PILLARS OF HEALTH

Country report on health worker migration and mobility

France

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List of abbreviations

ANSM	*Agence national de sécurité du médicaments et des produits de santé* – the French national agency for medicines and health products safety
ARS	*Agences regionales de santé* – Regional health agencies
Covid-19	Official name for the disease caused by the SARS-CoV-2 (2019-nCoV) coronavirus. Coronavirus is a group of viruses belonging to the family Coronaviridae. Coronavirus Disease first appeared in 2019.
DARES	*Direction de l'animation de la recherche, des études et des statistiques* – a department in the Ministry of Labour, Employment and Integration
DREES	*Direction de la recherche, des études, de l'évaluation et des statistiques* – a department in the Ministry of Solidarity and Health
EU	European Union
GDP	Gross Domestic Product
HAS	*Haute Autorité de Santé* — French National Authority for Health
HOSPEEM	European Hospital and Healthcare Employers' Association
INSEE	*Institut national de la statistique et des études économiques* – French national statistics office
ODENORE	*Observatoire des non-recours aux droits et services* Observatory on non-use of rights and services at the University of Grenoble- Alpes
OECD	Organisation for Economic Co-operation and Development
ONDPS	*Observatoire national de la démographie des professions de santé* – National Observatory of Health Workforce Demography at the University of Grenoble-Alpes
OOP	Out-of-pocket expenses
SHI	Social Health Insurance
UNCAM	*Union nationale des caisses d'assurance maladie* – the national union of health insurance funds
URSSAF	*Union de recouvrement des cotisations de Sécurité sociale et d'allocations familiales* – the organisation responsible for collecting employee and employer social security contributions
VHI	Voluntary (i.e. complementary) health insurance
WHO	World Health Organization

About Pillars of Health

Pillars of Health is an alliance of EU-based organisations that wants to contribute to an equitable geographic distribution of health workers across the European Union (EU), to ensure that all European citizens have equal access to health workers. In 2021, as part of the Pillars of Health project, lead partner organisation Wemos (the Netherlands) joined forces with the Center for Health Policies and Services (Romania), Media Education Centre (Serbia), and VU Athena (the Netherlands) to identify ways to address the negative effects of excessive health worker migration and recruitment. In 2022, we also started collaborating with the Association of Democratic Physicians (Verein demokratischer Ärzt*innen (vdää*)) (Germany). Moving forward, we aim to do joint advocacy within a wider coalition. Together, we aim to influence policy-makers so they actively implement policies that mitigate the negative effects of health worker migration and mobility, and instead contribute to a strong and sustainable health workforce across the EU. Read more about Pillars of Health, and join us.

This country report is part of a series on health workforce migration and mobility in the focus areas of Pillars of Health: France, Germany, Romania, Serbia and EU level (cross-country analysis).

This report was written by an independent EU public affairs consultant, Anna Macdougald, who is based in France.

Executive summary

This report describes and analyses the health system in France, as well as the challenges of its health workforce. We examined the flows of health workers into France in the last ten to fifteen years, and to which extent France, as an affluent destination country, is dependent on health professionals from less affluent source countries. We also looked into the degree to which France is working towards achieving self-sufficiency in its health workers. This report is largely based on a comprehensive desk review and, where possible, includes first-hand information gleaned from the main stakeholders, highlighting their main interests and positions. We also provide recommendations at national and international/EU level to improve the French health system.

Main findings

As the country emerges from the Covid-19 pandemic, it is clear that France's health system and workforce are experiencing **major challenges**: an ageing population and its specific care demands, an ageing population of doctors, medical deserts, the distraction of time spent form-filling by practitioners to the detriment of care, and exhaustion from unremitting work demands. While some of these challenges had already been apparent, the pandemic served to bring them into sharper focus.

Recent reforms to the health and education sectors to tackle the shortage of health workers and significant investments announced for hospitals and the upgrading of facilities, are expected to partially alleviate the pressure, particularly in France's public hospitals and its nursing and care homes. However, there is considerable room for France to make **further progress towards self-reliance in training and retaining health professionals**.

For example, **many health workers in France have trained in other EU Member States** because they can take advantage of the opportunities introduced in the EU Directive 2005/36/EC on the mutual recognition of professional qualifications and move freely between EU countries. However, it is evident that French-trained health professionals also migrate to other EU countries and to Switzerland. The **traffic is two-way**, although when French health professionals migrate, they tend to move to other French-speaking countries, such as Belgium, Luxembourg, and Switzerland.

In addition, accounting for two-thirds of the health work force, **nurses play a pivotal role in France's health system**. The proportion of foreign-trained nurses in France rose from 1.71% in 2000, to 2.44% in 2010, and to 2.86% in 2019. However, some of these are French nationals who have been trained elsewhere in the EU. With a view to improved resource allocation in the health system, nurses are calling for a greater role in decision-making (much of which is currently doctor- and male-dominated), more team work, improved working conditions, and greater use of digital technologies to allow more time to care for patients. Moreover, they are calling for some of the boundaries between professions to be eliminated, for example, to play a coordinating role in multidisciplinary practices and the right to prescribe in certain circumstances.

Recommendations

It is generally acknowledged that healthcare delivery needs to be radically reorganised to guarantee universal access to healthcare. Based on our findings, we therefore recommend the following measures to address the health system and health workforce challenges in France:

Recommendations for the French government:

- **Implement more robust data collection methods** to ensure that statistics on the stock and flows of France's health workforce are reliable, up to date, comparable, and compatible with those of its EU and international partners;
- **Engage more effectively** with professional bodies representing doctors in France who have so far been reluctant to contribute to this report, perhaps because of their central position and the political sensitivity of the issues involved;
- **Continuously engage** with bodies representing nursing staff and a wider diaspora of health-related professionals such as pharmacists and midwives, as well as trade unions, patient associations, and recruitment agencies.
- **Ensure better resource allocation,** which will entail, among other things:

- **reviewing and upgrading the role played by nurses in care pathways** and ensuring the continuity and quality of care, deploying digital technologies to tackle issues such as time-consuming form-filling, leading to more face-time with patients and enhanced job satisfaction;
- **reviewing how the roles of pharmacists and other health professionals might be extended** to relieve the pressure on doctors, especially in under-served areas;
- **enhancing the attraction of the health professions** to improve retention and recruit fresh talent, and
- **giving higher priority to prevention and lifestyle changes**, possibly with initiatives carried out, in part, by nurses in local communities.

- **Ensure increased availability of continuing training** for healthcare workers, which could also help to attract the younger generation of nurses who can often be more mobile than older cohorts and which could also be an incentive to counteract some inconveniences associated with nursing, such as working unsociable hours, weekends, and holidays.

- **Invest in training in new technologies** to lighten the administrative burden, particularly on nurses, allowing more time to care for patients.

- **Improve planning methods** for the health professions of the future. Given the ageing population, there will be greater demand for care, likely to be more complex because of combinations of conditions. Digital health is likely to develop at a rapid rate and there will be an increasing need for nurses with specialisms.

- **Constantly review curricula and training course content** to ensure that they meet the public's present and future needs.

Recommendations for the European Union:

- **Agree on uniform and harmonised definitions** in the health and care fields. The international comparability of statistics and data collection systems is vital for reliable planning and policy-making for the future.

- **Evaluate the feasibility of promoting a policy initiative to compensate less affluent source countries** for their investment in training, and for the opportunity cost of not being able to employ the professionals who have migrated, should the inflows of healthcare professionals to more affluent destination countries increase. A system along the lines of Global Skills Partnerships[1] - a bilateral public-private partnership to link skill creation and skill mobility in a mutually beneficial and equitable way - might be envisaged.

- **Engage with Member States and EU institutions**, and raise any concerns on professional mobility issues with respect to the healthcare workforce, such as during the European Commission's two-yearly reviews of the **implementation of Directive 2005/36/EC** on the mutual recognition of professional qualifications.

- **Follow and offer support to organisations representing healthcare professionals** at EU level and, where appropriate, **become involved in their initiatives** where these can be related to or link in with the mobility aspects, e.g. European Council of Medical Orders, European Nursing Council, European Federation of Nurses' Associations, European Midwives Association, and European Health Management Association.

- **Monitor closely any developments in the European Care strategy** following the European Parliament resolution[2] adopted in July 2022. In addition to prioritising the development of universal and high-quality long-term care systems, it also stresses the importance of improved working conditions for care professionals, better recognition and support for informal carers and families, and the need to ensure decent work for all.

- **Examine** the possibility of a special health-related initiative under the Erasmus programme, greater alignment of curricula and protocols, and new digital projects and infrastructure to share knowledge and data, as well as further initiatives under the EU4Health programme 2021-2027.

[1] Global Skill Partnerships: A proposal for technical training in a mobile world, Michael Clemens, OECD, Paris, 2016.

[2] European Parliament resolution of 5 July 2022 towards a common European action on care (2021/2253(INI))

Introduction

Although the EU's single market offers many benefits, such as free movement of persons, goods and services, substantial asymmetric migratory flows of health workers have been observed from less affluent member states or candidate countries (source countries) to the more affluent countries (destination countries). France, the subject of this report, has been a major destination country for health workers from source countries.

Flow of healthcare resources

This flow of resources from source to destination countries impacts on health system resilience and health status in the countries in question. It contradicts the spirit of 'levelling up', of improving economic and social conditions, and of reducing disparities, underpinning the EU.

France's health spending

France's health spending levels have historically been some of the highest in Europe. Since the early 2000s, a series of attempts have been made to cut spending with a view to reducing the deficit in social security budget, particularly in public hospitals.

Training – overly strict quotas

It will also be seen that the impacts of serious shortcomings in strategic health worker planning dating back to the 1980s have been making themselves felt for the past decade or so. Strict quotas for the training of medical and paramedical staff were introduced in the 1970s (because it was felt that France was producing too many graduates) and then further tightened in the late 1970s in the expectation that the population was going to decrease after 2000. In fact, although it was already evident that France's fertility and life expectancy rates were some of the highest in Europe in the 1980s, these quotas were only raised in the 1990s. This policy has resulted in serious shortages in personnel — particularly of doctors — and the arrival of the phenomenon of 'medical deserts' — areas of the country where medical services are under-resourced.

Serious strains

It will be seen that for many years — and long before the Covid-19 pandemic — France's health system had been coming under serious strain with calls for reforms with regard to the situation of health professionals, but also the health system as a whole. Health professionals' concerns mainly related to the need to tackle understaffing, lack of beds, and poor pay and working

conditions. Since 2017, when Emmanuel Macron was elected President of the Republic for the first time, some progress has been evident in reforming the health system, and the hospital sector in particular. However, much remains to be done.

Exhausted and undervalued

Despite various initiatives taken by the French government in 2021-2022 to address various issues, France's health system, in common with many other countries in the wake of the Covid-19 pandemic, still finds itself in a highly vulnerable situation. The continuing shortages of health workers, many of whom have emerged from the pandemic feeling exhausted and undervalued, compounded by hospital bed and emergency service closures, have led to a real sense of alarm in some quarters.

Recruitment and retention

The report set out to review France's implementation of the principles laid down in the WHO Global Code of Practice on the International Recruitment of Health Personnel (2010) particularly that "all [WHO] Member States should strive to meet their health personnel needs with their own human resources for health". However, since the country has not reported to the WHO on its implementation of the Code since 2015, our report therefore seeks to assess the degree to which France has been working towards self-reliance in health workers in the absence of these implementation reports.

Demographics

As a recent article[3] in *Le Monde* states, **'the number of people aged 85 and over in France will increase by almost 90% between 2030 and 2050'**, geriatrics remains the poor relation of an already stretched hospital system. Keeping the elderly in their homes calls for a national policy. France's demographic clock is ticking and it is not going to stop.' Clearly, in the past two decades, there have been serious shortcomings in strategic planning to deal with the needs of France's ageing population. The country is going to have to prepare to meet the challenge of an ageing population.

Methodology

This report is largely based on a comprehensive desk review. It describes and analyses the specific context of France. It contains facts, figures, and background information on the French

[3] 'France must prepare for the challenge of an aging population', *Le Monde,* 12 August 2022

health system and how it works. Where possible, it has sought to include first-hand information gleaned from the main stakeholders, highlighting their main interests and positions. Although a number of stakeholders were approached with a view to getting their input and views, several were not responsive.

1. France: country profile and baseline data

Baseline data at a glance

- Population: 67.66 million in 2021 (34.9m. women, 32.7m. men) (Eurostat)
- Population over 65: 20.7% (EU average 20.8%) (Eurostat)
- Fertility: 1.9 births per woman (2020, European Observatory on Health Systems and Policies)
- World Bank classification: High income country
- Purchasing power adjusted GDP per capita (in euro): €33,800 (2021) (Eurostat)
- Gross national income per capita, PPP (current international $): $50,728.7 (2021) (World Bank)
- Relative poverty rate: Males: 18.2%, Females: 20.3% (2021) 18.9 (Eurostat)
- Annual economic growth rate (GDP):
    - 2017: 2.3%
    - 2018: 1.9%
    - 2019: 1.8%
    - 2020: -7.8%
    - 2021: 6.8% (Eurostat)
- Main GDP sector: services
- Seasonally adjusted unemployment rate (September 2022): 7.1% (European Commission)
- Current per capita health expenditure (in Euro PPP): €3,644 (OECD, 2019)
- Health expenditure as % of GDP: 12.2% (OECD Health expenditure and financing, 2020)
- Population covered by health finance (Eurostat, 2019):
    - SHI financed 83.7% of total health expenditure in France, while
    - VHI and household out-of-pocket (OOP) payments account for the remaining 16%. OOPs, at 9.3% in France, are low compared with the EU average of 15.4%.
- Health workforce numbers per capita: 167.7 doctors, nursing personnel, midwives, dentists, pharmacists / 10,000
    - Medical doctors: 32.7 / 10,000
    - Nurses: 114.3 / 10,000
    - Midwives: 3.55 / 10,000 (WHO)
- UHC service average index (SDG 3.8.1): 84

France is the second largest European Union Member State after Germany (83.2 million) in terms of population, and accounts for 15% of the EU total population. There are approximately 107 women for every 100 men. In the course of 2020, France recorded the **highest rate of population increase** (+119,000, +0.2%) in the EU, while the total EU population fell by 312,000.

France comprises metropolitan France (i.e. that part of the country on the European continent) with an area of 551,500 km², and its overseas regions whose combined area amounts to 89,179 km².

1.1 Governance and politics

France is a republic and a democracy with a presidential/parliamentary political system. The Head of State is the President, elected every five years. The President appoints the Prime Minister as head of government. The French parliament comprises two Houses: the National Assembly (*Assemblée Nationale* – the lower house, comprising 577 *deputés* who are elected every five years in a two-round election system) and the Senate (*Sénat* – comprising 348 senators elected by indirect and universal suffrage by 162,000 municipal, departmental and regional delegates for a term of 6 years).

The most recent presidential elections took place in April 2022, while the parliamentary elections were in June 2022. Emmanuel Macron was re-elected President, with a slimmed down majority over Marine Le Pen representing the far right (*Rassemblement national*). However, in the parliamentary elections, Macron's *La République En Marche* party emerged as the largest party but did not win the overall majority in the *Assemblée* that it had enjoyed for the previous five years.

Although most decisions are taken by central government, there are three further tiers of government with limited powers: 18 regions (*régions*) including five overseas territories; 96 counties (*départements*); and approximately 35,000 *communes* (ranging from cities to towns and villages – thus varying widely in size).

- ***Régions*** have an important role to play in decisions relating to education and infrastructure;
- ***Départements*** manage a number of social and welfare allowances, school buildings, and technical staff, local roads, school and rural buses, and some municipal infrastructure;
- ***Communes*** receive funding from government based on population, and their powers vary depending on how populous they are. In less populated areas, *communes* often band

together to form ***communautés*** (intercommunal structures) which allows them to jointly provide services such as water distribution and garbage collection.

1.2 Demographics

On 1 January 2022, according to INSEE (*Institut national de la statistique et des études économiques* -the French national statistics office), the **average age** in France was 40.7 for men and 43.6 for women, giving an overall average of 42.3. The **median age** was 39.7 for men and 42.75 for women, giving an overall median age of 41.2. The median age of French citizens has been rising gradually and steadily over the past 50 years and is expected to reach 45.9 years in 2050, compared with 36.2 years in 1995. Like most other developed economies, France has an ageing population.

Among the EU Member States, France reported the highest **total fertility rate** in 2020, with 1.83 live births expected per woman over her lifetime, followed by Romania (1.80) and Czechia (1.71). Nevertheless, the overall trend in France's fertility rate has been falling since the 1960s.

Eurostat estimates that the percentage of the French population **aged 65 or over** was 20.7% in 2021, marginally below the EU-27 average of 20.8%. It is worth noting, however, that France has one of the highest proportions of **young people** (under 15) in its total population (17.7%), only surpassed by Ireland at 20%. The EU-27 average is 15.1%.

Population density in metropolitan France (i.e., European France) was 119 inhabitants per square kilometre in 2020. This figure was up from 117 in 2007. However, as shown in Table 1, the French population is very unevenly dispersed, with large areas remaining sparsely populated. In 2020, France's rural population accounted for 19% of the total.

France has five **overseas regions**: Guadeloupe (Caribbean), Martinique (Caribbean), French Guiana (South America), Mayotte (Indian Ocean) and Réunion (Indian Ocean). Together, they cover almost 120,000 km² and are home to more than 1.1 million people (*INSEE* estimate, 1 January 2022).

Table 1: France's regions, population, and density per km², 2020.

Region (and its main population centres)	Population (in millions)	Density per km²
Ile de France (Greater Paris area)	12.2	1001
Auvergne-Rhône-Alpes (Lyon, St Etienne area)	8	112
Hauts de France (Lille, Valenciennes, Amiens)	6	189
Nouvelle-Aquitaine (Bordeaux)	6	70
Occitanie (Toulouse, Montpellier)	5.9	79
Grand-Est (Strasbourg, Mulhouse)	5.5	97
Provence-Alpes-Cote d'Azur (Marseille, Nice)	5.1	159
Pays de la Loire (Nantes)	3.8	115
Normandie (Rouen, Caën)	3.3	112
Bretagne (Rennes, Brest, Quimper)	3.3	120
Bourgogne-Franche Comté (Dijon, Dôle)	2.8	59
Centre-Val de Loire (Orléans, Tours)	2.6	66
Corse (Ajaccio, Bastia)	0.34	37
Guadeloupe	0.373	247
Martinique	0.35	329
Guyane	0.294	3.4
La Réunion	0.869	346
Mayotte	0.299	751
France (average density)	**67.4**	**105**

Source: *INSEE* (French national statistics office)

1.3 France's economy

France is considered a high-income country in the World Bank classification. According to Eurostat, France's real GDP per capita[4] was €32,650 in 2021. This contrasts with figures of €35,290 in Germany and €26,700 in Italy, and an overall EU-27 average of €27,810.

Calculating GDP per capita in PPPs (Purchasing Power Parities)[5], France's GDP was 104 in 2020, if the EU-27 average is set at 100.

Between 2017 and 2019, France's annual growth rates hovered around 2% (2.3%, 1.9% and 1.8% respectively). In 2020, it was -7.9%, recovering in 2021 to +7%. However, more recent figures (summer 2022) appear to suggest that growth is beginning to falter.

The European Commission's Summer 2022 Economic Forecast predicted a growth rate for France of 2.4% in 2022 and 1.4% in 2023. These estimates are both below those for the EU-27 as a whole of 2.7% for 2022 and 1.5% for 2023 respectively. However, these estimates should be viewed with caution given that it is difficult to compute with any precision the impact of the war in Ukraine and the energy and cost of living crises.

In spring 2022, France's **unemployment rate** dropped to 7.4%, its lowest level since 2008, according to INSEE.

Table 2: France: Distribution of value added by economic sector in 2020 in %.

Business sector	2020
Agriculture, forestry, and fishing	1.8
Manufacturing, mining, quarrying, and others	13.2

[4] Real GDP tracks the total value of goods and services calculating the quantities but using constant prices that are adjusted for inflation.

[5] The volume index of GDP per capita in Purchasing Power Standards (PPS) is expressed in relation to the EU average set to equal 100. If the index of a country is higher than 100, this country's level of GDP per head is higher than the EU average.

Construction	5.2
Traded services	56.4
Non-traded services*	23.4
Total	**100**

* "Public administration, education, human health, and social work" group.

Source: *INSEE* (French national statistics office)

As in other developed economies, France's services sector accounts for most (80%) of the country's economic activity, with manufacturing only contributing to 13.2%. Almost a quarter of the economy's added value comes from **non-traded services**, comprising public administration, education, human health, and social work.

1.4 Poverty and social exclusion in France

As in other EU countries, there is an association between poverty and poor health in France, with those living in poverty often suffering a higher risk to health due to poor nutrition, stress, smoking, and substance abuse.

One of the goals in the EU's blueprint 'Europe 2020: A European strategy for smart, sustainable and inclusive growth' was to reduce the number of people at risk of poverty or social exclusion in the EU by at least 20 million between 2008 and 2020.
11,150,000 people (18.5% of the population) were at risk of poverty and/or social exclusion in 2008. The government committed to reducing this figure by 1.9 million by 2020. By 2019, there were 11,120,000 people or 17.9% of the French population in this situation — a reduction of just 30,000 — a considerable distance from the initial goal.

The most recent Eurostat figures[6], which relate to 2021, suggest that, overall, around 19.3% of French people were at risk of poverty or social exclusion. This is somewhat lower than the EU-27 average of 21.7% for the same year.

[6] These figures are taken from: https://ec.europa.eu/eurostat/web/income-and-living-conditions/data/database?node_code=ilc

In France, there is a disparity between the 2021 figure for males (18.2%) and for females (20.3%). The overall EU-27 averages are 20.7% for males and 22.6% for females.

The OECD / European Observatory on Health Systems and Policies Country Profile 2021 gives France a **relative poverty rating**[7] for 2019 of 13.6% compared with an EU average of 16.5%.

As discussed later in this report (see section 4.5 on health insurance), there is, in principle, universal access to France's health system. Regular surveys by ODENORE[8] on behalf of the General Health Insurance Scheme indicate that this facility is not fully taken up. Potential users in financial difficulty do not always apply for the financial assistance available to them or may turn to other solutions, such as loans from relatives, while still others postpone treatment.

[7] Percentage of persons living with less than 60% of median equivalised disposable income (i.e., the total disposable income of a household divided by the number of household members, each weighted according to age).

[8] ODENORE (Observatoire des non-recours aux droits et services), University of Grenoble-Alpes.

2. The French healthcare system

The French healthcare system is administered by the *Ministère des Solidarités et de la Santé* (Ministry of Social Affairs and Health). The Ministry is responsible for formulating and implementing the government's **health strategy** and **organising and funding** the health care system.

Although most key decisions on organising the health system and determining its operating conditions are taken at national level, regional health agencies (*agences régionales de santé*) have, since 2010, played a greater role in managing and planning health care provision at regional level, with a view to improving coordination between out-patient and in-patient care, including hospital capacity planning.

Since 2003, the *Observatoire national de la démographie des professions de santé* (ONDPS – the French National Observatory of Health Professionals Demography) has provided the Ministry with guidance on the human resources aspects and scrutinises strategic planning at national and regional levels.

Every year, the French parliament adopts a **social security finance act** (*Loi de financement de la sécurité sociale*) which sets the national spending targets for health.

Healthcare providers fall into two main groups:

- health institutions (hospitals, nursing homes, and laboratories) which provide most of the in-patient care and employ salaried professionals, and
- mostly self-employed professionals (general practitioners, specialists, dentists, nurses, and pharmacists) providing out-patient care.

According to Eurostat, statutory health insurance contributions financed 83.7% of total health expenditure in France in 2019, while voluntary health insurance and household out-of-pocket (OOP) payments account for the remaining 16%. OOP payments, at 9.3% in France, tend to be low compared with the EU average of 15.4%.

2.1 National health strategies

France prepares **multiannual national health strategies**, the most recent of which covers the 2018-2022 period. These national strategies are based on analysis by the *Haut Conseil de la santé publique* (French High Council for Public Health) of the population's health status, and on the principle that good health should be one of the objectives of **all** government policies. Given social and geographical factors are recognised as crucial drivers of health inequality, a major focus of the health strategy is on:

- Implementing a policy of promoting life-long health, including preventive healthcare in every life situation;
- Tackling social and geographical inequalities in access to health;
- Guaranteeing quality, safety, and appropriateness at every stage of a patient's case management;
- Breaking new ground in transforming the health system by reaffirming the role of its users.

Investment in promoting health and preventing disease has historically been lower in France than in many other western European countries. This was addressed in France's most recent national health strategy and by other initiatives. For example, to achieve better cancer prevention and care, France launched its **National Cancer Plan (2021-30)** in February 2021. With a budget of €1.74 billion over five years, it aims to reduce the number of avoidable deaths from cancer by up to 60,000 every year until 2040.

2.2 Recent legislative developments

Since 2000, the French health system has undergone a series of reforms. These sought to address the challenges facing it in a period of lacklustre economic growth and a persistently high deficit in the social security budget, along with the increasing demands of an ageing population and rising costs, especially of new therapies.

The 2017 presidential election campaign saw the issue of healthcare take centre stage. During one of the televised debates, one of the candidates, François Fillon of the Republican party, suggested that state insurance should reimburse patients for treatment only for chronic and serious diseases, as a way of reducing the social security system's deficit, leaving patients to pay for the rest out of their own pockets or from private top-up schemes. This remark led to a national outcry.

Another candidate, Emmanuel Macron, the son of two doctors, pledged to increase public health spending by an annual 2.3% over his five-year term, investing €5 billion in hospitals, primary care, and innovation, cutting existing costs by €15 billion, and balancing the deficit-ridden social security budget.

In autumn 2018, the now President Macron, announced the publication of a new draft law **My Health 2022** (*Ma Santé 2022*) intended to restructure the French health system for the next 50 years. It sought to put the patient at the centre of care, address France's 'medical deserts', and created the post of **medical assistant**, to take some of the pressure off doctors.

The scope of the medical assistant positions was deliberately left broad to allow doctors to define the tasks themselves. These tasks were envisaged to range from administrative (managing files and welcoming patients), to assisting with certain technical procedures. These could include, for instance, taking blood pressure or preparation and assistance in carrying out electrocardiograms. They might also include making appointments with specialists and other health professionals to ensure the onward care of patients with chronic illnesses.

The new draft law also promised to reorganise the hospital system, with 'local hospitals' (*hôpitaux de proximité*) to be refocused on general medicine, geriatrics, and rehabilitation, while university and larger hospitals would offer more specialised services, leaving GPs to deal with less complex cases. It also included proposals for other changes, in particular developing **telemedicine**.

The proposals were met with considerable opposition and strikes in spring 2019 with many health workers of the view that investment levels, particularly in the hospital sector, were inadequate, as were salaries and working conditions.

In July 2019, certain aspects of the **My Health 2022** plan were adopted into law (Loi n° 2019-774), although it should be noted that some of its articles required subsequent government orders to be published before they could enter into force, e.g., the local hospitals (*hôpitaux de proximité*) initiative[9].

[9] Ordonnance n°2021-582 du 12 mai 2021 relative à la labellisation, à la gouvernance et au fonctionnement des hôpitaux de proximité; décret n°2021-586 du 12 mai 2021 relatif à la labellisation des hôpitaux de proximité (Journal officiel du 13 mai 2021).

4,000 **medical assistant positions** received the green light, as well as some other key measures to counter medical deserts.

These measures included abolishing the *numerus clausus* which, since 1971, had limited the number of medical students (as well as pharmacy, dentistry and midwifery students) admitted to universities. From the 2020 academic year onwards, universities, have been able to decide on the number of admissions, in line with their training capacities and the health requirements of the local area, with the approval of their Regional Health Agency.

To **stem the drain of personnel from public hospitals**, a 'non-competition clause' was introduced to prevent doctors, dentists, and pharmacists working in public health establishments from engaging in remunerated activity in private for-profit health establishments, private practices, private medical biology laboratories, or pharmacies. However, this non-competition clause is limited to a 24-month period and applies to a maximum radius of 10 km around the former employer's place of work.

In May 2020, the French government launched the *Ségur de la santé* — a national consultation of healthcare stakeholders on health system reforms. It involved a plan to **improve career paths** and **working conditions**, a new policy on **investment in and funding of care**, proposals to simplify the organisation and routines of medical teams, and a more **patient-oriented healthcare system** nationwide.

In July 2021, agreement was reached on reforms proposing expenditure of more than €8.2 billion per year designed to boost recruitment, with 15,000 new posts envisaged (although this figure is disputed). The agreement would also mean the retention of medical, paramedical (nurses, nursing assistants, masseurs-physiotherapists, etc.) and non-medical (technicians, hospital porters, administration) workers in hospitals, nursing homes, and care homes. In addition to pay increases across the board, increases were also agreed for extra hours worked, night working, and working on Sundays and public holidays.

The *Ségur de la Santé* also resulted in a €19 billion **investment plan** over 10 years. This comprises:

- €9 billion to fund large infrastructure projects (new hospitals and upgraded facilities)
- €6.5 billion to reduce hospital debt
- €1.5 billion to modernise nursing/care homes

- €2 billion for digital technology (telemedicine).

A significant share of the *Ségur de la Santé* investment (around €6 billion) will receive funding under France's National Recovery and Resilience Plan (NRRP) from the EU's **Recovery and Resilience Facility** – a fund which seeks to mitigate the economic and social effects of the Covid-19 pandemic. In the NRRP, €2.5 billion has been allocated to **priority hospital projects**, including hospitals at local level; €1.5 billion will go to the **renovation, transformation and equipping of nursing and care homes** (known as *EHPADs*) over the period 2021-2025, and €2 billion will be used to **develop digital tools** for the health sector, including, tools to allow medical files to be shared among health professionals or that permit patients to access their health data, launched in January 2022.

2.3 The situation in summer 2022

Some of the developments discussed above, such as the removal of the *numerus clausus*, will take time to have a palpable effect. Human resources remain stretched, and the trade unions claim that hospitals are no longer able to fulfil their role as a 'public service of last resort'.

The government has made some attempts to remedy the situation by introducing measures to tackle the shortage of healthcare workers. Former Health Minister, Brigitte Bourguignon, announced in June 2022 that extra hours worked would attract double pay, and student nurses would be 'immediately' employable in order to keep feeding new staff into struggling hospital services.

But June 2022 also saw a national strike of hospital workers over staff shortages and, in the same month, the *Samu-Urgences de France* (a trade union representing emergency medicine personnel) asserted that at least 120 hospitals were facing operational difficulties due to a lack of staff, with some having to close their emergency departments.

France's *Cour des Comptes*, a body responsible for scrutinising public spending, estimates **that one in five people** who show up at emergency departments are not actually emergency patients, adding further tension to already strained units. This situation reflects, in part, the problem of medical deserts — the shortage of doctors in private practice in under-served areas. This concern is echoed by the patients' grouping *France Assos Santé*, which has suggested that doctors should be required to organise out-of-hours care (a practice dropped in 2002).

On 30 June, before he was appointed Minister for Health, François Braun, an emergency doctor, put forward 41 proposals (known as the *'mission flash'*) to alleviate the high-risk situation in hospital emergency departments.

2.4 Healthcare spending

According to the OECD, resources devoted to healthcare in France are above average at international level, with higher-than-average spending, and more hospital beds and nurses per capita. The Eurostat figures from 2020 in the table below support this.

Table 3: Healthcare expenditure across the EU in 2020.

Current healthcare expenditure, 2020

	€ million	€ per inhabitant	PPS per inhabitant	% of GDP
EU (*)	1 462 373	3 269	3 269	10.9
Belgium	50 535	4 380	3 764	11.1
Bulgaria	5 226	754	1 478	8.5
Czechia	19 889	1 859	2 649	9.2
Denmark	32 902	5 642	3 964	10.5
Germany	431 805	5 192	4 831	12.8
Estonia	2 080	1 565	1 900	7.8
Ireland	26 479	5 311	3 740	7.1
Greece	15 720	1 469	1 731	9.5
Spain	120 203	2 538	2 588	10.7
France	281 065	4 160	3 807	12.2
Croatia	3 897	963	1 448	7.8
Italy	159 628	2 686	2 609	9.6
Cyprus	1 750	1 961	2 065	8.1
Latvia	2 194	1 154	1 551	7.5
Lithuania	3 732	1 335	2 006	7.5
Luxembourg	3 704	5 875	3 918	5.8
Hungary	9 965	1 022	1 672	7.3
Malta (2)	1 298	2 575	2 943	9.2
Netherlands	89 098	5 108	4 302	11.1
Austria	43 524	4 881	4 095	11.5
Poland (2)	34 183	902	1 591	6.5
Portugal	21 108	2 050	2 331	10.6
Romania	13 728	713	1 428	6.3
Slovenia	4 435	2 110	2 419	9.5
Slovakia	6 659	1 220	1 480	7.2
Finland	22 880	4 138	3 206	9.6
Sweden	54 687	5 282	4 008	11.4
Iceland	1 811	4 941	3 216	9.6
Liechtenstein	346	8 892	:	6.5
Norway (2)	38 113	7 127	4 588	10.5
Switzerland	77 824	9 009	4 997	11.8
Bosnia and Herzegovina	1 723	:	:	9.8

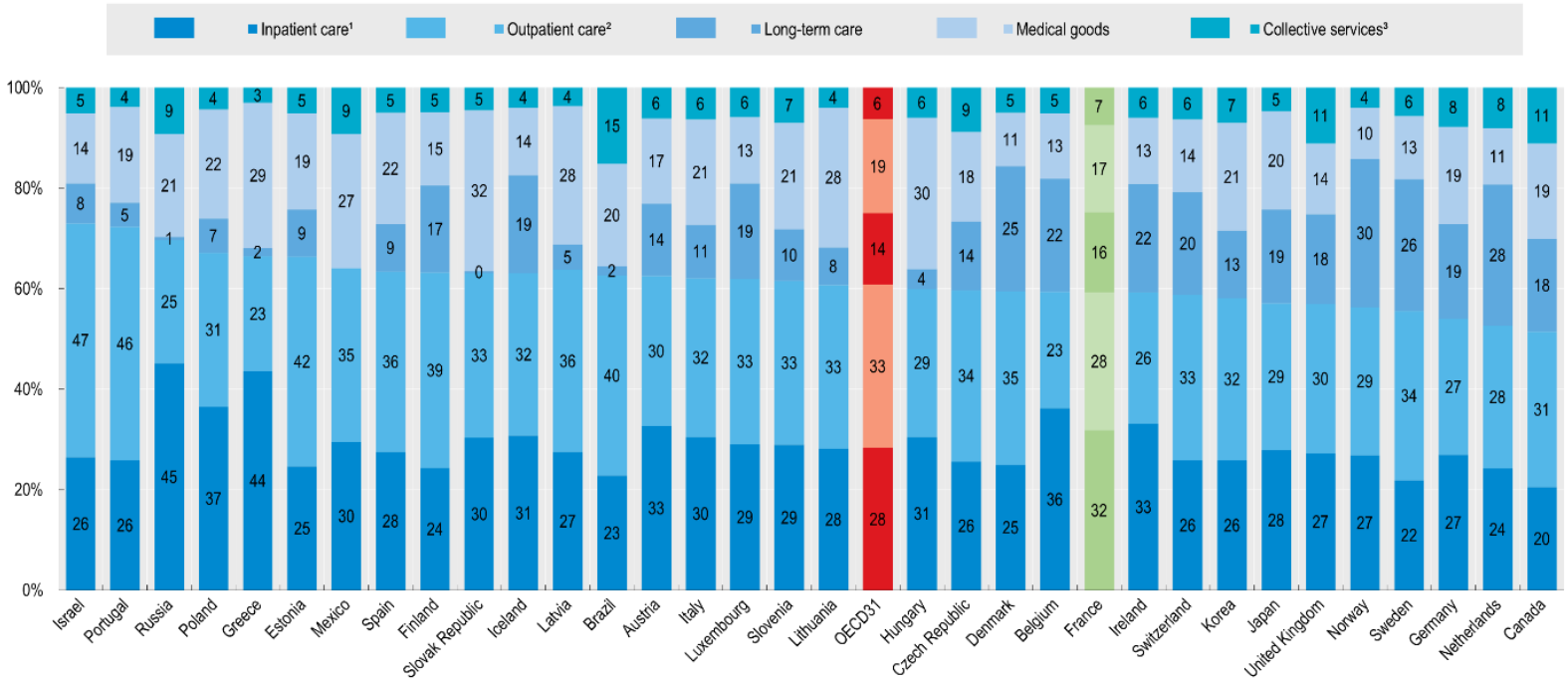
(*) Estimates.
(2) 2019.
(3) Provisional.
Source: Eurostat (online data code: hlth_sha11_hf)

eurostat

According to Eurostat, in 2020, France (12.2%) and Germany (12.8 %) had the highest healthcare expenditure relative to GDP in the EU.

How healthcare spending breaks down, by country

Table 4: Healthcare expenditure by type of service, 2019 (or nearest year).



1. Refers to curative and rehabilitative care in inpatient and day care settings.
2. Includes home care and ancillary services.
3. Includes preventive care, governance and health system and financing administration, and other health care services unknown.

Source: OECD – Health at a Glance 2021: OECD Indicators

Looking at an international comparison of how health expenditures break down by type of service, it can be seen that spending on **inpatient care** in France, at **32%**, is **higher than the OECD average of 28%**, and at broadly similar levels to those in Belgium, Ireland, Austria, Slovakia, and Iceland. However, it is 5 percentage points higher than in Germany and the UK (both 27%) and 8 points higher than in the Netherlands.

Spending on **outpatient care**, at **28%**, is **below the OECD average of 33%**, and similar to the level recorded in the Netherlands, the UK, Ireland, Norway, Germany, and Hungary.

France's spending on **long-term care**, at **16%**, is **2 points higher than the OECD average**, but is **substantially below** the levels recorded in Norway, the Netherlands and Sweden.

For spending on **medical goods**, France's figure of **17%,** is **2 points below the OECD average** of 19%, which is broadly similar to levels in other western European countries.

Under collective services, France's figure of **7% exceeds the OECD average** by one point and is at **similar levels to other EU countries**.

2.5 Health insurance in France

Prior to 1945, when France's social health insurance (SHI) system was established, health and social care was mainly provided through *mutuelles* (non-profit organisations regulated by the state which cover a percentage of the costs not covered by the state). The 1930 Social Insurance Act created a system of compulsory protection funded by employers for employees whose earnings fell below a certain level. The system covered illness, maternity, disability, old age, and death. According to Health Systems in Transition, by 1939, two-thirds of France's population was covered for illness by *mutuelles*.

France's **public health insurance system** (PHIS) combines Bismarckian characteristics (its centralised nature) and Beveridge characteristics (the state playing a major role). It was set up in 1945 and gradually extended over the years to cover all legal residents: employees in 1945, self-employed people in 1966, and unemployed people in 2000. In 2016, the universal health protection law (*Protection universelle maladie – PUMa*) came into force to plug any remaining gaps in coverage. It allows foreigners, for example, access to state healthcare after three months' residence.

Social health insurance (SHI) is funded by:

- compulsory contributions from employers, employees, and self-employed people levied on ***earned*** **income**;
- compulsory contributions levied on ***unearned*** **income** (investment income, pensions, etc.);
- the State's **general budget** (including, for example, revenue generated by taxes on tobacco).

URSSAF[10] is responsible for collecting these contributions, grouped together in the French National Union of Health Insurance Funds *(Union nationale des caisses d'assurance maladie – UNCAM*).

On average, the employer's contribution represents 45% of an employee's gross salary, and the employee's share ranges from 20 to 23% of salary, depending on income level and household composition.
France's SHI does not cover all medical costs and the reimbursement rate depends on the type of care received. Although SHI covers over 90% of hospital care, it only covers 44% of the costs for non-pharmaceutical medical goods in ambulatory (outpatient) care.

The remaining costs not covered by the SHI are largely taken care of by a system of **voluntary, complementary health insurance** (VHI), managed by *mutuelles*. Almost 95% of the population has VHI cover. There are means-tested subsidies for 10.5% of the population and 8% of lower-income individuals are fully subsidised. Further details on *complementaire santé solidaire* are available from ameli.fr.

Since January 2021, the *100% Santé* reforms have allowed those on modest incomes who have *complémentaire santé responsible* or *complémentaire santé solidaire* contracts to benefit from a range of medical equipment (hearing aids, eyeglasses, and dentures) at no additional cost.

Reimbursement for doctors' consultations falls into two main categories.

- *Conventionné* sector 1: doctors can charge the set amount (*tarif de convention)* which is agreed with the social security authority, e.g., a €25 copayment for a GP visit. Certain other higher rates apply for 'complex' consultations for more serious illnesses such as multiple

[10] *Union de recouvrement des cotisations de Sécurité sociale et d'allocations familiales*

sclerosis and Parkinson's disease, and for 'more complex' consultations, such as for malignant conditions.

- *Conventionné* sector 2: doctors' fees in this sector are not fixed. Generally, a consultation with a doctor in this sector will be reimbursed by the state, but at a lower rate than in sector 1. Frequently, specialists will fall within sector 2.
- *Hors convention* or *non-conventionnés*: applies to doctors (around 500 in France[11]) who have not signed an agreement with the state. Doctors in this category often practise in branches of medicine that involve lengthy consultations, such as psychiatry.

[11] http://faq.qare.fr/fr/articles/5847058-medecins-secteur-1-2-et-3-quelle-s-difference-s

2.6 Delivery of health services in France

2.6.1 Hospitals and clinics

The main types of hospital/clinic facilities in France are:

- Public hospitals — *hôpitaux publics* — which receive an annual budget from the State mainly from SHI, with voluntary insurance (VHI) and direct patient payments accounting for their remaining income.
- Private hospitals and clinics (*hôpitaux et cliniques privés*) which, if state-approved, can work for the national health system and are paid for doing so. These may either be not-for-profit or for-profit. For-profit clinics tend to be more expensive, and patients consequently need to have the necessary insurance cover or be prepared to pay out of their own pockets for anything not covered by the social security system.

Hospitals are reimbursed under SHI for inpatient and outpatient admissions.
They provide services such as:

- general care (e.g., surgery) and more specialised care and diagnoses,
- emergency medicine,
- care, including palliative care (with or without accommodation), as an outpatient, or in the home,
- coordination of care by working with health professionals in private practice and with health and social facilities and services, and
- teaching and professional training, as well as research (public hospitals).

2.6.2 Primary care

Primary care in France is mainly provided by general practitioners (GPs - *médecins généralistes*), specialists, dentists, and midwives. Patients have the right to choose their GPs (*médecins traitants*) and those GPs have freedom to choose where they wish to practice.

2.6.3 Diagnostic tests and therapy

Prescribed by doctors, diagnostic tests tend to be carried out by private medical laboratories. Doctors may also prescribe therapy to be carried out by paramedical professionals, such as nurses, physiotherapists, or speech therapists.

2.6.4 Hospital beds

In 2019, France had 584 hospital beds per hundred thousand inhabitants, a figure that has fallen significantly over the past decade (634 in 2012, 606 on 2016) (Eurostat).
According to the *DREES* (Direction de la recherche, des études, de l'évaluation et des statistiques, the Ministry of Health's statistics service), in the past 20 years, the number of **full hospitalisation** stays has been falling.

Conversely, over this same period, there has been a significant increase in the number of places for **partial hospitalisation** (without overnight stay) and hospitalisation at home. This shift towards more out-patients is mainly due to innovations in medical technologies and drug treatments.

In 2020, the decline in full hospitalisation stays was much more marked than in previous years because of the pandemic, with 10.3 million stays recorded, i.e. a decline of 12.4% (compared to -0.5% per year on average over the period 2013-2019).

2.6.5 Long-term care

Long-term care spending in 2019 amounted to 2.4% of France's GDP, according to the OECD's Health at a Glance 2021: OECD Indicators. There are two main categories of long-term care:

- **Institutional long-term care** is provided in retirement homes and long-term care units, totalling around 10,000 institutions with 728,000 beds. Of these institutions, currently 54% are public, 28% private not-for-profit, and 18% for-profit. The percentage of for-profit institutions is increasing.
- **In-home care**: care providers bring temporary care to dependent patients as well as respite services for their caregivers.

2.6.6 Pharmacies

As in many other countries, a pharmacist in France can practice in a range of settings including industry, laboratories, health establishments/institutions and in the retail and distribution of medicines. In this report, the focus is on pharmacists who work in high street pharmacies, dispensing medication to the public.

According to the OECD, in 2017, there were 104 practising pharmacists per 100,000 population in France. This compares with higher figures for Belgium (124), Italy (117) and Spain (116) and contrasts markedly with figures of 21 (the Netherlands), 52 (Denmark) and 65 (Germany).

2.7 Oversight, regulatory and advisory organisations

The *Agences regionales de santé* (ARS – Regional health agencies) have inspection-verification powers, in particular in relation to the operation of health and social care facilities and services. They also carry out inspections and run awareness programmes for health professionals on aspects such as the safety, quality, and appropriateness of care: drug prescriptions, prescriptions for medical transportation, medical justification for services, and compliance of medical practices with the best practice recommendations issued by the health agencies.

The *Agence national de sécurité du médicaments et des produits de santé* (ANSM – the French national agency for medicines and health products safety) is responsible for health product safety, from manufacture to sale. It focuses mainly on scientific assessment, laboratory oversight and advertising regulation, inspection of industrial sites, and providing information to health care professionals.

The *Haut Conseil de la Santé Publique* (High Council for Public Health) comprises independent experts from a variety of disciplines, ranging from doctors and economists to chemists, engineers, and sociologists. Its main task is to assist the Ministry of Health with decision-making on public health, but it can also be consulted by other ministries and by parliamentary committees on any matter relating to the danger and risk of accident and illness, as well as health security and health system performance. It is involved in all areas of public health, from emerging infectious diseases to the environmental impact on health, chronic diseases, and the organisation of the health system.

The *Haute Autorité de Santé* (HAS — French National Authority for Health) brings, under one umbrella, a number of activities designed to improve the quality of patient care and guarantee equity within the healthcare system. Established in 2004, it has several roles including assessing drugs, medical devices, and procedures as well as publishing guidelines, accrediting healthcare organisations, and certifying doctors. Training in quality issues and information provision are also key components of its work programme.

Health workforce planning at **national level** is undertaken by the ***Observatoire national de la démographie des professions de la santé*** (The National Observatory of Health Workforce Demography) and at **regional level** by regional committees coordinated by the regional health agency and comprising representatives of universities, professional regulatory bodies, trade unions representing health professionals, patients, and students in the various fields. Established in 2003, the Observatory reports to the Ministry of Health and analyses and disseminates knowledge relating to the geographical distribution of health professionals and training health professionals. Regional committees fix residency quotas and internship positions at regional level, taking local conditions into account.

2.8 Professional organisations and trade unions

Professional associations (or ***ordres***) focus on ethics and supervision of the professions concerned.

- *Ordre National des Médecins* – Doctors
- *Ordre National des Infirmiers* – Nurses
- *Conseil National de l'Ordre des Sages-Femmes* – Midwives
- *Ordre National des pharmaciens* – Pharmacists

In most cases, there are **trade unions** in parallel which represent the interests of the various professional groups principally in relation to working conditions and remuneration.

In the case of nurses, these include:

- The CFDT (*Confédération Française Démocratique du Travail* – French Democratic Confederation of Labour)
- The CGT Santé Action Sociale (*Confédération Générale du travail* – General Confederation of Labour)
- The FO (*Force Ouvrière* – Workers' Force)
- The UNIPA (*Union Nationale des Infirmier.es en Pratique Avancée* – Advanced Practice Nurses Union).

3. French population health status

3.1 Life expectancy

French people are among those with the longest **life expectancy** in Europe. Whereas the average EU-27 citizen born today can expect to live 80.4 years, the figure for France is 82.3 years. *INSEE*, the national statistics office, estimates the life expectancy of a woman born in 2021 to be 85.37 years and of a man 79.26 years.

In 2020, life expectancy at birth in France was almost two years longer than across the EU. It temporarily fell by eight months in 2020 because of deaths due to Covid-19 — the biggest reduction since 1945. Gains in life expectancy had already begun to slow in 2010, in part because of increased mortality rates from influenza, pneumonia, and other respiratory diseases among older people.

3.2 Mortality rates and main causes of death

In 2017 in France, the **maternal mortality rate** was 8 per 100,000 live births, according to the World Bank (WB). In 2019, the **infant mortality rate** was 3 per 1,000 live births (WB).

According to the State of Health in the EU: France, the age-standardised preventable mortality rate in France in 2016 was 134 per 100,000, whereas the age-standardised treatable mortality rate was 63 per 100,000. Age-standardised mortality rates are weighted to adjust for differences in the age distribution of the population by applying the observed age-specific mortality rates for each population to a standard population.

In 2020, the main causes of death were Covid-19 (9.6%), ischaemic heart disease (5.6%), stroke (5.4%), lung cancer (5.4%), Alzheimer's disease (3.6%), pneumonia (3.6%), colorectal cancer (3%), breast cancer (2.2%), diabetes (2%), and chronic obstructive pulmonary disease (1.9%) (EHO).

France has a higher burden of cancer than the EU average.

- For men, the age-standardised rate (all cancers) in France is 761 per 100,000 population compared with the EU average of 686 per 100,000 population.

- For women, the equivalent rates were 512 per 100,000 in France and 484 per 100,000 in the EU.

The State of Health in the EU: France publication also highlights the fact that France has lagged behind other western European countries in investing in **health promotion and disease prevention**. Around a third of all deaths in 2019 can be attributed to behavioural risk factors (below the EU average of 39%) such as tobacco smoking, dietary risks, alcohol consumption, and low physical activity. Air pollution in the form of fine particulate matter (PM2.5) and ozone exposure alone also contribute to the number of deaths each year.

3.3 Health risk factors

According to the State of Health in the EU publication, the main health risk factors in France in 2019 were:

- Smoking: 14% (FR), 17% (EU)
- Dietary risks: 11% (FR), 17% (EU)
- Alcohol 7% (FR), 6% (EU)
- Low physical activity: 2% (FR), 2% (EU)
- Air pollution: 2% (FR), 4% (EU).

3.4 Vaccine coverage

For many years, there has been compulsory vaccination of children in France against diphtheria, tetanus and poliomyelitis. In view of insufficient vaccination coverage for certain vaccinations, and the reappearance of epidemics, all children born after 1 January 2018 must also be vaccinated against whooping cough, Haemophilus influenzae b, Hepatitis B, Meningococcus C, Pneumococcus, Measles, Mumps and Rubella.

Influenza vaccination coverage for the 65+ age group is at 60% (State of health in the EU: France, 2021).

3.5 Self-perceptions of health

According to the EU-SILC (Statistics on Income and Living Conditions) survey, in 2020, more than two thirds (68.6%) of French adults (male: 70.2%; female: 67.1%) considered themselves to be in good health — a figure close to the EU average (69.5%).

The results of the EU-SILC survey also show that, in France, as in other countries, people in higher income groups are more likely to assess themselves as being in good health. In 2019, 72% in the highest income quintile assessed themselves as being in good health in contrast to only 58% in the lowest quintile.

4. Developments during the Covid-19 pandemic

4.1 The Covid-19 pandemic – how France mobilised

According to the European Centre for Disease Prevention and Control update on 19 July 2022, there had been 150,979 deaths from **Covid-19** in France from more than 33 million officially recorded cases, some of the highest figures observed in Europe. According to Johns Hopkins Coronavirus Resource Center estimates, France had 244.72 deaths per 100,000 population, fewer than in the UK (313.15), Italy (299.52), Belgium (287.51), and Spain (227.89), but more than in Germany (189.40). OECD figures suggest that the pandemic caused health spending in France as a share of GDP to rise sharply, from 11.1% in 2019 to 12.4% in 2020 (compared with an average 0.9 percentage point increase in OECD countries as a whole).

Preliminary estimates for 2020 for a number of OECD countries all point to a significant increase in the ratio of health spending to GDP. This reflected both the extra health spending needed to combat Covid-19 and the reductions in GDP caused by restrictions on economic activity.

At the outbreak of the pandemic in February 2020, many **public hospitals** in France were on strike demanding more resources, and many **nursing homes** had high vacancy rates. The London School of Economics study Sustainability and Resilience in the French Health System points out that France's centralised presidential regime, with its strong public administration, meant that France could take rapid nation-wide decisions. However, this top-down response, the report continues, 'overlooked the significant variations between regions in terms of local epidemiological situations and clusters, healthcare needs, health workforce and care configuration'. The report nevertheless applauds the considerable flexibility and solidarity that were demonstrated within the health system, blurring the traditional limits between public and private sectors and between health professions.

Hospitals are reported to have mobilised rapidly and the permanent healthcare workforce was soon backed up by volunteers from the national medical care reserve (mainly retired nurses, doctors, medical students, and some non-medical staff). Training programmes were organised

for nurses to work in ICU, and doctors working in public and private hospitals created **new networks** for sharing information and patients.

The lockdowns and decisions to de-programme surgery, as well as the recommendations regarding social distancing, all had consequences on **levels of hospital activity**. The public's fear of contamination or contributing to the saturation of hospitals had an effect on hospital use, as did the fact that there were significantly fewer road accidents and sports / leisure injuries to be dealt with. This meant that adjustments could be made to the supply and methods of care. For example, some emergency rooms were redeployed to fight Covid-19 and double rooms were converted to single occupancy to avoid transmission.

Although the **regional health agencies** increased the ICU capacities rapidly and were successful in organising patient transfers between hospitals to make better use of existing bed capacities, their approach was criticised as being overly hospital-centred and ignoring the needs of the other care providers, in particular those in the long-term care sector.

As was the case in many other countries, France was short of **personal protective equipment** (PPE) and masks were reserved for health care workers and other professionals at high risk of contamination, as well as for infected patients. Many health professionals outside the hospital system had to wait several weeks before getting access to masks. **Advice to the public** on preventive measures such as hand hygiene, social distancing and respiratory etiquette was also slow to arrive, and it was only in July 2020 that the public was required to wear masks in all closed public spaces.

Other than in hospitals, **testing capacity** was limited during the first wave of the pandemic. At that stage, tests required a medical prescription and were reimbursed at 60% of the rate set by the social health insurance. By the time the second wave hit France, however, pharmacies were permitted to carry out testing.

With successive waves, coordination between public and private hospitals improved and bed capacity was increased. Although there were initial delays, the **vaccine roll-out** in France was smooth with more than 500 vaccination centres opened country-wide. Pharmacists were also involved in administering the vaccine, taking some of the pressure off the vaccination centres and reducing the need for travel.

There was, however, considerable public resistance to mass vaccination in France and more than a quarter of health workers were either hesitant (23%) or reluctant (4%) to be vaccinated, despite it being made mandatory by the government in September 2021. Health workers who were unable to provide proof of at least one vaccination were suspended from their posts, further exacerbating staff shortages.

Reasons advanced for the particularly marked reluctance among health workers to be vaccinated mainly revolve around the suspicion that the vaccines were developed very rapidly within the space of a year, and that some were based on genetic technology. In spring 2021, the confused and inconsistent official messaging, as well as the other rumours circulating regarding blood clots and other side-effects from the Astra-Zeneca vaccine, saw some opinion polls in France showing a majority of participants more likely to regard the vaccines as unsafe[12]. It should be added, however, that the French population has for many years had a relatively large anti-vax community[13], which has been fuelled by influential health professionals.

Like other EU Member States, France introduced the interoperable EU digital health pass in June 2021,obtainable on presentation of a certificate of complete vaccination, a negative virological test, or a certificate of recovery. The pass permitted the holder to access facilities such as cafes, restaurants, hospitals, retirement homes, planes, trains and long-distance buses.

By August 2022, Covid-19 vaccination coverage[14] in France was as follows:

- at least one dose: 80.5%
- primary dose: 78.3%
- first booster: 59.6%
- second booster: 5.8%

Another important development during the pandemic was the increased use of **telehealth**, using digital technology for interactions between healthcare professionals and their patients. This consists of **telemedicine** and **telecare** — remote interventions carried out by medical and non-medical healthcare professionals respectively.

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12 How have different European countries reacted to the AstraZeneca vaccine doubts? | Euronews

13 The State of Vaccine Confidence 2016: Global Insights Through a 67-Country Survey - eBioMedicine (thelancet.com)

14 ECDPC, Vaccine Tracker, August 2022

As an example, more than 60,000 doctors participated in teleconsultations facilitated by **pharmacists** during the lockdowns when movements were strictly limited to the local area. The French Parliament adopted laws setting out the conditions under which telehealth could take place. These consultations offer rapid access to a GP or specialist and are a way of supporting chronically ill, isolated, and elderly people by maintaining contact between doctor and patient.

To guarantee patient confidentiality and privacy, the pharmacist must have a closed room to carry out this activity, with equipment appropriate to patients' clinical situations to guarantee a quality teleconsultation, including at least connected stethoscopes and otoscopes, an oximeter, and a blood pressure monitor.

4.2 Deaths of health workers from Covid-19

President Macron announced that 'dead while serving the Republic' status (normally reserved for army personnel killed in action), will be awarded to healthcare workers who died from Covid-19 between 1 January 2020 and 31 July 2022. In recognition of those who "took care of the lives of others in the middle of the pandemic", their children would also be made wards of the state (*pupilles de l'Etat*) to benefit, in the words of President Macron, from "material and moral support to help them recover, grow, choose their path, and build their lives."

According to *Santé publique* figures, there have been 19 healthcare worker deaths linked to COVID in France, including five doctors, five carers, one nurse, two other 'related staff' and six professionals who were not treating patients.

4.3 Hospital beds and ward closures

Evidence supplied by the CGT and *Force Ouvrière* trade unions and media reporting in 2021-2022 suggests that there have been significant hospital and ward closures, and it is likely that both staffing and bed levels have fallen still further. The trade unions are calling for a second *Ségur de la Santé* negotiation.

In December 2021, a representative of the National Union of Nursing Staff (*Syndicat National des Personnels Infirmiers*) told the *France Info* radio station that there were 60,000 vacant nursing positions in hospitals at that time, and of those remaining in post, 10% were on sick

leave due to burnout or depression. The representative asserted that even between Covid-19 waves, nurses were working flat out to catch up with procedures that had been deferred[15].

More recently, in April 2022, the Director General of the main public hospital group (AP-HP) in the Ile-de-France region, told Radio France that in his region – where the situation is less serious than elsewhere in France – around 15% of hospital beds were closed due to staff shortages. The issue of newly qualified nurses often choosing to work on temporary contracts, thus choosing the days that they work, rather than taking a fulltime job was also raised[16].

It is clear that France has the dual challenge of addressing the disruptions arising from the pandemic, and of finding ways to address longer-standing, pre-Covid-19 issues. Section 2.2. discusses recent legislation and initiatives introduce to tackle these issues.

[15] Covid-19 : "Il y a 60 000 postes infirmiers vacants dans les hôpitaux", s'inquiète Thierry Amouroux (francetvinfo.fr)

[16] Hôpital : "Il nous manque 8% d'infirmières", alerte Martin Hirsch, directeur général de l'AP-HP (radiofrance.fr)

5. Health labour market

Since 2000, employment in the health and social care sector has grown much more rapidly than other sectors in France. Over the period 2000-2019, employment in health and social work increased by an average of 49% in OECD countries, which was even faster than growth in the service sector as a whole. The health and social care sector continued to grow even during the 2008-2009 downturn.

It can be seen in Table 5 below that employment in health and social work now accounts for 10% of total employment in OECD countries on average. The equivalent figure for France is 13.8%, slightly above Germany's figure of 13.4%.

Table 5: Employment in health and social work as a % share of total employment, in 2000 and 2019, in selected OECD countries.

Country	2000	2019
Norway	17.8	20.2
The Netherlands	12.3	15.3
Switzerland	10.4	13.9
France	**11.9**	**13.8**
Germany	10.4	13.4
Belgium	9.8	13.2
United Kingdom	10.1	12.4
OECD 38	8.5	10.0

Source: OECD National Accounts

In August 2022, the French national statistics office, INSEE, released the latest figures for salaried employees in human health activities. The figures show a steady rise since late 2010,

from 1.479 million, to 1.636 million by the end of the first quarter of 2022. Since the first quarter of 2020, there has been an increase of roughly 73,000 in the period corresponding broadly with that of the pandemic.

5.1 Composition of the health workforce

The WHO publication 'State of the world's nursing 2020' provides a breakdown of France's workforce. Nurses account for two-thirds of the total, while doctors account for one fifth.

Table 6: Breakdown by category of health workforce in France.

Occupation	
Nurses	**67.5%**
Doctors	**19.8%**
Midwives	**2.1%**
Dentists	**4.0%**
Pharmacists	**6.5%**
	100%

Source: WHO State of the world's nursing, 2020

Table 7, which follows, shows the stock of health workers in France and how they are distributed per head of population.

Looking at the relative **density of various health occupations (per 10,000 population)**, how do France's figures compare with its neighbours?

- **Doctors**: 33 — lower than Belgium (61), Germany, Switzerland and Spain (44), Italy (39), but higher than Romania and Luxembourg (30);
- **Nurses**: 114 — higher than Portugal (71), Spain (59) and Italy (60) but lower than Belgium (189), Switzerland (179), Germany (139) and the Netherlands (116):

- **Midwives:** 3.55 — higher than Germany (2.99), Portugal (2.91), Italy (2.83), and Spain (2.04), but the figures recorded in Belgium (12.16), Sweden and Finland (13.06) and Ireland (21.84) are considerably higher.

Table 7: Stock of health workers in France by occupation (2019).

Occupation	Number	Density (per 10,000 pop)
Medical doctors	213,201	32.73
Nursing personnel	744,307[17]	114.28
Midwifery personnel	23,139	3.55
Dentists	42,559	6.53
Pharmacists	69,078	10.61
Total	1,092,284	167.71

Source: WHO National Health Workforce Accounts Data Portal

5.2 Age distribution of the health workforce

Table 8 below demonstrates the degree to which France relies on doctors aged over 65, of which 13.6% fall within this age-group. In 2019, more than four doctors in ten were 55 or over. The situation is broadly similar for dentists, although the relevant statistics date from 2014, meaning that many of the 45-54-year-olds will now be in the 55+ cohort.

In 2016, more than 75% of nurses were aged between 25 and 54, with around one-fifth between 55 and 64.

[17] As mentioned elsewhere in this report, the figures provided for nurses in France may need to be interpreted with some caution. In January 2022, the DREES (the French government health and social statistics portal) estimated the number of nurses as 765,000. However, in July 2022, it reduced this figure to 637,000. This was due to an error whereby some nurses who had retired had not been removed from the calculation.

Table 8: Health workforce in France – age distribution by occupation, for latest available year.

	<25	25-34	35-44	45-54	55-64	>65
Doctors	6.5%	14.5%	18.9%	18.6%	27.8%	13.6%
Nursing personnel	2.5%	25.8%	24.2%	26.9%	20.7%	--
Midwifery personnel	6.1%	36.4%	25.4%	21.5%	10%	0.6%
Dentists	2.4%	18.5%	18%	26.7%	28.6%	5.8%
Pharmacists	2.4%	22.4%	22.8%	26.9%	23.2%	2.4%

Source: WHO National Health Workforce Accounts Data Portal. Note: Statistics for doctors are from 2019, nurses from 2016, and midwives, dentists, and pharmacists from 2014.

5.3 Gender distribution of the health workforce in France

Table 9 provides a picture of the health workforce delineated by gender. The vast majority of nurses and midwives are women, as are 46% of doctors in these statistics. It will be observed later in this report, that women now outnumber men among new registrations of doctors recorded by the *Ordre des Médecins*.

Table 9: Healthcare workforce in France, % female by occupation, most recent available figures.

	%
Doctors (2019)	46.1
Nursing personnel (2016)	87.6
Midwifery personnel (2014)	97.1
Dentists (2014)	42.7

Pharmacists (2014)	67.8
Source: WHO National Health Workforce Accounts Data Portal.	

5.4 Why do health workers move to France to practise their profession?

People have many reasons for migrating, and health professionals are no different from the general populace. Reasons for migrating can be personal, economic, and political. The decision of non-French health workers to practise their profession in France depends on the interplay of a range of push and pull factors.

Push factors influencing health workers to practise their profession in France include:

- Lack of employment opportunities in the home country where, for example, there may be insufficient jobs for new graduates;
- Low levels of pay or poor working conditions in the home country;
- A wish to gain experience of working in a country with a better-resourced health system with a view to returning home later to allow their home country to benefit from the experience and skills acquired.

Pull factors attracting health workers to practise in France include:

- Demography: France has an ageing population which is living longer, and which has growing needs for a raft of medical services as it ages;
- Doctor demography: reflecting France's overall population structure, the country's stock of doctors is also ageing, a situation compounded by the *numerus clausus* system (see below);
- The relatively attractive career prospects and working conditions, such as good salaries, holidays, and working hours, offered by high-income countries like France.

The *numerus clausus* system was introduced in the 1970s to limit the number of medical graduates, resulting in France producing insufficient numbers of graduates for a long period in the 1980s and 1990s. The *numerus clausus* was eventually adjusted to allow admissions in greater numbers and was eventually abandoned in 2020.

5.5 France and the WHO Global Code of Practice

France is a signatory to the WHO Global Code of Practice on the International Recruitment of Health Personnel[18] (2010) which aims to ensure ethical practices in recruiting international health workers. The Code applies to signatory countries and relevant stakeholders, such as employment agencies. Member countries report on its implementation every three years through a national reporting instrument.

The most recently completed national reporting instrument for France relates to 2015[19]. Measures taken by France at that stage, to educate, retain, and sustain the health workforce, included raising course quotas for physicians, midwives, nurses, dentists, and pharmacists. It also reported that it had been supporting medical students via the CESP (*contrat d'engagement de service public*) and that it has been changing and improving the working conditions of health workers by developing telemedicine.

The report goes on to mention bilateral agreements with six Gulf States from 2006 with respect to the training of specialist doctors in France[20]: 50 doctors per year from Saudi Arabia, 10 from Kuwait and the United Arab Emirates, and five each from Bahrain, Oman, and Qatar.
To address the challenges of the distribution of health workers in France, the report states that the French Ministry of Health has been encouraging *Maisons de santé* (a pluri-professional approach), changing and improving working conditions by encouraging task shifting, and offering more positions to medical students in underserved areas[21].

When asked to describe the steps taken to **implement** the WHO Code, the report states that actions were taken to **communicate and share information** across sectors on health worker recruitment and migration issues, as well as the Code itself, among the relevant ministries, departments, and agencies, nationally and sub-nationally. It also says actions were being considered to introduce changes to laws or policies to bring them into conformity with the

[18] https://www.who.int/publications/m/item/migration-code

[19] Available on the WHO extranet. https://extranet.who.int/dataformv3/index.php/plugins/direct?plugin=NRIDataOverview&function=printAnswer&surveyid=662132&srid=314&language=en&pass=U_IL3

[20] https://ressources.campusfrance.org/publications/focus_pays/fr/focus_pays_du_golfe_fr.pdf

[22] https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex:32005L0036

recommendations of the Code. It also states that steps have been taken to increase the number of health workers in training.

As for the main constraints to implementing the Code in France, the report states

- there are a lot of different stakeholders, which makes it difficult to disseminate the Code everywhere (possible solution: improve communication);
- autonomy of each of the stakeholders (possible solution: strengthened coordination);
- health worker migration data collection is complicated (possible solution: improving data collection).

Since no subsequent report has been submitted and no response has been received from the division in the Ministry of Health responsible, it is not possible to know if these actions were taken and, if so, whether they were met with success.

Regarding assistance to other countries/stakeholders to support their implementation of the Code, the report states that this has occurred mainly in African and Asian countries, and that France actively cooperates on medical and technical issues with many countries, including other developed countries.

As will become apparent in the sections that follow, recruitment of health workers from countries with more sensitive health systems is limited due to the EU directive on the mutual recognition of professional qualifications (Directive 2005/36/EC)[22] which means that the vast majority of health professionals who have not trained in France but are working there, come from elsewhere in the EU. It will also be seen that the recruitment of doctors from elsewhere in the EU has decreased substantially over the past five years.

5.6 Doctors

5.6.1 Training and access to the profession

In France, a general medical degree takes nine years of study. A specialism takes a further two years.

[22] https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex:32005L0036

A quota system (*numerus clausus)* was introduced in the 1970s when it was believed that medical 'consumption' was excessive and that there were too many doctors qualifying and insufficient posts for them to fill. It was believed that having fewer doctors would solve the 'problem'. At that point, the objective was to ensure that there would be 250 physicians per 100,000 inhabitants. In the late 1970s, given that the population was projected to fall after 2000, a tighter *numerus clausu*s policy was gradually introduced to reduce intakes of medical students. The *numerus clausus* operated geographically in the hope that upon graduation doctors would remain in the region in which they had trained. However, these campus-by-campus limits resulted in many good potential students being rejected.

Historically, public universities in France have not normally operated a selective system for first year students, meaning that there were virtually no limits on the numbers of school leavers enrolling in first year of medical studies. The government therefore introduced a law to limit the number of students admitted to the second year of medical studies. This meant that effectively only around 15-20% would pass the competitive exam at the end of the first-year foundation course.

Although demographic trends indicated that the numbers allowed in the *numerus clausus* should have been increased in the late 1980s, this did not occur until 1999, when the numbers admitted to medical training started to rise. New admissions reached 7,400 in October 2009, from a mere 3,400 ten years earlier.

With a view to training 20% more doctors, year-on-year, the system of *numerus clausus* was finally abandoned for the 2020 intake of medical students.

According to the French Medical Council (*Ordre des Médecins*), to practise medicine in France three cumulative criteria need to be fulfilled. The doctor must be a French citizen or an EU/EEA national, hold a diploma that allows them to practise in France and be registered on the roll of a departmental council of the Order of Physicians (CDOM).

For non-European nationals holding European or non-EU diplomas, ministerial authorisations to practise in France are granted by the Minister of Health exceptionally, after verification of competence. The *Ordre* has three lists specifying the conditions of access to the PAE (procedure for authorising the practice of non-European doctors).

A lack of language skills may justify the refusal of the *Ordre* to register a doctor. This refusal may be appealed.

5.6.2 Doctors per capita

The number of doctors in France between **2000 and 2019 grew only slightly** from **around 2.8 per 1,000 population in the year 2000 to 3.2 per 1,000 in 2019.** In most **OECD countries**, the numbers of doctors rose at a more rapid rate than population growth from 2.7 per 1,000 population in 2000 to 3.6 in 2019. Numbers of doctors per capita in France were well below the EU-27 average of 3.9 per 1,000 in 2019.

According to the *DREES*[23], the French government health and social statistics portal, there were 214,224 medical doctors[24] in France in 2021 of whom 94,537 (44%) were **generalists** and 119,686 (56%) were **specialists**.

Among the specialisms, psychiatry accounts for 12%, surgery 11%, anaesthetics and intensive care each 9%, and radio diagnostics and medical imagery 7%.

Since 2012, the number of generalists has fallen by 5.6% while specialist numbers have risen by 6.4%.

5.6.3 Doctors by age profile

According to the *DREES*, on 1 January 2021, the average doctor in France was 49.3 years old. The average age given in the *Ordre des Médecins'* publication '*Atlas de la démographie médicale'* is slightly higher at 50.3 years.

The *DREES* further notes that the average age of doctors has fallen over the past decade. In 2012, 60% of doctors were 50 or older, whereas that percentage is now down to 54%.

[23] Quelle démographie récente et à venir pour les professions médicales et pharmaceutique ? Constat et projections démographiques, *DREES*, March 2021

[24] This figure differs from the OECD Health Workforce Migration cited later in this section.

5.6.4 Doctors by gender

Breaking down the figures by **gender**, across the OECD countries, the proportion of female doctors has increased from 39% in 2000 to 48.7% in 2019. Over this same period, there has also been an increase in the proportion of **female doctors** in France from 36.5% to 46.1%, although this rate is somewhat lower than in other countries. The French *Ordre des Médecins'* records observe that, in 2021, 49.8% of doctors were women, while **58% of first-time registrants are women**.
On average, female doctors tend to be younger than their male counterparts and many tend to work in general medicine and specialties such as paediatrics, with fewer working in surgery.

5.6.5 Doctors by type of activity

Doctors fall into two groups: salaried and independent (*iberal*).

- **Salaried doctors** generally work in public hospitals and are considered as employees of their host establishment. Under normal (i.e., non-pandemic) circumstances, they are less likely to work overtime. They can take paid holidays and receive various other benefits.
- **Liberal (self-employed) doctors** work on their own account, in their own practice, and do not receive a salary from the State. Their earnings depend on the number of patients seen. In medical deserts, they may be offered favourable conditions by the local town hall (to set up consulting rooms, living accommodation, and for a vehicle).

The *Ordre des Médecins* records show that, in 2021, fewer doctors (41.8%) were practising as **sole practitioners**, 11.3 percentage points down on 2010. Regularly active physicians working as **salaried employees** represent 47.6% of the workforce against 10.5% for **mixed activity**.

Over one year (2020-2021), salaried activity increased by 0.8%, while self-employed activity and mixed activity decreased by 0.5 and 1.1 percentage points respectively.

5.6.6 Doctors by origin of diploma

According to OECD Health Workforce Migration figures, 26,989 of the 227,939 doctors in France in 2020, had been trained outside France (**11.8%,** up from 11.6% in 2019). The most recent figures available, for the year 2020, show that the proportion of foreign-trained doctors who were not born in France, which had been falling between 2015 and 2019, began to rise

again. It is too early to say whether this reflects the start of a new upward trend in foreign-trained doctors not born in France, or whether this was a reaction to the need to recruit doctors during the pandemic.

Looking at the **annual inflow** of doctors between 2011 and 2020, we observe that the highest numbers of foreign-trained doctors arriving in France were recorded in 2014 and 2015 (1,683 and 1,647 respectively). The numbers of foreign-trained doctors fell between 2015 and 2019, with figures of 1,149 and 950 recorded in 2018 and 2019 respectively. However, the figure rose again in 2020 to 1,073, even if, once again the absolute number of foreign-trained French-born doctors rose to 796, representing 74.2% of the total of foreign-trained doctors recorded as arriving in France in 2020.

Nevertheless, **in terms of absolute numbers**, there is still an upward trend in the figures for foreign-trained French-born doctors (from 739 in 2019 to 796 in 2020).

Table 10: France – Total stock of doctors, foreign-trained doctors' annual inflow 2011-2019 and numbers of foreign-trained French nationals.

Year	Total stock of doctors	Foreign-trained doctors – annual inflow	Inflow of French-born foreign-trained doctors	Inflow of foreign-trained doctors not born in France
2011	215,925	1,547	536	1,011 (65.0%)
2012	217,595	1,410	553	857 (60.8%)
2013	219,562	1,489	584	905 (60.8%)
2014	220,995	1,683	609	1,074 (63.8%)
2015	222,448	1,647	624	1,023 (62.1%)
2016	223,734	1,457	648	809 (55.5%)
2017	225,041	1,315	686	617 (46.9%)
2018	225,057	1,149	698	451 (39.3%)
2019	227,291	950	739	211 (22.2%)

2020	227,939	1,073	796	277 (25.8%)

Source: OECD Dataset - Health Workforce Migration

The **overall stock** of doctors working in France who have trained abroad has increased from 17,625 (8.1% of total number of doctors in France) in 2011 to 26,355 (11.6%) in 2019. However, given that, until the 2019/20 reforms, a *numerus clausus* was in place, a significant proportion of these foreign-trained doctors were in fact French nationals who had gone abroad to train.
EU doctors, like many other professions, benefit from automatic recognition of their qualifications on the basis of harmonised requirements under the EU Directive 2005/36/EC, and are thus able to practice in EU countries other than their own, as well as in European Economic Area (EEA) countries and Switzerland. It is therefore perhaps unsurprising that 11.6% of doctors in France trained outside the country.

Table 11: Doctors in France who trained elsewhere in Europe (EU, EEA, or Switzerland), 2011 and 2019.

Country of training	2011	2019
Romania	2,697	4,911
Belgium	1,639	1, 750
Italy	861	1,656
Germany	767	731
Spain	330	746
Bulgaria	298	469
Poland	241	253
Greece	115	283
Switzerland	95	99
The Netherlands	81	111

Portugal	26	121

Source: OECD Dataset - Health Workforce Migration

The main trends between 2011 and 2019:

- the stock of doctors in France who had trained in **Romania** rose from 2,697 in 2011 (1.25% of total doctors in France) to 4,911 (2.16%) in 2019. In absolute terms, France has more doctors trained in Romania than Germany (4,058 in 2019). However, the OECD observes that some universities in Romania offer medical training in French and English.
- the stock of doctors in France who had trained in **Belgium** rose from 1,639 to 1,750 over the period (note: some may have trained in Belgium because of the *numerus clausus* in effect in France until 2020, and because French is one of Belgium's national languages).
- The stock of doctors in France trained in Italy, Spain, Bulgaria, Poland, the Netherlands, and Greece has risen over this period, while the stock of doctors trained in Germany has fallen.

The *DREES* estimates that, in 2021, around 10% of doctors under 70 in France had obtained a foreign diploma compared with 6.6% in 2012.

5.6.8 Doctors who trained outside the EU, European Economic Area and Switzerland

There appears to be a pattern in the source countries of doctors who trained outside France and the EU. Most come from countries with which France has strong historical or linguistic connections.

Table 12: Main source countries of doctors in France who trained outside France and the EU, EEA, and Switzerland – stock, 2011 and 2019.

Country of training	2011	2019
Algeria	2,646	3,882
Syria	711	1,015
Morocco	750	923
Tunisia	316	873

Madagascar	239	371
Lebanon	191	255
Russia	153	304
Egypt	118	133
Togo	77	139
Senegal	53	96
Côte d'Ivoire	41	119

Source: OECD Health Workforce Migration, Foreign-trained doctors by country of origin – Stock, 2011 and 2019

In 2021, figures published by the *Ordre des Médecins* show that the proportion of French-trained doctors newly registering with the *Ordre* in 2020 was 86.2% and greatly exceeds the proportion recorded in 2010 (76.5%). However, in 2021, the proportion of doctors trained in France (84.3%) fell by almost two percentage points and there was only a slight rise in those who had trained in the EU (+0.3 percentage points), meaning that the proportion of those who had trained outside the EU rose by one and a half percentage points. Although t**he general trend over recent years has been one of rising numbers of doctors who have trained in France,** the proportion of doctors who had trained **outside the EU in fact rose by 1.5 percentage points in 2021.** These figures will therefore need to be monitored closely in the years to come.

Table 13: Origin of diploma of newly registering doctors in 2010 and 2015-2021.

	France	Outside European Union	European Union
2021	84.3%	8.3%	7.4%
2020	86.2%	6.8%	7.1%
2019	88.0%	4.0%	8.0%
2018	85.2%	6.5%	8.3%

2017	84.0%	8.0%	8.0%
2016	80.4%	9.2%	10.4%
2015	77.6%	11.3%	11.1%
2010	76.5%	12%	11.5%

Source: Ordre des Médecins : Atlas de la démographie médicale, various editions 2015-2021

From the data in Table 13, it appears that the proportions of French-trained doctors registering to practise in France have been rising steadily since 2010. Conversely, the proportions holding diplomas from outside the EU/EEA have been falling, as have the proportions of doctors with diplomas from other EU and EEA countries, and Switzerland.

This trend is likely to be largely explained by the upward adjustment of the *numerus clausus* in the 2000s which resulted in the numbers of French medical graduates rising since the late 2000s. It might be interesting to explore whether France has become a less attractive destination relative to certain other EU countries where doctors are better paid.

According to the *Ordre des Médecins*, relatively few foreign-educated doctors work in France's medical deserts compared with other countries. GPs who are born and qualified abroad are over-represented in certain departments such as the Nièvre, Cantal, Indre, Loir-et-Cher and Pyrénées-Orientales. In 2017, the largest proportion of foreign graduate doctors was located in city centres (30%), followed by the rural margins (21.6%) and under-resourced peri-urban spaces (16%). There is a greater tendency for foreign graduates to locate in the rural margins than doctors born and trained in France (10%).

Newly registered general practitioners (*médecins généralistes primo-inscrits*) born and trained abroad are found in all regions and departments, but with significant variations. In some areas, very few new registrants born and trained abroad have settled since 2007, such as the former Franche-Comté region, and the Oise, Somme, Marne, Meuse, Moselle, Ardèche, Lozère, Hautes-Alpes or Alpes-de-Haute-Provence *départements*. On the other hand, many new registrants have settled in the Aisne, Orne, Nièvre, Cher, Indre, Loir-et-Cher and Pyrénées-Orientales. The breakdown by type of area shows that the majority of new registrants settled in the rural margins (36%), followed by cities (19%) and under-resourced peri-urban spaces

(18%). By comparison, 10% of their counterparts who trained in France settle in the rural margins.

Lastly, it is worth mentioning that, in 2009, an agreement was signed between France and Quebec (Canada) which allows Quebecois specialists to practice in France by ministerial order. French doctors may also be issued a license to practice a specialty in Quebec.

5.6.9 Private practice or salaried

According to the *DREES,* more than half of doctors (56%) work **in private practice** even if, in one in five cases, this is combined with a salaried activity. Private practice is more common among general practitioners, 65% of whom are self-employed, than specialists (48%).

Nevertheless, **numbers in private practice are declining**. In 2012, 109,000 doctors were practising exclusively on their own; in 2021 there were only 93,000. This trend not only reflects a disaffection with exclusive private practice, it is also the result of the development of mixed practice, combining private and salaried activities.

The greater proportions of **women** entering the profession is a likely explanation for the rising trend towards salaried activity, as is the desire of **younger generations of doctors** in general to have a better life-work balance than their more senior colleagues.

The decline in private practice is particularly marked for certain specialties such as gynaecology or dermatology (-29%), psychiatry (-27%), otorhinolaryngology (-24%), paediatrics (-20%), and ophthalmology (-20%). The decrease in private practice in these specialties is due to many doctors retiring and not being replaced by younger generations, who prefer salaried work. For example, 66% of gynaecologists over 55 years of age in 2012 were exclusively self-employed, whereas, in 2021, this is the case for only 20% of gynaecologists under 40 years.

5.6.10 Projections in numbers of doctors

As a 2017 *DREES* paper points out, making projections regarding the supply and demand for medical care in the future is not an exact art. Estimating the demand for care is a delicate matter dependant both on how pathologies evolve and the ways in which they are treated. The

paper offers some projections for doctor numbers by 2040[25], expecting the number of practising doctors to remain almost stable between 2016 and 2019, and then rise again from 2020, assuming there are no radical changes in the trends of doctors' behaviour and in the legislation in force.
The paper predicts that **general practitioners** will grow in number less rapidly than specialists (some of whom have qualified abroad) and that exclusive private practice will continue to decline in favour of salaried employment and mixed practice. By 2040, it expects the population of doctors to be younger overall (lower average age), and to include greater proportions of women and salaried doctors, although it expects the supply of medical care over the decade (up to 2027) will grow less rapidly than demand.

The number of doctors primarily depends on the ***numerus clausus***, the **length of doctors' careers** and the **arrivals of doctors who qualified outside France**. For the years leading up to 2020, relatively high numbers of doctors retired from the profession, reflecting the high *numerus clausus* when they were admitted to their medical studies between 1971 and 1978, 45 or so years earlier.

At the same time, the number of doctors entering the workforce - excluding doctors with foreign qualifications – was due to increase fairly substantially until 2020, and more moderately between 2021 and 2026. These trends reflect the variations in the *numerus clausus* over the previous fifteen years: a sharp increase between 2000 and 2006, and more moderate growth between 2007 and 2015.

From 2025 onwards, it was therefore expected that there would be fewer departures and that the labour market for doctors would stabilise.

The advent of foreign-trained doctors, from the early 2000s, with numbers rising markedly between 2007 and 2015, has ensured the ranks of specialists have not become depleted – 80% of foreign-trained doctors have a specialist qualification. Without this inflow, the document states that specialists in medical imagery and ophthalmology would have seen declining numbers.

[25] https://drees.solidarites-sante.gouv.fr/sites/default/files/2020-08/er1011.pdf

Since a 2010 pension reform, there are fewer permanent departures before the age of 65 than before. Indeed, many French doctors have chosen to continuing practising after they reach retirement age.

Nevertheless, it should be noted that the Covid-19 pandemic has occurred in the intervening period since the publication of the *DREES* paper, these projections need to be treated with some caution.

5.7 Nurses

5.7.1 Training

Since 2009, nursing education has switched from vocational programmes to higher education (university) programmes, and nurses are required to have a bachelor's degree to align with other European countries. Upon successful completion of their course, nurses are awarded the French state diploma in nursing (*Diplôme d'Etat d'infirmier(ère)*).

Training to become a registered nurse in France takes three years and, after two or more years' experience, registered nurses can go on to specialise, for example in paediatric nursing, operating theatre nursing, or as a nurse-anaesthetist (recognised as a Master's degree).

Nurses with at least three years' practice may then opt to train for a State diploma of advanced practice nursing (*Infirmier(ère) en Pratique Avancé* - IPA), which takes two years at Master's level. The IPA works as part of a team with other health professionals, coordinated by a doctor to organise the care pathway and ensure regular monitoring in areas including oncology, psychiatry, and chronic renal conditions.

Discussions with a nursing instructor and officer of the *Ordre des Infirmiers*, reveal that the profession is not experiencing particular difficulties in attracting people to train in the profession. The challenges lie in ensuring that student nurses can find placements during their training since so many public hospital departments have closed.

This concern was echoed by the trade unions interviewed (*Force Ouvrière* and *CGT*) which also pointed to the rising numbers of student nurses not completing their studies because of their

experience during in-hospital training where they have observed low morale among nursing staff.

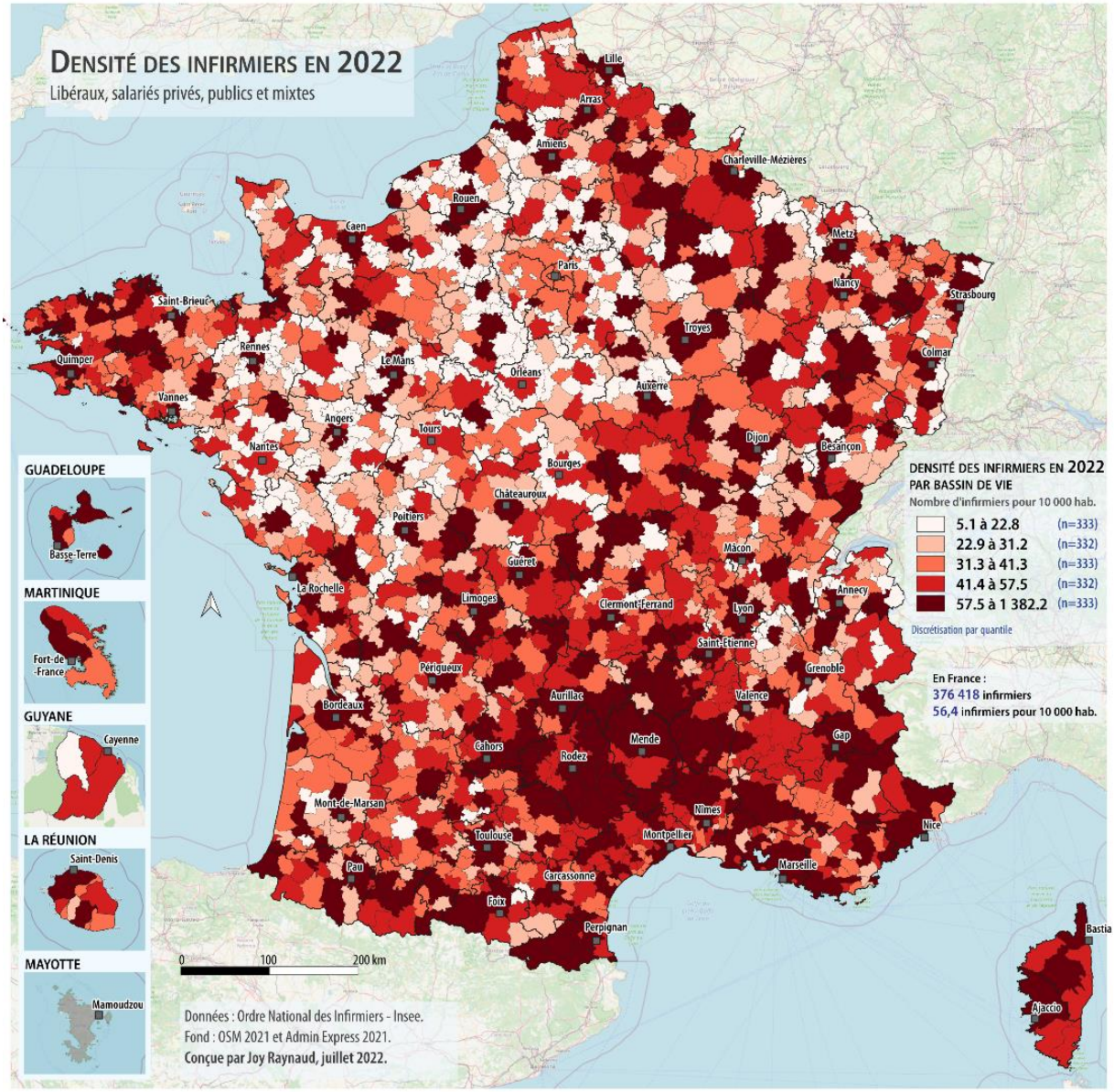
5.7.2 Nurses per capita

According to the OECD, the number of nurses in France has grown from 404,564 in 2000 to 547,861 in 2010, and to 744,307 in 2019. It should be noted, however, that there is concern that the statistics on the numbers of nurses practising in France are inaccurate. In July 2022, the *DREES* announced that it had overestimated the number of nurses practising in January 2022 and that it was around 637,000 rather than the 765,000 it had previously announced. **This large discrepancy could have serious implications for workforce planning** and France's efforts to be self-sufficient in **training** its nurses. The proportion of nurses in France increased from 7.9 per 1,000 population in 2008 to 11.1 in 2019 — well above the EU average of 8.4.

On 4 October 2022, the *Ordre des Infirmiers* issued its first ever *cartographie*[26] (mapping of the nursing profession). Importantly, this detailed mapping – see Figure 1 below – highlights the presence of nurses in the 1,663 catchment areas covered and shows that there is **a strong presence of nurses in medical deserts**, where there is a shortage of doctors, particularly GPs. It also shows that **multidisciplinary health centres** (*maisons de santé*) are becoming widespread – in almost two-thirds of catchment areas – and represent new forms of more coordinated practices between health professionals.

[26] https://www.ordre-infirmiers.fr/assets/files/000/communiqu%C3%A9s%20de%20presse/ONI_Communiqu%C3%A9-Octobre-2022_VF_.pdf

Figure 1: Distribution of nurses in France 2022.



Source: Ordre des Infirmiers

5.7.3 Nurses by age profile

In 2019, 28% of nurses were under 35, 51% were 35-54, and 21% were aged 55 and over. However, this pattern may be changing since the CGT trade union informs us that the average length of time following qualification that a nurse remains working **in public hospitals** is just

four years after receiving their qualification. After working in the public hospital system, nurses often become self-employed (*libéral*) or change profession.

This reflects the situation among doctors, where the younger cohorts are more concerned about better work-life balance than their more senior colleagues.

The *Ordre des Infirmiers'* recently released mapping (mentioned in the previous section) gives the average age of nurses as 39.4 years. It points out that in areas where the median age of the population is high, so is the median age of nurses.

5.7.4 Nurses by gender

Although gender inequality has narrowed in many professions, nursing remains a predominantly female profession. In France, 88% of nurses are **female**.

5.7.5 Nurses by origin of diploma

The proportion of foreign-trained nurses in France has risen from 1.71% in 2000, to 2.44% in 2010, and to **2.86%** in 2019. A proportion of these are French nationals who have trained elsewhere in the EU, while others are nurses who trained in other EU countries and who, under Directive 2005/36/EC, have exercised their right to free movement and work outside the country in which they trained. Relatively few are non-EU nationals since, under the directive, nurses who do not hold a nursing qualification awarded in an EU country are unable to practice elsewhere in the EU.

Table 14: Stock of foreign-trained nurses in France - main source countries 2010-2019.

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Stock of foreign-trained nurses *including*		14,495	15,797	16,754	17,682	18,647	19,405	20,053	20,757	21,269
Belgium	6,949	7,482	7,913	8,378	8,996	9,691	10,268	10,791	13,311	11,663
Spain	1,234	1,365	1,517	1,660	1,734	1,765	1,790	1,809	1,827	1,840
Portugal	266	504	920	1,117	1,235	1,287	1,315	1,338	1,361	1,380

Germany	629	634	637	641	640	632	633	632	637	638
UK	561	570	569	568	580	576	574	583	581	576
Italy	196	216	239	262	281	301	317	329	341	355
Netherlands	227	228	232	235	233	234	229	225	222	221
Others (not elsewhere classified)	2,756	2,841	3,066	3,156	3,219	3,366	3,461	3,513	3,582	3,664

Source: OECD Health Workforce Migration Foreign-trained nurses by country of origin - Stock

Table 15: Flows of foreign-trained nurses into France – main source countries - 2010-2020.

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Total inflow of all foreign-trained nurses *including*	447	574	803	566	542	619	571	470	433	201	392
Belgium	231	225	215	242	348	405	406	351	302	104	204
Spain	35	75	88	71	32	23	12	12	11	6	3
Portugal	50	150	261	107	57	20	9	9	13	2	3
Romania	30	27	15	7	6	8	4	6	7	10	2
Others (not elsewhere classified)	64	69	190	107	80	143	120	75	75	66	164

Source: OECD Health Workforce Migration Foreign-trained nurses by country of origin – Annual inflow

Table 15 shows that there were inflows of 500-600 per year between 2011 and 2016, after which figures started to decline, down to just 201 in 2019. However, it should be noted that in 2020, the figures rose again, coinciding with the Covid-19 outbreak. Figures for *foreign-born* nurses are not recorded in the WHO National Health Workforce Accounts.

From where do these foreign-trained nurses originate?

- Table 14 shows that more than half of the stock of nurses in France trained in **Belgium** (11,663 in 2019) — this has been the case throughout the 2000-2019 period; many of these are French nationals;
- The next largest group (3,664) come from 'unspecified countries' (i.e., no data recorded) so it is impossible to draw precise conclusions;
- The next largest cohorts of foreign-trained nurses come from **Spain** (1,840), **Portugal** (1,380), **Germany** (638), the **United Kingdom** (586), **Italy** (355), **Romania** (250), the **Netherlands** (221), and **Switzerland** (181).

However, there is **two-way traffic**. For example, roughly half the foreign-trained nurses recruited in **Switzerland** in 2018 and 2019 were French (1,382). Similarly, a not insignificant proportion of nurses who train in the Grand Est region of France are attracted by employment in Luxembourg because of advantageous working and pay conditions. It is easy for French nurses to work in these two countries because in both cases, French is one of the official national languages.

A representative of the *Ordre national des Infirmiers* reports that while this situation has always existed, it is becoming more pronounced and is resulting in a serious shortage of nurses in hospitals, clinics, and nursing homes, especially in Meurthe-et-Moselle (the area around the city of Nancy). According to figures compiled locally, over the past five years, an average of 5 students from a class of 85 have been going directly to practice in Luxembourg at the end of their studies[27].

Of the 8,990 foreign trained nurses in **Belgium** in 2020, most were trained in **France** (2,235), followed by **Romania** (1,791) and **the Netherlands** (880).

5.7.6 Addressing the issues faced by the nursing profession in France

Nursing is considered a vocation – many individuals sense they have been 'called' to work in this occupation which involves caring, compassion, and commitment and, as discussed in Section 7.6.1., it also involves rigorous technical training.

[27] ActuSoins article May 2022: Fuite des soignants français au Luxembourg : la région Grand Est touchée « de plein fouet ».

Long before the pandemic, pressure had been building for changes to be made to the Decree of 29 July 2004 [28] on the role of the nurse. However, the immense weight borne by nurses during the pandemic served to cement the need for action, with 85% of nurses surveyed by the *Ordre des Infirmiers* in late 2021[29] considering that their working conditions had deteriorated since the beginning of the health crisis. In the same survey, 72% described their state of mind as weary, and more than half of nurses working in public hospitals (54%) believed they were suffering from burnout, with detrimental effects on the quality of care.

A subsequent *Ordre des Infirmiers* survey of 40,000 nurses was carried out in May 2022 to get their views on their profession, on access to care, and on the need for the profession to evolve to become more patient-centric.

The results of this survey were telling:

- 82% of nurses take pride in exercising their profession, but 65% regret that their skills and the role they play with respect to patients are not recognised;
- 93% of nurses are worried about the healthcare situation in their region;
- 77% say their patients' main concern is the difficulty of accessing health care facilities and health professionals;
- 68% believe that access to health care in their area/region is unequal;
- 71% feel that they cannot spend enough time with each of their patients;
- 71% believe that, in practising their profession, they strengthen social links in the area/region in which they operate;
- 61% are not satisfied with the balance between their professional and personal life;
- 94% consider that it is urgent to update the decree that governs nursing skills.

These issues are all addressed in detail in a paper 'How to build a health system that is closer to the patient, and that is more efficient and sustainable' published in July 2022 in the Journal of Health and Sickness Insurance Law [*Journal de Droit de la Santé et de l'Assurance Maladie*].

The main directions to be taken are:

- putting users back at the heart of the healthcare system, bringing an end to the concept of the passive patient undergoing their care pathway; bringing an end to the loss of

28 https://www.legifrance.gouv.fr/jorf/id/JORFTEXT000000787339

29 https://www.ordre-infirmiers.fr/actualites-presse/articles/resultats-consultation-infirmiere-lordre-national-infirmiers-alerte-de-nouveau-sur-la-situation-de-la-profession.html

opportunities due to lack of access to healthcare; and bringing an end to over-centralised governance.
- putting the patient back at the heart of health professionals' schedules, freeing nurses from administrative tasks by means of digital tools, and prioritising time spent with the patient and relational care.
- putting the job logic back into the heart of the healthcare system, by encouraging cooperation / team work and skills-sharing between professionals, by bringing an end to the historically hierarchical operation of the health system, and favouring the autonomy of healthcare professionals at the heart of a more optimal healthcare chain.

The Ministry of Health has committed itself to revisiting the law governing the role and status of nurses. A report on the subject is under preparation, and consultations and discussions are expected to be launched with the stakeholders in autumn / late 2022.
Efforts are under way to make health and caring professions appear more appealing. FEHAP, the French member of HOSPEEM[30], reports that it is working to do this via the *Pôles Emploi* (the government agency with offices throughout the country where people register as unemployed, apply for benefits, and are assisted to find jobs).

5.8 Long-term care

5.8.1 Long-term care spending

Long-term care spending in 2019 amounted to 2.4% of France's GDP. According to the OECD31, more than 70% of long-term care spending in France goes towards residential facilities, such as nursing homes.

Long-term care in France is implemented at *département* (county) level. It is funded from a combination of social contributions and local authority funds (taxation).

[30] European Hospital and Healthcare Employers' Association (HOSPEEM)

[31] https://www.oecd.org/health/health-systems/Spending-on-long-term-care-Brief-November-2020.pdf

5.8.2 Long-term care workforce

According to a European Foundation for Living and Working (Eurofound) report[32] in 2018, France's long-term care **workforce** breaks down as follows:

- Residential long-term care: 53% public sector, 19% for-profit, and 27% non-profit.
- Home care (*service d'aide à domicile):* 20% for-profit, 70% private non-profit, and 10% public.

According to the same Eurofound report, with a figure of 4.4%, France was one of five EU countries where long-term care workers accounted for more than 4% of the workforce. This proportion was exceeded by Sweden (7.1%), the Netherlands (6.4%), Belgium (5.5%) and Finland (5.3%).

Eurofound also reports that more than 35% of the long-term care workforce in France is employed in non-residential long-term care. Most of the country experiences recruitment challenges, particularly the areas bordering on Switzerland and Luxembourg, where higher salaries attract carers from France. It states that, by 2015, almost half of residential homes had been reporting recruitment issues and that, in 2017, there was an immediate need for around 17,000 home-care workers.

In a 2019 document, the Ministry of Social Affairs and Health[33] estimated that, between 2019 and 2025, 350,000 posts would need to be filled in the care sector as follows:

- 92,000 new posts,
- 60,000 unfilled posts, and
- 198,000 posts to be renewed because of retirement and turnover.

In France, the number of people working in the field of loss of autonomy in old age is expected to increase by about 20% by 2030[34], or by around 30% if additional policy measures, including increased staff–user ratios, are implemented.

[32] Long-term care workforce: Employment and working conditions, Eurofound, 2020

[33] Plan de mobilisation nationale en faveur de l'attractivité des métiers du grand-âge, Ministry of Social Affairs and Health, Paris

[34] https://solidarites-sante.gouv.fr/archives/consultation-place-des-personnes-agees/concertation-grand-age-et-autonomie/article/rapport-de-la-concertation-grand-age-et-autonomie, Ministry of Social Affairs and Health, Paris

The broad direction of these figures is echoed in a report prepared jointly by *France Stratégie*[35] and *DARES*[36] on Occupations in 2030[37]. It predicts that employment growth in the period up to 2030 will be largely dominated by the services sector, including education, healthcare, and social action. It expects growth in the number of **nursing and midwifery professionals** as well as **personal care workers** to be 18%, of **auxiliary nurses** to be 15%, and of **doctors and related medical professions** to be 13%.

In 2017, it was estimated that 98% of people working with older persons are **women**, with an average age of **45 years**.
40% of long-term care workers and 89% of home-care workers in France are **part-time**. According to the Eurofound report, there may be some scope to increase hours among part-time long-term care workers who want to work longer hours.

5.8.3 The future of the long-term care sector

A **37-point action plan**[38] to run for the 2020–2024 period is now in place with a view to promoting careers working with older and dependent people. Its actions focus on:

- better job and pay conditions
- reducing accidents and improving the quality of life at work
- modernising training and changing the image of the long-term care professions
- innovating to transform the organisations working in the sector
- ensuring that the players in the sector and its funding are better mobilised and coordinated.

A national **communications campaign** has also been launched addressing the negative stereotypes that society holds about older people and people with disabilities to help to make employment in the sector more appealing.

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[35] France Stratégie is an independent institution reporting to the Prime Minister. France Stratégie contributes to public policy via its analyses and proposals. It drives the public debate and highlights policy options on social, economic and environmental issues. It also evaluates public policy at the government's request.

[36] DARES is a department in the Ministry of Labour, Employment and Integration, which produces analyses, studies and statistics on labour, employment, vocational training and social dialogue.

[37] https://www.strategie.gouv.fr/publications/metiers-2030

[38] https://solidarites-sante.gouv.fr/IMG/pdf/plan_d_action_pour_les_metiers_du_grand_age_et_de_l_autonomie_-_un_an_d_avancees_majeures_pour_les_professionnels.pdf

6. Main findings

6.1 General findings

- As the country emerges from the Covid-19 pandemic, it is clear that France's health system and workforce, in common with those of other countries, are experiencing **major challenges.** These include an ageing population and its specific care demands, an ageing population of doctors, medical deserts, the distraction of time spent form-filling by practitioners to the detriment of care, and exhaustion from unremitting work demands. While some of these challenges had already been apparent, the pandemic served to bring them into sharper focus. In many instances, the solutions chosen to address them during the pandemic will continue to be used and be built upon in the post-pandemic period.

- The experience of living through the pandemic has demonstrated the paramount importance of a robust, flexible and efficient health system. Such a system is dependent on a variety of factors including the availability of a **skilled and well-resourced workforce** and the **ability to plan and manage resources** using reliable, up-to-date and comparable **data and information**. We have seen that there have been problems encountered with accurately estimating nurse numbers. There is a need for work to be done both to harmonise **data collection methods** so that figures can be relied upon and also to identify **new indicators** that might be used to measure progress in the future. If new training modules are created, for example, it will be important to ensure that those who are trained actually put the training to use, i.e., that the investment in their training bears fruit.

- Recent reforms to the **health and education sectors** to tackle the shortage of health workers, accompanied by significant investments announced for hospitals and the upgrading of facilities, are expected to partially alleviate the pressure, particularly in France's public hospitals and its nursing and care homes. However, there is considerable room for France to make further progress towards self-reliance in training and retaining health professionals.

- Many health workers in France have trained in other EU Member States because they can take advantage of the opportunities introduced in the EU Directive 2005/36/EC on the **mutual recognition of professional qualifications** and move freely between EU countries. However, it is evident that French-trained health professionals also migrate to other EU

countries and to Switzerland. The **traffic is two-way**, although when French health professionals migrate, they tend to move to other French-speaking countries, such as Belgium, Luxembourg, and Switzerland.

- The pandemic brought out the importance of how **fundamentals** such as education, income, employment – essentially the environment in which people live – can influence public health and impact outcomes. Given the fact that **health promotion and disease prevention programmes**, which until recently have not been a high priority in France's healthcare policies, have enormous potential in reducing the pressures on healthcare professionals, these initiatives should now occupy a more prominent place.

6.2 Key findings in relation to doctors

- The issue of the **age profile** of French doctors, some of whom are among the oldest in Europe, has arisen due to planning failures in the 1980s by the Ministries of Health and Education. This kept in place a highly restrictive quota system for medical students (*numerus clausus*) for a much longer period than should have been the case. This resulted in a structure which was unsuited to deal with the country's health demands and gave rise to the imperative to recruit doctors from outside France and for French nationals to study abroad.

- A particular focus of the report was therefore to examine the degree to which France has been dependent on the migration of health professionals, particularly doctors, from less affluent countries. The report notes that the overall stock of doctors who had **trained outside France** and were practising in the country increased from 8.1% in 2011 to 11.8% in 2020.

- Since Romanian-trained doctors constituted the largest group of foreign-trained doctors, the report looks at the flows of doctors trained in Romania, a less affluent EU member state. In 2019, there were 4,911 doctors practising in France who had trained in Romania (2.16% of the total stock of doctors in the country), a considerable increase from a figure of 2,697 in 2011. However, it is important to note that some universities in Romania offer medical degree courses in French as well as English, which meant that French nationals could do their medical studies in Romania.

- A detailed examination of the figures reveals that the overall inflow of foreign-trained doctors (i.e., those who were trained elsewhere in the EU and beyond) has been falling since 2014.

In addition, the inflow of foreign-trained doctors who were not born in France has fallen from 65% of the total foreign-trained doctors in 2011 to just 22% in 2019, while the inflow of foreign-trained French nationals, at 739 in 2019, is more than three times that of foreign-trained non-French nationals (211). Whether the recently released figures for 2020, showing that the inflow of non-French born foreign-trained doctors had increased (to 25.8%), herald the beginning of a new trend is an open question. In 2020, the inflow of foreign-trained French-born doctors (796) still greatly exceeded the inflow of foreign-trained doctors who had not been born in France (277).

- Figures from the *Ordre des Médecins* show that, in 2020, the proportion of French-trained doctors registering with it for the first time was 86.2%, contrasting with just 76.5% in 2010. This trend is likely to be explained by the upward adjustment of the *numerus clausus* in the 2000s, which has resulted in increased numbers of medical graduates in France since the late 2000s.

- The *Ordre des Médecins'* **most recent registration records** also show the increasing **feminisation of the profession** and a growing preference of doctors to be salaried rather than self-employed. As in other countries, doctors in France are seeking a **better work-life balance**.

- In our exchanges with the *Ordre des Médecins*, it was reported that the creation of the post of 'medical assistant' under the *Ma Santé 2022* reform has had a positive impact on doctors' working conditions and on the numbers of patients followed. This is substantiated in the Health Minister's response to a question in the French Senate[39] on the topic.

6.3 Key findings in relation to nurses

- Accounting for two-thirds of the health work force, **nurses play a pivotal role in France's health system**. The proportion of foreign-trained nurses in France rose from 1.71% in 2000, to 2.44% in 2010, and to 2.86% in 2019. However, some of these are French nationals who have trained elsewhere in the EU. Perhaps because salaries have not been high historically, the numbers of nurses migrating to France have been relatively low.

[39] https://www.senat.fr/questions/base/2022/qSEQ220700767.html

- Nurses have been central to the **resilience** of France's health system. At the outbreak of the pandemic, many nurses who had been on strike mobilised and threw themselves into the national effort to combat Covid-19. However, after being on the frontline during the pandemic, many are exhausted and feel their contribution has been forgotten. The issues of exhaustion and burnout among nurses (problems not unique to France) must be addressed urgently.

- Although most nurses say they take pride in their profession, many regret that their **skills and knowledge** are not put to better use. For this reason, 94% of nurses responding to a survey conducted by the *Ordre des Infirmiers* in 2022 consider that the **government decree on the role of nurses** needs to be updated. The French Ministry of Health is scheduled to launch work on this in autumn 2022.

- With a view to **improved resource allocation** in the health system, nurses are calling for a greater role in **decision-making** (much of which is currently doctor- and male-dominated), more **team work**, **improved working conditions**, greater use of **digital technologies** to allow more time to care for patients, and for some of the **boundaries between professions** to be eliminated, for example, to play a coordinating role in multidisciplinary practices and the right to **prescribe** in certain circumstances.

- The *Ordre des Infirmiers'* mapping initiative reveals that nurses are well-represented in medical deserts and that they potentially hold one of the major keys to alleviating the challenges experienced in these areas. It also shows that the average age of nurses, at 39.4 years, is younger than that of other health professionals.

7. Recommendations

7.1 French government

It is generally acknowledged that healthcare delivery needs to be radically reorganised to guarantee universal access to healthcare. We therefore recommend the following measures:

- **More robust data collection methods** to ensure that statistics on the stock and flows of France's health workforce are reliable, up to date, comparable, and compatible with those of its EU and international partners;

- **More effective engagement** with professional bodies representing doctors in France who have so far been reluctant to contribute to this report, perhaps because of their central position and the political sensitivity of the issues involved;

- **Continued engagement** with bodies representing nursing staff and a wider diaspora of health-related professionals such as pharmacists and midwives, as well as trade unions, patient associations, and recruitment agencies.

- **Better resource allocation** which will entail, among other things,

    - **reviewing and upgrading the role played by nurses in care pathways** and ensuring the continuity and quality of care, deploying digital technologies to tackle issues such as time-consuming form-filling, leading to more face-time with patients and enhanced job satisfaction;
    - **reviewing how the roles of pharmacists and other health professionals might be extended** to relieve the pressure on doctors, especially in under-served areas;
    - **enhancing the attraction of the health professions** to improve retention and recruit fresh talent, and
    - **giving higher priority to prevention and lifestyle changes**, possibly with initiatives carried out, in part, by nurses in local communities.

- **Increased availability of continuing training** for healthcare workers which could also help to attract the younger generation of nurses who can often be more mobile than older cohorts and which could also be an incentive to counteract some inconveniences associated with nursing, such as working unsociable hours, weekends, and holidays.

- **Training in new technologies** to lighten the administrative burden, particularly on nurses, allowing more time to care for patients.

- **Improved planning methods** for the health professions of the future. Given the ageing population, there will be greater demand for care, likely to be more complex because of combinations of conditions. Digital health is likely to develop at a rapid rate and there will be an increasing need for nurses with specialisms.

- **Constant review of curricula and training course content** to ensure that they meet the public's present and future needs. For example, the 2022/2023 review of the role of nurses may require training courses beginning in autumn 2023 to be modified and augmented.

7.2 European Union

Some initiatives are more appropriately carried out at international or European level:

- **Uniform and harmonised definitions** are needed in the health and care fields. This is an issue that can only tackled at international and pan-European level. The international comparability of statistics and data collection systems is vital for reliable planning and policy-making for the future.

- In the event that it is observed that inflows of healthcare professionals are increasing to more affluent destination countries, **the feasibility of promoting a policy initiative to compensate less affluent source countries** for their investment in training, and for the opportunity cost of not being able to employ the professionals who have migrated, will need to be evaluated. As in the case of the EU's Structural Funds, where the values on which the EU is founded - in particular solidarity - are brought to bear, a system along the lines of Global Skills Partnerships[40]- a bilateral public-private partnership to link skill creation and skill mobility in a mutually beneficial and equitable way - could be envisaged.

[40] Global Skill Partnerships: A proposal for technical training in a mobile world, Michael Clemens, OECD, Paris, 2016.

- The two-yearly reviews of the **implementation of Directive 2005/36/EC** on the mutual recognition of qualifications undertaken by the European Commission might represent an opportunity to engage with the Commission and raise any concerns on professional mobility issues with respect to the healthcare workforce.

- Follow-up a French EU Presidency (first half of 2022) conference which was held in January 2022 to share initiatives taken in EU Member States to address the health crisis and to identify tools for cooperation that can be further developed to improve the organisation of and access to healthcare. This could be pursued in the first instance by contacting the French Permanent Representation in Brussels to find out who at the Ministry of Health in Paris is responsible for this.

- **Follow and offer support to organisations representing healthcare professionals** at EU level and, where appropriate, become involved in their initiatives where these can be related to or link in with the mobility aspects, e.g. European Council of Medical Orders, European Nursing Council, European Federation of Nurses' Associations, European Midwives Association, European Health Management Association, etc.

- **Monitor closely any developments in the European Care strategy** following the European Parliament resolution[41] adopted in July 2022. In addition to prioritising the development of universal and high-quality long-term care systems, it also stresses the importance of improved working conditions for care professionals, better recognition and support for informal carers and families, and the need to ensure decent work for all.

- **Examine the possibility of a special health-related initiative** under the Erasmus programme, greater alignment of curricula and protocols, and new digital projects and infrastructure to share knowledge and data, as well as further initiatives under the EU4Health programme 2021-2027.

[41] European Parliament resolution of 5 July 2022 towards a common European action on care (2021/2253(INI))

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