

Trends in perinatal care provision across the regions

2025

2025-012R

Lucie
LIGIER

Aquilino
Morelle

Alexandre
Pascal

Marie-Odile
Saillard

SUMMARY

Members of the General Inspectorate of Social Affairs

Follow us on LinkedIn



SUMMARY

- [1] Forming part of the work programme of the General Inspectorate of Social Affairs (IGAS), the study on 'trends in perinatal care provision across the regions' was carried out by a team comprising Dr Aquilino MORELLE, Alexandre PASCAL, Marie-Odile SAILLARD and, until the end of September 2025, Lucie LIGIER.
- [2] ***Against a backdrop in France over the last fifteen years of a continuous and serious rise in infant mortality*** – a situation of particular concern in several parts of the country – the primary aim of the study, in light of this crisis, was to take stock of perinatal care provision, and to assess its organisation, distribution and evolution over recent decades. It was also asked to identify the conditions for the successful reorganisation of services at local level where such reorganisation proves necessary, by seeking the participation and support of all stakeholders (healthcare professionals, elected representatives, local authorities, service users, government departments, etc.).
- [3] This study was carried out at a time when INSEE had confirmed an infant mortality rate of 4.1 per 1,000¹births in 2024; issues relating to infant mortality and the organisation of our healthcare system around pregnancy and childbirth were therefore very much at the forefront of public debate. For example, these issues were the subject of several parliamentary alerts and the first-reading vote last spring on a draft bill providing, in particular, for a moratorium on the closure of maternity wards², as well as various widely discussed publications.
- [4] The working group focused its study on the period from the ^{third}month of pregnancy to the child's ^{first}month. It is indeed during these seven months that the majority of the key issues arise.
- [5] Whilst not overlooking the other issues raised – equal access for citizens to perinatal care facilities, spatial planning, the aspirations of the various health professions, and financial considerations – it adopted as its guiding principle what it considers to be **the primary imperative: public health**.
- [6] To carry out its work, the task force held hearings with the key stakeholders involved in perinatal care or affected by the issue. It also sought written contributions from the main learned societies and the main organisations representing the healthcare professionals concerned. Finally, it undertook several visits to different regions representative of the diversity of situations ³ or organised specific discussions with their representatives (particularly for the overseas territories).

¹ Throughout the remainder of the report, data expressed as 'per thousand' will be accompanied by the symbol '‰'.

² On 15 May 2025, the National Assembly adopted at first reading a draft bill 'aimed at combating infant mortality', which provides, in particular, for the introduction of a three-year moratorium on the closure of maternity wards.

³ The areas visited were selected, in particular, to ensure that the sample included both urban and rural areas, as well as areas that had faced challenging changes to healthcare provision (closures

[7] It also carried out **a number of specific tasks**: a review, in collaboration with the Directorate for Research, Studies, Evaluation and Statistics (DREES), of the main epidemiological studies available, including international ones; the conduct of an in-depth survey of all Regional Health Agencies (ARS) to establish a precise overview of the perinatal situation in each region and to gather their analysis of the changes in healthcare provision that have taken place locally in recent years; an in-depth statistical analysis, carried out with the assistance of the IGAS's 'data centre', of data relating to healthcare provision and its evolution; and, finally, the production of detailed international comparisons with the support of the Delegation for European and International Affairs (DAEI) and the social affairs advisers (CAS) at the embassies. The results of these various studies are set out in specific annexes to this report.

[8] **The mission first examined trends in the main perinatal health indicators.** It thus found that:

- after reaching its historic low of 3.5 ‰ in 2011, the infant mortality rate (deaths occurring from day 0 to day 364) has since then risen steadily, reaching 4.1 ‰ in 2024, **representing 2,709 children who died before their first birthday (representing one death for every 250 live births)**;
- **this 0.6-point rise in the infant mortality rate is attributable exclusively to the 0.6-point increase in neonatal mortality (occurring from day 0 to day 27)**, whilst post-neonatal mortality (from day 28 to day 364) remained stable over the period in question;
- certain urban departments, as well as some rural ones, are experiencing particularly poor outcomes. *Conversely*, other departments are achieving results comparable to those of the best-performing countries in Europe (the Scandinavian countries, for example, but also those in southern Europe). These disparities thus reflect **serious territorial health inequalities**;
- **given its demographic weight, its population growth and the serious deterioration in its perinatal outcomes, the impact of the Île-de-France region alone on the rise in infant mortality observed since 2011 across the country as a whole is very significant and must be emphasised**;
- the situation in the overseas territories is very serious – from 2004 to 2022, the average infant mortality rate, *all other things being equal*, has remained more than twice as high in the overseas departments and regions (DROM) (8.0 ‰) as in mainland France (3.5 ‰)—and warrants particular attention (in this regard, the mission recommends that decisive action be taken to improve perinatal care and combat infant mortality in the overseas territories – **recommendation 3**). However, according to the mission's calculations, the mission, be held responsible for the rise in infant mortality in France: ***it is indeed in the current trends within mainland France alone that the explanation for the deterioration in perinatal health indicators across the whole of France must be sought***;

maternity wards in particular), territories that have experienced temporary closures of maternity wards, territories that have implemented innovative organisational models, territories facing poor indicators (in terms of infant mortality), and territories at risk of no longer having a maternity ward.

- Compared with similar developed countries, recent trends in infant mortality now set France apart, as it has fallen from 3rd place within the European Union (EU) between 1996 and 2000 to 20th in 2021⁴, then to 23rd from 2022 onwards. **This decline in ranking is due to the upward trend in our neonatal and infant mortality rates from 2011 onwards, whilst the rest of our EU partners have continued on a downward trajectory.** The report thus highlights that, **if France had the EU average infant mortality rate of 3.3 per thousand, the deaths of 529 children in their first year could have been prevented in 2024. And if, again in 2024, France had achieved the same results as Italy or Portugal – an infant mortality rate of 2.5 per thousand – it would have prevented the deaths of 1,057 children before their first birthday. It is thus clear that there is currently a considerable excess of neonatal, and therefore infant, mortality in France;**
 - maternal mortality, measured by the number of mothers who died during the period in question per 100,000 live births, has, for its part, fallen in France from 11.1 to 7.6 for mortality measured at 42 days and from 12.1 to 11.3 for mortality measured at one year. Between 2016 and 2018, 272 maternal deaths were recorded in France, or around 91 per year, which equates to one maternal death every four days. **This places France in line with the average for comparable countries; however, according to Public Health France (SpF), more than half of these deaths are likely or possibly preventable.** This finding necessitates a continuation, and indeed a strengthening, of efforts to reduce this rate (**recommendation 2**).
- [9] Following in the footsteps of others, the task force has identified shortcomings in the current statistical monitoring system for perinatal care, leading it consequently to **support the initiative already underway to establish the National Perinatal Information System (SNIP)**, to which the necessary human and material resources must be allocated on a sustainable basis (**recommendation 1**).
- [10] Whilst the rise in infant mortality is a multifactorial phenomenon, **population-level factors play a predominant role**, particularly in the increased prevalence of prematurity (severe and extreme), which itself accounts for the bulk of neonatal mortality. Among the factors contributing to this situation, the mission highlighted in particular the impact of:
- the rise in the average age of pregnant women (from 29.9 to 30.7 years between 2010 and 2019), as well as the proportion of mothers aged 35 and over (from 19.1 to 25.8 per cent over the same period). It has in fact established that the risk of complications, and in particular of neonatal mortality, increases as the age at which women become pregnant and give birth rises. Thus, over the period 2004–2022, on average, the infant mortality rate was below 4 per thousand for mothers aged 26 to 37, and below 5 per thousand for those aged 22 to 43. By contrast, it is higher than 5 per thousand for mothers aged 44 or over, and even peaks at 11.3 per thousand when the mother is 47 years old;

⁴ INSEE, 'Since 2015, infant mortality in France has been higher than the European average', INSEE Focus 301, 2023

- the increase in the number of multiple pregnancies (the risk of dying before the age of one is five times higher for children born in a multiple birth than for those born in a single birth: 16.7 per thousand compared with 3.3 per thousand). However, between 2010–2014 and 2015–2022, the infant mortality rate for children from multiple births rose significantly from 16.4 per thousand to 18.7 per thousand, an increase of 2.3 percentage points;
- the rise in the prevalence of maternal conditions and complications during pregnancy and in *the postpartum period*: in particular, the proportion of women who were overweight or obese before pregnancy has risen, from 22.8 per cent in 2003 to 31.8 per cent in 2016, representing a sharp increase of 9 percentage points;
- **the impact of social vulnerability and socio-economic difficulties:** neonatal mortality is strongly linked to socio-economic factors, and the risk of neonatal death is significantly higher in the most deprived areas where the poorest women live. These social inequalities account, to a large extent, for regional inequalities in France; moreover, they constitute a preventable factor in neonatal mortality. Thus, from 2004 to 2022, amongst working mothers, the infant mortality rate ranged on average from 2.2 per thousand for managerial staff to 3.5 per thousand for manual workers and 3.6 per thousand for clerical staff. This rate is even higher for women who are not in work or those whose social category is unknown, at 5.1 per thousand;
- partly as **a result** of this pervasive socio-economic and cultural issue, **the higher number of pregnant women of foreign origin has significant implications for infant mortality:** the children of immigrant women are indeed at increased risk of complications, whilst their mothers face a higher risk of maternal death or severe maternal morbidity. However, on the one hand, the proportion of children whose mothers were born outside the EU has risen by 7.4 percentage points, from 16.11 per cent in 2010 to 23.51 per cent in 2024 ⁵ : overall, according to INSEE, this quantitative increase would *have 'raised the infant mortality rate by 0.1 per 1,000'*; and, furthermore, the infant mortality rate rose amongst women born abroad (+0.8 points), from 4.5 per thousand to 5.3 per thousand, whilst that of mothers born in France remained stable at 3.3 per thousand, with the rise in the infant mortality rate among mothers born abroad thus accounting for 100 per cent of the total increase of nearly 0.2 points (0.17 points) recorded between 2010–2014 and 2015–2022. Consequently, the average infant mortality rate stood at 4.6‰ for mothers born in the Maghreb and 7.5‰ for those born in another African country, which is 2.2 times higher than the rate recorded among women born in France. Indeed, these mothers are more likely to face precarious living conditions and experience health problems more frequently; their antenatal care is less regular. Furthermore, they face barriers to accessing primary healthcare and do not benefit from nor optimal care. **The combination of these two factors – quantitative – The increase in the number of mothers born abroad – accounting for 0.08 percentage points – and, in qualitative terms, the rise in the infant mortality rate amongst these women – accounting for 0.17 percentage points – have therefore led to a 0.25 percentage point rise in the infant mortality rate, according to INSEE.**

⁵ *Ibid.*, calculations by the task force.

- [11] The task force's investigations, however, have generally led it to put into perspective the influence of the organisation of maternity services on trends in infant mortality and, in particular, to conclude that ***restructuring of healthcare provision does not appear to have had a significant effect on trends in infant (neonatal) mortality since 2011.***
- [12] Beginning in the mid-1970s (there were 1,747 maternity units in France in 1972), the trend towards the closure of maternity units – driven mainly by economic and budgetary considerations – entered a new phase with the publication of the two decrees of 9 October 1998. The public authorities then sought to regulate this initial trend, this time on the basis of public health concerns: to improve the safety of childbirth and the quality of care for newborns. The introduction of a minimum activity threshold below which maternity units would have to be closed (300 births per year) and a classification system for these units based on their technical facilities and medical expertise (1, 2A, 2B and 3) was explicitly intended to achieve two objectives considered to be linked: to make progress in terms of health safety, in particular through the closure of 'small' maternity units deemed to be 'dangerous'.
- [13] Thus defined and openly pursued, this new policy—which involved increasing the regulatory and structural constraints on healthcare facilities—quickly bore fruit: the number of maternity units performing fewer than 300 births fell from 80 in 1998 to 54 in 2000, then to 15 in 2010, representing a 5.3-fold reduction over twelve years. In this regard, the report emphasises that the planned and deliberate closure of maternity units deemed 'dangerous' – those carrying out fewer than 300 deliveries per year – initiated by the two decrees 'perinatal care' decrees of 9 October 1998, could be regarded as largely completed by 2010.
- [14] At the same time as this massive reduction in the number of maternity units, their intended concentration within levels 2 and 3 was, logically, taking place.
- [15] This extensive restructuring took place largely on an ad hoc basis, without any real national guidelines or evaluation; it has continued to the present day, without any notable impact in terms of neonatal mortality or serious adverse events (SAEs), according to the available studies, although a certain increase in births outside maternity units, following these closures, may be linked to it. Conversely, the paradoxical situations observed in certain particularly well-resourced departments contradict the argument that the concentration of maternity units is essential. Thus, departments that are particularly well-resourced in terms of Level 2 and 3 maternity units, and where a significant or even overwhelming proportion of births take place in these types of facilities, nevertheless record deteriorating or even highly concerning health outcomes.
- [16] The work carried out by the task force in collaboration with the IGAS's 'data centre' supports these empirical findings. Thus, an analysis of trends in neonatal and early neonatal mortality across all French departments – categorised into six sub-groups, each with very different characteristics in terms of the organisation of care provision – reveals that, despite these differences, and regardless of the few annual variations in rates observed, all sub-groups have, since 1990, followed a comparable trend, within the same 'corridor', along the same trajectory, without any particular breaks or inflections, with a

, with no worsening—admittedly—but no reduction either, in the structural health inequalities existing between these sub-groups.

- [17] ***It follows from all this that one cannot argue for the existence of a direct, let alone unambiguous, link between the organisation of maternity services and the observed rise in infant mortality since 2011.***
- [18] More generally, in light of these analyses and the international comparisons—even the brief ones—carried out by the task force, ***it does not appear that a standard model for the regional organisation of maternity services can be put forward:*** by way of example, whilst Sweden has long centralised its maternity services in very large facilities (some handling 8,000 to 9,000 births per year) with an excellent infant mortality rate (2.1 per thousand) in 2023, Italy, on the other hand, with a large number of maternity units (395 in 2023), many of which are small in size, achieves a result that is almost as satisfactory (2.5 per thousand in 2023).
- [19] ***Consequently, to propose in 2026 – almost 30 years after the enactment of the 1998 decrees – as a solution to a serious, multifaceted and multifactorial public health problem, merely raising the minimum activity threshold for maternity units – for example, from 300 to 1,000, as some have suggested – would constitute a mechanical, outdated response, as if superimposed on the current situation, and out of step with the scale of the population-level problem underlying the observed deterioration in health outcomes.***
- [20] On its own, a new wave of restructuring and consolidation of maternity units, triggered by such an increase in the minimum activity threshold, would not resolve the serious difficulties facing our perinatal system in terms of population demographics, the prevention of the main obstetric risk factors, access to such prevention and to care for the poorest women and those furthest removed from the health system, and in improving neonatal care for premature babies.
- [21] According to the review panel, ***the key to reducing the risk of infant mortality lies, firstly, in the early stages – during pregnancy – in the ability to prevent, detect and then manage high-risk situations; and, secondly, in the later stages – after childbirth – in the ability to provide care for young children whose condition requires it in neonatal units.***
- [22] The mission therefore ***examined each stage of the perinatal pathway*** (pregnancy, labour and birth, any neonatal care, and return home) in order to identify the strengths and potential difficulties of the current system and to pinpoint opportunities for improvement, particularly with a view to better preventing the risks of neonatal, infant and maternal mortality.
- [23] ***The mission first addressed the crucial issue of the human resources available to support and care for women, and subsequently their newborns, throughout this perinatal pathway.*** It noted the apparent paradox of increasingly acute pressures on human resources, even as the number of births is falling and the numbers of certain categories of healthcare professionals (midwives, but also paediatricians) have actually risen in recent years. In addition to a ‘societal shift’, characterised by new workplace dynamics (the search for a better work-life balance, the pursuit of greater collegiality), cited by many stakeholders, certain

aspects relating to the training and distribution of healthcare professionals—and sometimes even to collaboration or ‘competition’ between them—must be highlighted in this regard.

- [24] On this issue—which goes far beyond the sole question of perinatal care and concerns our entire health system—the task force recommends, with a view to strengthening maternity units, that, following consultation with the parties involved, the current provision allowing midwives to set up in private practice immediately upon graduation be reconsidered (**recommendation 4**). It also recommends regularly assessing the individual skills of healthcare professionals and the quality of care, as part of a system of periodic certification ⁶ of healthcare professionals for all (**recommendation 5**).

[25] With regard to each stage of the antenatal care pathway, the review panel considers that:

- ***the current organisation of the care pathway for pregnant women*** is punctuated by appointments which enable, provided they are attended, satisfactory monitoring and risk prevention. Numerous schemes have gradually been put in place (local perinatal centres (CPPs), birth centres (MDNs), designated midwives, etc.) to strengthen the support provided to pregnant women. The task force recommends evaluating these (**recommendation 6**) and proposes to further strengthen the organisation proposed during the pregnancy by *improving* the care of pregnant women, in particular through the systematic designation of a designated healthcare professional or a designated maternity unit (**recommendation 7**), as well as by seeking to reach out more effectively to the most vulnerable groups and those who are most distanced – culturally, socially or geographically – from healthcare pathways, for example through ‘outreach’ initiatives, reminders regarding health insurance or targeted communication campaigns (**recommendation 8**);
- ***with regard to childbirth itself***, the organisation of current services must be partially reviewed and a genuine ‘childbirth policy’ must be defined and implemented: the regulations governing maternity units and their operating conditions must be updated; their distribution across the country – which, as has been noted, is often the result of a fait accompli following the widespread wave of closures in recent years – must be guided by stated principles and a clear strategy; furthermore, and above all, women’s choice between a natural birth and a more medicalised birth must, unless medically necessary, be respected, and they must be able to make an informed choice of maternity unit. The working group therefore recommends a review of the 1998 decrees (**recommendation 9**), and the publication, for each maternity unit, of a set of indicators providing all the information necessary, in particular, to inform users’ choices

⁶ Act No. 2019-774 of 24 July 2019 on the organisation and transformation of the healthcare system; Order No. 2021-961 of 19 July 2021 on the periodic certification of certain healthcare professionals
Decree No. 2025-1335 of 26 December 2025 on the procedures for monitoring and the information system for the periodic certification of certain healthcare professionals, published in the Official Journal on 27 December 2025.

but also to enable more precise management of service provision at regional level (**recommendation 10**).

To address geographical remoteness and situations requiring special care arrangements (high-risk situations necessitating proximity to a maternity unit a few days before the expected due date) and to enable exceptional management of certain risks associated with births outside maternity units, the task force proposes, respectively, to raise awareness amongst stakeholders of the possibilities for utilising the ‘maternity commitment’ scheme, which provides, in particular, for accommodation

in the days leading up to the expected date of delivery (**recommendation 11**), as well as to ensure the systematic availability of mobile teams that can be deployed across all regions (**recommendation 12**);

- **neonatal care for children requiring it is a crucial issue.** In this regard, the task force recommends strengthening the neonatal sector, in particular by taking swift action to improve bed availability (with a minimum ratio of one neonatal intensive care bed per 1,000 births) (**recommendation 13**);
- **the moment of discharge home marks the final stage of the care pathway.** Here too, as with the antenatal care stage, the task force considers that the systems and tools already in place are suitable for addressing the challenge, but that their effectiveness should be enhanced (**recommendation 14**) and efforts should be more closely targeted at supporting groups facing social vulnerability or geographical isolation (**recommendation 15**);
- **across all the stages described above,** the task force considers that it is crucial for maternal and child health centres (PMI) to strengthen their work in the area of perinatal care (**recommendation 16**), for information on the perinatal care pathway and its appointments to be better organised, and for women to be made more aware, throughout their journey regarding the steps they should take and certain prevention messages (**recommendation 17**).

[26] **Finally, the task force examined issues relating to the governance and steering of perinatal policy in France.** In this regard, it noted a lack of a clear strategy and of governance bodies sufficiently engaged with this issue, at both national and local levels.

[27] The review emphasises the need to **restore the priority that perinatal policy has lost over the last two decades. It suggests that a ‘2027–2030 strategic plan for perinatal care’ be implemented to reflect this renewed national ambition**, along with effective monitoring of the plan (**recommendation 18**). Throughout the report, it proposes a set of concrete measures aimed at underpinning and structuring this plan at every stage of the perinatal journey for women and then for young children.

[28] In terms of local governance, the task force recommends that the issue of perinatal care and its organisation should, from 2026 onwards and then at regular intervals thereafter, **within the framework of existing regional health democracy bodies (CTS, CRSA), and for each region, at the level deemed appropriate (‘perinatal catchment area’ if necessary), a detailed assessment involving all stakeholders, along with the resulting concrete and tailored actions. These must be developed without preconceptions, in a pragmatic manner, on a case-by-case basis, with the sole**

objective: public health (recommendations 19 and 20). In particular, the closure of a maternity unit must be decided whenever this is necessary from a public health safety perspective; conversely, the continued operation of another maternity unit must be supported if this requirement is met, and where the local situation permits, or even demands, it.

- [29] Despite the commitment of stakeholders, the existence of dedicated schemes and the efforts made at local level, there remains insufficient coordination between those supporting women and their young children throughout their perinatal journey and the practical monitoring schemes and tools. The review therefore recommends improving and simplifying the operational coordination mechanisms between perinatal care providers, in particular by standardising and sharing professional communication materials to prevent gaps in care and streamline care pathways and the transfer of information between stakeholders (**recommendation 22**). It considers it is also useful to carry out an evaluation of the specific regional perinatal care schemes (DSRP) (formerly the 'perinatal networks') (**recommendation 21**), which play a significant role in coordinating local stakeholders.
- [30] Finally, the task force noted that, all too often, when changes to service provision needed to be implemented at local level, these were insufficiently planned for, projects were not sufficiently coordinated, and stakeholders were not sufficiently involved, thereby increasing the risk of tension and making it more difficult for all stakeholders to buy into the new organisational structures, which were then perceived as having been imposed. The review therefore recommends, once again, that, in addition to clear guidelines set out in the future national 'strategic plan', tools appropriate measures can be devised to better support local stakeholders in these transformations when they have to carry them out (**recommendation 23**) and that, in terms of procedure, the preparation, actual implementation and subsequent monitoring of operations to reorganise the enable all stakeholders to be involved, with a constant focus on dialogue and transparency (**recommendation 24**).