

## International Health Care System Profiles

May 2026

### Overview

France's statutory health insurance system provides coverage to all legal residents and undocumented migrants residing in the country for more than three months. Centrally governed by the Ministry of Health, Families, Autonomy and Persons with Disabilities, the system is financed through a combination of payroll taxes, national income taxes, and other taxes. While statutory health insurance covers most health care costs, most residents also have complementary health insurance.

Health care spending in France is high compared with many European countries: public funding makes up more than three-quarters of all health expenditure. The system performs comparatively well on several health outcomes, including life expectancy and maternal mortality. However, there are ongoing challenges related to workforce shortages, regional disparities in access to care, and growing pressure to improve efficiency. Since 2020, reforms have focused on improving care coordination and mental health care and on expanding the digital health infrastructure.

### Coverage and Access

#### Background and History

Universal coverage was achieved over seven decades by extending statutory health insurance (SHI) to all employees and retirees (in 1945), to self-employed people (in 1966), and to individuals not covered by any occupational systems (in 2000). Also in 2000, Universal Health Coverage (*Couverture maladie universelle*, or CMU) was created for residents not eligible for SHI.<sup>1</sup> The program required both yearly renewals and reports of entitlement changes whenever a beneficiary's professional or family situation changed.<sup>2</sup>

In 2016, SHI eligibility was universally granted under the Universal Health Protection system (*Protection universelle maladie*, or PUMa), which replaced and simplified the existing system by providing systematic coverage to all French residents. It merged the coverage for people previously covered by CMU with that for immigrants covered by the state-sponsored health insurance.<sup>3</sup>

#### The Role of Public Health Insurance

Since PUMa came into effect, all legal residents are entitled to public health coverage, although residents must complete an application to enroll. Once their application has been approved, coverage is continuous, and reenrollment is not necessary. Children under age 18 are automatically included in their parent or guardian's coverage as dependents.<sup>4</sup>

#### HEALTH SYSTEM BY THE NUMBERS

11.5%

Health care spending as a percent of GDP

82.6 years

Life expectancy at birth

100%

Public insurance coverage

SHI is divided into three types of noncompetitive programs, with enrollment in a particular program dependent on employment status (PUMa covers unemployed people). These programs are as follows:<sup>5</sup>

- **National Health Insurance Fund (*Caisse nationale d'assurance maladie*, or **CNAM**):** In 2021, this fund covered 88 percent of the population. It includes all residents who are not eligible for one of the other programs.
- **Agricultural Social Mutual Fund (*Mutualité sociale Agricole*, or **MSA**):** This fund covers agricultural workers, farmers, and their families, who make up about 5 percent of the population.
- **Programs for defined groups of workers:** More than 20 programs have been designed for workers ranging from civil servants and railway employees to the clergy and military personnel. In 2022, these covered about 7 percent of the population.

The state covers health care for undocumented migrants residing in France for more than three months (see *Safety Nets*).<sup>6</sup> Visitors from the European Economic Area (E.E.A.) and Switzerland are covered by an E.U. insurance card.<sup>7</sup>

## Insurance Coverage (Percentage of Population)



\* Coverage is either through nonprofit mutual insurance companies, nonprofit institutions, or private for-profit insurance.

Source: OECD Data Explorer, [Healthcare coverage – France](#), distributed by OECD, accessed November 2, 2025; Aurélie Pierre and Thierry Rochereau, “[Lack of supplementary health insurance coverage in France in 2019: Initial results from the European Health Survey \(EHIS\)](#)” (L’absence de couverture par une complémentaire santé en France en 2019: Premiers résultats de l’Enquête santé européenne [EHIS]), Institute for Research and Information in Health Economics (Institut de recherche et documentation en *économie* de la santé), accessed November 2, 2025.

Annual contributions for each form of coverage are determined by parliament.<sup>8</sup> In 2024, SHI funding was supplied as follows:<sup>9</sup>

- 37 percent from payroll contributions (employer only — employee contributions were removed in 2018)
- 23 percent from the generalized social contribution (*contribution sociale généralisée*, or CSG), which is a revenue-based tax levied on multiple income sources
- 31 percent from taxes (including value-added tax [*taxe à la valeur ajoutée*, or TVA] and taxes levied on tobacco and alcohol)
- 9 percent from other contributions and state subsidies.

## Services Covered by Public Health Insurance

The following services are covered under SHI:<sup>10</sup>

- Preventive care (vaccinations and cancer screenings)
- Inpatient care (partial coverage)
- Outpatient care provided by dentists, physicians, and midwives
- Maternity care
- Primary care
- Pharmaceuticals (partial to full coverage for approved medication)
- Basic dental services
- Eye care (optical devices)
- Mental health care (partial coverage)
- Palliative care (partial coverage)
- Long-term care
- Rehabilitation
- Home visits, including full coverage for patients over age 80, women more than six months pregnant, individuals suffering from a disabling illness, and people hospitalized at home, with other home-visit patients subject to copayments
- Assistive devices (specifically prescribed medical and prosthetic devices, such as wheelchairs, are listed as eligible for reimbursement).

When a patient has been referred by primary care, SHI covers care from allied health professionals such as physiotherapists, nurses, and podiatrists.<sup>11</sup>

The 100% Health reform (*réforme 100% santé*) was introduced in 2020 to reduce out-of-pocket costs for dental care, eye care, and hearing equipment. Services and products in the program's "basket," such as basic dental care, dentures, glasses, and hearing aids, are covered. Children under age 16 are covered for annual dental checkups, cleaning, fillings, root canal work, orthodontic treatments, and extractions.<sup>12</sup>

The government covers 90 percent of the costs associated with home-based palliative care; patients with long-term chronic conditions (including cancer and neurodegenerative diseases) are fully covered. Inpatient palliative care is also covered by SHI, except for a daily hospital fee that's typically reimbursed by the patient's complementary health insurance (see [The Role of Private Health Insurance](#)).<sup>13</sup>

## Safety Nets

In 2019, the government introduced a complementary health insurance (*complémentaire santé solidaire*, or C2S).<sup>14</sup> C2S eligibility is based on income and household size. In mainland France, for example, a single person earning EUR 10,339 (USD 9,553) or less a year qualifies for free C2S coverage. If their income is higher but still below EUR 13,957 (USD 12,896), they must pay a small monthly contribution (typically less than EUR 1 [USD 1] per day).

Income thresholds increase with household size and are slightly higher in France's overseas territories, where the limits for a single person range from EUR 11,507 (USD 10,632), which gains them free coverage, to EUR 15,534 (USD 14,353), which gains them coverage with a contribution.<sup>15</sup>

State medical aid (*Aide médicale de l'État*, or AME) provides a similar safety net for undocumented migrants who have lived in France for at least three months. AME covers all health care costs within standard reimbursement rates and doesn't require upfront payments. Eligibility for AME is based on the same income thresholds as C2S without a contribution. Under AME, a nine-month wait period applies for certain nonurgent treatments, such as prostheses and cochlear implants.<sup>16</sup>

## The Role of Private Health Insurance

Complementary health insurance (CHI), mostly provided by private health insurance (*mutuelles de santé*), is designed to supplement SHI, not replace it. CHI mainly covers copayments, balance billing, and services partially covered by SHI. Some CHI plans also offer coverage for services that aren't included in SHI, such as corrective eye surgery, or provide access to enhanced hospital amenities, such as private rooms.<sup>17</sup>

CHI is available through one of the following:<sup>18</sup>

- Nonprofit mutual health insurance companies, which mainly offer individual policies and largely serve older adults
- Nonprofit institutions, which are jointly managed by employer and employee representatives and focus on collective contracts for working people
- Private for-profit insurance companies, which operate across both individual and collective segments
- C2S, which is state-funded complementary insurance (*see Safety Nets*).

As of 2019, 96 percent of the population had CHI: over half (53%) were covered by an individual contract; 37 percent were covered by a collective contract; and 6 percent by free C2S coverage.<sup>19</sup>

Premium contributions and access to CHI are affected by employment status. Since 2016, all employers have been required to offer CHI to their employees and to cover at least 50 percent of the premium cost. Anyone not covered through employment — such as self-employed and unemployed people — purchases individual contracts.<sup>20</sup>

## The Role of Government

The provision of health care is a national responsibility under the Ministry of Health, Families, Autonomy and Persons with Disabilities (*ministère de la Santé, des Familles, de l'Autonomie et des Personnes handicapées*, as of October 2025). It oversees health policy, social protections and family affairs and defines the national health strategy.<sup>21</sup>

Locally, the ministry is represented by the Regional Health Agencies (*Agences régionale de santé*, or ARS), which are responsible for coordinating population health and health care, including prevention and care delivery, public health, and social care. ARS works in partnership with local authorities, health professionals, and public institutions to implement regional health strategies and coordinate services across sectors.<sup>22</sup>

Other important government agencies include:<sup>23</sup>

- **The Public Health Agency (*Santé publique France*)**, which monitors public health trends, supports health promotion and prevention, and responds to health threats
- **The National Authority for Health (*Haute Autorité de santé, or HAS*)**, which assesses drugs, medical devices, and procedures; publishes guidelines; accredits health care organizations; and handles the certification of health professionals
- **The National Agency for the Safety of Medicines and Health Products (*Agence nationale de sécurité du médicament et des produits de santé, or ANSM*)**, which oversees the safety of health products, from manufacturing to marketing
- **The Technical Agency for Information on Hospital Care (*Agence technique de l'information sur l'hospitalisation, or ATIH*)**, which manages the hospital activity data used for planning and financing.

## Integration and Care Coordination

Since 2016, the government has been rolling out territorial professional health communities (*communautés professionnelles territoriales de santé, or CPTS*). These voluntary networks of primary, secondary, and long-term care professionals work together to address population-level health needs and improve care coordination. As of 2021, 670 CPTS had been established, but levels of implementation vary because of administrative complexity and uneven uptake.<sup>24</sup>

In parallel, the government has supported the growth of multidisciplinary health centers (*Maisons de santé pluriprofessionnelles, or MSPs*). These bring together general practitioners (GPs) and allied health professionals and were particularly important during the COVID-19 pandemic. Group practices, including MSPs, were more resilient than solo practices during the pandemic, offering better continuity of care, remote consultation capabilities, and patient follow-ups.<sup>25</sup>

In 2023, the government announced plans to create new MSPs and CPTS to improve access and coordination for more than 2 million additional patients in underserved areas.<sup>26</sup>

# Operations and Resources

## Overview of the Delivery System

Health care delivery can be broadly categorized into the following groups:<sup>27</sup>

- **Primary care** is provided in health care centers and emergency walk-in centers by self-employed GPs and nurses in group or solo practices, covering urgent and nonurgent care needs.
- **Specialist care** is provided in hospital outpatient departments by self-employed specialists in group or solo practices for nonurgent care needs. Patients can access this care directly or via referral.
- **Acute care** is provided in hospitals and emergency departments. Patients with nonurgent care needs can get this care directly or via referral.
- **Post-acute care** is provided in rehabilitation hospitals and through home care services for nonurgent care needs. Patients can get this care directly or via referral.

Provider payment mechanisms have traditionally relied on fee-for-service systems for self-employed practitioners and activity-based payments for hospitals. As these models have been criticized for incentivizing quantity over quality and limiting care coordination, a series of reforms since 2015 have introduced mixed payment systems, including capitation (a fixed payment for every patient), global budgets, pay-for-performance, and bundled payments (*see Hospitals*).<sup>28</sup>

These reforms also piloted lump-sum payments for services such as extended hours and interprofessional care planning. By 2020, over half of registered MSPs were receiving these add-on payments, and more than 1,600 MSPs had been established — up from just 312 in 2008 (*see Integration and Care Coordination*).<sup>29</sup>

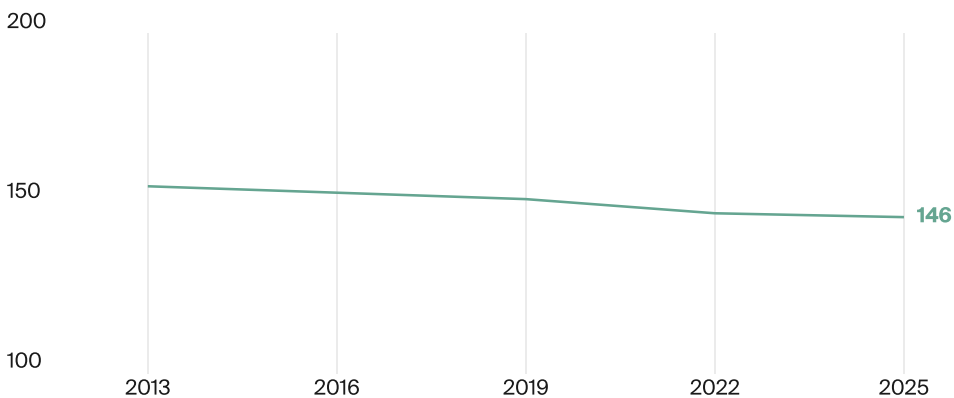
## Primary Care

Primary care is provided by a broad range of health professionals, including GPs, medical specialists (such as gynecologists and pediatricians), and allied health professionals (such as nurses and pharmacists).<sup>30</sup>

As of 2022, 69 percent of GPs were practicing in group settings, up from 54 percent in 2010. These settings range from monodisciplinary arrangements (for example, several independent GPs sharing a space) to multidisciplinary teams of health professionals. Patients are encouraged to designate an attending GP or specialist to coordinate their care, manage any referrals, and maintain their medical file, although doing so is voluntary for those age 16 and older.<sup>31</sup>

In 2025, France had 100,019 GPs — 146 for every 100,000 people — a higher rate than in England (64 in 2024) or Germany (105 in 2023).<sup>32</sup> Of these GPs, 56 percent were self-employed, 34 percent were salaried (including GPs at hospitals or health clinics), and 10 percent were both salaried and self-employed.<sup>33</sup>

## Number of GPs per 100,000 People, 2013–25



Source: Directorate of Research, Studies, Evaluation, and Statistics (Direction de la recherche, des études, de l'évaluation et des statistiques), *The demographics of healthcare professionals since 2012* (La démographie des professionnels de santé depuis 2012), distributed by DREES, accessed December 19, 2025.

Self-employed primary care providers are paid on a fee-for-service basis, with nationally negotiated fees determined by agreements involving SHI funds, professional unions, and the government. Group practices can also access alternative payment models that reward collaboration, care coordination, and accessibility improvements (see *Overview of the Delivery System*).<sup>34</sup>

Primary care physicians are not mandated to provide after-hours care. Instead, out-of-hours services are provided by on-call centers that operate during evenings, weekends, and holidays to manage nonemergency conditions. These facilities are organized regionally by ARS, and access is coordinated through emergency call centers. Physicians participate in scheduled rotations and are compensated through regulated on-call and consultation surcharges.<sup>35</sup>

Despite efforts to improve organizational integration, there are access challenges. In 2020, 6 percent of the population lived in areas with insufficient GP coverage, and in 2021, 20 percent reported difficulty seeing one or more primary care providers.<sup>36</sup>

In response, the government expanded the roles of allied health professionals. Since 2021, patients can designate an “attending pharmacist” to renew prescriptions, adjust dosages, and monitor specific patient groups, such as people with asthma. Additionally, direct access to physiotherapists, speech therapists, and orthoptists has been introduced in selected care settings.<sup>37</sup>

In 2022, there were 328 doctors for every 100,000 people, lower than the averages for both high-income countries (360 in 2020) and E.U. countries (410 in 2020).<sup>38</sup>

## Outpatient/Specialist Care

In 2024, there were 196 specialists for every 100,000 people, up from 180 in 2021 but below other E.U. countries, such as Germany (349) and Spain (277), in 2021.<sup>39</sup> In 2024, roughly the same proportion of specialists were salaried (including at public or private hospitals or outside hospital settings, such as in health clinics) as were self-employed (45% and 43%, respectively). Twelve percent of specialists were both salaried and self-employed.<sup>40</sup>

Some specialties, such as infectious diseases and genetic medicine, are mainly hospital-based. Others, such as nephrology, have a significant share of outpatient consultations, which are reimbursed on a fee-for-service basis.<sup>41</sup>

Just as in primary care, group practices among specialists are becoming more common, particularly in fields that require substantial technological investment, such as radiotherapy and pathology.<sup>42</sup>

In 2024, specialist consultation fees began a phased increase. For example, the consultation fee for gynecologists was increased to EUR 37 (USD 34) and reached EUR 40 (USD 37) in July 2025. Psychiatric consultations increased to EUR 55 (USD 51) in December 2024 and to EUR 57 (USD 53) in July 2025.<sup>43</sup>

## Physician Education and the Workforce

Medical education typically lasts nine to 12 years, depending on the specialty. The curriculum is divided into three cycles:

- First cycle (three years): Students can choose between a health-focused first year with a non-health-related minor or a general bachelor's degree with a health option. Both options contain introductory courses in biology, chemistry, public health, and medical ethics.<sup>44</sup>
- Second cycle (three years): The teaching over this period combines theoretical instruction with hospital-based clinical training.<sup>45</sup>
- Third cycle (three to six years): This is a residency that sees students take on additional responsibilities, culminating in a final year as junior doctors. In their final year, students can serve as short-term replacement physicians in underserved regions.<sup>46</sup>

General medicine graduates must complete at least six months of outpatient training in ambulatory care services (which are mostly found in underserved regions). This requirement is gradually expanding to other specialties. As of 2023, physicians must undergo recertification every six years, a process which involves continuous training and evaluation overseen by professional councils.<sup>47</sup>

Public tuition costs are low because of state subsidies. For the 2025–26 academic year, standard annual tuition fees range from EUR 178 (USD 164) for initial medical studies to between EUR 525 (USD 485) and EUR 1,376 (USD 1,271) for final degrees and health specializations, depending on the program. These rates also apply to E.U./E.E.A. and Swiss nationals, as well as to non-E.U. students with protected status, such as refugees.<sup>48</sup>

Unprotected non-E.U. students who enrolled in 2025–26 are required to pay differentiated fees ranging from EUR 2,895 (USD 2,675) to EUR 3,941 (USD 3,641) per year, depending on the level of study.<sup>49</sup>

The number of medical graduates in France has increased from 9 for every 100,000 people in 2016 to 11.3 in 2023, but it is still below the E.U. average of 15.2.<sup>50</sup>

## Number of Medical Graduates per 100,000 People, 2023



Source: Eurostat Data Browser, [Health graduates](#), distributed by Eurostat, last updated July 15, 2025.

There are several workforce challenges, including an aging physician population — nearly one-third of people were over age 60 in 2024 — and workforce shortages.<sup>51</sup> Shortages are particularly severe in rural regions. For example, in 2024, the number of GPs ranged from 234 for every 100,000 people in Paris to 88 in Seine-et-Marne (a suburban department); the number of specialists ranged from 676 in Paris to 84 in Eure (a provincial department).<sup>52</sup>

Financial incentives and group practice models have had limited success in attracting doctors to underserved areas. Surveys show that young doctors, when choosing where to practice, often prioritize proximity to family, quality of life, and local infrastructure over financial compensation.<sup>53</sup>

In April 2025, parliament adopted a proposal stipulating that doctors must seek approval from regional health authorities before establishing a practice in a well-served area.<sup>54</sup> While intended to increase access to care in “medical deserts,” this proposal was met with resistance from medical professional unions, which viewed it as a threat to practice autonomy.<sup>55</sup>

In the same month, the government proposed an alternative plan requiring all physicians to work up to two days per month in underserved areas, with potential penalties for noncompliance.<sup>56</sup> These reforms quickly triggered nationwide strikes and protests, in which medical students, residents, and practicing doctors all participated.<sup>57</sup>

As of 2020, 11.8 percent of physicians were foreign-trained, although a large proportion of these were French nationals. France is a net importer of physicians, but the number of foreign-trained, non-French-born doctors entering the country has declined from 65 percent of foreign-trained entrants in 2011 to 22 percent in 2019. In contrast, it’s common for French-trained doctors to emigrate to Belgium, Switzerland, and other neighboring countries, where salaries are higher and working conditions are often better.<sup>58</sup>

## Hospitals

As of 2019, there were 3,008 hospitals, of which 45 percent were public, 33 percent were private for-profit, and 22 percent were private nonprofit hospitals.<sup>61</sup> The private sector handles the majority of surgical procedures (57%) and outpatient surgeries (68%), while public hospitals are more likely to handle emergency services (83%) and complex medical cases.<sup>62</sup>

The government has introduced mixed payment systems to improve the quality and coordination of care in hospitals (see [Overview of the Delivery System](#)).

## HOSPITALS BY THE NUMBERS

In 2022, there were **565 hospital beds per 100,000 people** (average of 540 across high-income countries in 2020).<sup>59</sup>

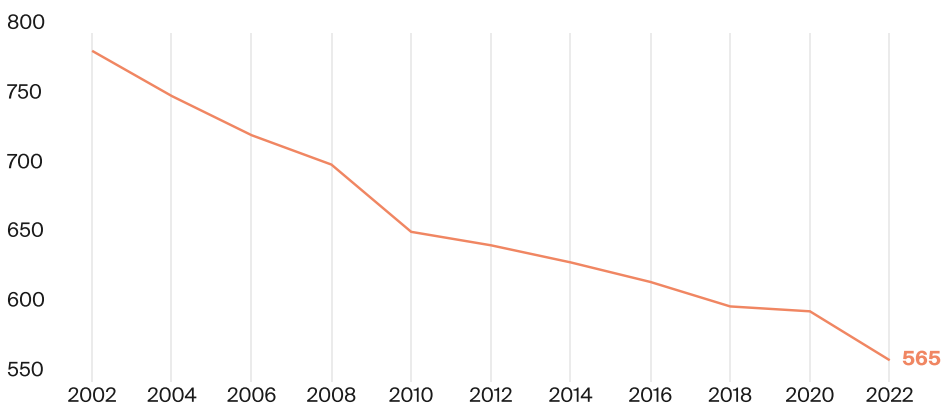
In 2021, there were **942 nurses per 100,000 people** (average of 826 in Europe in 2022).<sup>60</sup>

Notably, emergency department funding shifted in 2021 to a model that combines capitation, activity-based payment, and pay for performance.<sup>63</sup>

All hospitals are subject to a mandatory certification process every four years, overseen by the HAS. In 2020, the process was overhauled to emphasize patient outcomes, teamwork, and local care coordination.<sup>64</sup> As of 2021, nearly every acute-care hospital had participated in a national pay-for-performance program that rewards facilities based on quality indicators such as safety, organization, and patient experience.<sup>65</sup>

Hospitals have been facing mounting structural pressures. The number of beds fell by 11 percent between 2013 and 2023 — a loss of 43,000 beds — making it more difficult to admit patients from emergency departments.<sup>66</sup> In addition, although the proportion of nurses is higher than the European average, hospitals struggle to retain nursing staff because of the heavy workloads, low autonomy, and limited recognition.<sup>67</sup>

### Number of Hospital Beds per 100,000 People, 2002–22



Source: The Global Health Observatory, [Hospital beds \(per 10,000 population\)](#), distributed by World Health Organization, accessed November 1, 2025.

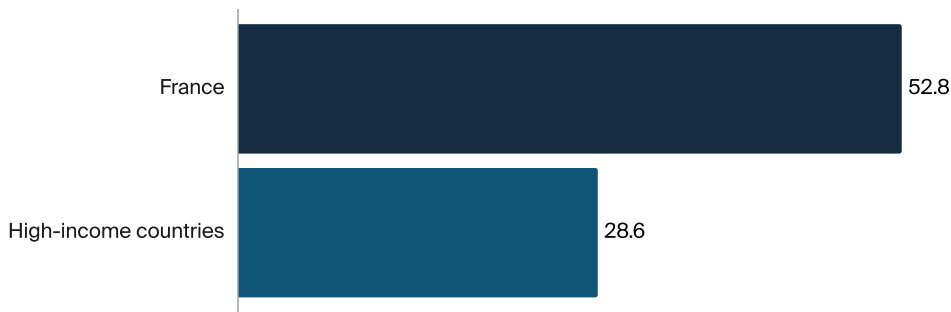
These pressures have led to longer wait times. In 2023, the median time spent in emergency departments exceeded three hours, up from 45 minutes in 2013. The problem is worse for older patients: 36 percent of those 75 and older waited longer than eight hours.<sup>68</sup>

A hospital reform package announced in 2023 included changes to hospital funding to better support complex care, the recruitment of thousands of medical assistants to ease physicians' workloads, and a review of hospital working hours.<sup>69</sup>

## Mental Health Care

Services for people with mental illness are provided by both the public sector and the private nonprofit sector. However, care remains predominantly hospital-centered, despite efforts to strengthen community-based provision.<sup>72</sup>

### Number of Mental Hospital Beds per 100,000 People, 2020



Source: World Health Organization, *Mental Health Atlas 2020* (WHO, 2021).

Since 2022, SHI has partially reimbursed sessions with psychologists through the “My Psychological Support” (Mon soutien psy) program.<sup>73</sup> This was launched to expand access to psychological care for individuals experiencing mild to moderate mental health conditions such as anxiety, depression, sleep issues, and eating disorders. Patients age 3 and older can access up to 12 sessions a year with a licensed psychologist. SHI covers 60 percent of the consultation fee, with the remainder typically covered by CHI. Copayments don’t apply to patients diagnosed with long-term psychiatric disorders, including bipolar disorder and depression.<sup>74</sup>

Mental health is a significant public concern. As of 2024, 41 percent of adults reported having experienced a mental health issue such as depression, burnout, or suicidal thoughts.<sup>75</sup> In March 2025, the government estimated that one in four people would suffer from a mental health issue at some point during their lifetime.<sup>76</sup>

In response, the government designated mental health its top priority for 2025.<sup>77</sup> The aim has been to combat stigma, improve early diagnosis and access to care, and better integrate mental health into all aspects of public policy and daily life.<sup>78</sup>

Psychologists are increasingly involved in regional mental health planning, community-based prevention, and support for at-risk groups, particularly adolescents. In 2024, the government announced that it would double the number of youth mental health centers offering integrated psychological support by 2028. Currently, there are 125 such centers.<sup>79</sup>

### MENTAL HEALTH CARE BY THE NUMBERS

In 2020, there were **53 mental hospital beds per 100,000 people** (29 across all high-income countries).<sup>70</sup>

There were **24 psychiatrists per 100,000 people** in 2020, higher than the average of nine for high-income countries.

In 2020, there were **142 mental health professionals per 100,000 people**, much higher than the average of 62 in high-income countries.<sup>71</sup>

## Long-Term Care and Social Support

Health and social care for elderly and disabled people comes under the jurisdiction of the country's general councils (départements français), which are the governing bodies at the local level.<sup>80</sup>

In 2019, long-term care was provided in 7,519 residential nursing homes, 600 long-term care hospital departments, 2,291 publicly funded residential care facilities, and 620 private care homes. Of the residential nursing homes, 44 percent were public, 31 percent were private nonprofit, and 24 percent were private for-profit.<sup>81</sup>

Home care for the elderly is provided by self-employed physicians and nurses, home nursing services, and community services. These are covered by SHI and aren't means-tested.<sup>82</sup> Temporary care and respite services are also available without means-testing and have been strengthened under a national caregiver strategy that introduced a paid caregiver leave allowance in 2020. This was increased in 2022 and now covers more caregivers, including those looking after people with milder levels of dependency, and pays up to about EUR 62 (USD 57) per day or EUR 31 (USD 29) for half a day of leave. However, uptake remains limited: between October 2020 and January 2023, only 10,614 people had been granted the allowance, and 60 percent of applications had been turned down, mostly because people didn't meet the eligibility criteria.<sup>83</sup>

SHI covers the medical costs of long-term care in facilities, but informal caregivers are responsible for housing costs. These out-of-pocket payments can be partially reimbursed by CHI. End-of-life care provided in hospitals and through hospital-at-home arrangements is covered by SHI.<sup>84</sup>

The funding for home care and services for the elderly and disabled comes from the National Solidarity Fund for Autonomy (Caisse Nationale de Solidarité pour l'Autonomie, or CNSA), which is financed by SHI, earmarked taxes, and the revenues from "solidarity day" (Journée de solidarité) — one day each year when employers pay a contribution to SHI equivalent to a day's wages. Local authorities and payroll taxes also contribute to financing these services.<sup>85</sup>

Means-tested cash allowances are provided through the Personal Autonomy Allowance (Allocation personnalisée d'autonomie, or APA), a national program administered by general councils that supports individuals age 60 and over who need help with daily activities. The amount of APA paid is based on assessed levels of dependency and income; recipients can use it to pay for approved personal care services at home or in residential facilities.<sup>86</sup> The number of people receiving APA has increased dramatically over the past few decades: from 596,917 people in 2002<sup>87</sup> to 1.3 million people in 2022.<sup>88</sup>

Long-term care providers are increasingly facing worker shortages, particularly of nursing aides and home support staff. In 2018, 44 percent of nursing homes reported difficulties in recruiting personnel. These challenges are mainly linked to difficult working conditions and low pay.

The 2020 health plan reform (Ségur de la santé) aimed to improve working conditions for 1.5 million health professionals in acute and long-term care facilities. By 2021, the reform had increased the wages of health professionals by an average of 15 to 20 percent.<sup>89</sup>

# Cost and Affordability

## Health Care Spending Overview

Health care spending has remained stable since 2009, staying between 11 and 12 percent of gross domestic product (GDP). In 2023, it was 11.5 percent, higher than the average in both high-income countries (8.2%) and across Europe (8.1%).<sup>90</sup>

## Health Care Spending as a Percentage of GDP, 2022



Source: The Global Health Observatory, [Current health expenditure \(CHE\) as percentage of gross domestic product \(GDP\)](#), distributed by World Health Organization, accessed November 1, 2025.

In 2023, total health spending in France was EUR 325 billion (USD 300 billion) — 3.5 percent more than in 2022. In 2022, per capita spending was EUR 4,615 (USD 4,992) compared with EUR 3,468 across the E.U. (USD 3,753).<sup>91</sup>

The biggest contributor to health expenditure is public funding, which accounted for 75.4 percent of spending in 2022, followed by prepaid private spending (15.7%) and out-of-pocket spending (8.9%).<sup>92</sup>

These figures are based on international standards. France generally measures health expenditure using the consumption of healthcare and medical goods (consommation de soins et de biens médicaux, or CSBM) indicator, which tracks expenditure on distinct health care goods and services. The CSBM reports that public funding in 2023 accounted for 80.1 percent of spending, followed by 12.4 percent from complementary health insurers and 7.5 percent in out-of-pocket costs.<sup>93</sup>

Thomas Rapp, codirector of the Health Policy program at the Laboratory for Interdisciplinary Evaluation of Public Policies (a Sciences Po research platform) and professor of economics at Université Paris Cité, notes that there are growing concerns about how efficiently resources are used in health care. “Close to 20 percent of health care spending is wasted,” he says. “This has prompted national conversations about how to reallocate spending from low-value to high-value care — particularly through improved data use, care coordination, and performance-based approaches.”<sup>94</sup>

## Pharmaceutical Spending

Pharmaceuticals made up 12.9 percent of health spending in 2023.<sup>95</sup> That same year, the average spend per capita on pharmaceuticals was USD 881, making for a compound annual growth rate of 3.1 percent since 2013.<sup>96</sup>

France is the fourth-largest pharmaceutical manufacturer in Europe and represents 2 percent of the global market (based on 2024 figures).<sup>97</sup> Its pharmaceutical market generated USD 27 billion in revenue by 2024, with oncology being the leading therapeutic area. By 2030, the overall market is forecast to reach USD 36 billion.<sup>98</sup>

SHI covers about 80 percent of pharmaceutical spending, reimbursing prescription medicines based on their assessed effectiveness. To qualify for SHI reimbursement, drugs must appear on a “positive list” approved by ministerial decree, following evaluations by the Transparency Commission (Commission de la Transparence, or CT) and the Economic Committee for Health Products (Comité économique des produits de santé, or CEPS).<sup>99</sup> These negotiate the prices of all reimbursable medicines before they enter the market, taking into account factors such as therapeutic benefit, cost-effectiveness, and pricing in other European countries.<sup>100</sup>

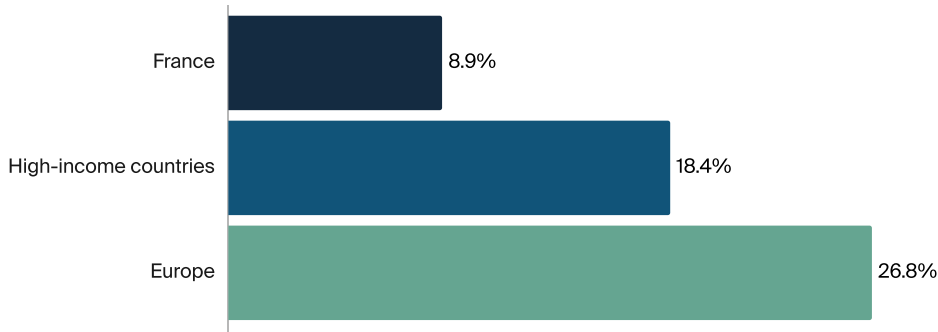
Despite various policies aimed at promoting the use of generic medicines — including pharmacist substitution rights, financial incentives for doctors and pharmacists, and lower reimbursement for non-generic medicines — generic pharmaceutical use was just 30 percent of the reimbursed pharmaceutical market in 2019. By comparison, generic usage is 83 percent in Germany and 85 percent in the U.K.<sup>101</sup>

Since December 2024, the pricing process has taken manufacturing location and public procurement prices into account as part of a policy push to boost domestic production and supply security.<sup>102</sup>

## Cost Sharing and Out-of-Pocket Spending

In 2023, out-of-pocket spending made up 9.3 percent of total health expenditure, up from 8.9 percent in 2022.<sup>103</sup> Measured using the CSBM (see [Health Care Spending Overview](#)), total out-of-pocket spending in 2023 made up 7.5 percent of total health expenditure, representing EUR 18.6 billion (USD 17 billion).<sup>104</sup>

## Percentage of Health Care Spending That Is Out of Pocket, 2022



Source: World Health Organization, [Out-of-pocket expenditure as percentage of current health expenditure](#), accessed November 5, 2025.

In 2023, out-of-pocket spending on medicines was 12.4 percent higher than the average out-of-pocket rate. France's higher out-of-pocket spending is largely driven by spending on nonreimbursable medicines (which made up 10 percent of outpatient drug spending in 2023) or medicines purchased without a prescription (which cannot be reimbursed by SHI or CHI).<sup>105</sup>

Therapies with the highest clinical value are eligible for up to full reimbursement, and less essential drugs are reimbursed at rates starting at 15 percent.<sup>106</sup> Patients have to pay a flat charge of EUR 1 (USD 1) for each prescribed medication (except for any that are prescribed in hospital), but France applies an annual cap of EUR 50 (USD 46) for every person on this charge.<sup>107</sup>

Coinurance and copayments vary according to the type of service and the effectiveness of the treatment. SHI covers 80 percent of inpatient stays, 70 percent of outpatient visits, and between 15 and 100 percent of approved medications (see *Pharmaceutical Spending*).<sup>108</sup>

To encourage gatekeeping, patients who bypass referral by their attending physician are subject to a reduced reimbursement rate of 30 percent. Psychiatric, gynecological, and ophthalmological care for individuals under age 26, together with all pregnancy-related care, are excluded from this deterrent. These services can be accessed without a referral and are reimbursed at the maximum rate of 70 percent.<sup>109</sup>

While specific exemptions exist for certain groups, such as individuals with chronic illnesses or those enrolled in the C2S system (see *Safety Nets*), no annual or income-based cap is placed on total out-of-pocket costs.<sup>110</sup>

There are currently no data available that confirm whether people have been pushed below the poverty line by out-of-pocket costs.

## How Are Costs Contained?

One initiative that helps to contain costs is the expansion of hospital-at-home (hospitalisation à domicile, or HAD) services, which provide complex medical care in the patient's home as an alternative to inpatient stays. In 2023, HAD activity (as measured by the number of care days) increased since the previous year by 6 percent. The service is integrated into care pathways, with 50 percent of HAD activity following hospital stays and 39 percent coming directly from patients living at home.<sup>111</sup>

Some physicians are allowed to charge more than the standard national fee reimbursed by SHI — a practice known as balance billing. To encourage moderation, a voluntary controlled pricing program (Option de pratique tarifaire maîtrisée, or OPTAM), asks doctors to agree to limit their extra charges in exchange for financial incentives.<sup>112</sup>

To control pharmaceutical spending, policies implemented in February 2025 raised the pharmacy-level discount ceiling for both generic and biosimilar medications to 40 percent. Pharmacists can now offer lower-cost biosimilars after just one year following the drug's appearance on the market, instead of two years. However, uptake of generics remains uneven, partly because of patient preference for branded drugs.<sup>113</sup>

## Quality and Outcomes

### Health Outcomes

In 2024, life expectancy at birth was 85.6 years for women and 80.0 years for men — a gap of 5.6 years.<sup>123</sup>

In 2023, the maternal mortality rate was low: 7.3 deaths for every 100,000 live births, compared with a European average of 11.2 and a global average of 197.3.<sup>124</sup>

A 2022 study estimated that 925,886 people in France had Alzheimer's disease.<sup>125</sup> The Paris Brain Institute (Institut du Cerveau) at Pitié-Salpêtrière University Hospital reports that there are 225,000 new cases annually, and women comprise about 60 percent of those diagnosed.<sup>126</sup>

### Addressing Health Inequities

Although women in France have longer life expectancies, they're more likely to live a longer portion of their lives with physical limitations. In 2020, 31 percent of women over age 65 reported activity limitations, compared with 25 percent of men. In 2019, women also reported higher rates of anxiety and depression, while alcohol and substance use disorders were more common in men.<sup>127</sup>

Ethnic minorities and migrant groups also face health disparities (despite the AME system — see *Safety Nets*). This was particularly noticeable during the COVID-19 pandemic: in 2020, increases in mortality among people born in sub-Saharan Africa (114%), Asia (91%), and North Africa (54%) were far higher than increases in mortality among people born in France (22%).<sup>128</sup> A major factor here is housing conditions. Between 2019 and 2020, migrants were more than three times as likely as the general population to live in overcrowded housing (26% versus 8%).<sup>129</sup>

## HEALTH OUTCOMES BY THE NUMBERS

Average life expectancy was **82.6 years** in 2023 (81.1 years in high income countries).<sup>114</sup>

The avoidable mortality rate was **162 per 100,000 people** in 2022.<sup>115</sup>

In 2021, the top three causes of death were:<sup>116</sup>

- Ischemic heart disease  
**96 deaths per 100,000 people**
- COVID-19:  
**93 deaths per 100,000 people**
- Alzheimer disease and other dementias:  
**64 deaths per 100,000 people**

The maternal mortality rate was **seven deaths per 100,000 live births** in 2023 (11 on average in Europe).<sup>117</sup>

The infant mortality rate was **three deaths per 1,000 live births** in 2023 (seven on average across Europe).<sup>118</sup>

In 2021, the share of the population with mental health disorders was **18 percent** (16% on average in high-income countries).<sup>119</sup>

The suicide rate was **16 per 100,000 people** in 2023 (14% on average across high-income countries).<sup>120</sup>

Guns were responsible for **three in every 100,000 deaths** in 2023.<sup>121</sup>

In 2022, **10 percent** of adults were affected by obesity.<sup>122</sup>

Language barriers also contribute to disparities in care. A 2024 report from the international humanitarian organization Doctors of the World (Médecins du Monde), found that when interpretation was needed in clinical settings, a professional interpreter was provided in only 36 percent of cases.<sup>130</sup>

The lack of linguistic support compounds broader structural challenges within the French health and social protection systems. These systems are frequently described as complex, costly, and poorly adapted to the needs of culturally and linguistically diverse populations.<sup>131</sup> Navigating them often requires digital literacy and familiarity with bureaucratic procedures — skills that can be limited among new arrivals or marginalized communities.<sup>132</sup>

Socioeconomic inequities further intensify these structural challenges. Migrants and descendants of migrants face higher unemployment rates — 13 and 12 percent, respectively, in 2021, compared with 7 percent for nonmigrants. Labor force participation is especially low among women from non-European backgrounds, limiting both financial stability and employer-provided health coverage.<sup>133</sup>

Discriminatory practices within administrative systems also play a role. Frontline workers at local health care offices (caisses primaires d'assurance maladie, or CPAM) sometimes rely on nationality-based assumptions when handling applications. In addition, applicants for programs such as AME can be routed into separate, harder-to-access channels or excluded altogether, especially when their paperwork deviates from standard formats or requires extra processing time.<sup>134</sup>

Beyond disparities linked to ethnicity and migration status, COVID-19 also revealed the significant regional inequities in access to care. For example, in 2020, excess mortality in the Île-de-France region rose by 91 percent, compared with 27 percent nationally.<sup>135</sup> In rural and outer suburban areas that are considered medical deserts, such as Seine-et-Marne and Val d'Oise, more people had only limited access to GPs: 35 percent in Seine-et-Marne and 39 percent in Val-d'Oise in 2020, compared with 11 percent nationally.<sup>136</sup>

The National Health Strategies 2018–22 and 2025–30 aimed to reduce health inequities across regions and social groups. For example, general postgraduate students are now required to spend at least six months of their final year in outpatient settings, including placements in underserved areas.<sup>137</sup>

Despite efforts to address inequities, they persist. In 2022, unmet medical needs were reported by 5.9 percent of people in the lowest income quintile, compared with 1.4 percent in the highest. The gap was even greater for dental care.<sup>138</sup>

# Innovation and Reform

## Health Care Innovation

### Villages of the future (Villages d’avenir)

Launched in 2023, this program aims to support small rural communities (under 3,500 residents) to improve access to essential services, including health care. Since its launch, the initiative has deployed more than 100 project managers to work alongside local authorities.<sup>139</sup>

### Health plan reform (Ségur de la santé)

In 2020, in response to chronic staff shortages and system inefficiencies, the government held health reform consultations.<sup>140</sup> In 2024, the reforms were extended to the nonprofit private health and social care sector, expanding monthly wage increases to benefit additional types of health care professionals.<sup>141</sup>

### Child health booklet (carnet de santé)

France’s official child health booklet is a medical record given to every child at birth. The booklet is used by doctors and parents to track health checkups, vaccinations, and developmental milestones throughout a person’s childhood and adolescence.

In January 2025, the booklet was updated to better reflect current knowledge in pediatric care. It now includes guidance on screen use and neurodevelopmental disorders and introduces a new mandatory health check at age 6 to help strengthen preventive care in early childhood.<sup>142</sup>

## Health Care Technology

### My health space (Mon espace santé)

The “my health space” platform was launched in 2022 to serve as a universal electronic health record. It allows individuals to store and share their medical documents with health care professionals, track their appointments, access a secure health messaging service, and manage their personal health data.<sup>143</sup>

The platform is also designed to enhance prevention, including an agenda feature that reminds users of upcoming vaccinations, screenings, and checkups. The government aims to increase personalization based on a person’s lifestyle and self-reported health information.<sup>144</sup>

As of January 2025, 97 percent of insured individuals had an active account on this platform, and more than 17 million people had used the service. The government has stated that more than 2.5 million people connect each month.<sup>145</sup> The platform is also being integrated into routine professional workflows. By the end of 2024, nearly 95,000 health professionals, including 67,000 doctors and 17,000 pharmacies, were contributing to the platform.<sup>146</sup>

*This profile reflects data as of January 2026. New or updated information may have become available since its release.*

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