectors, while the for-profit sector receives only about 15 % of its allocation through this method. Conversely, patient-based allocation (based on the number of hospitalisation days and ambulatory procedures performed per patient per year) constitutes only around 15 % of funding in the public and not-for-profit sectors, but around 85 % in the for-profit sector.

7 Key findings

- Life expectancy in France remains substantially higher than the EU average, but it fell by more than half a year between 2019 and 2022 due to deaths from COVID-19, bad flu seasons and heatwaves in 2022.
- Behavioural risk factors – notably smoking, poor nutrition, alcohol drinking and lack of physical activity – contributed to about one third of all deaths in France in 2019. Public health has traditionally been neglected in France. Smoking rates and heavy drinking among adults have decreased over the past decade, but remain above the EU average.
- Health spending in France increased to 12.3 % of GDP in 2021, which was the second highest share in the EU after Germany and over 1 percentage point above pre-pandemic levels, although it fell slightly in 2022. The peak in 2021 was due mainly to the large increase in public spending on health during the pandemic.
- The French health system provides good financial access to care, with low out-of-pocket payments. Unmet needs for medical care are generally low, but they are higher among people on low incomes – particularly for services that are less comprehensively covered by public insurance such as optical and dental care, although public coverage has improved since 2021.
- Low numbers of general practitioners practising in underserved areas ("medical deserts") have raised growing concerns about access to care. A series of measures have been implemented over the past decade to attract and retain more doctors in underserved areas, including financial incentives to set up their practice in these areas and the creation of multidisciplinary health centres. The number of medical students has also increased sharply in recent years, and since 2017 40 % of all postgraduate internship positions must be allocated to general medicine. Other recent measures also aim to expand the roles of other health professionals to improve access to primary care – especially nurses and pharmacists. A new role of medical assistant was introduced to reduce the administrative tasks of general practitioners.
- To help maintain access to care during the pandemic, France rapidly changed the regulation on teleconsultations to scale them up, and they reached a peak of 24 % of all doctor consultations during the first lockdown in spring 2020. Thereafter, their popularity waned as confinement measured were lifted, and they made up only 4 % of all doctor consultations in 2021.
- Public spending on health grew by nearly 9 % in 2021, driven mainly by a catch-up effect following the drop in healthcare activities caused by the disruption to services in 2020, as well as the cost of the COVID-19 testing and vaccination campaigns. Preliminary estimates indicate that growth in public spending on health in 2022 returned close to the long-term trend, with a 2 % increase in real terms.
- Recent additional budget allocations to the health system aim to restore the financial capacity of public hospitals, improve the working conditions and pay rates of health professionals (especially nurses) to increase retention rates, improve coordination between ambulatory and hospital care, increase digitalisation of the health system and modernise the long-term care sector. Some of these new investments are supported by European funds.
- The prevalence of mental health issues in France is estimated to be slightly higher than the EU average. The most common issues are anxiety and depression. Substantial gender and income disparities exist, with individuals on lower incomes – particularly women – experiencing higher rates of depression. Despite improved public coverage of psychotherapy since 2022, challenges persist in the availability and coordination of care for those with mild-to-moderate disorders.

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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 2023

The *Country Health Profiles* are a key element of the European Commission's *State of Health in the EU* cycle, a knowledge brokering project developed with financial support from the European Union.

These Profiles are the result of a collaborative partnership between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, working in tandem with the European Commission. Based on a consistent methodology using both quantitative and qualitative data, the analysis covers the latest health policy challenges and developments in each EU/EEA country.

The 2023 edition of the Country Health Profiles provides a synthesis of various critical aspects, including:

- the current state of health within the country;
- health determinants, with a specific focus on behavioural risk factors;
- the structure and organisation of the health system;
- the effectiveness, accessibility and resilience of the health system;
- For the first time in the series, an account of the state of mental health and related services within the country.

Complementing the key findings of the Country Health Profiles is the Synthesis Report by the European Commission.

For more information, please refer to: ec.europa.eu/health/state

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