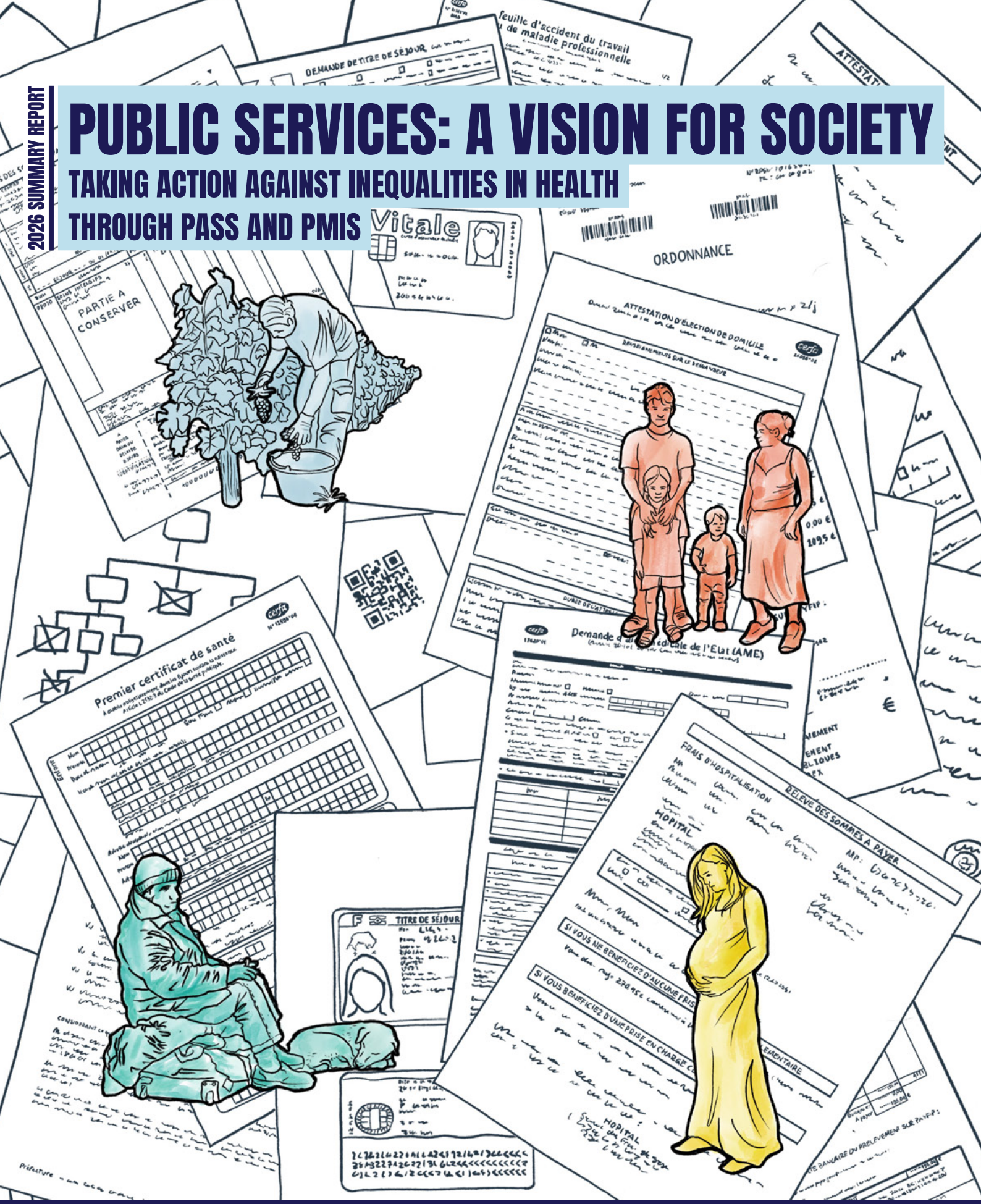
2026 SUMMARY REPORT

PUBLIC SERVICES: A VISION FOR SOCIETY

TAKING ACTION AGAINST INEQUALITIES IN HEALTH THROUGH PASS AND PMIS



OBSERVATORY ON ACCESS TO HEALTHCARE

IN MÉDECINS DU MONDE PROJECTS IN FRANCE

PROMOTING PUBLIC HEALTH SERVICES

For the past 26 years, we have been documenting obstacles to access to healthcare for vulnerable people. This year, the report of the Observatory on Access to Healthcare is published in a particularly concerning and uncertain context.

Several indicators show a **very significant rise in poverty** and health and regional inequalities, with health indicators showing a worrying decline. There has been a significant increase in child mortality, from 3.5‰ in 2011 to 4.1‰ in 2024, with a sharp rise in the risk of neonatal mortality in the areas and families experiencing the greatest vulnerability. The gap in life expectancy between the richest and poorest is widening. Between 2012 and 2024, the life expectancy of the poorest 25% dropped, while that of the richest increased[1].

In the highly tense context of the run-up to the presidential and parliamentary elections in 2027, **draft finance and social security finance bills** are being debated in the French Parliament, and at the time of writing this report, overall budget cuts of €54 billion had already been announced. To cite but one extremely worrying example, the budget for public hospitals – which are, after all, essential – is set to be cut yet again, even though their deficit has already risen dramatically since 2019 and the fact that staff are already under immense pressure. These newly announced cuts in public and social spending raise serious concerns as to whether our social security system can respond to the needs of the population. Needs are growing rapidly and it is precisely in this context that we should be rethinking collective security mechanisms to strengthen, reinforce and adapt them.

This year, we have chosen to highlight **two essential public services: Hospital-Based Health Access Services (PASS) and maternal-and-child health services (PMI)**. Targeting different audiences and different stages of life, these mechanisms are irreplaceable in terms of ensuring access to care, prevention and support and in reducing health inequalities. They are often one of the last points of entry to the healthcare system for people who experience not only vulnerability and administrative difficulties, but who also lack stable housing and are excluded from mainstream health services.

This report shows how much these mechanisms, and many other facilities, have been weakened. We want to use this opportunity to reiterate **our support for these professionals** and for everyone working on the front line, fighting to maintain the principles of public service in increasingly difficult conditions. In this highly tense context, MdM recalls the importance it places on the principles which must underlie healthcare: equality of treatment, social justice, unconditional access and non-discrimination. Going beyond issues affecting the most vulnerable people, this report also raises questions about the vision of the society we wish to build. Faced with uncertainty and the new economic, social, environmental, epidemiological, demographic and geopolitical issues of our time, the decision to maintain solid public services that are accessible to all, collectively funded and democratically governed, represents a form of protection and social cohesion. The PASS and PMI mechanisms are practical illustrations of what public investment can produce when it is directed towards the essential needs of the population: preventing rather than enduring, supporting rather than excluding, protecting rather than selecting, with the ultimate aim of social justice and public health.

This report also highlights the importance of synergy between different public and voluntary organisations if we are to meet the reality on the ground. These facilities, whether they be in the public or voluntary sector, have been weakened by far-reaching funding cuts and their consequences. Voluntary organisations have also seen their legitimacy being brought into question around critical advocacy work and a desire to downplay the counter-balancing role exercised by civil society.

Sandrine Simon,
Executive Director of
Médecins du Monde



1 Insee Première: *De 2012-2016 à 2020-2024, l'écart d'espérance de vie entre les personnes modestes et aisées s'est accru*, N°.2085, 15 December 2025.

OVERVIEW OF MÉDECINS DU MONDE PROJECTS IN FRANCE IN 2025

In response to the needs of people living in highly vulnerable situations, Médecins du Monde has built an intervention strategy around three pillars:

- Projects based on unconditional access in fixed centres and through outreach work;
- Advocacy, building on observations, data and testimonies from various projects;
- Partnerships with partners in the public and voluntary healthcare sectors.

In 2025, Médecins du Monde France carried out 42 projects in mainland and overseas France and one cross-cutting programme on Sexual and Reproductive Health and Rights.

19 PROJECTS TO STRENGTHEN THE HEALTHCARE SYSTEM: 12 FIXED CENTRES, 7 OTHER FIXED AND MOBILE PROJECTS

In the wake of multiple political decisions which have weakened the rights and healthcare of people living in France, MdM teams continue to encounter people in increasingly vulnerable situations, far removed from preventive health services and healthcare.

The fixed centres[2] have been in place since 1986 and are not intended to be a substitute for mainstream services. Their aim is to improve access to preventive health, healthcare and rights for the most vulnerable people in France. They offer a dignified service in response to needs, medical consultations and medicines, and social support to help people access health cover and/or preventive health services. In this way, these centres work to integrate people into the healthcare system. Medical, psychological and social support is inclusive and is offered from the perspective of empowerment with a view to building people's independence. Access to these fixed centres is unconditional: either people are dealt with by the multidisciplinary teams or they are referred to another mainstream facility. The treatment offered is holistic (physical, mental and social) and is focussed on the individual's requests. In 2025, there were 12 fixed centres, in Bordeaux, Grenoble, Lyon, Marseille, Montpellier, Nancy, Nice, Paris, Rouen, Saint-Denis, Strasbourg and Toulouse.

Two of the fixed centres (Marseille and Rouen) supplemented their work with outreach activities. In addition to these 12 fixed centres, MdM has established seven other projects aiming to strengthen the healthcare system in three overseas territories (Mayotte, Cayenne, La Reunion) and in mainland France (Strasbourg, Lens-Hénin, Nantes, Haute Vallée de l'Aude).

8 PROJECTS SPECIFICALLY WORKING ON THE ISSUES OF MIGRATION, EXILE, RIGHTS AND HEALTH

An individual's administrative status is a structural determinant of health. In the majority of our projects in mainland and overseas France, teams meet with people who are migrants. Outreach projects enable us to reach the most vulnerable people, those living in squats, camps and on the street. Our teams offer medical consultations, nursing care, preventive health services and social support. They also take into account mental and psychological suffering resulting both from the migration journey and from the indecent living conditions they face in France.

Médecins du Monde also carries out specific projects with migrants on the French-Italian border in Briançon (mobile shelter unit), in Paris (health checks and mental health centre), in Caen (health mediation for young migrants), in Angoulême (health mediation for adults with precarious administrative status and unaccompanied minors), and on the coast of Dunkirk (outreach unit).

In 2025, the activities of the Mental Health and Psychosocial Support Resource Centre, aimed at migrants, were transferred to the Arpade association, a leading medical-social organisation in and around Toulouse.

Because they are unaccompanied, minors are often poor, lost and worn down by their migration journey, not to mention the conditions under which they are welcomed (or not) and in which they have to survive in France. The structural failings of the child protection mechanism have serious consequences on their physical and mental health. This includes a lack of protection, questions around their age and identity, extremely precarious living conditions in squats and camps, expulsions and police harassment, and no access to health cover. A Médecins du Monde project in Nantes for unaccompanied minors who find themselves excluded from child protection measures offers these young people a listening ear, group workshops on health promotion and building psychosocial skills, referrals and support with accessing rights and healthcare from a health mediation perspective. Support with setting up an address and obtaining essential items was transferred to third-party facilities in 2025. In 2026, healthcare activities will also be handed over to another organisation in the region. In Paris, the project targeting unaccompanied minors aims to contribute towards improving and developing the mental and physical healthcare ecosystem. The project is based on a health mediation approach, encouraging a holistic range of services through interventions in fixed centres or through outreach.

9 PROJECTS SPECIFICALLY FOCUSSING ON ENVIRONMENT AND HEALTH ISSUES

As intermediate and structural determinants of health, respectively, housing and working conditions can make people vulnerable and generate or aggravate health problems. This extreme vulnerability is reflected in poor housing conditions linked to the lack of stable and decent accommodation, but also in indecent working conditions, as is the case for workers in the seasonal wine industry and those making deliveries for digital platforms.

Through our mobile teams, Médecins du Monde continues to work in squats and slums, in accommodation and reception day centres, as well as in the streets of Lyon, Toulouse, Paris, Montpellier, Saint Denis, Marseille and Metz.

The projects offer:

- Health monitoring, medical consultations, psychosocial support and health mediation;
- Support with administrative procedures, accessing healthcare rights within the health system;
- Information and awareness-raising workshops allowing people to better understand and take control of their own health;
- Support to medical and social actors to encourage a better understanding of the issues of precarious housing, homelessness, vulnerability and their impacts on health;
- Participation in initiatives encouraging direct access to stable housing for people living in the streets;
- Inter-organisational advocacy to promote appropriate and long-term accommodation and housing, mobile mechanisms to provide medical, psychological and social support, and access to effective care for the most excluded people.

Médecins du Monde also continues its work in Bordeaux and the Médoc region with vulnerable workers involved in making deliveries for digital platforms and seasonal workers in the wine industry. This includes:

- Support with accessing rights and healthcare;
- Health mediation activities through outreach and "bring-back" mechanisms helping people to move closer to healthcare facilities;
- Medical and physical therapy consultations;
- Information and awareness-raising activities on occupational risks and how to prevent them;
- Promotion of good practices encouraging health at work;
- Collective support to help people assert their rights, take greater control over their health, and speak out about their advocacy messages;
- Inter-organisation advocacy to increase visibility around poor working conditions for those in vulnerable situations.

The observational study on digital platform couriers (Sante-course / INED, 2025)[3] in Bordeaux and Paris was led by the Institut de Recherche pour le Développement (IRD). It was conducted in collaboration with courier collectives (AMAL and CIEL), researchers (IRD, INED, CEPED, dial, LEDa) and staff from three organisations (Médecins du Monde, the Maison des Livreurs de Bordeaux, and the Maison des Coursiers de Paris). It evaluated the occupational risks to which digital platform couriers are exposed and strived to understand the effects of these risks on their physical and mental health and wellbeing. Collectives and organisations were able to identify areas for advocacy.

In close collaboration with the relevant ministries and in partnership with several operational partners, MdM is involved in an experimental project in Marseille striving to find an alternative to incarceration through housing and intensive monitoring (Ailsi). Notably, it includes a research angle and offers an alternative to incarceration, prior to detention, for people living in the streets and presenting with several psychiatric disorders. The objective of this project is to combat the "prison-streets-accommodation-hospital" route.

2 The practices and scope of projects referred to as Care and Advice Centres (CASOs) and Reception, Guidance and Support Centres (CAOAs) have changed (see the 2025 Observatory Report). In order to be able to encompass these 12 projects under a single name, whether they be CASOs, CAOAs or had a different name, they are now known as "fixed centres".

3 https://www.ird.fr/une-enquete-scientifique-sur-la-sante-et-les-conditions-de-travail-des-livreurs-de-plateformes-en

1 CROSS-CUTTING PREVENTIVE HEALTH PROGRAMME ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR) AND 1 SPECIFIC PROJECT

A central health issue is the ability to enjoy one's sexuality freely, without danger or violence and without fear of unintended pregnancy or sexually transmitted infections. Médecins du Monde has found that access to reliable information, without judgement, and preventive healthcare and information on living well and understand one's sexuality remains a major challenge in France, particularly for the most vulnerable.

More than half of Médecins du Monde projects in France, grouped together under the cross-cutting SRHR preventive health programme, implement activities aiming to improve effective access to SRHR in mainland France and in overseas territories. The following initiatives are under way in different locations:

- Individual preventive health interviews offering screening and collective workshops on SRHR;
- Access to preventive health materials such as condoms and self-test kits;
- Support for victims and referrals to mainstream services, for example to sexual health centres, test centres, and maternal-and-child health services;
- Involving people in taking control of their own health through health mediation, the use of professional interpreters, and patient-focussed interview techniques;
- Documentation of people's sexual and reproductive health and breakdowns in access to services and rights;
- Advocacy to promote public policy on the subject, including advocacy for abortion to be integrated into the French constitution and for screening and treatment mechanisms to be simplified.

Since 2025, Médecins du Monde has been working to improve access to and guarantee the right to abortion in its programmes. Funding is provided throughout the year to our partner, Planning Familial Pays de la Loire, enabling the organisation to continue its local services. The Montpellier regional office began a study to assess the accessibility of services.

A series of training sessions for workshop facilitators to discuss values aligned with abortion were also rolled out for employees and volunteers, to prepare them to defend the right to abortion when faced with the rise in conservatism and the right to control one's own body.

A specific SRHR project has been in place in Pays de la Loire since 2020. The objective is to improve access to and the quality of SRHR services for people living in unstable, indecent, unsanitary and/or informal conditions, following a community-based approach in the city of Nantes and Angers.

5 HARM REDUCTION PROJECTS LINKED TO DRUG USE AND/OR SEX WORK

Scenes of crack cocaine use continues to be seen across the north-east of Paris, with deal sites across the area being regularly evacuated by police, increasing people's vulnerability by isolating them and driving them away from specialised centres. Acute violence, particularly towards women who use psychoactive drugs has left medical and social services struggling to find appropriate responses. Voluntary organisations are often left to manage extreme health and social emergency situations. The Médecins du Monde project engages in complementary activities to support mainstream medical and social services.

In 2022, MdM set up a programme aiming to reduce the risks of morbidity and mortality among vulnerable people who use drugs in Paris. In 2025, the programme noted that women, who are often not mobile and who may be isolated and experiencing multiple forms of violence, encounter difficulties accessing care, even from specialised services. The teams decided to review the intervention strategy to improve the health response focussed on women who use drugs while advocating for mobile consumption spaces to be made available to them.

In partnership with other organisations, Médecins du Monde adopts a harm reduction perspective to ensure that health policies take into account the specific needs of sex workers. The organisation speaks out against the criminalisation of sex work and calls for greater support to community health organisations which are best placed to respond to need. The Médecins du Monde programmes in Montpellier, Paris and Rouen encourage access to health and rights for sex workers through outreach, reception and support work. Finally, Médecins du Monde leads a national programme to combat the violence which sex workers experience as part of their work, based in Île de France.

Since 2023, the Rosela project in the Hérault department has taken a harm reduction approach to supporting sex workers by focussing on overall health and access to rights. In 2025, the project stepped up its work by combining a front-line presence with digital interventions. Fifty-two in-person outreach missions took place, including one at night, and virtual patrols were also carried out on websites. This strategy allowed us to reach a wide variety of people, often far removed from traditional healthcare services.

The Lotus Bus, created in 2004, is an iconic MdM programme. For over twenty years, it has worked to promote access to healthcare and rights for Chinese sex workers. In 2025, the transfer of the programme was finalised: activities and partnerships were taken over by Roses d'Acier, an organisation committed to improving access to rights and healthcare for Chinese sex workers.

IN 2025, MÉDECINS DU MONDE HAD

42 PROJECTS CONDUCTED WITH 1,365 VOLUNTEERS AND 163 EMPLOYEES AT 23 SITES IN MAINLAND AND OVERSEAS FRANCE.

19 PROJECTS TO STRENGTHEN THE HEALTHCARE SYSTEM, INCLUDING:

8 PROJECTS ON MIGRATION, EXILE, RIGHTS AND HEALTH ISSUES

12 FIXED CENTRES

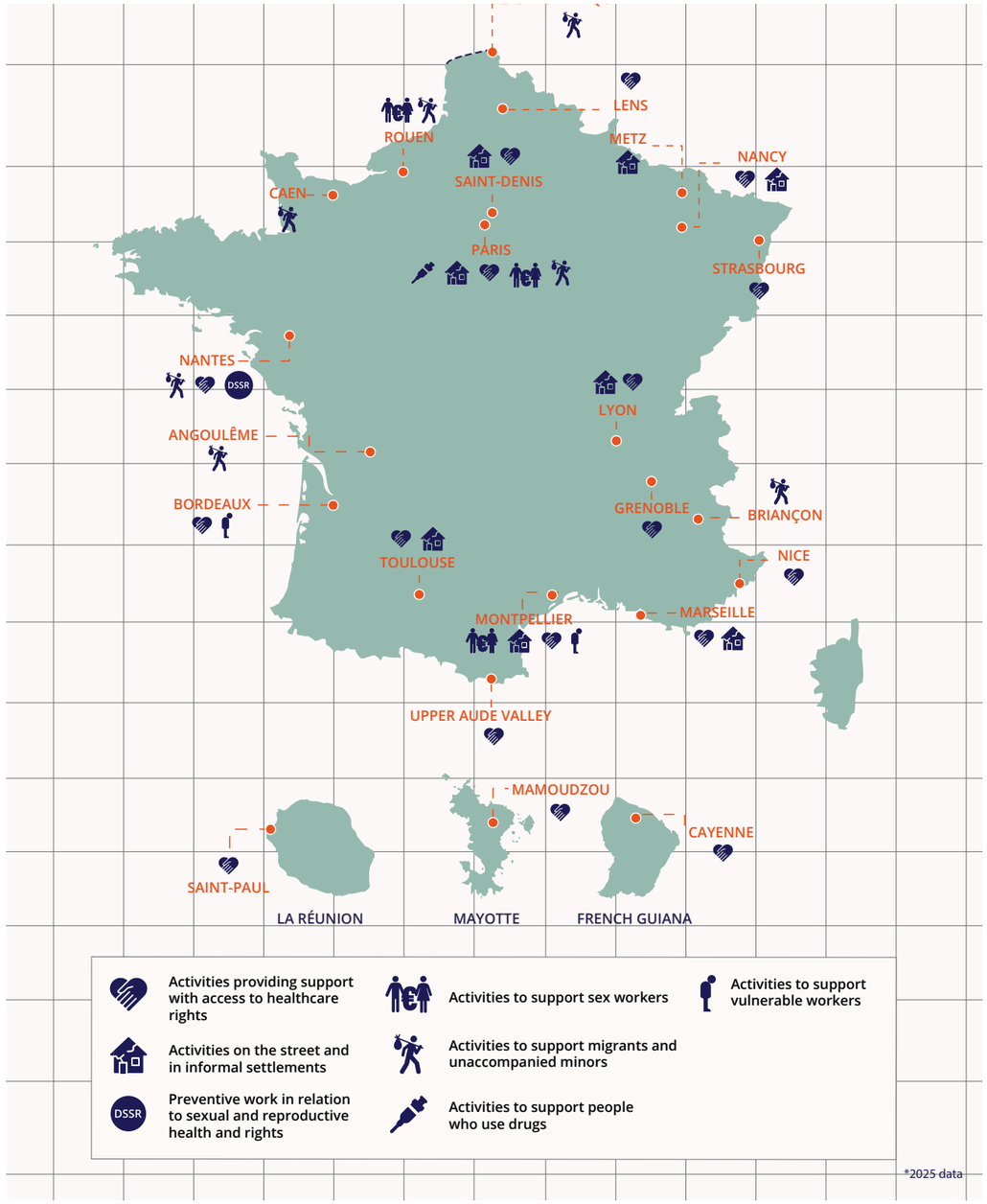
9 PROJECTS ON ENVIRONMENT AND HEALTH ISSUES

7 FIXED AND MOBILE PROJECTS

1 CROSS-CUTTING PROGRAMME ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR) AND ONE SRHR PROJECT

5 HARM REDUCTION PROJECTS LINKED TO DRUG USE AND/OR SEX WORK

MAP OF PROJECTS IN FRANCE IN 2025



Observatory on Access to Healthcare 2026

Public health services: a choice for society

Analysis involving the people concerned, MdM teams and professionals from the PASS and PMI facilities

ACCESS TO HEALTHCARE: GROWING DIFFICULTIES

- Despite access to healthcare being universal in theory, people in vulnerable situations encounter many obstacles including administrative, financial and social barriers in practice.
- The hospital-based PASS and PMI facilities are key to reducing health inequalities but, as with many public services, their capacity to act has been weakened by increasing demand and further constrained by cuts to financial and human resources.

METHODOLOGY

A mixed study (qualitative and quantitative) carried out in 2025-2026

On people who had withdrawn from healthcare:
- **206 people who had withdrawn from healthcare**
- **12 semi-directive interviews**
- **and 770 MdM medical diagnoses analysed**

On the PASS and PMI facilities and their accessibility:
- **38 PASS facilities documented by 17 MdM teams**
- **6 interviews with PASS staff**
- **5 interviews with PMI staff**

Delay in seeking healthcare according to MdM's medical diagnoses:
46% of patients affected
58% of patients with at least one chronic illness

« I only went in the end, when it got out of control »

COST OF CARE AND PRIORITISATION OF NEEDS

The price of care and the fear of costs (37% and 24%) contributed towards people withdrawing from care. Housing, food, safety and other vital needs took priority.
"I'll just have to put up with it"

LIMITED ACCESS TO RIGHTS

People expressed difficulties accessing rights and health cover.
"I gave up [...] it's a nightmare with social security"

ACCESSIBILITY AND INAPPROPRIATE COVER

Healthcare is difficult to access and can be inappropriate for individual needs. Negative experiences of the healthcare system contribute towards withdrawing from care.
"Nobody explained anything to us [...]"

PASS

According to the MdM teams:
- **16% of PASS facilities did not have a complete basic team;**
- **45% of PASS facilities described provide medical consultations by appointment only, with waits of up to 1 to 2 months in a quarter of cases.**

PMI

- **Complex social and health needs;**
- **Lack of sufficient resources, teams now concentrate on the most complex situations.**

"There are only three of us. We need at least one full team to be able to cover all the needs"

RECOMMENDATIONS

ACT ON THE KEY DETERMINANTS OF ACCESS TO HEALTHCARE

- **Simplify access and improve rights and health protection**
- **Guarantee stable and decent accommodation, which is an essential condition for health and for ensuring the continuity of the healthcare pathways**

MAINTAIN AND STRENGTHEN PUBLIC HEALTH SERVICES FOR VULNERABLE PEOPLE

- **Strengthen and re-fund hospital-based PASS facilities**
- **Sustainable re-fund PMIs so that they can fully meet their preventive health missions**

ADAPT THE HEALTH SYSTEM TO THE NEEDS OF THE PEOPLE WHO ARE THE FURTHEST REMOVED FROM HEALTHCARE

- **Develop professional interpreting services**
- **Fight against discrimination in the healthcare pathway**
- **Support front line healthcare, coordination and access to sexual health services**

MÉDECINS DU MONDE

November 2026

SUMMARY

Health disparities do not result from a single factor but from the accumulation and interaction of multiple social, economic, environmental and institutional circumstances. Living conditions, material resources, economic insecurity, experiences of discrimination, the social environment and ineffective access to rights and healthcare profoundly influence people's state of health. For people in vulnerable situations, these difficulties are mutually reinforcing: the lack of stable housing, administrative or financial insecurity, social isolation and obstacles to accessing healthcare damage their physical and mental health over the long-term. This accumulation of disadvantages is a powerful mechanism for producing and aggravating social health inequalities and remains a major public policy challenge.

For more than 25 years, the Médecins du Monde France Observatory on Access to Healthcare has documented the lived realities of people who are the furthest removed from the healthcare system. Its annual report has a three-fold objective:

- To better understand vulnerable situations and difficulties around access to rights and healthcare, which are often invisible in public data;
- To feed into public debate and engage with policy makers, institutions and actors in the health sector;
- To present recommendations based on experience to improve effective access to rights and healthcare.

The 2026 report is structured into two complementary parts.

The **first part** presents the main lessons from the Observatory **barometer**, based on data collected from people who attended the 12 fixed centres in 2025. It analyses their situation with regard to the main determinants of health, whether they be structural or linked to living conditions.

The **second part** of the report, the focus, looks at effective access to healthcare for people who are highly vulnerable, by studying access to two specific public services, hospital-based PASS facilities and PMIs. Chapters 1 and 2 document how highly vulnerable people withdraw from care and note the frequency of chronic illnesses and delays in seeking healthcare. Chapter 3 investigates the ways in which these two mechanisms are accessed and looks both at the conditions of access observed by MdM teams and at the practices and points of view of the professionals working in these facilities. Finally, Chapters 4, 5 and 6 address and discuss the responses and facilitating factors used by the services, as well as recommendations from MdM.

The results are based on seven studies using quantitative and qualitative methods, conducted with different groups and services. They shed light on the situations observed and identify trends but are not intended to be representative of all the populations concerned.

HEALTH BAROMETER

In 2025, **13,556 people were seen in the 12 Médecins du Monde fixed centres in mainland France**. Of those who were attending a centre for the first time, **80.4% came to MdM for health reasons**, either exclusively or combined with social, administrative or legal support needs. Of them, 37.4% were women and the average age was 36. In our centres, which are open to all without condition, the vast majority of people seen are foreign nationals (98.5%). Their situations vary when they first visit: nearly a third have been in France for less than three months, while more than a third have lived in the country for more than two years. Of the foreign adults, nearly two-thirds (65.8%) were in an irregular administrative situation with regards their residence. Of those who originated outside the European Union, one-third had submitted or had tried to submit an application for asylum. For many of them, the procedure had stalled: more than one in five were waiting for an appointment at the prefecture and more than one in ten were caught up in a Dublin III procedure.

The individuals all accumulated multiple factors of vulnerability. Only a quarter of people aged 16 and over were in paid employment in France. **Two-thirds of the individuals considered their living situation to be temporary or unstable.** More than one in five lived on the streets or in emergency accommodation. Of the parents living with their minor children, nearly half of mothers were raising their children alone.

Every year, the Observatory reports that the people seen in the fixed centres encounter persistent difficulties accessing health cover. In 2025, **85.1% of those seen for the first time had no health cover** at the time of the first interview. This is in spite of the fact that nearly two-thirds (64.0%) were eligible for health cover. Of those who were eligible for health cover, **only 20.3% had activated their cover**. Under-use remains particularly marked for State Medical Aid (AME): 89.2% of those eligible for AME had not activated it, compared to 57.9% of those eligible for PUMa.

Preventive health indicators also reveal insufficient access to healthcare. During their first medical consultation (n = 578), **71.5% of people reported never having been tested for HIV**, 71.4% for hepatitis B and 73.4% for hepatitis C. **Of women aged 25 to 65, 79.0% had never been screened for cervical cancer or were not aware if they had been**. Among the **pregnant women** asked about their pregnancies, **one in two had delayed seeking care**.

Their living conditions and obstacles to accessing healthcare have repercussions for the health of these individuals.

In 2025, **11,801 general medical consultations were carried out with 8,155 patients**. The most frequently diagnosed illnesses related to the digestive system (21.2%), osteoarticular system (19.6%), respiratory system (17.2%) and dermatology (12.9%). More than half of patients (59.2%) were diagnosed with at least one chronic illness during the year. The doctors estimated that **38.4% of patients had delayed seeking healthcare** for at least one illness, a situation which was more frequent for individuals without health cover and in those living with a chronic illness.

FOCUS – PUBLIC HEALTH SERVICES: A CHOICE FOR SOCIETY TO COMBAT WITHDRAWAL FROM HEALTHCARE

FIGHTING HEALTH INEQUALITIES THROUGH THE HOSPITAL-BASED HEALTH ACCESS SERVICES (PASS) AND MATERNAL-AND-CHILD HEALTH SERVICES (PMI)

At a time when health inequalities in society are widening and needs are increasing, effective access to healthcare is a major challenge for many people who are in situations of economic, social, administrative and residential vulnerability. Despite the theoretical existence of rights and health services, in practice many people still face obstacles which delay, complicate or prevent them from accessing consultations, exams and treatments and disrupt the continuity of care.

In 2025-2026, Médecins du Monde carried out a study consisting of seven investigations looking at its teams, staff in Hospital-Based Health Access Services (PASS) and Maternal and child health services (PMI) facilities, and people who had withdrawn from healthcare. The results highlighted a concerning two-fold deterioration. On the one hand, delays in accessing care and withdrawal from care are frequent among the most vulnerable people seen by MdM. On the other, public services which contribute towards preventing these disruptions to care, particularly the PASS and PMIs, are themselves becoming increasingly fragile. Faced with rising demand, the erosion of rights, increasingly difficult access and insufficient funding, these services are seeing their capacity to act being gradually reduced. This situation falls within a wider deterioration of certain public services and a growing complexification of administrative procedures. The professionals interviewed described an increasing shift in the burden towards the PASS and PMI facilities, voluntary organisations and front-line services, which are now expected to compensate for difficulties which go far beyond healthcare alone. Recent reports (*Défenseur des droits, 2026b*) have highlighted an increase in the difficulties that people encounter in their relationships with public services, particularly regarding administrative procedures and the rights of foreign nationals.

Historically designed to reduce health inequalities and ensure access to healthcare for those the furthest removed from the system, PASS and PMI facilities now play a more essential role than ever, given the increase in these inequalities. The professionals we interviewed described increasing difficulties with recruitment, insufficient resources and longer waiting times, as well as increasingly complex administrative and social cases. In some areas, these tensions had led to staff prioritising certain cases, delaying certain forms of support or concentrating available resources on the most critical situations.

These changes are not without consequence. They bring into question the collective capacity of public policies to guarantee effective access to healthcare and to combat social health inequalities. Because when the most vulnerable people withdraw from healthcare and the facilities responsible for preventing this withdrawal are themselves weakened, the universality promised by our healthcare system is put to the test.

This report sheds light on the mechanisms which produce delays and result in withdrawal from care, analysing their consequences on the health of the people concerned. It examines the difficulties encountered by professionals in the PASS and PMI facilities in their work but also identifies the levers for action which could strengthen effective access to healthcare and preserve public healthcare services which are accessible, welcoming and non-discriminatory.

WITHDRAWAL FROM HEALTHCARE: A COMMON REALITY IN VULNERABLE SITUATIONS

Withdrawal from care, defined as not consulting a medical professional despite an identified health need, is a major indicator in inequalities in access to healthcare. IRDES identifies two distinct forms (*Desprès et al., 2011*): **obstacle-related withdrawal** linked to financial, administrative or organisational obstacles, and **refusal-related withdrawal**, which is more closely associated with a distrust of healthcare or the healthcare system. The first often comes down to a limited choice, with people having to prioritise their needs according to their available resources (*Poirot-Mazères, 2021*). These two forms of withdrawal are not exclusive but often form a continuum: repeated obstacles can lead to a distrust of the healthcare system, while this distrust can, in turn, increase people's reluctance to seek care (*Desprès et al. 2011*). The discrimination experienced within the healthcare system, linked in particular to social circumstances, gender, actual or perceived origin, and state of health, is another important factor contributing towards a withdrawal from care.

In 2020, 4.4% of the population in France reported that they had withdrawn from an exam or treatment (*Lapinte, 2023*). This phenomenon, which is more common among vulnerable populations and in areas where healthcare is insufficient, results from a combination of social, regional and institutional factors (*Blanco-Cazaux, 2023; Chapin-Guillot et al., 2014; IRDES, 2018*). Homeless people and migrants are some of the most vulnerable groups (*Fabrique territoires santé, 2025; Médecins du Monde, 2022*). The quantitative and qualitative data collected for this report made it possible to analyse both the scale of the withdrawal from care and the complexity of lived experiences, relations with healthcare professionals and facilities, and the adaptation strategies that individual adopt. The study reveals the scale of withdrawal from healthcare among the people that MdM teams encountered: it is not a marginal or occasional phenomenon but arises often for people whose lives are marked by economic vulnerability, administrative difficulties, residential instability and social isolation.

The quantitative study carried out in 2025 with 206 people who were met during MdM activities showed that the withdrawal from healthcare affects a significant proportion of people we support: **41% reported having already withdrawn from healthcare and of them, one in two had done so several times. The main reasons mentioned were the cost of healthcare** (37%) and difficulties in accessing health cover or administrative documents (36%), as well as the fear of having to pay (24%). These results underline the impact of financial and administrative barriers on effective access to healthcare and show that, for many highly vulnerable people, withdrawal is less a choice than a consequence of the obstacles they encounter during their lives and in their healthcare pathways.

Analysis of the digital patient records of nine MdM projects (690 patients) show that **nearly one person in two (46.2%) seen by doctors had experienced a delay in accessing care**. This proportion rises to six people in ten **(58.4%) among those living with a chronic illness**, despite the fact that their healthcare needs were particularly significant. These results suggest that the obstacles to access to care are often long-term and contribute towards further weakening people whose health condition requires regular monitoring.

THE CAUSES AND REASONS FOR WITHDRAWING FROM CARE

Analysis of the qualitative study carried out in 2026[4] shows that the withdrawal from healthcare is rarely an individual choice. Rather, it most often results from an accumulation of financial, administrative, social and institutional constraints which gradually distance people from the healthcare system.

A lack of health protection, i.e. lack of cover for healthcare costs, difficulties in accessing or maintaining cover and the fear of having to pay medical expenses are major determinants. People describe long, complex and sometimes discouraging procedures, which can delay or prevent access to healthcare, including when their state of health requires rapid treatment. As one person summarised: "*I have given up [...] it's a nightmare with social security, the documents they ask for and all that.*"

The interviews also show that **precarious living conditions result in a prioritisation of needs**, when health often falls behind housing, food, safety and taking care of loved ones. The most vulnerable people are constantly required to choose between their health needs and daily essentials, which encourages them to delay healthcare and disrupts their healthcare pathway.

The difficulties encountered do not always result from people's situations. The interviews also showed a gap between the **organisation of healthcare and the lived realities of the most vulnerable people**. Multiple appointments, waiting lists, a lack of interpreting services and complex administrative procedures are all obstacles which can discourage people from accessing healthcare.

A **lack of understanding of the French healthcare system** is another factor in explaining withdrawal from healthcare, particularly for people who have recently arrived in the country.

The accounts also highlight the impact of **lived experiences of healthcare**. A refusal of treatment, lack of listening or experiences seen as discriminatory can weaken people's trust in the healthcare system over time. One woman reported that: "*I was in pain for a year.*"

Finally, withdrawal from healthcare is often reinforced by **a minimisation of symptoms or of their seriousness** in a context where day-to-day concerns take priority over health concerns. Some people report that they would prefer to wait or put up with the pain for as long as possible: "*I'll just have to put up with it*". Others only consult once the situation has become critical: "*I only went towards the end, when it was completely uncontrollable.*"

Ultimately, these results show that delaying and withdrawing from treatment results less from an individual choice than from ongoing structural obstacles. This analysis backs up other studies (*Levesque et al., 2013*) which stress that access to healthcare results from the interaction between individual characteristics and the healthcare system. These results directly question the capacity of public policies to ensure effective access to healthcare and stress the importance of improving access to rights, adapting the organisation of healthcare to the realities of the most vulnerable people, and restoring confidence in healthcare institutions.

PALLIATIVE PRACTICES AND WITHDRAWAL FROM CARE

The interviews reveal that when access to healthcare is delayed, compromised or impossible, people develop different strategies to relieve their pain and symptoms, using resources which are immediately available. These practices demonstrate an ability to take action when faced with their healthcare needs not being covered and may be compared, in a certain way, to the self-care approaches defined by the World Health Organization (*World Health Organization, 2026*), as actions taken by individuals to preserve their health or deal with health problems. However, these practices are less like real alternatives to care than **forced choices to deal with uncovered health needs**.

The most frequently mentioned strategy is **self-medication**. People use medicines obtained from friends and family, other facilities, outreach patrols or directly bought from a pharmacy when they have the resources to do so. The objective is primarily to relieve the pain and continue day-to-day activities. As one person explained: "*I was looking for codeine like a mad person. Everyone has their little emergency kit.*"

Some people also turned to **traditional knowledge and remedies**, particularly to treat fever, pain or certain common symptoms. These practices, inherited from the family environment or the country of origin, represent an accessible resource when healthcare is not available or when relations with health facilities have been disrupted. One person talking about using "little things at home" such as salt, onions and herbal teas after a negative experience in a healthcare facility.

These different strategies illustrate certain responses people use when faced with withdrawal from healthcare but, above all, they reveal the consequences of insufficient access to healthcare. Generally, they enable people to temporarily relieve their symptoms without addressing the root causes of their health problems and may sometimes expose people to new risks. **The results show that these practices should be seen as responses to persistent obstacles to access to healthcare rather than as deliberate choices or substitutions for the healthcare system.**

4 With ten individuals and two health care professionals.

HOSPITAL-BASED "PASS" FACILITIES

Created by the French law to combat exclusion of 1988, the hospital-based PASS facilities are a groundbreaking mechanism to provide access to healthcare for those furthest removed from the healthcare system. Their aim is to ensure access to healthcare in a hospital for people with no resources, without having to pay upfront, to help them access the rights to which they are entitled and to encourage referral to mainstream services. In 2023, there were 451 hospital PASS facilities in France, including some specialised in mental health, dental health and gynaecology (*Rehbinder et al., 2025*).

Designed as a mechanism for reducing health inequalities, the PASS facilities now play a key role in improving access to healthcare for people facing social, administrative or residential vulnerability. They are, however, facing increasing pressure in a context marked by rising needs and the complexification of access to rights.

DIFFICULTIES ACCESSING THE HOSPITAL-BASED PASS FACILITIES AS SEEN BY THE MÉDECINS DU MONDE TEAMS

In response to a questionnaire sent at the end of 2025, the MdM teams reported that they felt the hospital-based PASS facilities with which they were in contact was essential for ensuring access to healthcare for the most vulnerable people. However, they also noted that the PASS facilities were marked by significant operational disparities and faced growing pressure. Of the 38 PASS facilities described by the MdM teams, 16% do not have a full basic team as set out in the national specifications (*DGOS, 2022*) and, according to information reported by the teams, 45% provide medication consultations by appointment only, with waits which can reach up to two months in a quarter of cases.

According to the MdM teams, access to healthcare is also unequal depending on the administrative situation of the individual. More than half of the PASS facilities described apply conditions to access which were observed by the field teams, and people without health cover found it more difficult to access specialised consultations, additional exams or certain treatments. In almost a third of the PASS facilities described, **access was considered to be rare for people who were not eligible for health cover**. The results also highlight **difficulties with referral and the continuity of care**. According to the MdM teams, nearly half of the PASS facilities refer certain people to MdM, often due to complex administrative situations or due to locally-established priorities.

Finally, although the teams largely described facilities which were welcoming and committed, they also reported insufficient access to professional interpreting services, sometimes fragile relationships with other hospital departments and situations of discrimination.[5] For 26% of the PASS facilities described, it was felt that people could experience discriminatory comments or behaviour and discriminatory refusal of treatment[6] was reported in 16% of cases.

As a whole, these reports indicate that, according to the MdM teams who responded to the questionnaire, the PASS facilities remain an essential tool for reducing health inequalities, but they increasingly struggle with limited resources and growing demand, which is likely to limit their ability to guarantee effective access to healthcare for all.

PASS FACILITIES AS SEEN BY PROFESSIONALS: KEY MECHANISMS FACING WITH GROWING CONSTRAINTS

The analysis of the semi-directive interviews carried out in 2026 with staff of six PASS facilities showed that these mechanisms play a key role in access for those furthest removed from the healthcare system, but that they face growing pressure which limits their ability to respond to need. **Despite the strong commitment from the professionals who were interviewed, human, financial and material resources often appear insufficient, given the rising demand and the complexity of situations.** The results highlight a widening gap between the missions entrusted to the PASS facilities and the resources effectively available to them.

The professionals described very diverse organisations which shared a unanimous conclusion: managing waiting lists and prioritising cases has become a significant part of their activity. The challenge is not simply to meet individuals but to be able to refer them "to the right place at the right time" in order to reduce disruptions to their treatment despite often saturated capacities. Several professionals explained that they were forced to reorganise their work around the most critical situations, to prioritise demands or defer certain treatments due to a lack of available solutions. These decisions gradually become a part of their everyday work, even as needs continue to rise. This backs up other analyses (*Gasquet-Blanchard & Moine, 2021*), which describe "work that is being prevented from being done" when the gap between the needs observed and the resources available forces professionals to prioritise certain treatments or to defer certain responses. It also aligns with the work on triage in medicine (*Gelly, 2023; Lachenal et al., 2024*) which looks at the switch from medical reasoning in triage to other forms of reasoning (social, economic) in systems which are increasingly under pressure.

The interviews also stressed the key role of the PASS facilities in the **continuity of care**, particularly after people have attended emergency care. For many people without health cover, access to care depends on the capacity of teams to join up emergency care, hospital consultations, access to rights and referral to mainstream services. Professionals particularly stress the importance of health mediation positions and healthcare coordination to avoid interruptions in treatment.

The interviews show that, beyond care, the teams face a **growing complexification of access to rights. Administrative procedures are described as being increasingly long and difficult, both for the individuals concerned and for the professionals. This contributes directly to the saturation of mechanisms**: people remain longer in the PASS system and often return when their rights are interrupted. As one professional summed up: "*There is huge administrative complexity currently, [with] an extreme loss of rights which didn't exist before.*" Or, as another professional pointed out: "*People come back because they can't manage on their own, it's too complex.*"

The PASS staff also highlighted **inequalities in access to specialised care within the hospital, on the one hand, and dental and mental health on the other**. Budget constraints, the saturation of services and a lack of availability sometimes lead certain exams, treatments or referrals to be deferred. People without health cover are particularly exposed to these difficulties, which can lead to delayed treatment depending on their administrative status or their funding options.

The residential instability that people experience appears to be another major obstacle. The teams questioned also described increasingly complex situations combining a lack of accommodation, forced mobility imposed by the realities of emergency accommodation and the asylum system, life on the streets, repeated interruptions to rights, difficult migration journeys, administrative difficulties and growing mental health needs. This accumulation of vulnerabilities requires longer and more intensive support than before. Administrative and geographic red tape weakens the continuity of care, complicates referrals to mainstream services and prolongs follow-up. The professionals stress that residential stability is often essential to constructing a long-term care pathway. This downward trend is also seen by the teams as the consequence of a wider reduction in available resources, both in the public hospital system and more generally. As one professional summed up: "*Nobody is unaware: there is less money for fewer things.*"

Indeed, the interviews revealed the high pressure under which the teams work, making life difficult for professionals. The lack of resources, recruitment difficulties, the increase in needs and a broader reduction in hospital resources has an impact on working conditions. Despite this pressure, the professionals interviewed express strong commitment to their roles and use various adaptation strategies to maintain access to care.

As a whole, these results show that the hospital-based PASS facilities, although a key to preventing withdrawal from care, are also on the front line when it comes to dealing with the consequences on vulnerable people, the complexification of access to rights and the weakening of certain elements of the healthcare system. In some geographic areas, this situation has gradually led teams to make choices, prioritise and adapt treatment, raising questions as to the capacity of public policies to ensure effective access to care for the most vulnerable people.

PMI FACILITIES: A KEY PUBLIC PREVENTIVE HEALTH TOOL WHICH IS BEING ERODED

PMI facilities were created in 1945 as a free and universal public service aimed at pregnant women, children under the age of six, and their families. Based on a preventive health, multidisciplinary and local approach, they have played a major role in improving maternal and child health across France (*Dutton, 2024; Peyron et al., 2019*).

To this day, PMI facilities play a key role in preventive health, perinatal health, sexual health and support with parenting. However, even as needs increase and several indicators on perinatal health are declining, the mechanism has seen a gradual reduction in its resources (*Deneux-Tharaux & Saucedo, 2024; INSEE, 2025*). Medical resources have also significantly reduced in recent years: between 2010 and 2022, PMI facilities lost some 38% of their doctors and 20% of their psychologists (*Alonso et al., 2025*). Successive reports have also warned of the consequences of reducing the number of centres and dropping certain preventive health activities, and the existence of significant regional inequalities (*Amrous, 2022; Peyron et al., 2019*).

The PMI facilities thus illustrate a major paradox: while they are an essential tool for reducing health inequalities and ensuring early prevention, their capacity to act is gradually being eroded. In a context of rising social and health vulnerabilities, bolstering PMIs would seem to be a major public health issue.

5 Situations seen by the MdM teams as amounting to discrimination as defined by the law (Art. 225-1 to 225- 26 of the French Criminal Code).
6 Similarly, according to the legal definition. See the report from the Defender of Rights on discrimination in health (*Défenseur des Droits, 2025; 2026a*).

PMI FACILITIES AS SEEN BY PROFESSIONALS: AN ESSENTIAL PUBLIC SERVICE UNDER PRESSURE

In interviews carried out by MdM in 2026 with staff of five PMI facilities, they were described as a public service playing a central role in **early prevention, identifying vulnerabilities and long-term support** to women, children and their families. Thanks to their multidisciplinary approach, home visits, collective actions and outreach activities, they often operate as close as possible to where people life and are a key entry point into the health system for people who are facing multiple difficulties.

However, the interviews showed that teams are increasingly having to deal with **administrative and residential vulnerabilities**. Unstable housing, interrupted rights, forced mobility of families or a lack of long-term accommodation make follow-up more difficult and weaken the continuity of care. The professionals stressed that these difficulties also had direct consequences on child development and the possibilities of providing support to families. Everyone interviewed also warned of the scale of **mental health needs**, both for parents and for children, while specialised facilities are often saturated or very difficult to access. Waiting lists for access to medical-psychological centres (CMPs), specialised services or psychological treatment appear to be a major obstacle, particularly for the most vulnerable families.

Finally, the interviews highlight a **growing tension between the universal role of PMI facilities, the increase in extremely vulnerable situations and the lack of available resources**. Recruitment difficulties, in particular difficulties recruiting medical staff, as well as the lack of resources have led some teams to concentrate their work on the most complex situations. As one professional summed up: "*Although we are universal, we practically only see families who can't find help with what they are looking for from the PMI elsewhere.*" Behind this change appears to be a major public health issues: although PMI facilities were designed as a universal mechanism, the lack of resources has gradually forced some teams to concentrate their work on the most vulnerable, even though their role is the provide preventive health services to the entire population, a role to which they are deeply committed: "*We are cutting off an entire segment of the population, but unfortunately we are forced to make choices.*" The lack of resources is regularly mentioned: "*There are only three of us. We need at least one full team to be able to cover all the needs.*"

PMI facilities thus seem to be a major tool in preventive health and reducing health inequalities. But the professionals describe a growing risk of focussing on the most urgent, complex cases due to a lack of sufficient resources, at a time when social and health needs are rising.

FACTORS FACILITATING ACCESS TO HEALTHCARE

The results of all the questionnaires and interviews carried out by MdM as part of this study in 2025-2026 helped us identify several factors which facilitate access to healthcare. Effective access to healthcare not only depends on the existence of healthcare or eligibility. It is also dependent upon the capacity of actors to adapt their practices to people's lived realities, to build a relationship of trust and to ensure support over the long term. One of the main levers identified is the **adaptation of services to the practical constraints facing individuals**. The geographic proximity of facilities, outreach approaches, mobile teams, the possibility of bringing together several approaches or consultations in the same day and the presence of multidisciplinary medical-psychological-social teams facilitates entry into the healthcare system and limits interruptions in the healthcare pathway. The professionals underlined the importance of organising care as close as possible to where people are living and the real capacities of people to travel or come back multiple times.

The results also show that **support**, including physical support **and coordination are as important as the healthcare itself.** Discussions between organisations, PASS and PMI facilities, hospitals and mainstream professionals make it possible to unlock complex situations, reduce waiting lists for care and make pathways more secure. In some places, this cooperation makes it possible to coordinate several interventions on the same day, to avoid delaying care or unnecessary hospital stays.

The role of **health mediation** appeared to be central throughout the interviews. The professionals interviewed described mediators as key in the relationship between people and the healthcare system, particularly for people who accumulate vulnerability, linguistic barriers and administrative difficulties. As one PASS professional said: "Health mediation is now essential for patients who accumulate vulnerabilities." The results confirm the lessons from the HAS guidelines that mediation facilitates access to healthcare, improves mutual understanding and contributes towards preventing a withdrawal from care. They also suggest that this approach would benefit from further development in relation to observed needs. The **relationship of trust** appears to be another key condition of access to care. The people interviewed associate this trust with respect, listening, kindness and recognition of their dignity. Several reports showed that the quality of the human relationship can encourage engagement with healthcare, including in the wake of previous negative experiences: "*I find that the relationship with the patient is very important because they arrive in pain and need someone to care for them.*" "*I don't know, it's the consideration [...] someone who is paying attention to us.*"

Finally, the interviews highlighted that **the continuity of care depends on a collective effort** involving patients, health professionals, social workers, mediators, voluntary organisations and institutions. Faced with situations marked by social, residential and administrative vulnerability, no one person can respond to all needs alone. Voluntary sector support in particular appears to be a major factor in maintaining the healthcare pathway. As one person summarised: "Listen, if you don't help me, I'm lost." As a whole, the results show that combating withdrawal from care is not only about healthcare being available or eligibility for it. It is also based on the **capacity of the healthcare system to offer appropriate support, to develop health mediation, to build relationships of trust and to support cooperation between different actors involved in working with the most vulnerable people.**

CONCLUSION

Withdrawal from healthcare cannot be analysed simply as individual behaviour or situations. It is also the symptom of a growing weakness of the healthcare system and, more broadly, public services as a whole. While the PASS and PMI facilities play a key role in reducing social health inequalities, they are faced with a growing gap between the needs observed and the resources they have. The professionals interviewed described growing pressure to make choices, difficulties in ensuring continuity of care and a risk of focussing on the situations deemed the most pressing. The question this report asks is, therefore, not only that of access to healthcare for the most vulnerable people, but also that of the collective capacity to build structural and professional capacities which adopt non-discriminatory prioritisation practices in systems which are increasingly under pressure, as well as to preserve public health services able to effectively guarantee the universal right to health.

In light of these observations, several priorities appear essential. To ensure effective access to healthcare, it is essential to:

- **Simplify access to rights and strengthen health cover for people in unstable situations;**
- **Guarantee stable and decent accommodation, an essential condition for health and the continuity of the health pathways;**
- **Protect and strengthen the hospital-based PASS facilities, an essential link in the chain of access to healthcare for those who are the furthest removed from the health system, within a stronger public hospital;**
- **Save and provide long-term funding for PMI services so they can meet their universal mission of promoting preventive perinatal health and child health.**

These priorities should be supported by measures to practically improve access to care:

- **Develop professional interpreting services in the healthcare sector;**
- **Actively fight against discrimination in the healthcare pathway;**
- **Adapt sexual health and contraception services to the needs of people who are the furthest removed from the healthcare system;**
- **Support frontline health services and coordination mechanisms, particularly participative coordination structures (SECPAs).**

In addition to health policies, these guidelines call into question the capacity of public policies to guarantee living conditions and access to rights which are compatible with the effective access of the right to health for all.

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