How does France’s health sector contribute to the economy?
Health matters. The health sector is an important and innovative industry, as well as a source of stable employment for many people. Health systems support active and productive populations, reduce inequities and poverty, and promote social cohesion. A strong health system makes good economic sense and underpins the overall sustainable development agenda.

Countries around the world are grappling with the health, economic and fiscal implications of the COVID-19 pandemic. As they begin to recover from the crisis, difficult decisions will need to be made about how to allocate scarce resources. These snapshots share valuable evidence for policy-makers on how investing in health sectors and health systems helps to achieve national economic objectives.

This snapshot is part of a series developed by the European Observatory on Health Systems and Policies in collaboration with the WHO Barcelona Office for Health Systems Financing. It draws on comparable cross-country data and country-specific analysis and expertise to explore how well the health sector in France contributes to the economy – and how it can do more, especially in the context of COVID-19.

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How does France’s health sector contribute to the economy?

The health sector makes up a sizeable share of France’s economy, with further growth potential from health technologies and e-health

The health sector in France plays a key role in the economy, with high spending levels. In 2019, current health spending accounted for 11.1% of total gross domestic product, above the European Union (EU) average of 8.3% and the third highest in Europe after Germany (11.7%) and Switzerland (11.3%) (WHO, 2021). Measured in terms of spending per person, France’s position falls to 10th in the EU. Between 2000 and 2009 spending on health grew in real terms by 2.1% a year on average; since 2010, however, growth has slowed to under 1% per year (WHO, 2021).

Public spending on health accounted for 75.3% of current health spending in France in 2019, slightly higher than the EU average. The health share of the government budget grew from 13.5% in 2000 to 15.1% in 2019, but it remains significantly smaller than in peers such as Germany, Sweden and the United Kingdom (18–20%) (Fig. 1).

Public spending on health increased significantly in response to the COVID-19 crisis (European Observatory on Health Systems and Policies, 2021). In 2020, public spending on health grew by 9.5%, far higher than the planned increase of 2.5%, and it is expected to remain high in 2022. Exceptional measures related to COVID-19 cost over €15 billion in 2020, including spending to mitigate the social and economic consequences of the pandemic (Ministère des solidarités et de la santé, 2021). For example, in 2020 the social health insurance (SHI) scheme paid €7 billion to support long-term care facilities;

Fig 1 Despite having one of the highest current spending on health in the European Union as a share of gross domestic product (GDP), the share of the government budget allocated to health in France is significantly lower than in its peers


* Gross National Income is used in place of GDP for Ireland.
€4.8 billion for the procurement of specialized medical and personal protective equipment, such as masks and respirators; €2.7 billion in sickness allowances, which included payments to people who were unable to work because of lockdown measures; €2.2 billion for diagnostic tests; and €1.5 billion in income support to health professionals who lost wages because of reduced activity (Ministère des solidarités et de la santé, 2021).

Health technologies play a major role in the economy. Innovations in e-health, particularly the increasing use of electronic health records, teleconsultations and telemonitoring, are gaining market size and further boosting the economy. Digital health start-ups are growing: 2000 innovative start-ups in the health sector, which had a global turnover of €800 million in 2019, are estimated to generate an annual turnover of €40 billion by 2030 (Sintem, 2019; Biotech France, 2021). The use of artificial intelligence in health care has also expanded rapidly in recent years, presenting a range of business opportunities.

The COVID-19 pandemic ramped up the development and uptake of digital technology in health. The use of teleconsultations, strongly supported by the SHI scheme, increased exponentially to account for almost 30% of all consultations in April 2020, up from 1% before the pandemic. One start-up, with a value of over €1 billion in 2019, contributed significantly to the COVID-19 vaccination campaign. In 2021 more than 40 million vaccination appointments were made through their platform.

Growth in the telemedicine sector is likely to continue in response to challenges such as the lack of doctors in rural areas and long waiting times for some specialist consultations. Many hospitals have also developed programmes to telemonitor discharged patients remotely. These advances are supported by reforms encouraging digitalization to enhance health system resilience.

Other health-related industries play an important role in the economy. In 2019 the French National Institute for Health and Medical Research submitted more pharmaceutical patents to the European Patent Office than any other entity in Europe and the third highest number of biotechnology patents. France is the third largest manufacturer of pharmaceuticals in Europe and pharmaceutical products are among the country’s top three exports (with machinery and aeronautics) (Workman, 2021), resulting in a €30 billion trade surplus in pharmaceutical exports in 2019 (EFPIA, 2019; LEEM, 2020). With a turnover of €30 billion in 2019 (up from €28 billion in 2017), the medical device sector is growing, mainly composed of small-to-medium enterprises, and directly generates 90 000 jobs (Drees, 2020).

Health-related research and development (R&D), vital to innovation, also supports economic growth. In 2018, around 6.5% of the French government’s R&D budget was allocated to health, which is higher than Germany (5.1%), but lower than Spain (12.9%), Italy (10.1%) and the United Kingdom (21.5%) in the same year (OECD, 2020). Public investment in health research fell by 28% in France between 2011 and 2018, whereas it grew by 11% in Germany and 16% in the United Kingdom (CAE, 2021).

During the pandemic, France prioritized global R&D efforts for COVID-19 vaccines, contributing €500 million to the G20’s ACT-Accelerator initiative to ensure equitable access to vaccines in low- and middle-income countries (Atlani-Duault et al., 2020; Gouvernement, 2020; Ministère de l’Europe et des Affaires Étrangères, 2020). This is not just a much-needed investment in global public health but will also stimulate domestic economic growth through exports and tourism, generating an estimated €3.1 billion in 2020–2021 and a further €8.3 billion in 2020–2025 for France (The Bill and Melinda Gates Foundation, 2020).
Although the health sector is a growing source of jobs, and has shown resilience to economic shocks, poor working conditions lead to staff retention challenges

Health sector employment in France has grown steadily in the last 10 years, despite wider labour market fluctuations (Fig. 2). In 2018, the health sector employed over 1.9 million people, accounting for 6.6% of France’s economically active population, well above the EU average of 5.3% (Eurostat, 2020a).

Employment in the health sector also has a significant multiplier effect on the wider labour force, creating many jobs indirectly linked to health care. COVID-19 has underlined the importance of the health sector as a source of employment. Although unemployment rose slightly in 2020 (IMF, 2020), health professionals continued to be in high demand. This is likely to be the case in future because of the combined impact of the pandemic, France’s ageing population and the limited scope for automation in health-care delivery.

To meet increasing demand, the health and care sectors will need to address major challenges in staff recruitment and retention, particularly for allied health professionals in primary care and people working in long-term care. These challenges include low pay, anti-social working hours and poor working conditions – problems that have been exacerbated by the pandemic (Bernd, Dubois & McKee, 2006; OECD and European Observatory on Health Systems and Policies, 2019; Cook, 2020). For example, nearly half of all nursing homes had been struggling to recruit and retain staff before the pandemic, which contributed to the high death toll in nursing homes during the first wave (OECD and European Observatory on Health Systems and Policies, 2017; Or & Gandré, 2021). Recognizing the increased burden on the health workforce during the pandemic, and difficult working conditions in care facilities, the French government significantly increased wages for staff in public and private hospitals and nursing homes and for home-based carers for disabled and older people. It also took action to support the well-being of the health workforce (European Observatory on Health Systems and Policies, 2020).

Physician density, which is currently below the EU average (3.2 per 1000 population in France versus 3.8 per 1000 population in the EU) (OECD and European Observatory on Health Systems and Policies, 2020).

Fig 2 Jobs in the health sector have increased steadily in France despite labour market fluctuations

![Graph showing jobs in the health sector](image)

Source: Eurostat (2020a); IMF (2020).
and Policies, 2019), is expected to grow by 20% by 2040. For now, the geographical distribution of health professionals remains heavily skewed to well-off urban areas, undermining access to physicians (including general practitioners) in rural areas (OECD and European Observatory on Health Systems and Policies, 2019). To address this problem, France has encouraged multidisciplinary medical homes and supported telemedicine and skill-mix innovations by expanding the role of nurses (OECD and European Observatory on Health Systems and Policies, 2019). Nurses in France have traditionally had little clinical responsibility and autonomy compared with nurses in many other European countries, which has limited France’s capacity to provide appropriate care and increased the demand for physicians.

France achieves good health outcomes, fostering a healthy and productive workforce, but weak health promotion and disease prevention hampers progress

France achieves good health outcomes, in line with its relatively high levels of public spending on health (Fig. 3). In 2019, France had one of the lowest treatable mortality rates in the EU, outperforming the six other countries that spend more publicly on health than France does. This suggests that the French health system is effective in saving lives for acute conditions and averting the death of many people under 75 years of age through timely and quality care. Infant mortality has also fallen over time from 4.5 deaths per 1000 population in 2000 to 3.8 per 1000 population in 2019.

There is room for improvement, however. According to the World Bank’s Human Capital Index, as a result of investments in health care (and education), a child born in France in 2020 can expect, by the age of 18 years, to be 76% as productive as a child with complete education and full health (Human Capital Index 0.76) – above the EU average of 73% but behind the United Kingdom (78%) and the Netherlands (79%) (World Bank, 2020). Persistent gender and socioeconomic inequalities in life expectancy and health outcomes are another problem (OECD and European Observatory on Health Systems and Policies, 2019; Tikkanen et al., 2020). Addressing health inequalities would improve social cohesion, labour force participation and productivity, positively affecting the economy.

Health inequalities are associated with upstream determinants and exposure to risk factors, which in turn reflect a weak culture of health promotion and disease prevention and low levels of investment in these areas. Behavioural and environmental risks have a significant effect on mortality and health status in France. In 2019, for example, around one third of all deaths were attributed to behavioural risk factors such as smoking, dietary risks, alcohol consumption and low physical activity. Environmental factors like air pollution also contribute to mortality via circulatory and respiratory diseases and some types of cancer. These largely preventable conditions have serious economic implications in terms of population well-being, productivity and care costs.

Keeping people healthy across the life course contributes to a larger and healthier workforce and enables people to participate in the labour market for longer. This is especially important in the context of population ageing, increasing demand for long-term care and the threat of future viral risks. Labour force participation rates among older workers aged 55–64 years is much lower in France (55%) than the EU average (60%) (Eurostat, 2020b). To improve on this figure will require an increase in the share of health resources devoted to disease prevention, early detection and treatment; targeted training programmes for health and social care providers to strengthen health promotion and disease prevention in their work; and a push for multisectoral action on healthy ageing and keeping people in the labour market. These actions are part of the French National Health Strategy 2018–2022 (Ministère
France

Better health promotion and communication would also improve vaccination rates. Although France exceeds the WHO target for diphtheria–pertussis–tetanus immunization, it lags far behind on measles (WHO, 2020). Flu immunization is also inadequate, including among health workers: fewer than half of those looking after older people in nursing homes were vaccinated before the pandemic (Santé Publique France, 2021). Low vaccination rates can be attributed to public concerns about vaccine safety and effectiveness (France 24, 2019). When it comes to COVID-19 vaccination, France has achieved good vaccination rates: in February 2022, 79% of the population over 18 years old had been fully vaccinated (two doses), and 81% had received at least one dose (Ministère des solidarités et de la santé, 2022).

Publicly subsidized private health insurance covers co-payments and protects households from financial hardship, but there remain concerns about solidarity, equity and efficiency

The goals of universal health coverage are to ensure that everyone can use the quality health services they need without experiencing financial hardship (United Nations, 2015). Universal health coverage is central to health and well-being, alleviates poverty, reduces socioeconomic inequalities, contributes to health security and boosts economic growth (Cylus, Permanand & Smith 2018). Financial protection – central to universal health coverage and health system performance – is measured using two indicators: catastrophic health spending and impoverishing health spending.

France’s SHI scheme automatically covers all residents. In the last 25 years the Government has taken important steps to ensure that all residents are covered (the basis for entitlement to SHI was changed from employment and payment of contributions to residence in 2000) and to make coverage automatic (administrative formalities were reduced in 2016). The SHI scheme also provides...
all residents with access to a comprehensive range of benefits; however, user charges are applied to most health services, including primary care visits and hospital admissions. Co-payments range from about 20% for hospital care to 30% for physician visits and 35–85% for outpatient prescription medicines (Barroy, Or & Kumar, 2014; OECD and European Observatory on Health Systems and Policies, 2019).

Given how substantial these SHI co-payments can be, multiple mechanisms are in place to protect people from financial hardship and underuse of health services, including:

- exemption from co-payments for pregnant women and people with chronic conditions (under the Affection de Longue Durée scheme) (Chevreul, Berg Brigham & Durand-Zaleski, 2015);
- free access to basic health care for undocumented migrants (Aide Médicale d’État) (Barroy, Or & Kumar, 2014);
- free complementary private health insurance (Couverture maladie universelle complémentaire) covering co-payments for people whose monthly income is 20% below the poverty line;
- subsidized complementary private health insurance covering co-payments for other people under the poverty line; and
- subsidies for complementary private health insurance covering co-payments obtained through employers.

Ninety-five per cent of the population are covered by private complementary insurance and, as a result, out-of-pocket payments are very low in France. In 2019 out-of-pocket payments as a share of current spending on health were 9.3%, the lowest among EU and Organisation for Economic Co-operation and Development (OECD) countries and less than half the EU average (21.6%) (WHO, 2021). Rates of catastrophic and impoverishing health spending (indicators of financial protection) are also among the lowest in Europe (WHO Regional Office for Europe, 2019). In 2017 (the latest year for which data are available), 2.1% of households in France experienced catastrophic health spending and 1.5% were impoverished or pushed further into poverty as a result of out-of-pocket payments (Fig. 4) (Bricard, in press).

Challenges remain, however. The health system’s relatively heavy reliance on private health insurance, much of which is linked to employment, raises concerns around solidarity, equity, efficiency and financial stability in the face of economic fluctuations (Couffinhal & Franc, 2020). The combination of public and private health insurance also comes with a high management cost: France has the second-highest health system
administrative costs in the OECD (6% of current health spending in 2014) after the United States of America (OECD and European Observatory on Health Systems and Policies, 2017).

Although only 5% of the population lacks complementary private health insurance covering SHI co-payments, this rate is much higher among unemployed people (16%) and people in the poorest fifth of the population (12%) (Perronin & Louvel, 2018). The incidence of catastrophic health spending is also much higher than average among the poorest households and, within these households, higher among people who lack private health insurance or have free or subsidized private health insurance (Couverture maladie universelle complémentaire) (Bricard, in press).

Socioeconomic inequalities in access to private health insurance are particularly troubling because the poorest people are often the sickest (Lang, Kelly-Irving & Delpierre, 2009).

Out-of-pocket payments are higher for services that are not comprehensively covered by the SHI scheme (eye care, dental care and mental health services), leading to levels of self-reported unmet need due to cost, distance or waiting time that are higher for dental care (2.7% of the population in 2019) than health care (1.2%), particularly for the poorest fifth of the population (6% for dental care and 2.4% for health care) (Eurostat, 2020c).

Recent coverage expansions have reduced unmet need for dental care, but more can be done to reduce socioeconomic inequalities in access and financial protection.
Key lessons

Greater public investment in health promotion and disease prevention would improve health outcomes, reduce socioeconomic inequalities and boost productivity

France has scope to increase the share of the government budget allocated to public health. Any additional public investment in the health system should be carefully allocated to address socioeconomic inequalities in access, financial protection and health outcomes, in line with equity and efficiency goals. Investing in public health should foster a stronger culture of health promotion and disease prevention, reduce behavioural and environmental risks, and strengthen the prevention of chronic conditions.

Improving the well-being of the health workforce and encouraging new models of health employment would help address staff shortages, strengthen health system resilience and stimulate the labour market

The rigid task-based definition of health professions in France limits capacity for collaboration and service innovation. France also faces serious shortages of some health workers, particularly in primary care and long-term care, reflecting low pay, anti-social working hours and poor working conditions. The lack of health professionals in rural areas is a further problem. These challenges require France to increase the number of health workers; develop new models of health employment that encourage task shifting and team-work collaboration between health workers, with appropriate remuneration and career paths; and continue with efforts to improve the geographical distribution of health workers.

The COVID-19 crisis has shown the importance of enhanced support for health-related research

The share of the public R&D budget allocated to health research has fallen over time in France. Health research is also characterized by a strong separation between the public and private sectors, with limited scope for public–private research partnerships (CAE, 2021). Building on promising partnerships established during the pandemic, France can adjust traditional boundaries between the public and private sectors to promote health research and increase the attractiveness and international impact of French universities in the field of health.
Description of the health system

The French health system is organized through an SHI scheme involving several non-competing funds. The SHI scheme provides entitlement to publicly financed health services on the basis of residence. All funds offer the same benefits. Governance of the health system is strongly centralized and shared between the government and the SHI scheme.

The SHI scheme provides a comprehensive benefits package and funds about 78% of all spending on health (Drees, 2019). However, user charges are applied to most health services, including primary care visits and hospital admissions. About 95% of the French population has complementary private health insurance to cover these co-payments, accounting for almost 14% of current spending on health. As a result, out-of-pocket payments account for one of the lowest shares of current spending on health (around 9%) among OECD countries.

The population has a large choice of public and private health care providers. Most health professionals work on a fee-for-service basis, contracted by the SHI scheme, and usually respect the tariffs set by the SHI scheme, although some of them can charge additional fees. Private hospitals also contract with the SHI scheme and are paid through regulated tariffs set at the national level. They play an essential role in care provision, especially surgery. About 55% of all surgery and 25% of obstetric care is provided by private for-profit hospitals.

France promotes equity in access to health services through various regulatory tools and policies. The equity principle is rooted in law and reinforced by all SHI funds. Government policy towards private health insurance also aims to ensure equitable access through tax subsidies for poor households. Despite these efforts, the complex public–private health financing mix poses challenges for solidarity, equity and efficiency in the health system.

REFERENCES


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### Key indicators

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<th>France</th>
<th>EU Average</th>
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<tbody>
<tr>
<td>People aged 65 and above (% of total)</td>
<td>20.4</td>
<td>20.5</td>
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<tr>
<td>Life expectancy at birth (years)</td>
<td>82.6</td>
<td>81.1</td>
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<td>GDP per person (PPP US$)</td>
<td>49,673</td>
<td>48,340</td>
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<td>Current health spending per person (PPP US$)</td>
<td>5,492</td>
<td>4,010</td>
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<td>Health spending paid out of pocket (% of current health spending)</td>
<td>9.3</td>
<td>21.6</td>
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**Source:** WHO, Global Health Expenditure Data Base (2021), World Bank, World Development Indicators (2021)

**Note:** Data for 2019. PPP Int$, purchasing power parity in international dollars.

The European Observatory on Health Systems and Policies is a partnership hosted by WHO that includes international agencies, national governments, decentralized authorities and academic research institutes. It supports and promotes evidence-informed policy-making, using comparative analysis of European health systems and trends to give decision-makers insights into how their own and other systems operate; what works better or worse in different contexts; and why. Ultimately the Observatory aims to help countries strengthen their health systems to improve their peoples’ health and well-being. It engages directly with policy-makers and works with a range of experts, not least its Health Systems and Policies Network whose members provide key knowledge and insights into health systems in countries.

**WHO Barcelona Office for Health Systems Financing**

The WHO Barcelona Office is a centre of excellence in health systems financing for universal health coverage. It works with Member States across WHO’s European Region to promote evidence-informed policy-making. A key part of the work of the Office is to assess country and regional progress towards universal health coverage by monitoring financial protection – the impact of out-of-pocket payments for health on living standards and poverty. Financial protection is a core dimension of health system performance and an indicator for the Sustainable Development Goals. The Office supports countries as they develop policy, monitor progress and design reforms and is part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe.