France

Health Care & Long-Term Care Systems

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France

Health care systems

1.10. FRANCE

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

In 2013, France had a GDP per capita of 28.1 PPS (in thousands), slightly above the EU average of 27.9.

Population was estimated at 65.7 in million 2013. It has increased in the previous decade and it is projected to increase further, although at a slower rate.

Total and public expenditure on health as % of GDP

Total expenditure ([97]) on health as a percentage of GDP (11.7% in 2013) has increased over the last decade (from 10.8% in 2003) and is slightly over the EU average ([98]) of 10.1% in 2013. Public expenditure has increased as well: from 8.4% in 2003 to 9% of GDP in 2013.

When expressed in per capita terms, total spending on health at 3353 PPS in France is above the EU average of 2988 in 2013. So is public spending on health care: 2600 PPS vs. an average of 2208 PPS in 2013.

Expenditure projections and fiscal sustainability

As a consequence of demographic changes, health care expenditure is projected to increase by 0.9 pps of GDP, in line with the average growth expected for the EU ([99]), according to the "AWG reference scenario". When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), health care expenditure is expected to increase by 1.6 pps of GDP from now until 2060 (in line with the EU average).

Overall, for France no significant short-term risks of fiscal stress appear at the horizon, although some variables point to possible short-term challenges.

Risks appear, on the contrary, to be high in the medium term from a debt sustainability analysis perspective due to the still high stock of debt at the end of projections (2026) and the high sensitivity to possible macro-fiscal shocks.

No significant sustainability risks appear over the long run, under the no-fiscal policy change baseline scenario, notably thanks to pension reforms implemented in the past.

Health status

Life expectancy at birth (85.6 years for women and 79 years for men in 2013) and healthy life years (64.4 years for women and 63 years for men) are above the respective EU averages (83.3 and 77.8 years of life expectancy in 2011, 61.5 and 61.4 in 2013 for the healthy life years). ([100]) An infant mortality rate of 3.6‰ is lower than the EU average of 3.9‰ in 2011, having gradually fallen over most of the last decade (from 4.2‰ in 2003).

System characteristics

Coverage

The French system is a social health insurance system in which all legal residents have to register with the public health insurance program (sickness insurance funds) and provides universal population coverage. The universal coverage is given, first, on the professional/ occupational basis and secondly, since 2000, on the basis of residence.

The system is based on the principles of solidarity and the guarantee of financial protection against life's contingencies for everyone. The basic (though comprehensive in scope) social health insurance system had three dominant schemes –

([97]) Data on health expenditure is taken from OECD health data and Eurostat database. The variables total and public expenditure used here follow the OECD definition under the System of Health Accounts and include HC.1-HC.9 + HC.R.1.

([98]) The EU averages are weighted averages using GDP, population, expenditure or current expenditure on health in millions of units and units of staff where relevant. The EU average for each year is based on all the available information in each year.

([99]) I.e. considering the "reference scenario" of the projections (see The 2015 Ageing Report at http://ec.europa.eu/economy_finance/publications/european_economy/2015/pdf/ee3_en.pdf).

([100]) Data on health status including life expectancy, healthy life years and infant mortality is from the Eurostat database. Data on life-styles is taken from OECD health data and Eurostat database.

the general health insurance scheme, the agricultural scheme and the national insurance fund for self-employed non-agricultural workers – brought together under the National Union of Sickness Insurance Funds (UNCAM) since 2004.

These funds are not allowed to define the benefit basket, the level of coverage or premiums, and risk-equalisation is in place. In addition to the basic social insurance scheme (financed by social security contributions and taxation), more vulnerable households (i.e. with a yearly income below EUR 8,645 for a single person in 2015, EUR 15,560 for a 3-person household) ([101]) benefit from free complementary sickness insurance – "Complementary Universal Health Coverage" (CMUC), an effort by authorities to improve access to health insurance and therefore to health care by those more vulnerable groups. In order to avoid a threshold effect, if the income exceeds the threshold to the limit of 35%, the government finances a part of the premium paid by the insured for complementary insurance.

More and more people are also covered by private voluntary health insurance. 96% of the population is covered by complementary (to cover for patients' cost-sharing for public goods and services) and supplementary (to cover the services not covered by public provision/ funding) voluntary health insurance by individual initiative (57%) or in the context of employment (43%).

Administrative organisation and revenue collection mechanism

The Parliament and the central government set the level of taxes and social contributions financing basic health insurance. The Parliament also sets the total public budget for health and by type of care. The central government determines resource allocation across the regions and the payment methods of hospitals. Fees are defined in agreements negotiated between public health insurance funds and physicians unions. While the State plays the steering role in administering the system, some decentralisation has been introduced during the 1990's to give more responsibilities to regional authorities in the planning and financial resource allocation for hospitals.

([101]) See the official website of the CMU fund: www.cmu.fr.

This system involves a strong collaboration between the entities of the system. The legitimacy of the social partners in the management of the health insurance funds and their role with regard to the role of the state was, for example, one of the questions that have been raised often in the past. Over time, the balance tends to shift towards increasing state intervention. However, the division of responsibilities between the central government and the regions remains unclear in certain areas and could, therefore, benefit from further clarification to avoid conflict relations between the state authorities and the health insurance funds and improve the efficiency in running the health sector.

The number of actors involved in decision making may partly explain why public expenditure on health administration and health insurance as a percentage of GDP (0.36%) and as a % of current health expenditure (0.67%) is above the EU average (respectively 0.27% and 0.47%), amongst the highest in the Union in 2013. This shows that there is perhaps scope to reduce administrative costs and improve the general management of the sector despite current efforts. The setting up of the Regional Health Agency (ARS), in 2010, can certainly contribute to enhance the efficiency in running the health sector. For instance, the ARS aims at improving care coordination between outpatient and inpatient care and at optimising the regional health care supply.

In France, a non-mandatory national health care spending target (ONDAM) is voted each year by the Parliament as part of the social security budget law (Loi de financement de la sécurité sociale – LFSS). Compliance with this target has been met for the 5th year in a row in 2014 (with an undershooting of the target by EUR 0.3 bn) and, according to the warning committee's report of 6 October 2015, the 2015 target is also likely to be respected.

This is mostly explained by restrained growth in outpatient care spending, in particular reductions in pharmaceutical prices (detailed in the *Lois de financement de la Sécurité sociale - LFSS*) and measures to promote generic medicines. These measures include the implementation of incentive payments for general practitioners, specialists and pharmacists in 2012 (Rémunération sur objectifs de santé publique – ROSP) with prescribing

targets. Patients were also given a larger incentive to accept the substitution for generic drugs with the "tiers payant contre générique" measure: patients have to wait to be reimbursed the cost of their prescription from the Social Insurance if they do not wish to be dispensed the generic.

Although the ONDAM is not a budgetary ceiling, several monitoring and tracking levers, strengthened recently (especially after the 2010 Briet report) are used to ensure it continues to be respected. First, spending is monitored closely by an independent "warning committee", composed of 3 experts whose role is to give, three times a year, an opinion on progress towards the target and on the risks of overshooting. Second, there has been a gradual reduction of the warning threshold (amount above which the government must take corrective measures to ensure compliance with the target) from 0.75% of the target in 2010 to 0.7% in 2011, then to 0.6% in 2012 and finally to 0.5% in 2013. Finally, in late 2010, a monitoring committee co-chaired by the ministers of Health and Budget was implemented. This committee is assisted by a statistical group in charge of reviewing the data monthly in order to come up with propositions to curb spending and ensure compliance with the target. The committee overviews the implementation of the spending cuts decided along with the level of the target. It is in charge of monitoring the regulation strategy in the case of an overshooting of the target and of preparing the construction of the target the following year.

Role of private insurance and out of pocket co-payments

Cost-sharing applies to most goods and services, especially primary care and specialist consultations, laboratory tests, pharmaceuticals, eyeglasses and contact lenses, dental care and dental prostheses. Pregnant women, those with certain severe medical conditions, those with an income below a defined threshold, those on social assistance. Victims of accidents at work are exempted from cost-sharing. The private voluntary complementary health insurance increases the rate of reimbursement, reducing the discrepancy between the actual amount paid by patients and the amount they are reimbursed by their social health insurance fund. Voluntary insurance decreases this discrepancy to greatest extent for prostheses, drugs, optical and dental care. In doing so, complementary health insurance reduces the ability of cost-sharing to control overconsumption as it renders users less cost-aware. As a result, the authorities implemented a ticket, and a "deductible": the patient has to pay EUR 1 for each physician visit and each biomedical analysis, EUR 0.50 per drug box, EUR 0.50 on each paramedical procedure and EUR 2 for each medical transport. In the same time, government encourages with fiscal incentive "responsible contracts" that don't cover the deductible part in order to limit health sector inflation. As a result the deductible is usually not covered by complementary health insurance.

Private expenditure (patient co-financing and voluntary private health insurance) represented around 22.5% of the total health expenditure in 2013, i.e. a small increase since 2003 (22%), but still below the EU average (22.6% in 2013). Out-of-pocket spending accounts for a small part of private expenditure (7.4% of total health spending which is a small share in the EU context – EU average of 14.1% in 2013) and having remained relatively constant since 2003.

Types of providers, referral systems and patient choice

The French system is strongly characterised by freedom of choice and unrestricted access for patient, and by free practice of professionals on the basis of accreditation. The primary and secondary health care delivery relies then on an easily accessible combination of public and private supply. Providers are organised in two groups: the health institutions that include hospitals, nursing homes and laboratories, which provide most of the inpatient care and employ mainly salaried health professionals ([102]); and the generally self-employed professionals such as general practitioners (GPs), specialists, dentists, nurses, and pharmacists who provide outpatient care. Primary care is provided by self-employed physicians and other professionals mostly in private individual practices. This is also the case for specialist outpatient services, although sometimes these also work in private clinics. Day case and inpatient care is provided in hospitals.

([102]) The net salary of a full-time employed doctor in hospital is very close to the one earned by a self-employed GP.

Hospitals are organised in three categories: the public sector, the not profit and profit-making private sector, the latter is mainly concentrated on surgical procedures.

In 2013, the number of practising physicians per 100 000 inhabitants was 310 (slightly below the EU average of 344). The number of general practitioners was 155, far above the EU average of 78.3. Finally, the number of practising nurses per 100 000 in 2013 (940) was above the average EU number (837).

It should be noted that there are differences in the supply of physicians across regions as, while total supply is regulated, the location of physicians is not. The *numerus clausus* system was introduced in 1971 in order to regulate access to health professions. Indeed, a ministerial decree sets annually the number of places available for each health qualification and research units. This policy has resulted in the stabilisation of doctors' numbers but some specialities, such as anaesthesiology, gynaecology or obstetrics have been reported to need more professionals. The same problem, which might become more severe in the near future, concerns other specialities and nurses working in hospitals. On the one hand, specific incentives could be developed to promote and encourage staff to work in some specialities currently in shortage. On the other hand, geographical disparities could be reduced. More generally, the human resources strategy needs to tackle staff and population ageing in the future. In this view, some financial incentives have been granted since 2006 to physicians who settle in areas where there is a lack of supply of physicians.

The lack of coordination between primary, specialist and hospital care has been one major problem of the health care system, potentially leading to unnecessary use of specialist and hospital care and the duplication of procedures resulting in higher expenditure. To improve the situation, referring GP and provider networks were implemented as from July 2005. The patient chooses and registers with a general practitioner at the social health fund. The patient is free to change general practitioners but has to report any change. If necessary, the GP plays the role of gatekeeper and sends his patient to a specialist who will report, with the authorisation of the patient, any relevant information to the GP in order to follow-up and coordinate the care ([103]). The patient has to face financial penalties applied to the reimbursement rate by the national sickness fund, if he/she doesn't designate his/her preferred GP and does follow a referral procedure. Around 90% of the insured patients have designated a preferred doctor so far. Patients are also free to choose a specialist and a hospital.

Each patient has his own medical card called "Carte Vitale" which transmits all the transactions to the health fund where he is registered. However, plans to put prescriptions, reimbursements and information on the health status on the card have not been implemented. Therefore, it does not contain any medical information and cannot be used for care coordination. Since 2011, a new individualised medical record (Dossier medical personnalisé, DMP) has also put in place aiming to improve care coordination.

The central government evaluates via the High Authority for Health (HAS) the best medical practices and promotes compulsory life-long medical education. It sets a package of recommendations and targets after consulting with funds and professionals such as for drug prescriptions (generics, right prescription) which each physician is advised to follow. Penalties could be issued if non-compliance to the recommendations is frequent, serious or costly for the health system. Such procedures are likely to have a positive effect on doctors' prescribing behaviour and efforts should continue in that direction.

France has a number of acute care beds per 100,000 inhabitants (335 in 2013) below the EU average in that year (356). These results reflect efforts made during the 1980's and 1990's to reduce the number of hospitals beds as well as the average hospital length of stay (see further below).

Finally, pharmaceuticals are exclusively distributed by approximately 23,000 pharmacies and their establishment is regulated by a numerus clausus taking into account the size of the population and a distance factor.

([103]) Gynaecology, ophthalmology, stomatology and psychiatry are out of that procedure.

Treatment options, covered health services

There is a common basket of services of the National Health System that has to be delivered to the whole population covered.

Price of healthcare services, purchasing, contracting and remuneration mechanisms

Two payment systems have been implemented, the first one is a reimbursement system (ambulatory care) and the second one is a third-party payer system where the patient pays only the co-insurance or the co-payment (inpatient care and pharmaceuticals).

Outpatient primary and specialist care doctors are generally self-employed and paid on a fee-for-service basis paid by the patient at the consultation and partly reimbursed at a later stage by their social health insurance. The fees are fixed and negotiated between physicians' unions and the public health insurance funds under contracts signed for every four or five years. Medical practitioners and clinics, which are not under contract, have to display their prices. Almost no reimbursement is given by the statutory health insurance to patients visiting professionals not under contract.

Hospital inpatient doctors are mostly salaried employees of the hospitals, with the salary scale defined at central level. For hospital day care or inpatient care, a third-party payer system is generally used whereby the patient pays only the co-insurance or the co-payment.

The amount paid by the patient and not taken in charge by the compulsory insurance is called "ticket modérateur". An average of 70% of the cost of a visit to a GP is thereby refunded, from 80% to 95% for a surgery, 95% for childbirth, 70% for x-rays, dental care and 60% for nursing at home among others. Under certain conditions such as some chronic disease or care requiring hospital stay of at least 30 days ([104]) or beneficiaries of the CMUC, individuals could be entitled to a 100% reimbursement of medical and hospital costs. Hospitals are remunerated on a payment per case/ DRG basis. ([105]) Hospitals are legally autonomous and manage their own budgets. Since 2009, they have autonomy to recruit their own medical staff.

The number of inpatient discharges is below the EU average (15855 vs. 16402 per 100 000 inhabitants in 2011) but this is related to many policies that have been put in place in order to encourage methods of providing care that are alternative to hospitalisation such as day care surgery or hospitalisation at home. Among others, extension of hospital's capacity via a theoretical exchange rate of one acute bed for two "non-acute" beds is possible. Day cases as % of all hospital discharges are, at 37%, well above the EU average (29.3% in 2011). This share has fallen since the peak of 38.6% in 2008, but up to that point it had increased significantly from 28.4 in 2001.

Hospital average length of stay (5.2 days in 2011) has been slightly decreasing (5.6 days in 2001) and is lower than the EU average of 5.8 days in 2011.

The market for pharmaceutical products

The central government regulates the production and distribution of pharmaceuticals and any drug must obtain a formal authorisation to be sold. International price reference is used and based on manufacturing price in DE, ES, IT, and UK. The initial price is also based on the clinical performance and cost of existing treatments.

About 4900 pharmaceuticals are reimbursable in France, which represents approximately one half of the drug presentations available. The list of reimbursable drugs is established by ministerial ordinance and will contain only drugs having a sufficient medical service rendered (SMR). ([106]) The amount reimbursed will depend on various criteria such as the effectiveness, the side effects, the place in the therapeutic process, the seriousness of the condition, the properties of the drug and its importance for public health. According to the SMR, the reimbursement rate for prescribed drugs is chosen between four rates (100%, 65%, 30%, and 15%). In order to control final spending on reimbursable products, the central government sets

([104]) Although it should be noted that the 100% reimbursement in this case is only applied from the 31st day and patients pay a 20% “ticket modérateur” the first 30 days.

([105]) The OECD score for remuneration incentives to raise the volume of care in France is about 4.5 out of 6 as a result of the use of activity related payment elements in physician and hospital remuneration.

([106]) For a period of five years before revaluation.

the prices on producer's side, after bargaining with the drug's committee and the laboratory involved. In order to promote the use of generic drugs, the pharmacists have been financially encouraged to offer their clients generic drugs where this is possible. In such cases, an equivalent profit margin is guaranteed.

Generics also face a fast-track registration and automatic price setting (60% of the price of the brand name drug). Authorities promote rational prescribing of physicians through prescription guidelines, complemented with monitoring of prescribing behaviour and feedback, and education and information campaigns on the prescription and use of medicines. They also promote education and information campaigns for patients. Physicians receive feedback on their prescription behaviour in comparison with that of colleagues and in relation to some sort of national contract/ priorities established between the doctors and the social health insurance funds. Doctors are visited by delegates of the social insurance, who provide them with information on rational prescribing.

Use of Health Technology Assessments and cost-benefit analysis

Quality of care, especially in hospitals, is a major matter of concern to public French authorities. To improve it, from 1996, the central government decided that all health care institutions must be accredited to provide treatment by the Haute Autorité de Santé (HAS). An evaluation procedure is then done on several dimensions such as quality of care, information given to the patient, medical records, general management and risk prevention strategies. The HAS publishes afterward the accreditation reviews. Perhaps performance monitoring in the sector could be further improved by publishing more routine and comparable information on the activity and quality of providers (clinical outcomes, use of appropriate processes, patients' satisfaction and patient experience), which can support choice of provider while help identifying good practices and areas for improvement through peer reviews for example.

Health technology assessment information has been used to define guidelines and determine coverage of new procedures, new medicines and new high-cost equipment, the level of reimbursement of new procedures and new medicines, and to develop guidelines for high-cost equipment. The benefits package is defined on the basis of clinical effectiveness.

eHealth, Electronic Health Record

The government has the ambition to develop eHealth. The implementation of a medical personal data folder has been ongoing for years but will enter a second phase now.

The government is opening administrative data on reimbursements to researchers. Related to patient privacy, it can sometimes be merged with medical data. That should improve medical products surveillance.

Health promotion and disease prevention policies

The Ministry of Health, on the basis of the overall framework established by the parliament, is responsible for defining priority areas for national programmes in the field of health promotion and disease prevention. The main priorities include cancer, pain control and anti-smoking campaigns. Public health objectives are set in terms of process, outcomes and the reduction of health inequalities. Public expenditure on prevention and public health services as a % of GDP (0.22%) is slightly below the EU average of 0.24% in 2013, and as a percentage of public current health expenditure (2%) is below the EU average of (2.5%).

As for the lifestyle of the French population, the data shows that the proportion of regular smokers has increased slightly (from 23.4% in 2004 to 24.1% in 2012), above the EU average of 22%. Over the same period the proportion of the obese in the population has increased (from 9.4% in 2001 to 12.9% in 2010), while alcohol consumption shows a reduction from 13.5 litres per capita in 2003 to 11.4 litres in 2013 (still above the EU average of 9.8).

Recently legislated and/or planned policy reforms

Recent policy response

The success in not overshooting the planned expenditure increase in 2013 has led government to propose a reduction of the national health

spending target for 2014 by EUR 800 million (the 2014 target initially set at EUR 179.1 billion was brought down to EUR 178.3 billion) in the rectified social security budget bill. Furthermore, it was decided that EUR 10 billion would be achieved through health insurance savings, and the national health target budget increase would be set at respectively 2.1%, 1.75% and 1.75% for the 2015-2017 time period. These economies relative to the higher planned expenditure should stem from the implementation of the national healthcare strategy, which promotes greater efficiency in expenditure through structural reforms such as the streamlining of treatments, development of outpatient care, improving the share of generic drugs consumed and reducing their prices (along with other drug policies).

Recent policy changes adopted

From January 2016 collective complementary insurance is compulsory for all employees of the private sector.

New regulations and fiscal incentives for "responsible contracts" have been implemented in order to limit health price inflation due to complementary insurance coverage.

The “Loi de modernisation de notre système de santé” has been promulgated in January 2016. It rationalises the offer by care providers: for hospitals with the GHT (“groupements hospitaliers de territoire”) and for ambulatory care and coordination between inpatient and outpatient care (“Communautés professionnelles territoriales de santé”). Health care accessibility has also been improved by the direct payment to doctors (“tiers payant“) of the reimbursement of social security funds.

Challenges

The analysis above has shown that a range of reforms has been implemented in recent years to a very large extent successfully, which France should continue to pursue. For example, improvements in access to health insurance for those most vulnerable, improvements in hospital efficiency, improved data collection and monitoring and better control of pharmaceutical expenditure, greater use of primary care and improvements in care coordination from primary to secondary care. The main challenges for the French health care system are as follows:

- To reinforce human resources strategies to avoid a shortage of physicians in the future as a result of staff and population ageing. This can be done by pushing up numerus clausus ceilings according to projected needs. To improve geographical access to doctors especially between urban and rural areas through incentives system directed at doctors, especially primary care staff.

- To continue efforts to implement cost-containment policies in a system characterised by fee-for-service payment of doctors and unrestricted freedom of choice for patients. These include continuing to encourage a more rational and coordinated use of care through greater use of primary care and more effective referrals from family doctors to steer demand to other types of care and organise appropriate and cost-effective channels of treatment. Even if patients' financial contributions have already been implemented, it may also be worth exploring if cost-sharing can be further adjusted to encourage the use of more cost-effective interventions.

- To continue to promote generic pharmaceuticals by extending reference pricing schemes.

- To continue to improve the general governance of the system, through strategies to rationalise administrative procedures, therefore enhancing the global system's efficiency and quality. Possible areas include: increasing the financial responsibility of the funds, clarifying responsibilities of the various actors in the system, and improving accountability, perhaps through greater use of systems of rewards and fines.

- To improve data collection and comparability in order to evaluate more thoroughly the activity and quality of providers and the overall system. Possible indicators include preventable hospitalisations, readmission rates, mortality post-hospital, complication during and post operation, prescription mistakes (recommended by OECD). Public comparisons and peer

reviews can help providers identify areas for improvement and good practices.

- To enhance health promotion and disease prevention activities, i.e. promoting healthy life styles.

Table 1.10.1: **Statistical Annex – France**

General context												EU- latest national data		
GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
GDP, in billion Euro, current prices	1637	1711	1772	1853	1946	1996	1939	1998	2059	2087	2117	9289	9800	9934
GDP per capita PPS (thousands)	26.7	27.1	27.6	27.9	28.6	27.8	26.5	27.4	27.9	27.8	28.1	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	0.2	1.8	1.1	1.8	1.7	-0.6	-3.6	1.2	1.5	-0.5	-0.3	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	2.6	3.1	1.5	1.1	1.0	0.6	2.5	0.8	1.2	0.3	0.1	3.2	-0.2	-0.4

Expenditure on health*												**2009**	**2011**	**2013**
Total as % of GDP	10.8	10.9	10.9	10.9	10.8	10.9	11.6	11.6	11.5	11.6	11.7	10.4	10.1	10.1
Total current as % of GDP	10.4	10.5	10.5	10.4	10.4	10.5	11.2	11.1	10.7	10.8	10.9	9.8	9.6	9.7
Total capital investment as % of GDP	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.8	0.8	0.7	0.6	0.5	0.5
Total per capita PPS	2517	2664	2748	2832	2935	3030	3113	3179	3251	3306	3353	2828	2911	2995
Public as % of GDP	8.4	8.5	8.5	8.4	8.4	8.4	9.0	9.0	8.9	9.0	9.0	8.1	7.8	7.8
Public current as % of GDP	8.2	8.2	8.3	8.2	8.1	8.2	8.7	8.7	8.4	8.5	8.6	7.9	7.7	7.7
Public per capita PPS	1852	1951	2014	2065	2142	2199	2279	2317	2515	2557	2600	2079	2218	2208
Public capital investment as % of GDP	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.5	0.5	0.4	0.2	0.2	0.1
Public as % total expenditure on health	78.0	77.9	78.0	77.6	77.6	77.3	77.5	77.6	77.3	77.3	77.5	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	14.2	14.4	14.6	14.5	14.4	14.3	14.3	14.5	14.7	14.7	:	14.8	14.9	:
Proportion of the population covered by public or primary private health insurance	99.9	99.9	99.9	99.9	99.9	99.9	100.9	101.9	99.9	99.9	99.9	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	7.4	7.3	7.4	7.7	7.6	7.9	7.8	7.7	7.8	7.8	7.4	14.1	14.4	14.1

Note: *Including also expenditure on medical long-term care component, as reported in standard internation databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status												**2009**	**2011**	**2013**
Population, current (millions)	62.3	62.3	62.8	63.2	63.6	64.0	64.4	64.7	65.0	65.3	65.6	502.1	504.5	506.6
Life expectancy at birth for females	82.7	83.8	83.8	84.5	84.8	84.8	85.0	85.3	85.7	85.4	85.6	82.6	83.1	83.3
Life expectancy at birth for males	75.7	76.7	76.7	77.3	77.6	77.8	78.0	78.2	78.7	78.7	79.0	76.6	77.3	77.8
Healthy life years at birth females	63.9	64.3	64.6	64.4	64.4	64.5	63.5	63.4	63.6	63.8	64.4	:	62.1	61.5
Healthy life years at birth males	60.6	61.5	62.3	62.8	62.8	62.8	62.8	61.8	62.7	62.6	63.0	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	51	47	46	43	40	40	39	37	81	79	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	4.2	4.0	3.8	3.8	3.8	3.8	3.9	3.6	3.5	3.5	3.6	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data		
Composition of total current expenditure as % of GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	3.41	3.37	3.35	3.32	3.27	3.29	3.50	3.48	3.05	3.08	3.10	3.13	2.99	3.01
Day cases curative and rehabilitative care	0.52	0.60	0.61	0.62	0.61	0.63	0.69	0.69	0.70	0.72	0.74	0.18	0.18	0.19
Out-patient curative and rehabilitative care	1.80	1.79	1.79	1.77	1.75	1.76	1.85	1.84	2.04	2.08	2.11	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	1.82	1.84	1.84	1.81	1.80	1.80	1.88	1.85	1.73	1.69	1.65	1.60	1.55	1.44
Therapeutic appliances and other medical durables	0.42	0.43	0.44	0.44	0.45	0.47	0.50	0.51	0.53	0.54	0.56	0.31	0.31	0.32
Prevention and public health services	0.23	0.23	0.23	0.22	0.23	0.23	0.27	0.23	0.23	0.23	0.22	0.25	0.25	0.24
Health administration and health insurance	0.73	0.71	0.69	0.67	0.65	0.64	0.67	0.67	0.67	0.68	0.67	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative care	3.19	3.14	3.12	3.06	3.01	3.03	3.22	3.20	2.84	2.86	2.89	2.73	2.61	2.62
Day cases curative and rehabilitative care	0.49	0.56	0.57	0.57	0.57	0.59	0.64	0.64	0.65	0.66	0.69	0.16	0.16	0.18
Out-patient curative and rehabilitative care	1.15	1.14	1.12	1.11	1.10	1.10	1.15	1.16	1.17	1.19	1.42	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	1.26	1.28	1.29	1.26	1.25	1.21	1.27	1.25	1.19	1.16	1.15	0.79	1.07	0.96
Therapeutic appliances and other medical durables	0.14	0.14	0.15	0.15	0.16	0.17	0.18	0.19	0.20	0.20	0.21	0.13	0.12	0.13
Prevention and public health services	0.15	0.16	0.16	0.15	0.16	0.16	0.19	0.15	0.15	0.15	0.15	0.25	0.20	0.19
Health administration and health insurance	0.44	0.42	0.41	0.39	0.37	0.37	0.38	0.37	0.36	0.36	0.36	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.10.2: **Statistical Annex - continued – France**

												EU- latest national data		
Composition of total as % of total current health expenditure	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	32.9%	32.2%	31.9%	31.9%	31.6%	31.4%	31.3%	31.3%	28.5%	28.5%	28.4%	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	5.1%	5.7%	5.8%	5.9%	5.9%	6.0%	6.1%	6.2%	6.5%	6.6%	6.8%	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	17.4%	17.1%	17.0%	17.0%	16.9%	16.8%	16.6%	16.5%	19.0%	19.2%	19.3%	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	17.6%	17.6%	17.5%	17.4%	17.4%	17.2%	16.8%	16.6%	16.1%	15.6%	15.1%	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	4.1%	4.1%	4.2%	4.3%	4.4%	4.5%	4.5%	4.6%	4.9%	5.0%	5.2%	3.2%	3.3%	3.3%
Prevention and public health services	2.2%	2.2%	2.2%	2.1%	2.2%	2.2%	2.4%	2.1%	2.1%	2.1%	2.0%	2.6%	2.6%	2.5%
Health administration and health insurance	7.1%	6.8%	6.6%	6.4%	6.3%	6.1%	6.0%	6.0%	6.3%	6.3%	6.1%	4.2%	4.3%	4.9%
Composition of public as % of public current health expenditure														
Inpatient curative and rehabilitative care	39.1%	38.1%	37.8%	37.5%	37.1%	37.1%	36.9%	36.8%	33.8%	33.6%	33.6%	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	6.0%	6.8%	7.0%	7.1%	7.1%	7.2%	7.3%	7.4%	7.7%	7.8%	8.0%	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	14.1%	13.8%	13.6%	13.6%	13.6%	13.5%	13.2%	13.3%	13.9%	14.0%	16.5%	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	15.4%	15.5%	15.6%	15.5%	15.4%	14.8%	14.5%	14.4%	14.2%	13.6%	13.4%	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	1.7%	1.7%	1.8%	1.9%	2.0%	2.1%	2.1%	2.2%	2.3%	2.4%	2.5%	1.6%	1.6%	1.6%
Prevention and public health services	1.8%	1.9%	1.9%	1.8%	2.0%	2.0%	2.2%	1.7%	1.8%	1.8%	1.8%	3.2%	2.7%	2.5%
Health administration and health insurance	5.4%	5.1%	4.9%	4.7%	4.6%	4.5%	4.4%	4.3%	4.3%	4.2%	4.2%	1.4%	3.5%	3.5%

												EU- latest national data		
Expenditure drivers (technology, life style)	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
MRI units per 100 000 inhabitants	0.32	0.39	0.48	0.52	0.55	0.61	0.64	0.70	0.75	0.86	0.94	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	0.8	:	:	:	:	:	:	:	:	:	:	0.9	0.9	0.8
CTS per 100 000 inhabitants	0.8	0.9	1.0	1.0	1.0	1.1	1.1	1.2	1.3	1.3	1.5	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	:	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Proportion of the population that is obese	:	9.4	:	10.5	:	12.2	:	12.9	:	:	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	:	23.4	:	25.9	:	26.2	:	23.3	:	24.1	:	23.2	22.4	22.0
Alcohol consumption litres per capita	13.5	13.2	12.2	12.4	12.2	11.9	11.8	11.9	12.0	11.8	11.4	10.3	10.0	9.8

Providers	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Practising physicians per 100 000 inhabitants	:	:	:	:	:	:	:	:	307	308	310	329	335	344
Practising nurses per 100 000 inhabitants	743	763	785	804	791	819	847	876	901	910	940	840	812	837
General practitioners per 100 000 inhabitants	164	165	165	164	163	162	160	159	156	156	155	:	78	78.3
Acute hospital beds per 100 000 inhabitants	381	374	369	362	358	352	349	346	343	339	335	373	360	356

Outputs	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Doctors consultations per capita	7.4	7.0	7.0	6.8	6.8	6.7	6.7	6.7	6.8	6.7	6.4	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	16.6	16.5	16.4	16.3	16.1	16.1	16.0	15.9	15.8	15.7	15.6	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	8,224	8,722	9,629	10,205	9,378	9,287	9,158	9,297	9,541	9,731	9,982	6368	6530	7031
Acute care bed occupancy rates	75.0	75.0	74.0	74.0	74.0	74.2	74.4	75.0	75.0	:	:	72.0	73.1	70.2
Hospital curative average length of stay	5.6	5.5	5.4	5.3	5.3	5.2	5.2	5.2	5.1	:	:	6.5	6.3	6.3
Day cases as % of all hospital discharges	33.1	34.6	37.0	38.6	36.8	36.8	36.3	36.9	37.6	38.2	39.0	27.8	28.7	30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**Change 2013 - 2060**	**EU Change 2013 - 2060**
AWG reference scenario	7.7	8.0	8.3	8.6	8.7	8.6	0.9	0.9
AWG risk scenario	7.7	8.2	8.7	9.2	9.4	9.4	1.6	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**Change 2013 - 2060, in %**	**EU - Change 2013 - 2060, in %**
Population projections until 2060 (millions)	65.7	67.8	70.5	72.9	74.4	75.7	15.1	3.1

Sources: EUROSTAT, OECD and WHO

France

Long-term care systems

2.10. FRANCE

General context: Expenditure, fiscal sustainability and demographic trends

France, has a population of almost 65.6 million inhabitants, which is expected to grow by 15% up to 75.7 million by 2060, above the EU overall growth of 3%. With a GDP of more than EUR 2,117 bn in 2013, or 28,100 PPS per capita, it is above the EU average GDP per capita of EUR 27,900 PPS.

Health status

Life expectancy at birth for both women and men was, in 2013, respectively 85.6 years and 79years and is above the EU average (77.8 and 83.3 years respectively). In 2013, the healthy life years at birth for both sexes were 63 years (women) and 64.4 years (men) significantly above the EU-averages (61.4 and 61.5 respectively). At the same time, the percentage of the French population having a long-standing illness or health problem is higher than in the Union as a whole (36.2% versus 32.5% in 2013). The percentage of the population indicating a self-perceived severe limitation in its daily activities was in 2013 9%, slightly above the EU-average (8.7%).

Dependency trends

The share of dependents is set to increase in this period, from 8.9% in 2013 to 11.4% of the total population in 2060, an increase of 28%. This is lower than the EU-average increase of 36%. From 5.8 million residents living with strong limitations due to health problems in 2010, an increase of 48% is envisaged until 2060 to 8.6 million. That is a much steeper increase than in the EU as a whole (40%).

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. In the "AWG reference scenario", public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (non-disability) status. The joint impact of those factors is a projected increase in spending of about 0.8 pps of GDP by 2060. ([374]) The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 1.1 pps of GDP by 2060. Overall, projected long-term care expenditure increase is expected to add to budgetary pressure.

Overall, for France no significant short-term risks of fiscal stress appear at the horizon, although some variables point to possible short-term challenges.

Risks appear, on the contrary, to be high in the medium term from a debt sustainability analysis perspective due to the still high stock of debt at the end of projections (2026) and the high sensitivity to possible macro-fiscal shocks.

No significant sustainability risks appear over the long run, under the no-fiscal policy change baseline scenario, notably thanks to pension reforms implemented in the past. ([375])

System Characteristics ([376])

France is a unitary state subdivided in administrative areas (departments). Public provision of long-term care is organised as a two-pronged system. On the one hand, the public health insurance scheme – providing universal population coverage – covers the cost of health care provided in institutions to the recipients of care (including the dependent elderly or disabled patients). It also funds LTC units in hospitals, as well as nursing care provided directly in the patient's home. These health care costs are paid for by the health insurance scheme and patients do not need to pay for these services themselves.

On the other hand, there are two schemes, that are mainly financed by local authorities and that provide social benefits to the dependents (whether elderly or disabled) in order to help them meet part of the cost of care not covered by health insurance,

([374]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf
([375]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf
([376]) This section draws on OECD (2011b) and ASISP (2014).

whether that care is provided in an institutional or domiciliary setting: the "Prestation de compensation du handicap" (PCH - Disability compensation benefit) and the " L'Allocation personnalisée d'autonomie " (APA - Personalised Autonomy Benefit), briefly described below.

Public spending on LTC reached 1.3% of GDP in 2012 in France, above the EU average of 1% of GDP. 90.3% of public LTC expenditure was spent on in-kind benefits (EU: 80%), while 9.7% were provided via cash-benefits (EU: 20%).

In France, 40.7% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC, below the EU average of 53%. Overall, 3.6% of the population (aged 15+) receive formal LTC in-kind and/or cash benefits (EU: 4.2%). On the one hand, low shares of coverage may indicate a situation of under-provision of LTC services. On the other hand, higher coverage rates may imply an increased fiscal pressure on government budgets, possibly calling for greater needs of policy reform.

The expenditure for institutional (in-kind) services makes up 68.6% of public in-kind expenditure (EU: 61%), 31.4% being spent for LTC services provided at home (EU: 39%). Thus, relative to other Member States France has a focus on institutional care, which may be inefficient, as institutional care is relatively costly with respect to other types of care.

Administrative organisation

As explained above, the public provision of long-term care relies on a two-pronged system. The cost of health care is financed by the public health insurance scheme, while social benefits provided by two schemes (PCH and APA) are essentially financed by the State and by local authorities. The PCH and the APA are provided by departments (local authorities).

Types of care

The range of types of care available is very large. It comprises help with daily activities (cooking, cleaning and laundry, etc.), help with personal activities (bathing, getting dressed, etc.).

A dependant or disabled person can also receive a benefit specifically aimed to adapt their home to their level of need (stair lift, walk-in bathtub, etc.) and any charge due to their situation in relation to four activities: mobility, personal care, communication and capacity to protect themselves and to control their environment.

All of these can be provided either at home or in institution.

Eligibility criteria

In general, in the basic health care insurance system cost-sharing applies to most goods and services, especially primary care and specialist consultations. Some specific categories are exempted from cost-sharing. The private voluntary complementary health insurance increases the rate of reimbursement, reducing the discrepancy between the actual amount paid by patients and the amount they are reimbursed by their social health insurance fund. In doing so, complementary health insurance reduces the ability of cost-sharing to control overconsumption, as it renders users less cost-aware. As a result, the authorities implemented a ticket, and a “deductible” that are not covered by complementary health insurance. According to the ticket system implemented in 2005 the patient has to pay EUR 1 for each physician visit and each biomedical analysis. The so-called medical deductible has been implemented since 2008. The patient has to pay EUR 0.50 per drug box, EUR 0.50 on each paramedical procedure and EUR 2 for each medical transport.

As most EU countries, France does allow for users to have a discretionary use of cash benefits. Discretionary use may not necessarily lead to the most cost-effective use of cash resources, especially if the use of cash benefits is not monitored.

The PCH is available for the disabled under 60.

The dependent above 60 receive the APA, which is based on an assessment of a person's needs.

As mentioned above, the APA benefit amount varies both according to the person’s level of dependency (established by a socio-medical team, using a nation-wide unified grid – the AGGIR grid – which identifies 6 levels of dependency, with only the first 4 levels being taken into account for

the granting of the APA benefit) and according to the elderly's financial resources.

Co-payments, out of the pocket expenses and private insurance

For the disabled under 60, a new benefit is in place from January 2006, the PCH. It is intended to help cover the needs of the disabled person regardless of whether those needs have to do with labour market attachment, home adaptation, human and technical aids, etc. Average monthly spending per recipient is EUR 800.

From age 60 onwards, the dependent elderly – at home or in an institution – can receive the APA, a universal benefit for people over 60 that was established in 2002. This benefit is calculated on the basis of a "help plan" designed for each individual according to an assessment of their needs. The APA benefit is intended to cover part of the cost of the "help plan", with the rest (on average about one quarter of the total amount) being paid by the beneficiary through user fees which increase in proportion to their income. Recipients with an income below EUR 800.53 per month do not pay these fees. The benefit amount thus depends on both the person's level of dependency as well as on the recipient's financial resources. The level of dependency is established by a socio-medical team, using the unified AGGIR grid.

The APA is administered by the relevant local departments, which cover around two third of its cost, with the rest being financed by the National Solidarity Fund for Autonomy (CNSA). The average amount of the "Help plan" granted to home care recipients care is around EUR 482 per month, of which about a fifth (EUR 94 on average) is covered by cost-sharing. The amount provided through the "Help plan" varies depending on the level of dependency from EUR 342 to EUR 991 per month.

France is one of the leading markets in terms of the proportion of its population that is covered by private LTC insurance. In 2012, 18% of the population aged over 40 years had private LTC coverage. Indemnity policies are the most frequent type of private coverage arrangement. Under this model the insured typically pay annual fees in exchange for a determined future stream of income in case they become dependent.

Role of the private sector

Care for disabled people is provided almost exclusively by the public sector, although the private sector plays an increasing role in old-age LTC: a third of health expenditure for older people (including, home care and hospitals) is for care provided in a private institution (profit making: 14% of the total; non-profit making: 19% of the total). Among all institution for older people, A quarter of all institutions providing care for older people are private profit-making institutions.

Formal/informal caregiving

In 2003, about 75% of APA recipients received care from a family member. The majority of informal carers were women (62%, average age of 58 years old). Only about 10% of informal (family) carers are paid through APA.

In terms of the balance of care and work activities, informal carers who are in employment have the right to take 3 months of unpaid leave (up to 1 year over their career) to care for a dependent. There are also specific tax reductions available for carers.

Prevention and rehabilitation policies/measures

Prevention and rehabilitation are managed by the public health system.

Recently legislated and/or planned policy reforms

A reform for "the adaptation of society to ageing" was adopted by the Parliament by the end of 2015 and came into force in 2016.

This reform (645 million euros) was financed by the Additional Solidarity Contribution for Autonomy (CASA) introduced in 2013.

375 million euros were spent on the APA benefit in order to help the elderly remain longer in their own homes. The amount of the APA benefit was thus raised by 400 euros for the most dependent patients, and by 150 euros for the least dependent patients. Furthermore, the amount of co-payment

(ticket modérateur) was reduced by up to 80% in some cases.

25 million euros were also be devoted to improving the wages of the low-waged domiciliary care providers.

Information is encouraged by the 2015 bill, thanks to new financing and the creation of a "trustful person" accompanying the dependent person.

Finally, the bill also supports carers:

- It creates a new status and training for people helping a dependent relative;
- It gives them a "respite assistance", i.e. a replacement while they take a "break" or in the case of an hospitalisation.

To promote data sharing amongst public administrations, the "loi de modernisation de notre système de santé", promulgated in January 2016, creates a new database called « système national des données de santé » (article 193). It will contain data on the disabled and the elderly.

140 million euros were spent on subsidising technical aids to help the elderly, and especially those with most modest incomes, to remain longer at home.

80 million euros were devoted to adapt private housing to the needs of dependent people and to renovate intermediary forms of homes – named "autonomy residences" - for the elderly, who need help but not to the extent that they need to be in a nursing home.

Regulations on private dependency insurances were also introduced, as well as special help for informal carers (up to 500 euros per year in order to cover the cost of some time off).

Challenges

The main challenges of the system appear to be:

- **Improving the governance framework**: To establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities wrt. to the provision of long-term care services; To set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services; To strategically integrate medical and social services via such a legal framework; To define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; To deal with cost-shifting incentives across health and care.
- **Improving financing arrangements:** To face increased LTC costs, choices will be made to define the balance between public and private financing and between generations".
- **Providing adequate levels of care to those in need of care:** To adapt and improve LTC coverage schemes, setting the need-level triggering entitlement to coverage; the breadth of coverage, that is, setting the extent of user cost-sharing on LTC benefits; and the depth of coverage, that is, setting the types of services included into the coverage; To provide targeted benefits to those with highest LTC needs; To reduce the risk of impoverishment of recipients and informal carers.
- **Ensuring availability of formal carers:** To determine current and future needs for qualified human resources and facilities for long-term care.
- **Ensuring coordination and continuity of care:** To establish better co-ordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care co-ordination responsibilities to providers or to care managers, via dedicated governance structures for care co-ordination and the integration of health and care to facilitate care co-ordination.
- **To facilitate appropriate utilisation across health and long-term care:** To steer LTC users towards appropriate settings.

- **Changing payment incentives for providers:** To consider a focused use of budgets negotiated ex-ante or based on a pre-fixed share of high-need users.

- **Improving value for money:** To invest in assistive devices, which for example, facilitate self-care, patient centeredness, and co-ordination between health and care services; To invest in ICT as an important source of care management and coordination.

Table 2.10.1: **Statistical Annex – France**

GENERAL CONTEXT

GDP and Population	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
GDP, in billion euro, current prices	1,637	1,711	1,772	1,853	1,946	1,996	1,939	1,998	2,059	2,087	2,117	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	26.7	27.1	27.6	27.9	28.6	27.8	26.5	27.4	27.9	27.8	28.1	26.8	27.6	28.0	28.1	27.9
Population, in millions	61.9	62.3	62.8	63.2	63.6	64.0	64.4	64.7	65.0	65.3	65.6	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	1.3	1.4	1.4	1.5	1.5	1.6	1.7	1.7	1.8	1.3	:	1.0	1.0	1.0	1.0	:
Per capita PPS	313.5	332.9	353.5	378.8	404.7	418.7	441.8	464.8	485.6	355.8	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	2.6	2.6	2.8	2.8	2.9	3.0	3.1	3.1	2.2	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	82.7	83.8	83.8	84.5	84.8	84.8	85.0	85.3	85.7	85.4	85.6	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	75.7	76.7	76.7	77.3	77.6	77.8	78.0	78.2	78.7	78.7	79.0	76.6	76.9	77.3	77.4	77.8
Healthy life years at birth for females	63.9	64.3	64.6	64.4	64.4	64.5	63.5	63.4	63.6	63.8	64.4	:	62.6	62.1	62.1	61.5
Healthy life years at birth for males	60.6	61.5	62.3	62.8	62.8	62.8	62.8	61.8	62.7	62.6	63.0	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	36.1	34.6	34.4	33.7	36.7	37.0	36.9	36.5	36.6	36.2	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	7.3	6.6	6.3	6.1	8.6	9.0	9.6	9.3	8.8	9.0	:	8.1	8.3	8.6	8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
Number of people receiving care in an institution, in thousands	:	:	:	:	552	532	511	491	507	523	854	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	521	657	792	928	947	966	1,089	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	1.7	1.9	2.0	2.2	2.2	2.3	3.0	2.0	2.2	2.2	2.3	2.1
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients																
Providers																
Number of informal carers, in thousands	:	1,837	:	2,102	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	160	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO

Table 2.10.2: **Statistical Annex - continued – France**

PROJECTIONS

Population	2013	2020	2030	2040	2050	2060	MS Change 2013-2060	EU Change 2013-2060
Population projection in millions	65.6	67.8	70.5	72.9	74.4	75.7	15%	3%
Dependency								
Number of dependents in millions	5.83	6.39	7.14	7.96	8.39	8.61	48%	40%
Share of dependents, in %	8.9	9.4	10.1	10.9	11.3	11.4	28%	36%
Projected public expenditure on LTC as % of GDP								
AWG reference scenario	2.0	2.1	2.2	2.6	2.7	2.8	41%	40%
AWG risk scenario	2.0	2.2	2.6	3.4	4.1	4.7	139%	149%
Coverage								
Number of people receiving care in an institution	854,410	953,336	1,073,410	1,303,937	1,429,279	1,487,956	74%	79%
Number of people receiving care at home	1,088,588	1,203,116	1,345,218	1,599,657	1,731,392	1,793,138	65%	78%
Number of people receiving cash benefits	427,786	436,278	430,843	433,358	439,317	442,807	4%	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	3.6	3.8	4.0	4.6	4.8	4.9	36%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	40.7	40.6	39.9	41.9	42.9	43.3	6%	23%
Composition of public expenditure and unit costs								
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	90.3	91.0	92.0	93.3	93.8	93.9	4%	1%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	9.7	9.0	8.0	6.7	6.2	6.1	-38%	-5%
Public spending on institutional care (% of tot. publ. spending LTC)	68.6	68.4	67.9	66.4	65.8	65.6	-4%	1%
Public spending on home care (% of tot. publ. spending LTC in-kind)	31.4	31.6	32.1	33.6	34.2	34.4	10%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	93.9	93.2	91.3	89.2	88.0	87.1	-7%	-2%
Unit costs of home care per recipient, as % of GDP per capita	33.8	34.1	34.5	36.7	37.7	37.9	12%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	29.5	29.3	29.0	28.8	28.8	28.8	-2%	-2%

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)