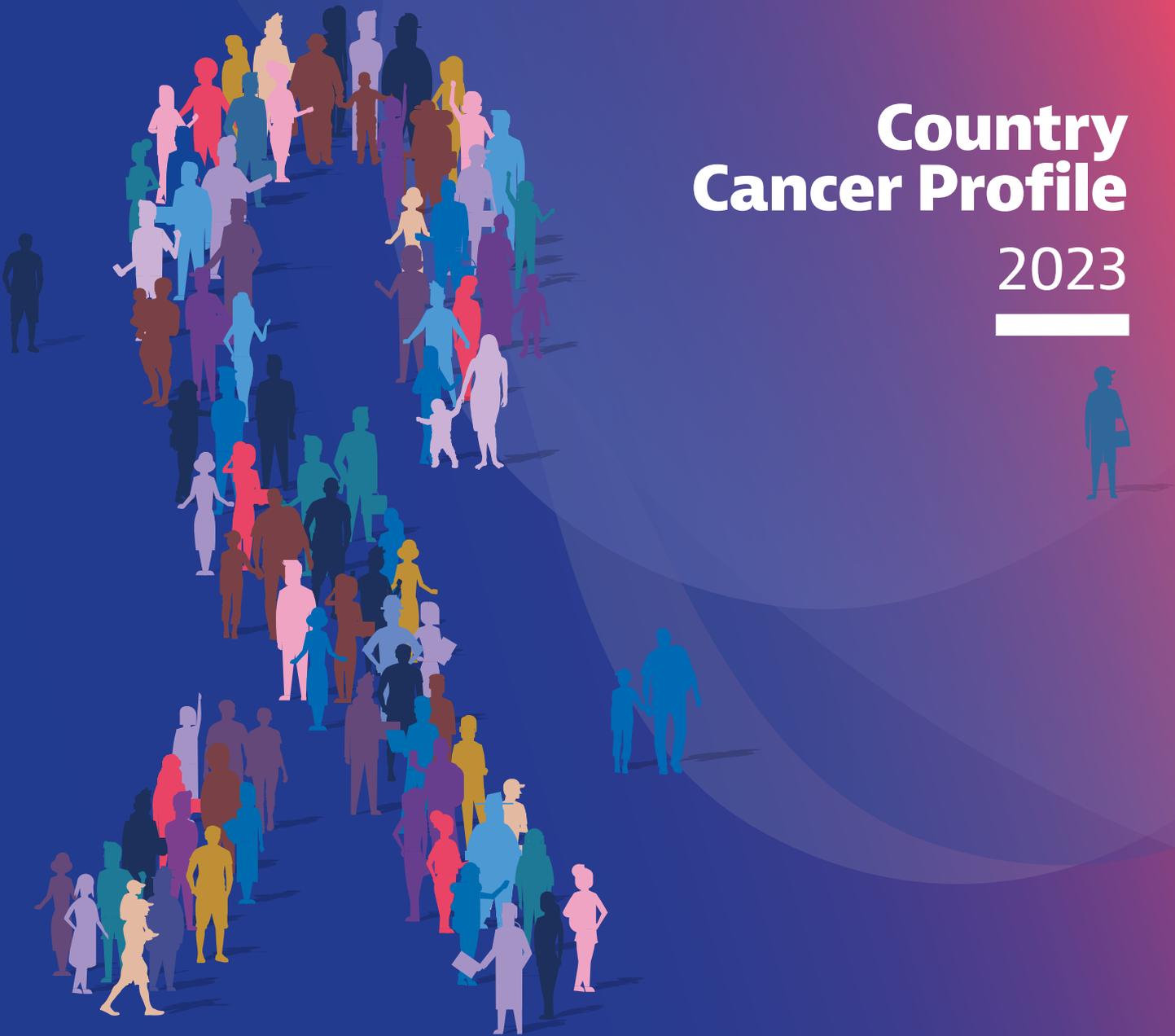




FRANCE

Country Cancer Profile

2023



The Country Cancer Profile Series

The European Cancer Inequalities Registry is a flagship initiative of the Europe's Beating Cancer Plan. It provides sound and reliable data on cancer prevention and care to identify trends, disparities and inequalities between Member States and regions. The Country Cancer Profiles identify strengths, challenges and specific areas of action for each of the 27 EU Member States, Iceland and Norway, to guide investment and interventions at the EU, national and regional levels under the Europe's Beating Cancer Plan. The European Cancer Inequalities Registry also supports Flagship 1 of the Zero Pollution Action Plan.

The Profiles are the work of the OECD in co-operation with the European Commission. The team is grateful for the valuable inputs received from national experts and comments provided by the OECD Health Committee and the EU Expert Thematic Group on Cancer Inequality Registry.

Data and information sources

The data and information in the Country Cancer Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD Health Database.

Additional data also come from the World Health Organization (WHO), the International Agency for Research on Cancer (IARC), the International Atomic Energy Agency (IAEA), the Institute for Health Metrics and Evaluation (IHME) and other national sources (independent of private or commercial interests). The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

Purchasing Power Parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.

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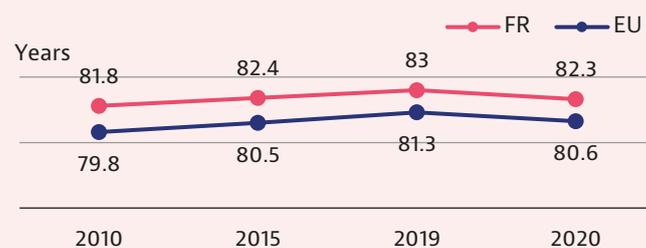
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Summary of the main characteristics of the health system

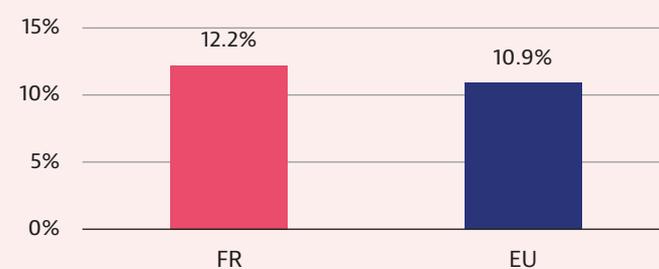
LIFE EXPECTANCY AT BIRTH (YEARS)



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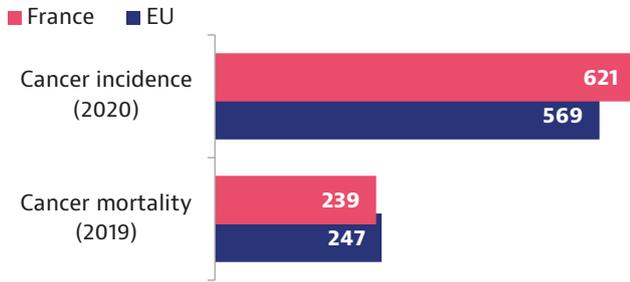


HEALTH EXPENDITURE AS A % OF GDP (2020)

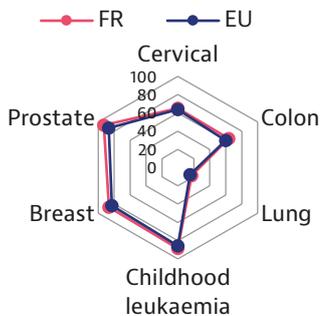
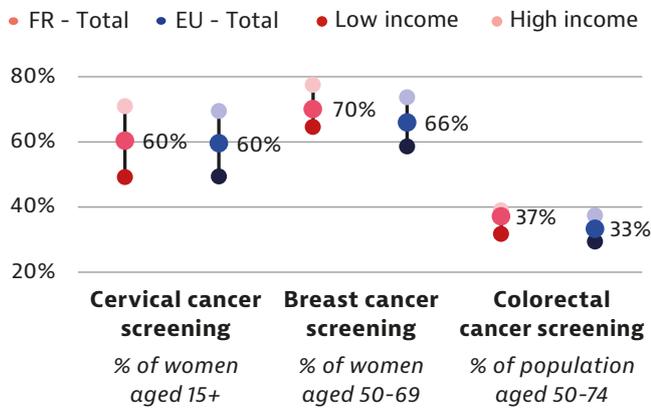
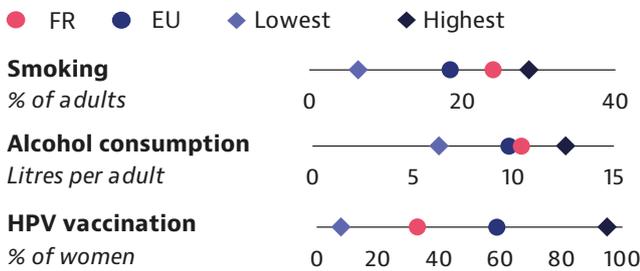


Source: Eurostat Database.

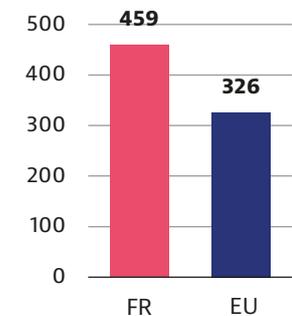
1. Highlights



Age-standardised rate per 100 000 population



Five-year net survival rate by cancer site, 2010-14



Total cost of cancer (EUR per capita PPP), 2018

Cancer in France

Estimated cancer incidence in France is slightly above the EU average, mostly driven by increased cases reported in women. Cancer mortality is below the EU average, however. As in most countries, cancer is particularly affected by social inequalities. To tackle this major public health issue, following the recommendation from the French Institute for Cancer, French authorities launched in 2021 a comprehensive 10-year strategy to improve cancer control, treatment and prevention.

Risk factors and prevention policies

Prevalence of daily smoking in France is among the highest in the EU, and social inequalities are particularly marked for this risk factor. Tobacco control policies have been adopted to reduce smoking rates, with encouraging results so far. Alcohol consumption also remains higher than in the EU. France has low rates of human papillomavirus (HPV) vaccination, despite public coverage for both girls and boys.

Early detection

In France, screening programmes are in place for breast, colorectal and cervical cancer. Uptake of breast screening is slightly above the EU average, while cervical cancer screening rates are close to the EU average, but social inequalities in screening uptake exist for both cancers. The National Cancer Strategy 2021-2030 sets ambitious objectives to increase screening uptake.

Cancer care performance

France compares well with other EU countries on five-year cancer survival rates, but faces a unidirectional social gradient for almost all cancers, with poorer survival rates for patients in the most deprived areas. Public expenditure on cancer has increased substantially in recent years, and per capita expenditure on cancer care in France is among the highest in Europe. France adopted in recent year several cost-containment measures.

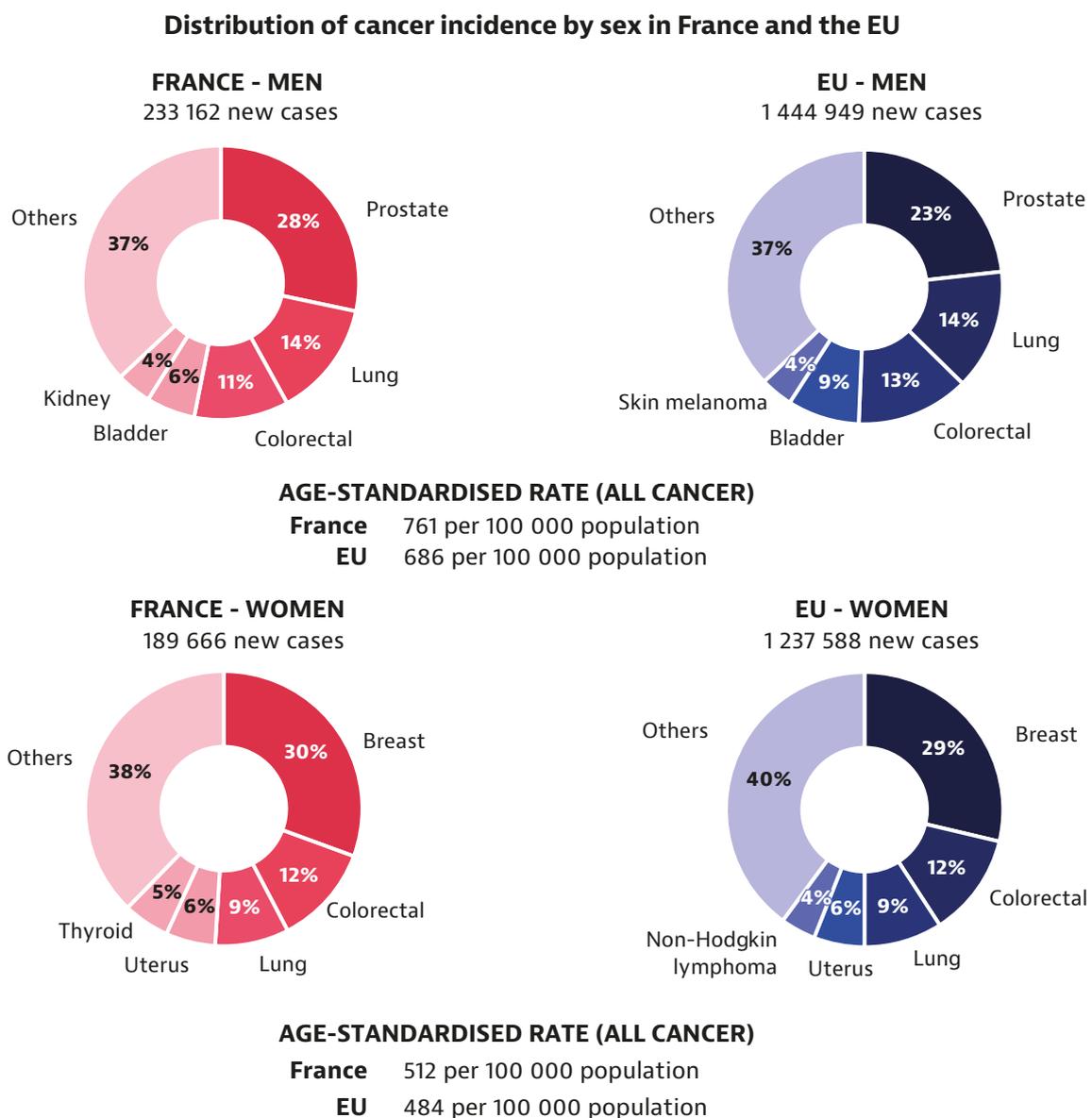
2. Cancer in France

Overall cancer incidence in France is above the EU average

According to European Cancer Information System (ECIS) of the Joint Research Centre based on incidence trends from pre-pandemic years, around 420 000 new cases of cancer were expected in France in 2020. Age-standardised incidence rates for all cancers were expected to be 10 %

higher for men and 5 % higher for women than the EU averages. As in most EU countries, the main cancers among men were expected to be prostate, lung and colorectal cancers, while among women they were expected to be breast, colorectal and lung cancers (Figure 1).

Figure 1. More than 400 000 new cancers cases were expected in France in 2020



Note: Corpus uteri does not include cancer of the cervix. These estimates were created before the COVID-19 pandemic, based on incidence trends from previous years, and may differ from observed rates in more recent years.

Source: European Cancer Information System (ECIS). From <https://ecis.jrc.ec.europa.eu>, accessed on 09/05/2022. © European Union, 2022.

In 2020, gastric (stomach) cancer was expected to constitute 2 % of new cancer cases in men and 1 % in women. Skin melanoma was expected to constitute 4 % of new cancer cases in both men and women. For paediatric cancer, the age-standardised incidence rate in children under 15 years in 2020 was expected to be 15 per 100 000 population, which is similar to the EU average.

During 2000 and 2016, potential years of life lost due to malignant neoplasms saw a relative decrease of 26 %, accounting for 1 389 years lost per 100 000 people aged up to 75 years in 2016. The relative decrease was larger among men (33 %) than women (14 %), with 1 662 and 1 139 years of life lost in 2016, respectively.

In the past two decades, cancer incidence has grown more rapidly in women

In a 2019 report, network Francim, the National Public Health Institute, the Hospices civils de Lyon and the French Institute for Cancer (INCa) described a general convergence of overall cancer incidence between men and women, probably linked to increased incidence of alcohol and tobacco-related cancers among women (Defossez et al., 2019). For instance, the lung cancer incidence rate in women increased four-fold between 1990 and 2018 – equivalent to a yearly increase of 5 %. However, other types of cancer also developed more significantly among women during the period – for example, pancreatic cancer incidence increased by 3.8 % yearly in women compared to 2.7 % in men.

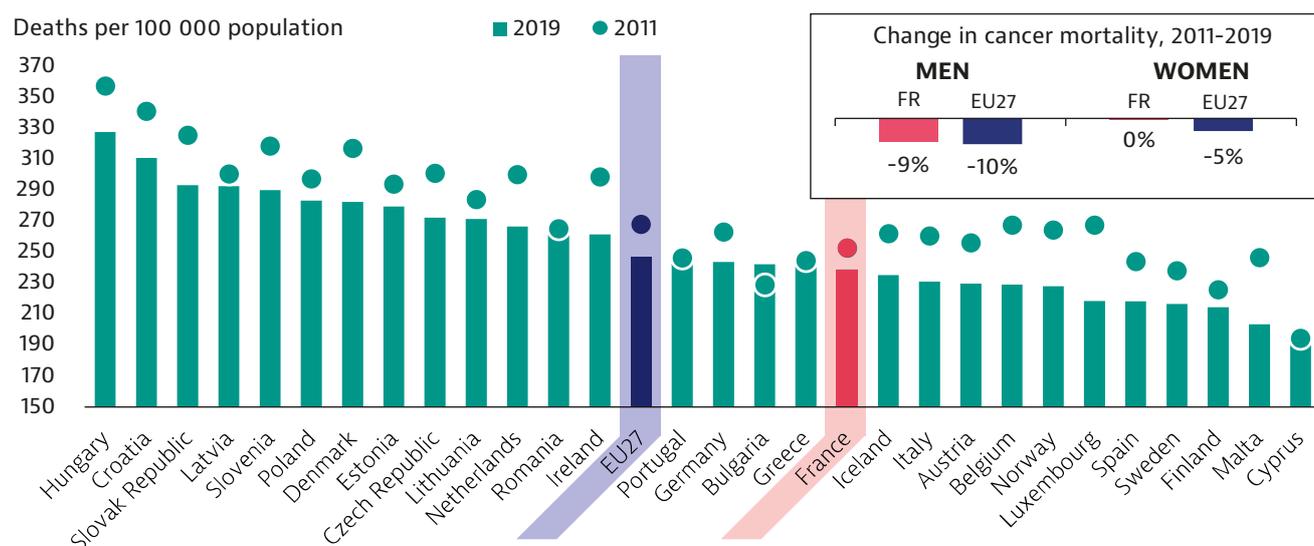
Among men, overall cancer incidence was stable between 1990 and 2018 (+0.1 % per year), with some encouraging elements such as reductions in incidence of two of the three most frequent cancers (prostate and colorectal cancer) and several alcohol- and tobacco-related cancers (lip-mouth-pharynx, larynx and oesophagus).

Overall cancer mortality in France is below the EU average

In 2017, 157 400 people died of cancer in France – a mortality rate of 239 per 100 000 population, which is slightly below the EU average of 247 per 100 000 (Figure 2).

Reductions in overall mortality from cancer have been slower than in most EU countries, however – mostly driven by the evolution of cancer mortality in women. In the past decade, overall cancer mortality rate in men has decreased by 9 % (similar to the EU decrease of 10 %), but it has stagnated in women, while the EU average has fallen by 5 %. Over the longer study period 1990-2018, cancer mortality rate among men decreased at a yearly rate of 1.8 % compared with 0.8 % among women (Defossez et al., 2019).

Figure 2. Reductions in cancer mortality rate have been slow in France, particularly in women



Note: The EU average is weighted (calculated by Eurostat for 2011-2017 and by the OECD for 2018-2019). Data for France refer to 2017. Source: Eurostat Database.

Lung, colorectal and breast cancers are the leading causes of death by cancer

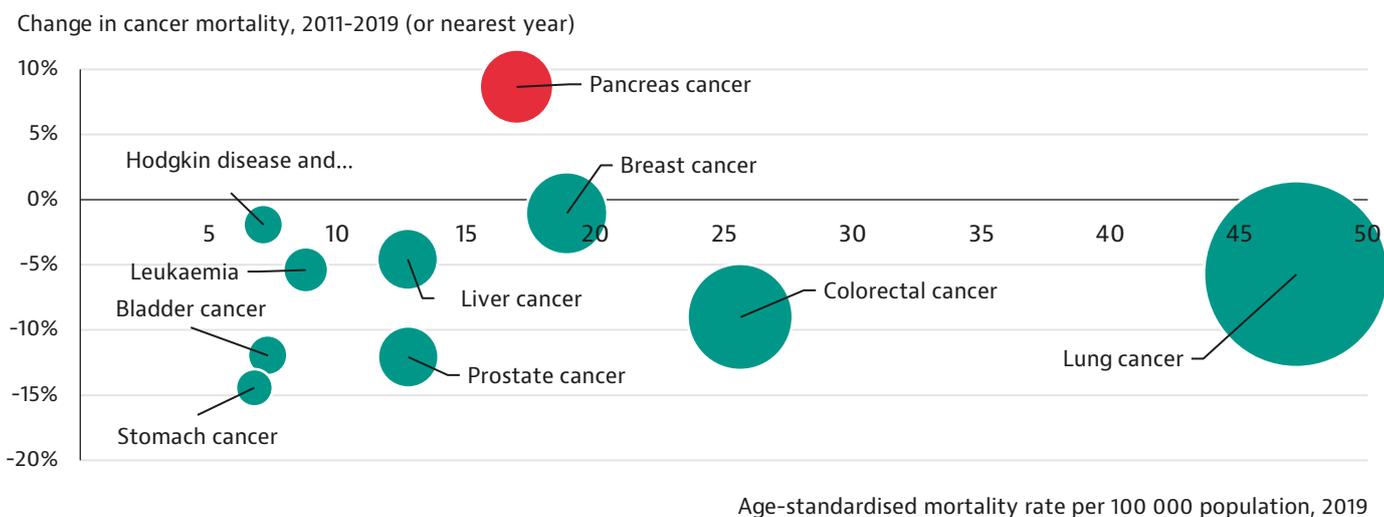
Lung, colorectal and breast cancers were the three leading causes of death by cancer in 2019 in France. Pancreatic cancer is the only cancer with a mortality increase in 2011-2019 (Figure 3), mostly driven by increased mortality in women (Defossez et al., 2019).

In 2018, the mortality rate from lung cancer was the highest, but it had decreased slightly over the past decade. These evolutions were mostly driven by a reduction in mortality rate of 1.6 % per year during 2010-2018 among men, and a mortality rate

increase of +3 % per year among women. Over the longer study period 1990-2018, mortality from lung cancer grew by 3.5 % per year in women.

In 2018, 12 100 women died from breast cancer, making it the third leading cause of death by cancer in France. The rate decreased by 1.6 % per year during 2010-2018; this can be linked in part to important therapeutic advances and an increase in early diagnoses – notably through screening (see Section 4).

Figure 3. Between 2011 and 2019 mortality decreased in most cancer sites in France



Note: Red bubbles signal an increase in the percentage change in cancer mortality during 2011-2019; green bubbles signal a decrease. The size of the bubbles is proportional to the mortality rates in 2019. The mortality of some of these cancer types is low; hence, the percentage change should be interpreted with caution. Bubble sizes for mortality rates are not comparable between countries. Source: Eurostat Database.

In France, cancer is a disease particularly affected by socioeconomic inequalities

Socioeconomic inequalities affect not only the incidence but also the prognosis of cancers, both of which can contribute to inequalities in mortality rates. A study (Bryere et al., 2017) quantified the influence of socioeconomic factors on incidence of cancers in France and reported an excess risk linked to social deprivation for respiratory and upper digestive tract cancers. A large part of this can be explained by the social determination of risk factors such as smoking, occupational exposure and exposure to atmospheric pollutants (see Section 3). A recent report however shows that the occurrence of a cancer diagnosis is lower among people with the lowest standard of living (Bagein et al., 2022). These differences may be due to the social determination of screening uptake and self-checking, and the overdiagnosis associated with this. Overall, for cancer locations where the

risk increases with social deprivation, nearly 15 000 cases could be avoided each year by improvements in living conditions and health promotion among the most deprived populations.

France launched the National Cancer Strategy 2021-2030 to improve cancer prevention and care

The National Cancer Strategy 2021-2030 was launched in February 2021, with the goal of reducing the number of avoidable cancers by 60 000 per year, by 2040. It is structured around four key priorities, which align with those set out in the Europe's Beating Cancer Plan (European Commission, 2021): a) improving prevention and early detection (with a target of one million additional screening tests by 2025); b) improving the quality of life of cancer patients; c) increasing cancer survival among adults and children, particularly for cancers with low prognosis; and

d) ensuring that all population groups can benefit equally from progress in cancer care (by tackling inequalities in access to care). Implementation

is supported by funding of EUR 1.74 billion over five years – an increase of 20 % on the previous strategy.

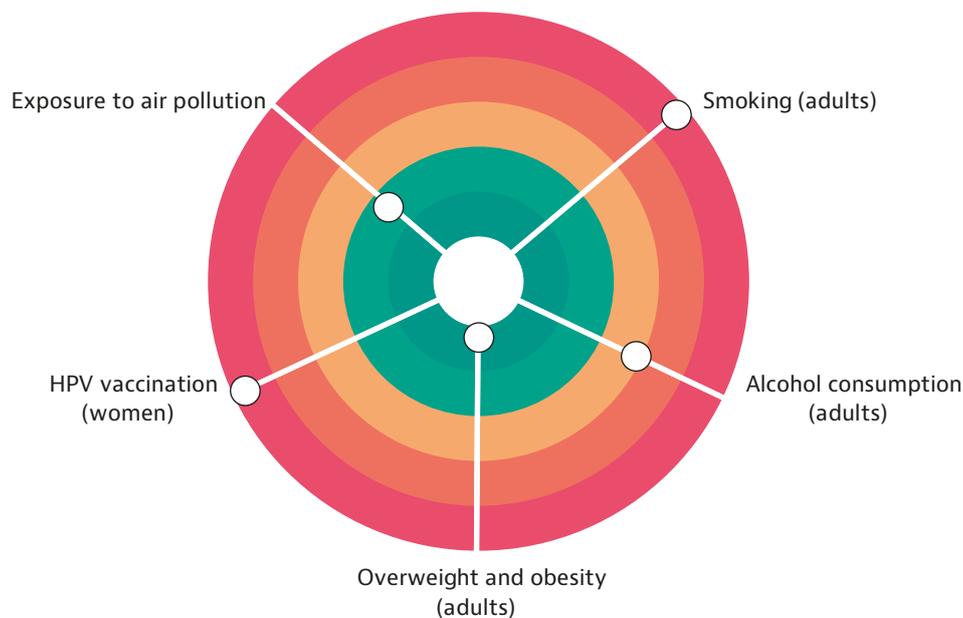
3. Risk factors and prevention policies

Smoking remains an important risk factor for cancer in France

Around a quarter of French adults declared that they smoked regularly in 2020. This proportion is among the highest in western EU countries and represents the most important avoidable risk factor

for cancer (Figure 4). Social inequalities remain very marked, with a 17 percentage-point difference in daily smoking between unemployed (43 %) and employed people (25 %), and a 12 percentage-point difference between those on the lowest (30 %) and highest incomes (18 %) (Pasquereau et al., 2020).

Figure 4. Smoking, alcohol and low levels of human papillomavirus vaccination are major risk factors in France compared to other EU countries



Note: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white “target area” as there is room for progress in all countries in all areas.

Sources: OECD calculations based on the European Health Interview Survey (EHIS) 2019 overweight/obesity rates, national sources for smoking, OECD Health Statistics 2022 and WHO Global Information System on Alcohol and Health (GISAH) for alcohol consumption (2020), WHO for HPV vaccination (through the WHO/UNICEF Joint Reporting Form on Immunization) (2020), and Eurostat for air pollution (2019).

Comprehensive tobacco control policies have been adopted to reduce smoking rates

High smoking rates have had a detrimental effect on cancer incidence and mortality (see Section 2), particularly in women. To combat this, since 2014 France has implemented national plans to reduce tobacco consumption, which have helped to reduce the proportion of adults who smoked daily

between 2014 and 2019 by 4.5 percentage points (Pasquereau et al., 2020). The 2018-22 National Plan Against Tobacco, which was a key action of the Cancer Plan 2014-2019 coordinated by INCa, set a goal of creating a “smoke-free generation”, with a specific objective to reduce smoking rates to less than 5 % among young people born since 2014 by 2032. Moreover, INCa launches regularly campaigns

on the main avoidable risk factors for cancer, like tobacco. In 2018, INCa developed the TABADO programme which aims to initiate smoking cessation among young apprentices and students in vocational high schools.

According to the National Observatory on Drugs and Addiction, 3.4 million people were involved in smoking cessation activities in 2018 – a 25 % increase from 2017. France also implemented policies including increase taxes on a pack of 20 cigarettes, better funding by social health insurance of nicotine substitutes from 2018, a public #MoisSansTabac campaign and creation of an app to help smokers quit.

Despite these measures and incentives, the daily smoking rate increased from 30 % to 33 % among the third of the population on the lowest income levels between 2019 and 2020. Social inequalities thus remain very pronounced.

Recent policies have loosened alcohol control measures in France

While alcohol consumption among adults decreased between 2000 and 2020, it was 6 % higher than the EU average in 2020. Alcohol-related mortality in France is very high: 41 000 deaths were estimated to be attributable to alcohol consumption in 2015, among which 16 000 were directly related to cancer (Bonaldi & Hill, 2019).

Historically, alcohol control policies in France have mainly consisted of laws regulating alcohol sales, consumption and marketing, as well as taxes. One major milestone was the Évin Law of 1991, which introduced strict regulations on advertising alcoholic drinks, forbidding it on all traditional media available to people aged under 18 years. A 2009 law extended the legislation to websites targeting mainly young people and sports websites, but online advertising of alcohol products on all other websites remained unregulated. However, application of the Évin Law has softened in 2016, allowing advertisement of alcohol products when it related to a region or to cultural heritage. The level of taxation on alcohol products generally depends on their strength, with some exceptions – especially for wine. While taxes on beers and liquors were increased in 2012, France continues to impose lower taxes on wine than most EU countries. Recent measures to reduce consumption have focused primarily on raising public awareness of the health risks of harmful alcohol consumption through information campaigns.

¹ Including Belgium, Finland, Hungary, Ireland, Latvia, Norway, Portugal and Spain.

² Particulate matter (PM) is classified according to size: PM₁₀ refers to particles less than 10 micrometres in diameter; PM_{2.5} to particles less than 2.5 micrometres in diameter.

Adult obesity rates are lower in France than in most EU countries

Based on self-reported data, nearly half the population declared themselves overweight or obese in 2019 (47 % compared to 53 % in the EU), with important disparities by gender – the rate was 10 percentage points higher in men (52 %) than women (42 %) – and by education level – 18 percentage points higher in groups with lower (56 %) than those with higher education (38 %). As in other countries, poor nutrition contributes to overweight and obesity. While the proportion of adults who report eating at least one portion of fruit or vegetables per day is higher than in most EU countries, in 2019 about 35 % of adults reported not eating any vegetables every day and 40 % not eating any fruit.

Santé Publique France developed an official “nutri-score” food label, which provides easy-to-understand information on the overall nutritional quality of food products. Nearly 60 % of the population reported that they had modified aspects of their food purchasing behaviour as a result in 2020, up from 43 % in 2019 (Santé Publique France, 2021). France is among the few EU countries¹ that have launched taxes on sugar-sweetened beverages. INCa launches regularly campaigns to promote changes in behaviours that are favourable to health thanks to a better understanding of the link between lifestyle habits and the development of cancers.

Exposure to air pollution is lower in France than in the EU

In 2019, exposure to PM₁₀² in France reached 17.4 µg/m³, which is lower than the EU average (20.5 µg/m³). France also had a lower concentration of PM_{2.5} than in the EU (10.4 µg/m³ vs. 12.6 µg/m³). According to the Institute for Health Metrics and Evaluation, ozone and PM_{2.5} exposure accounted for an estimated 2 % of all deaths in France in 2019, a rate lower than the average across the EU (4 %).

France lags behind other EU countries in prevention of human papillomavirus-induced cancers

Trend analysis reveals a slowing of the decline in incidence of cervical cancer from the 2000s for women aged 50-60 years. In 2020, 2 900 new cases and 1 100 deaths were reported, most of which could have been avoided through better prevention and screening.

HPV vaccination in France is offered on a voluntary basis to girls (since 2007) and boys (since 2018) aged 11-14 years, with catch-up vaccination available to the age of 19 years (and to 26 years for men who have sex with men). However, according to WHO estimates, coverage is low in France (33 % of

girls aged 15) and far below levels in neighbouring countries like Belgium (67 %) and Spain (80 %). Moreover, HPV vaccination is not 100 % covered (unlike most other vaccines) but only partly reimbursed by the Health Insurance Fund.

4. Early detection

Screening programmes are in place for breast, colorectal and cervical cancer in France

Population-based screening programmes, which are offered to a specific at-risk target population, have been rolled out for breast, colorectal and cervical cancer in France. Implementation of the strategy relies on a multi-stakeholder process. The Ministry of Health is responsible for managing and steering the screening programmes; INCa produces studies and oversees communication activities; the Health Insurance Fund funds the programmes; regional cancer screening coordination centres are responsible for practical implementation (such as sending invitations letters to patients); and Santé Publique France oversees evaluation.

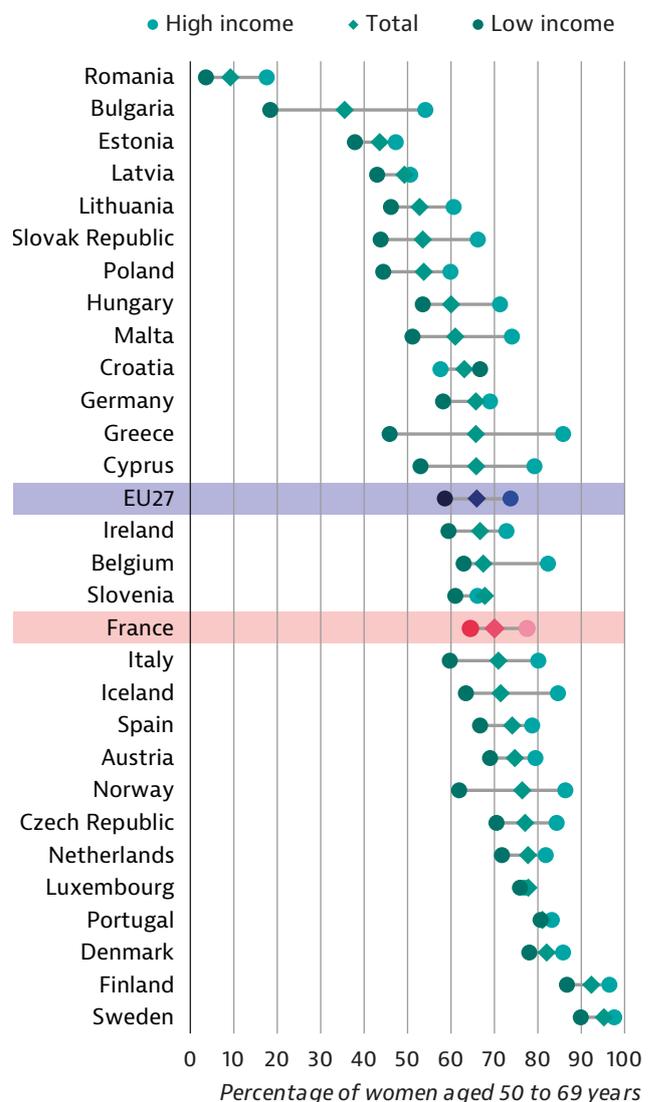
A 2022 report estimated overall expenditure on screening – via organised programmes and on an individual opportunistic basis – at approximately EUR 600 million, acknowledging that this amount and the associated results of the programmes remained below the set objectives (INCa, 2022).

Rates of breast cancer screening are above the EU average

A national breast cancer screening programme has been in place in France since 2004. All women aged 50-74 years are offered screening every two years, which is 100 % covered by the Health Insurance Fund. This includes a manual breast exam to detect any anomalies and a mammogram. The mammogram results are read by two radiologists for increased reliability. It is also possible to request mammograms outside the screening programme. They may be offered, for instance, to women with specific risk factors (such as family history of breast cancer).

In 2019, 70 % of women reported receiving a mammogram in the past two years (Figure 5). This is slightly above the EU average (66 %).

Figure 5. Uptake of breast cancer screening in France is slightly above the EU average



Note: The EU average is weighted (calculated by Eurostat). The figure reports the percentage of women aged 50 to 69 years who reported receiving a mammogram in the past two years. Source: Eurostat Database (EHIS). Data refer to 2019.

A cervical cancer screening programme was established in France in 2018

Before 2018, opportunistic screening for cervical cancer relied on individual initiatives or physician recommendations. A national cervical cancer screening programme was implemented in 2018, inviting women to attend a cervical cytology screening test every three years for those aged 25-30 years (following normal results on two tests at one-year intervals) and an HPV screening test every five years for those aged 30-65 years. Screening may be indicated before the age of 25 years – notably in immunocompromised women who require more specifically targeted care.

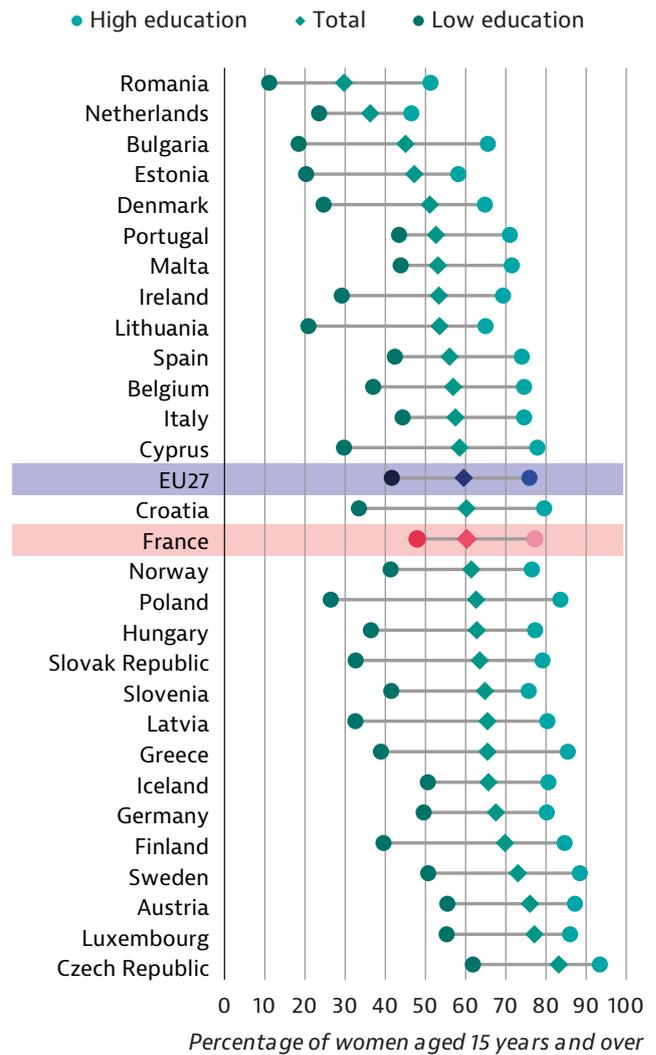
In 2019, around 60 % of women reported having a cervical smear test in the past three years, a proportion equivalent to the EU average (Figure 6). According to Santé Publique France, 58.8 % of women aged 25-65 took part to the national cervical cancer screening programme over 2018-2020.

Inequalities in breast and cervical screening uptake are substantial

Social inequalities are observed in the uptake of breast cancer and cervical cancer screening programmes. For instance, there is a 13 percentage-point difference in breast screening uptake between women in the highest and lowest income groups (see Figure 5). Similarly, the education gap in the uptake of cervical cancer screening is substantial (see Figure 6). These inequalities can mainly be explained by lower follow-up rates by gynaecologists or more frequent refusals of care among women on low incomes. Nevertheless, regular follow-up by a general practitioner has been shown to have a positive effect on these inequalities (Camacho et al., 2019).

Several local breast cancer screening initiatives have been set up with the aim of improving participation of specific social, cultural or geographical populations. From the early years of the national screening programme, some local leaders set up programmes based on the use of mobile mammography units or “mammobiles”. These travel to isolated populations in rural areas based several kilometres from radiology centres and to marginalised urban areas. A pilot mammobile programme, supported by local and national authorities (INCa, National Institute for health and Medical Research, etc), began in Normandy in autumn 2021 for women living far from radiology services (Guillaume et al., 2019).

Figure 6. Uptake of cervical cancer screening is close to the EU average



Note: The EU average is weighted (calculated by Eurostat). The figure reports the percentage of women aged 15 years and over who reported having a cervical smear test in the past three years. Source: Eurostat Database (EHIS). Data refer to 2019.

Despite a national programme, colorectal cancer screening uptake is very low in France

The French screening programme for colorectal cancer was rolled out nationwide from 2008. It targets men and women aged 50-74 years who are invited to perform a stool test, free of charge, every two years. If the stool test is positive, a colonoscopy is performed. The quantitative faecal immunological test has been used since April 2015. Despite this programme, colorectal cancer screening uptake is very low in France. In 2019, only 37.1 % of the population aged 50 to 74 years reported having been screened in the past two years. According to Santé Publique France, participation has decreased to 34.6 % in 2020-2021 since the COVID-19 pandemic.

Compared with breast cancer screening, colorectal cancer screening is less often publicly discussed in the media or among relatives, and receive less support from patient associations. Stronger participation in colorectal cancer screening is also expected from 2022, as pharmacists will be entitled to distribute self-screening test kits, and individuals will also be able to order these online.

Lung cancer screening is under consideration in France

A potential lung cancer screening strategy is being evaluated by the National Authority for Health, but several issues need attention. First, such a campaign requires sufficient material resources in radiodiagnostic imaging (X-ray and CT scan) to be deployed throughout the country. Second, the performance (sensitivity and specificity) of screening techniques needs to be improved, including the introduction of diagnostic and other markers in screening protocols to avoid overdiagnosis. Finally, lung cancer screening requires the necessary medical and paramedical human resources to manage the increased number of patients who will undergo treatments including surgery, chemotherapy and radiotherapy. A pilot population-based screening programmes, should be rolled out for lung cancer in France in the next two years.

The National Cancer Strategy sets ambitious objectives to increase screening uptake

The National Cancer Strategy 2021-2030 sets a target of conducting one million more screening procedures by 2025. Methods to achieve these objectives include: a) developing approaches

offering screening after a preventive operation or unscheduled treatment; b) providing all health care, medical and social workers with first contact information tools; c) simplifying screening access (via direct referral, diversified health care professionals and mobile teams); d) creating partnerships to conduct awareness campaigns; e) developing mobile information and reminder apps; and f) considering material incentives to facilitate participation in screening programmes.

The Strategy also includes development of new screening programmes in the medium term (Box 1). These new measures will complement the pre-existing ones such as the national campaigns set up by national authorities (INCa and the Ministry of Health), every year in March and October to increase the participation rates to colorectal and breast screening programmes respectively.

Box 1. Preparing future screening programmes

Screening programmes for cancers with poor prognosis or representing a health priority (such as lung cancer and melanoma) are under consideration as part of the National Cancer Strategy 2021-2030. The following actions are under consideration to screen more people in the future:

- Developing precision screening, through improved knowledge on high-risk subjects;
- Establishing an organised lung cancer screening programme;
- Rollout, after evaluation of new screening procedures, less invasive new technologies and new screening organisation procedures.

5. Cancer care performance

5.1 Accessibility

Features of the French health system limit financial inequalities in access to cancer care

France's health system is based mainly on a social health insurance (SHI) system, with a traditionally strong role for the state. While regional health agencies have played a greater role in managing health care provision at the local level since 2009, SHI and central government organise the health system and determine its operating conditions. The

SHI system offers coverage to the whole population, based on residence, through various compulsory schemes.

France reports the lowest share of out-of-pocket payments for health among all EU countries (8.9 % compared to a 15.4 % EU average) because public and private health insurance schemes cover most health spending. This is particularly the case under the scheme for people with chronic conditions, which covers all health-related costs linked to these. Cancer-related costs fall within this category

and benefit from 100 % coverage for all patients. As a result, barriers to accessing cancer care in France are not financial.

The general shortage of health professionals in France affects cancer care

While the number of doctors has increased in most EU countries over the past decade, it has remained stable in France. As a result, at 3.2 doctors per 1 000 population in 2020, the rate is well below the EU average of 4.0 per 1 000 population. As with most medical specialties, the lack of oncology specialists places a significant burden on the capacity of the health system to meet the needs of its population. However, in the past 15 years the Ministry of Health has acted to increase human resources for health, paying particular attention to increasing the number of cancer specialists: between 2017 and 2022 the number of clinical oncologists grew by 30 % and the number of radiotherapists by 8 %.

Delivery of cancer services is very controlled in France

An authorisation system for cancer treatment has been put in place to guarantee the same level of safety, quality and accessibility throughout the country: 865 health establishments and radiotherapy centres are authorised by the regional health agencies to look after cancer patients. The system is based on three obligations comprising cross-cutting quality measures, approval criteria for the main cancer therapies and minimum activity thresholds for treatment of certain types of cancer (see Section 5.2).

Health care for adult patients suffering from rare cancers is provided through national reference networks, established in 2009, with the aim of guaranteeing optimal care. Each network is organised around a reference centre and several regional or inter-regional competence centres. Any patient suffering from a rare cancer is guaranteed to benefit from a definitive diagnosis within these networks via re-reading of samples from the tumour, appropriate treatment and systematic discussion of the case by experts in the specific pathology, regardless of where the patient is treated.

France has also comprehensive cancer centres covering the entire country. Overall, there are 18 comprehensive cancer centres and 2 affiliate members across 22 hospital sites. The comprehensive and coordinated care of these centres ensures a high quality and accessible health care pathway to more than 530 000 patients each year.

Access to radiotherapy has been increasing in recent years

During 2012-2017, overall activity of radiotherapy centres in France increased by 12 % in patient numbers to reach 196 000 patients and by 6 % in session numbers to reach approximately 4.1 million sessions in 2017 (INCa, 2022). This is the result of an evolution of practices and techniques, which has allowed the number of sessions per patient for an equivalent treatment to be reduced.

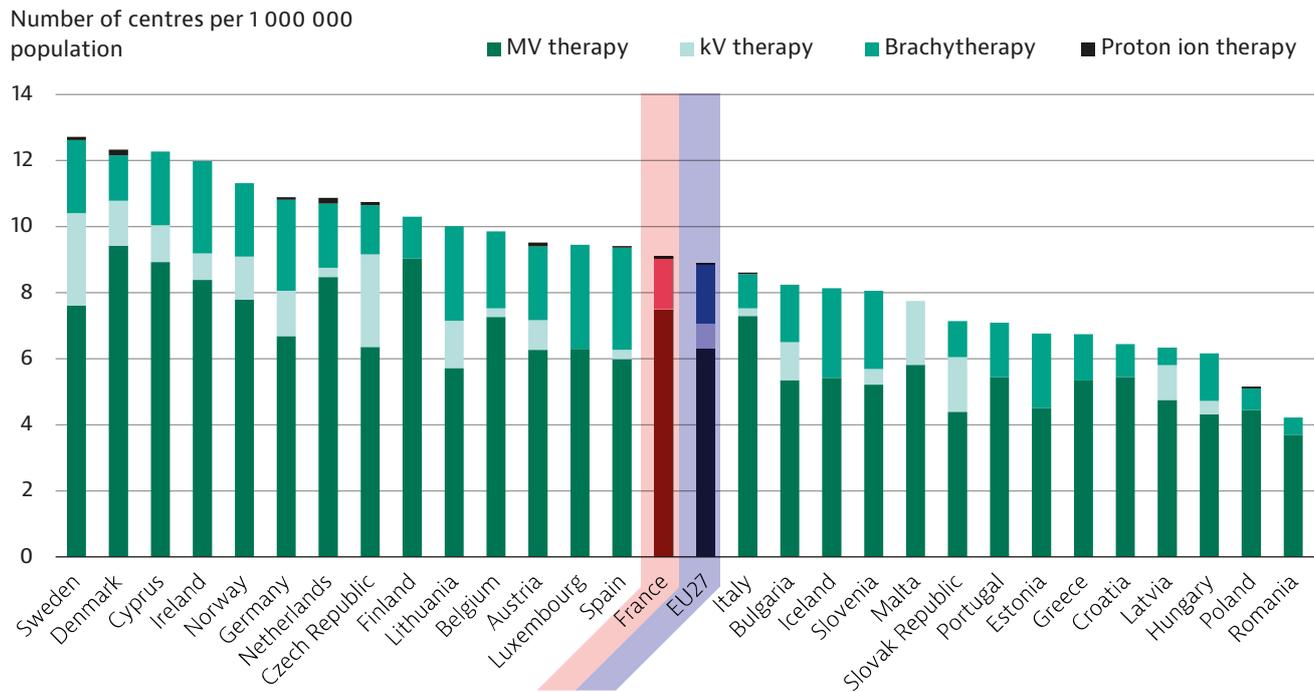
Overall, France reports 9.1 radiotherapy centres per million inhabitants, which is slightly higher than the EU average of 8.9 (Figure 7). France remains among the countries with the highest density of centres providing megavolt (MV) therapy, with 7.5 centres per million inhabitants (vs. a EU average of 6.8). Brachytherapy remains a highly specialised technique, and is less available than in most other EU countries (1.5 centres per million inhabitants vs. 1.8 per million across the EU).

The French health system ensures high access to novel cancer therapies

The National Authority for Health is responsible for health technology assessment, providing decisions on drugs for reimbursement and pricing purposes. Between 2010 and 2015, almost all the new haematology/oncology cancer drugs assessed received a positive decision and are fully reimbursed by the Health Insurance Fund (Grande et al., 2017).

Overall, France is a favourable market for new cancer treatments. The temporary authorisation for use (ATU) system (Box 2) allows a significant proportion to be made available at an early stage of development. Access to novel innovative therapies is high. In 2020, more than 50 000 patients were treated with immunotherapy and 230 by chimeric antigen receptor (CAR) T-cell therapy.

Figure 7. Radiotherapy capacity in France is close to the EU average



Note: MV stands for megavolt and KV stands for kilovoltage. The EU27 average is unweighted (calculated by the OECD).
Source: International Atomic Energy Agency.

Box 2. France is reforming its early access scheme

The ATU programme is the French compassionate access scheme, which provides early access to medicines for patients with a severe or rare disease with high unmet needs and for which no authorised therapeutic alternative is available. Most ATUs are issued at the request of the manufacturer to a group of patients treated and monitored according to a well-defined protocol. Most new cancer treatments benefit from an ATU in France before they are officially marketed, which significantly accelerates patients' access to new therapies.

As a result of expanded use of ATUs in recent years, funding of new products through the system has grown to over EUR 1 billion a year. In 2020, the Ministry of Health proposed several reforms to the ATU system. The new early access authorisation system will be used primarily for innovative medicines and will be subject to the relevant company's commitment to apply for marketing authorisation or for registration on a reimbursement list, within a specific timeline.

French patients benefit from broad access to molecular diagnostics

Molecular genetics is now essential for diagnosis, classification, choice and monitoring of treatment for a growing number of cancers. Dedicated

platforms carry out molecular tests that can determine access to targeted therapy, guide the diagnostic process and allow follow-up of the residual disease. Currently, more than 30 targeted therapies are associated with a molecular biomarker.

In France, 28 hospital platforms for the molecular diagnosis of cancers are spread throughout the country, including several laboratories, which may belong to different establishments. The objective is to offer patients all the essential molecular genetic techniques for all the pathologies concerned.

Social inequalities have an impact on delays to access cancer care in France

The analyses carried out in the VICAN2 survey³ for breast and lung cancers show that the most disadvantaged people (those on low incomes or living in a municipality characterised by a high level of social disadvantage) have longer delays in accessing care on average.

The time between surgery and the first radiotherapy session for breast cancer is shorter for patients in the highest income quartile than for those in the lowest. For patients aged under 65 years, a similar trend is observed, with longer delays for people benefiting from state-guaranteed complementary health insurance. For lung cancer,

3 A survey of patients on life two years after a cancer diagnosis.

the time between diagnostic imaging and first treatment is on average 8 days shorter among patients in the highest than the lowest income quartile, 4-5 days shorter for patients treated in a private institution and 7 days shorter in areas with high rather than low availability of hospital care (Chauvin et al., 2017).

5.2 Quality

Overall quality of cancer care has been improving

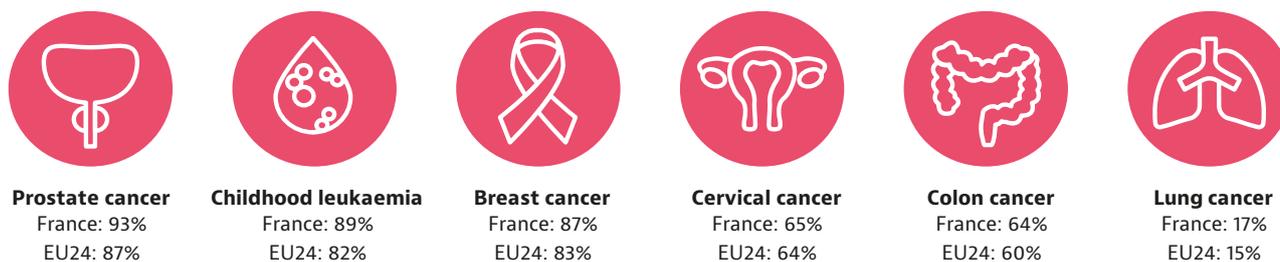
The quality of cancer care has improved over recent decades through the introduction of multidisciplinary teams and cancer networks, greater use of clinical guidelines and more rapid access to innovative medicines. France compares well with other EU countries for five-year survival rates following common cancers (breast, colon, cervical, prostate and lung cancer) and childhood leukaemia, based on the most recent data available for people diagnosed in 2010-14 (Figure 8).

While better detection and treatment facilitated a rapid increase of five-year survival rates for patients with breast and colon cancer, progress has been slower for other cancers with poorer prognosis, such as lung cancer.

France faces a unidirectional social gradient in survival for almost all cancers

Based on the analysis of population-based cancer registry data, survival rates were worse in the most deprived areas for almost all cancers, although the extent of the disparities varied substantially across cancer sites. The gap in age-standardised net survival between the least and the most deprived quintiles reached 34 % for liver cancer among men and 59 % for bile duct cancer among women. For cancers targeted by screening programmes (colorectal, breast and cervical cancer) such inequalities may result from lower participation in screening programmes, resulting in more cancers being diagnosed at an advanced stage and care being administered by less specialised institutions and with longer intervention times (Tron et al., 2021).

Figure 8. France compares well with other EU countries on five-year cancer survival rates



Note: Data refer to people diagnosed between 2010 and 2014. Childhood leukaemia refers to acute lymphoblastic cancer. Source: CONCORD Programme, London School of Hygiene and Tropical Medicine.

Minimum standards are defined in law for the provision of cancer care

Cancer care is structured according to an authorisation system in France. Since the end of 2009, health establishments must have specific authorisation from their regional health agency to treat cancer patients. Care systems have also been put in place to meet the needs of people with rare cancers and carriers of genetic predispositions, as well as elderly people and children and adolescents with cancer. The authorisation system is designed to guarantee the same level of safety, quality and accessibility of cancer care throughout the country. The conditions for setting up a cancer treatment activity were recently revised via three decrees of the Ministry of Health in April 2022.

Quality and safety indicators are being developed for breast, colorectal, ovarian and pancreatic cancer

Quality and safety of care indicators are being developed by the National Authority for Health based on centralised medico-administrative information. These are tools designed to help inter-institutional comparison for decision making. They evaluate care pathways (and not patients individually) throughout the cancer care continuum.

The indicators selected and validated by experts relate to all phases of the care pathway, depending on the type of cancer. They combine process and outcome indicators to assess the compliance with recommendation. Collection of indicators allows:

- identification of weak care coordination and

the need to improve care pathways, particularly in terms of time to access care; b) identification of territorial disparities; and c) provision of management tools, updated every year at local and national levels, for regional health agencies, health professionals and actors in the field (regional cancer networks, cancer coordination centres and health establishments).

Action has been taken in recent time to increase palliative care capacity

Four plans to strengthen palliative care and improve support to patients have been implemented in France since the end of the 1990s (CNSPFV, 2020). As a result, the number of palliative care beds more than doubled – from 3 340 in 2006 to 7 500 in 2019. In 2020, France had 164 palliative care units, compared with fewer than 100 in 2006, and the number of mobile palliative care teams increased from 288 in 2006 to 428 in 2021 (Ministère des Solidarités et de la Santé, 2022). However, France faces a strained medical demography, with an estimated 150 vacancies and one quarter of palliative care doctors set to leave their posts within five years. Doctors with expertise and experience in palliative care represent less than 2 % of hospital practitioners.

Despite the efforts to improve palliative care, lasting issues have been identified, including persistent cultural and societal obstacles to implementation of a “palliative culture” among the French population and lack of familiarity with the procedures to access palliative care services. In response, the 2021-2024 National Plan for the Development of Palliative Care and Support at the End of Life, launched in September 2021, aims to guarantee access for all citizens, throughout the country and as close as possible to all living areas.

In total, EUR 5 million was allocated at the end of 2021 to health care facilities to strengthen mobile palliative care teams. Moreover, as part of the Ségur Health Plan, EUR 3 million was allocated to regional health agencies at the beginning of 2022 to provide palliative care support systems accessible to health professionals practising at home.

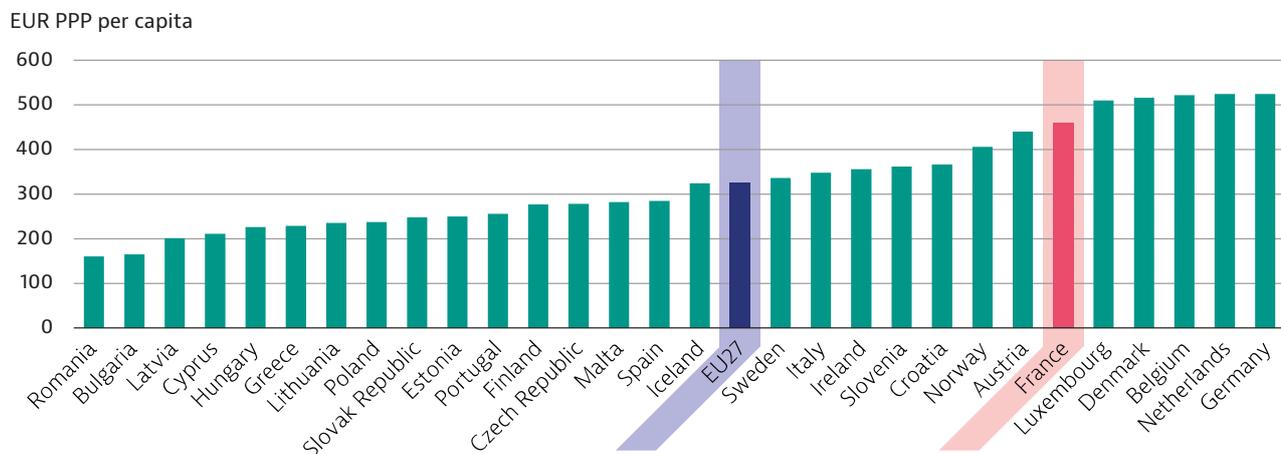
5.3 Costs and value for money

Public expenditure on cancer has increased substantially in recent years

Expenditure allocated by the Health Insurance Fund to cancer care amounted to EUR 20 billion in 2019, including EUR 18 billion for cancers in the active phase of treatment and EUR 2 billion for the care of cancers under surveillance. This represents 12 % of total health care expenditure. The costliest cancers were breast cancer in the active phase of treatment (EUR 2.9 billion), followed by lung cancer (EUR 2.3 billion), colorectal cancer (EUR 1.7 billion) and prostate cancer (EUR 1.5 billion). Expenditure related to the screening programmes was estimated at around EUR 600 million – equivalent to 2.5 % of overall cancer expenditure (IGAS, 2022).

Between 2015 and 2019, total expenditure increased for all cancers by more than 20 % on average. The determinants of expenditure growth vary by location and treatment phase, with a significant increase in average expenditure per patient with lung (+35 %) and prostate (+21 %) cancers. Overall, France appears to have among the highest cancer care costs in the EU, at EUR 459 per capita, adjusted for purchasing power parity (PPP), compared with an EU average of EUR 326 (Figure 9). Spending on prevention however accounted for 2.8 % of all health spending in 2020 – a share lower than the 3.4 % EU average.

Figure 9. Per capita expenditure on cancer care in France is among the highest in the EU



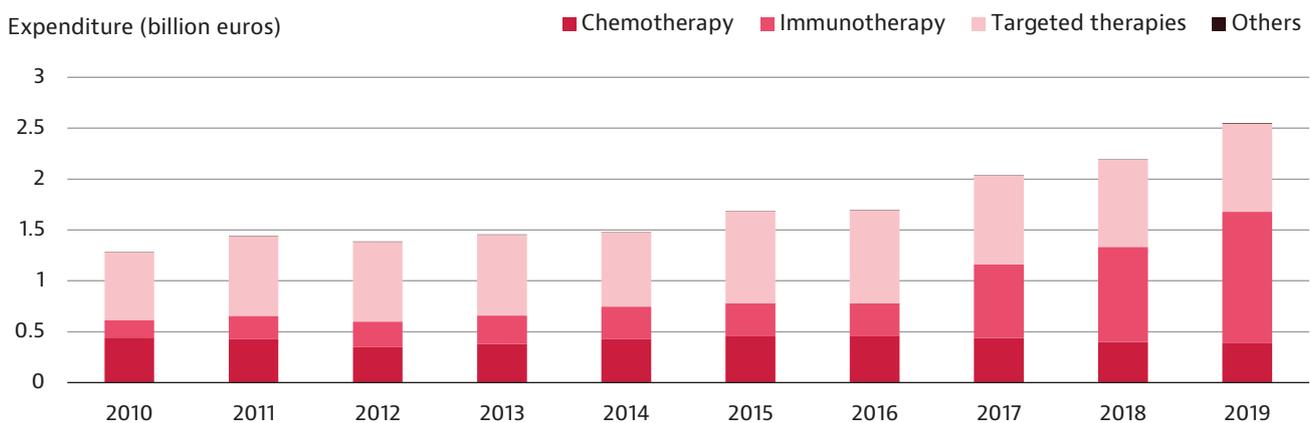
Note: The EU27 average is unweighted (calculated by the OECD).
Source: Hofmarcher et al. (2020).

Financial sustainability of the health system is threatened by increasing costs of new oncology drugs

Research in oncology is very active. In 2018, more than a third of medicines in development, across all stages, were anti-cancer therapies; over the past decade about a third of products or indications obtaining marketing authorisation were cancer drugs. In addition, these new products are increasingly specific, sometimes targeting small populations.

In 2020, oncology drugs (chemotherapies, hormone therapies, targeted therapies and immunotherapies) represented expenditure of EUR 7 billion in France, most of which was on targeted therapies and immunotherapies. In recent years, expenditure on cancer medicines has grown very rapidly. For instance, expenditure on hospital cancer medicines funded by the Health Insurance Fund grew from EUR 1.3 billion in 2010 to more than EUR 2.5 billion in 2019, mostly driven by increased use of targeted therapies and immunotherapies (Figure 10).

Figure 10. Expenditure on hospital cancer medicines funded by health insurance has grown substantially



Note: Expensive medications funded in addition, retrocession and outpatients.
Source: INCa (2022).

Similarly, a breakdown of per capita expenditure for lung cancer between 2016 and 2020 shows continuous growth for ambulatory medicine costs (+36 %) and especially for hospital drugs (rising from 9 % of total expenditure in 2016 to 29 % in 2019). Similar trends were observed for breast cancer.

The increasing costs of cancer medicines have led to policy responses aiming to foster good public finance management and medium-term sustainability. The Social Security Financing Law of 2015 introduced a system requiring laboratories to repay a portion of their turnover above a certain level of income. In addition, the Social Security Financing Law of 2017 created a fund to finance pharmaceutical innovation in order to smooth the impact over time of variations in expenditure caused by the arrival of therapeutic innovations.

5.4 COVID-19 and cancer: building resilience

Screening activity was severely affected by the first lockdown

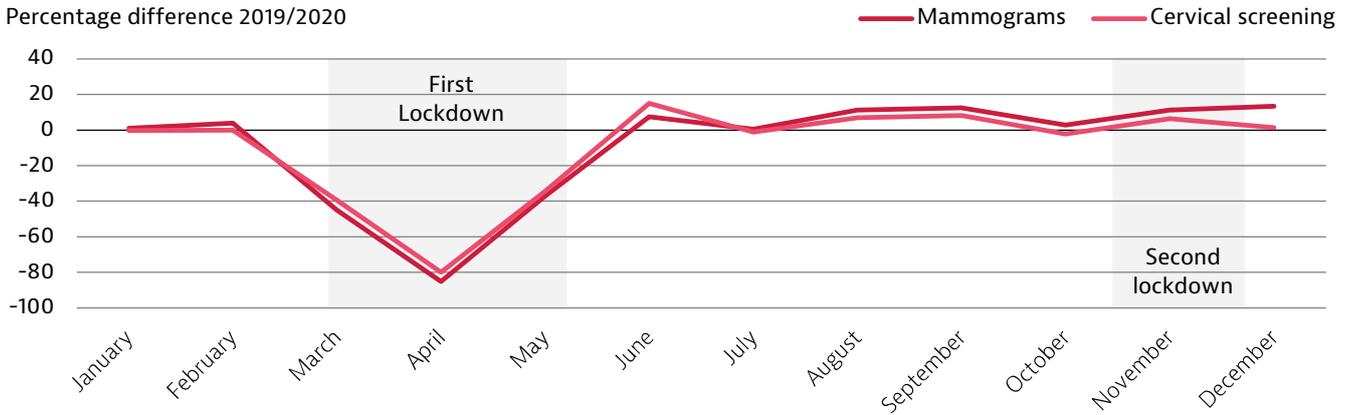
The COVID-19 pandemic-related lockdowns had a substantial and lasting impact on care provision, particularly in the field of cancer. During the first lockdown (from 17 March to 11 May 2020), invitations for breast, colorectal and cervical cancer screening programmes were suspended, and a number of treatments directly linked with cancer care were deferred (including surgery and cancer-related hospitalisations).

Diagnostic and screening activity was substantially affected by the first lockdown. For mammograms, the shortfall was around -45 % in March, -85 % in April and -37 % in May 2020 (Figure 11). Although no further decreases in activity occurred in June, a shortfall of -10 % remained over the full year. An overall decrease in cervical screening (HPV tests and cytology) was also observed between 2019 and 2020. However, during the

second lockdown, the directives to safeguard diagnostic activities in cancer care appear to have been followed, thus limiting the impact of

this further lockdown period on screening rates (Figure 11).

Figure 11. The first lockdown stopped almost all screening activities in France



Source: Le Bihan Benjamin et al. (2022).

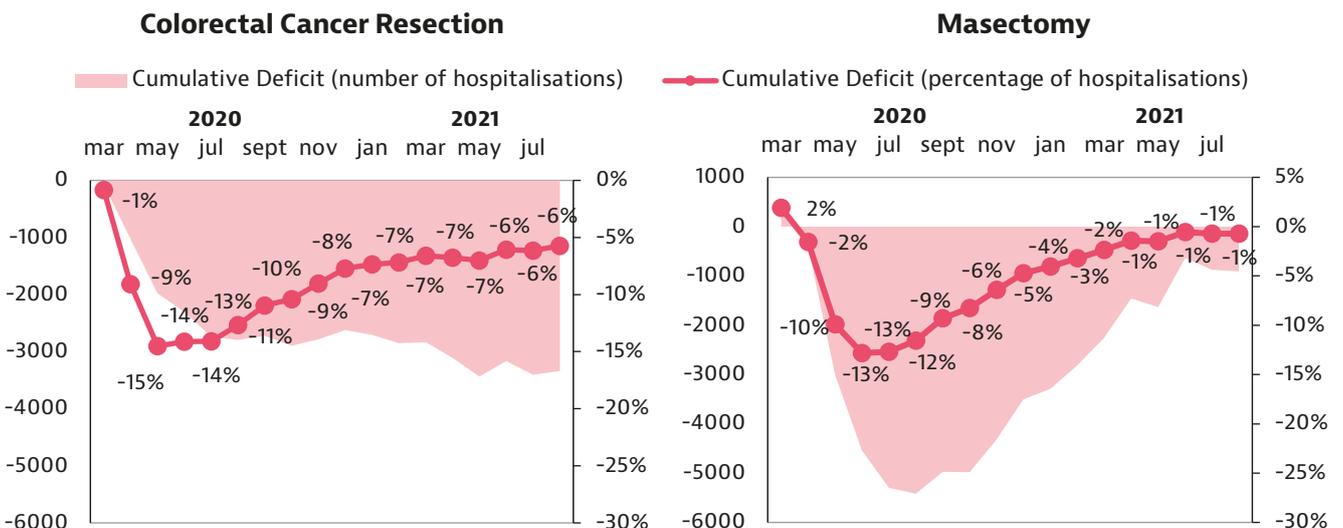
For some cancers the backlog has not been cleared

Figure 12 presents the evolution of cumulative activity since January 2020 compared to the activity in the same months of 2019. The two examples illustrate a lack of recovery for colorectal cancer resections and a virtual catch-up for mastectomies.

For colorectal cancer resections, the cumulated deficit of -2 700 stays observed in July 2020 (-14 % of activity between January and July 2020), stabilised

until March 2021, signalling an absence of catch-up activity. It then increased again to reach -3 300 stays in August 2021 (equivalent to a reduction of 5 % of activity during January 2020 to August 2021) (INCa, 2022). For breast cancer resections, the cumulated deficit of -5 400 stays in August 2020 (-12 % of activity between January and August 2020) gradually subsided to be limited to -900 stays by August 2021 (-1 % of activity during January-August 2021).

Figure 12. Many colorectal cancer resections and mastectomy or lumpectomy were forgone during the pandemic



Source: INCa (2022).

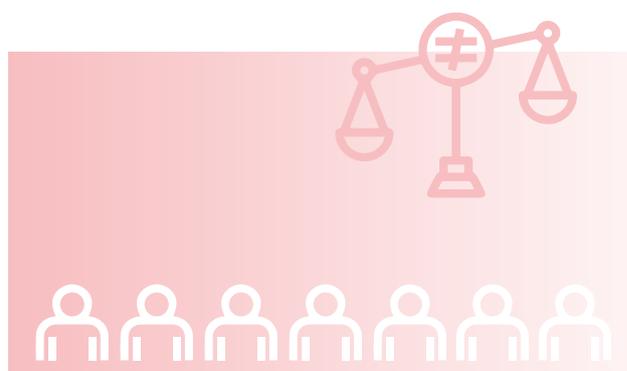
6. Spotlight on inequalities

The French health care system offers coverage to the whole population, based on residence, with no financial barriers to accessing cancer care and services. Thanks to its early access scheme and generous benefits package, new and innovative oncology treatments are also widely and swiftly available to patients in France. However, there are marked inequalities in cancer prevention, access to early diagnosis, care quality and outcomes.

- The risk of developing cancer is significantly linked to social deprivation for respiratory cancers and upper digestive tract cancers, which can be explained by the social determination of certain risk factors such as smoking, occupational exposure and exposure to atmospheric pollutants.
- Behavioural risk factors for health are major drivers of cancer mortality in France. While tobacco consumption has fallen over the past two decades thanks to various control measures, almost one quarter of adults still smoked daily in 2019. Social inequalities remain very marked, with a 17 percentage-point difference in daily smoking between unemployed (43 %) and employed (25 %) people, and a 12 percentage-point difference between those on the lowest (30 %) and highest (18 %) incomes.
- Nearly half of the population declared themselves overweight or obese in 2019, with important disparities by gender – 10 percentage points between men and women– and by education level – 18 percentage points higher in groups with lower than higher education.
- Organised screening programmes have been rolled out for breast, colorectal and cervical cancer in France. However, screening rates face substantial social and economic gaps. There is a 13 percentage-point difference in breast screening uptake between women in the highest and lowest income groups.
- Cancer survival rates are worse in the most deprived areas for almost all cancers. The reduction in age-standardised net survival between the least and the most deprived quintile reached 34 % for liver cancer among men and 59 % for bile duct cancer among women.

Several policies have been implemented to improve access to high cancer quality and reduce disparities – including, for example, use of multidisciplinary teams and cancer networks, greater use of clinical guidelines and use of “mammobiles” as a pilot programme.

The COVID-19 pandemic and associated containment and mitigation measures had substantial adverse effects on cancer diagnosis and treatment in France. Shortfalls in screening rates and surgical procedures will require close monitoring in the coming years to identify the effects of such delays and forgone care, especially among the most vulnerable populations who already face strong inequalities in cancer care.



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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovak Republic	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czech Republic	CZ	Greece	EL	Lithuania	LT	Portugal	PT		

European Cancer Inequalities Registry

Country Cancer Profile 2023

The European Cancer Inequalities Registry is a flagship initiative of the Europe's Beating Cancer Plan. It provides sound and reliable data on cancer prevention and care to identify trends, disparities and inequalities between Member States and regions. The Registry contains a website and data tool developed by the Joint Research Centre of the European Commission (<https://cancer-inequalities.jrc.ec.europa.eu/>), as well as an alternating series of biennial Country Cancer Profiles and an overarching Report on Cancer Inequalities in Europe.

The Country Cancer Profiles identify strengths, challenges and specific areas of action for each of the 27 EU Member States, Iceland and Norway, to guide investment and interventions at the EU, national and regional levels under the Europe's Beating Cancer Plan. The European Cancer Inequalities Registry also supports Flagship 1 of the Zero Pollution Action Plan.

The Profiles are the work of the OECD in co-operation with the European Commission. The team is grateful for the valuable comments and suggestions provided by national experts, the OECD Health Committee and the EU Expert Thematic Group on Cancer Inequality Registry.

Each Country Cancer Profile provides a short synthesis of:

- the national cancer burden
- risk factors for cancer, focusing on behavioural and environment risk factors
- early detection programmes
- cancer care performance, focusing on accessibility, care quality, costs and the impact of COVID-19 on cancer care.

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