WHITE PAPER 2026

Patient transport in France and nine European countries

Independent research synthesis based on public sources. National rules change; verify current legislation and eligibility conditions before operational decisions.

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Executive summary

Patient transport is a quiet but essential part of access to healthcare. It connects homes, hospitals, dialysis units, oncology departments and rehabilitation facilities. Its performance cannot be measured by journey volume or cost per kilometre alone: it also depends on continuity of treatment, patient safety and the ability to assign the right vehicle at the right time.

In France, public data for 2024 describe a large and diverse reimbursed market. The French National Health Insurance Fund reported 6.5 million patients transported and €6.74 billion in reimbursable expenditure in 2024: €3.67 billion for healthcare transport operators and €3.07 billion for contracted taxis. Statistical scopes differ across publications: some include or exclude contracts, allowances, inter-facility transfers or patient travel reimbursements. Figures should not be added or compared without checking their definitions.

The clearest structural trend is the growing share of contracted taxis in journey expenditure, alongside cost-containment policies, shared transport and tighter billing controls. The 2025–2027 period is a major transition phase, with new contractual frameworks, electronic billing, certified geolocation and stronger controls.

The nine countries reviewed do not form a single European market. Some fund specialist transport when medical or mobility criteria are met; others reimburse travel under restricted conditions, prior authorisation or patient contributions. In several countries, regional authorities, insurers or public purchasers play a central role.

Method note: figures and eligibility criteria reflect the cited sources; they are not universal tariffs or an automatic individual entitlement.

Methodology, scope and limitations

This paper is an independent documentary synthesis based on public primary or institutional sources consulted on 24 November 2026. French material draws on DREES, the National Health Insurance Fund, the Cour des comptes, legislation published in the Official Journal and relevant public authorities. Country profiles rely on national or regional public bodies.

The countries covered are France, Germany, England, the Netherlands, Belgium, Spain, Italy, Norway, Finland and Sweden. England is treated separately from the United Kingdom because NHS rules and health responsibilities differ across the UK.

Indicators are not harmonised. Expenditure may include or exclude inter-facility transfers, emergency transport, allowances, reimbursed patient travel or non-medical transport services. Vehicle counts may refer to fleets, authorised vehicles, companies, licences or operators. Robust cross-country numerical comparison requires common definitions that are not available in every source reviewed.

Important limitation: the project brief refers to a 41-page document and data closed on 12 November 2026. This edition is a new text based on the information and sources available for this assignment; it does not claim to reproduce a pre-existing RoullePro publication or independently validate every figure in the supplied summary.

France: system architecture

The French system includes several transport categories: ambulances for patients who need to travel lying down or require appropriate assistance; light medical vehicles (VSL) for seated medical transport; contracted taxis for seated journeys performed by taxi operators who have signed an agreement with National Health Insurance; and, where reimbursement conditions are met, certain journeys by private car or public transport.

The transport mode is prescribed by a medical professional based on the patient’s condition, autonomy and the applicable rules. An ordinary non-contracted taxi or a private-hire vehicle does not become reimbursable simply because a prescription exists. This distinction matters to patients and booking platforms.

Contracted taxis and medical transport operators are governed by different professional and pricing frameworks. Contracted taxis remain taxi businesses with a Health Insurance agreement; VSL and ambulance services are provided by authorised medical transport companies. A booking platform cannot erase these regulatory distinctions.

France: expenditure and activity

The National Health Insurance Fund’s 24 September 2025 announcement reports that 6.5 million patients received reimbursed transport in 2024, for €6.74 billion in reimbursable expenditure: €3.67 billion for medical transport operators and €3.07 billion for contracted taxis. It also reports nearly 15,000 contracted ambulances and more than 14,000 VSL vehicles.

DREES reports that, in 2024, contracted taxis accounted for 49% of journey expenditure, ambulances 31%, VSL 16% and other modes around 4%. These shares refer to journey expenditure, not every aggregate expenditure category in all statistical scopes.

The Cour des comptes and social security policy evaluations highlight spending growth, the role of hospital prescribing and the difficulty of steering expenditure when the prescriber does not directly bear the cost. The policy debate therefore concerns the balance between access to care, appropriate prescribing, available capacity and financial sustainability.

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France: 2025–2027 reforms

The September 2025 agreement with medical transport operators aims to generate savings by 2027. Its levers include more appropriate use of ambulances, wider shared transport, improved booking organisation and stronger billing controls. The regulatory text of 29 September 2025 places these measures within a 2025–2027 expenditure-control objective.

The national taxi framework approved in May 2025 provides for a transition to the integrated electronic billing system (SEFi) and certified vehicle geolocation. The contractual timetable provides for implementation no later than 1 January 2027. The Cour des comptes notes that technical implementation and compliance with deadlines are significant operational challenges.

According to the transport ministry, the law on combating social and tax fraud was promulgated on 25 June 2026 and strengthens several tools against irregular practices in the taxi and private-hire sectors. Practical implementation may depend on secondary legislation where required.

France: empty mileage, shared journeys and capacity

Empty mileage is an economic and environmental issue, but public sources do not always provide a consistent national measure from which a single rate can be inferred. Empty return journeys may result from the geography of care, appointment times, imbalances between pick-up and drop-off areas, or vehicle scheduling constraints.

Shared transport aims to group patients whose journeys are compatible without compromising safety or care. It requires medical compatibility rules, robust planning, clear patient information and reliable arrival-time management. A high sharing rate is not automatically efficient if detours, waiting times or delays become excessive.

A useful platform must therefore optimise subject to constraints: prescription, vehicle type, accessibility, treatment schedules, consent and billing rules. Merely clustering geographic points is not enough.

France: billing, fraud and oversight

The Cour des comptes highlights weaknesses in billing processes and the need to improve the reliability of submitted data. It notes persistent challenges in rolling out SEFi and linking billing with geolocation. Traceability can improve checks on mileage, times and pick-up/drop-off locations, but it must remain proportionate and secure.

Fraud risk should not be confused with a general presumption against professionals. Controls should distinguish administrative errors, non-compliance, improper billing and intentional fraud. Due process, understandable rules and prompt correction of mistakes are essential to trust.

Geolocation data associated with healthcare journeys are sensitive by context. Platforms and operators should define purposes, access rights, retention periods, security safeguards and data-processing responsibilities under the applicable framework.

European comparison: cross-cutting patterns

The countries reviewed can be grouped into three broad approaches. First, specialist transport funded or organised by the public system when medical or mobility criteria are met, as in England’s NHS. Second, reimbursement through health insurance, often subject to prescription, prior authorisation or patient contribution, as in Germany, the Netherlands and Finland. Third, regional or territorial schemes whose conditions depend on residence, as in Belgium and Sweden.

The main differences are not simply the vehicles available. They concern who assesses eligibility, who books the journey, who pays the operator, how much the patient contributes and what data are required to justify reimbursement.

Non-emergency transport is not universally free. In several countries, ordinary travel remains the patient’s responsibility, while recurring treatment, disability, functional limitations or specific medical needs may qualify for organised transport or reimbursement.

Country profiles: Germany, England, the Netherlands

Germany. The federal health portal gesund.bund.de distinguishes journeys without specialist medical assistance (Krankenfahrten), patient transport with medical assistance (Krankentransporte) and emergency transport. Coverage is tightly defined. Outpatient journeys are generally exceptional and may require a prescription and prior approval. Taxis and hire vehicles may be used when the conditions are met.

England. The NHS funds Non-Emergency Patient Transport Services (NEPTS) when a patient’s medical condition, mobility, cognitive or sensory needs, safety or care pathway justify transport. NHS England reports more than 11 million journeys a year in its service review. Services are commissioned locally by Integrated Care Boards, and most patients are expected to arrange their own travel.

The Netherlands. Patient travel may be by ambulance, car, taxi or public transport. Reimbursement for seated transport is limited to defined categories, including dialysis, oncology treatment, wheelchair use or circumstances covered by the hardship clause. Insurers may specify approved providers and booking routes. A statutory contribution and deductible may apply.

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Country profiles: Belgium, Spain, Italy

Belgium. Non-emergency transport operates in a landscape where responsibilities and benefits can vary by region and mutual health fund. In Wallonia, AVIQ describes non-emergency medical transport by ambulance as a regional competence, distinct from federal emergency medical assistance. Mutual funds may provide additional benefits, approved provider networks and direct-billing arrangements; amounts and eligibility are not uniform nationwide.

Spain. The common portfolio of the Sistema Nacional de Salud distinguishes publicly funded emergency transport from non-emergency medical transport, which is subject to medical prescription for clinical reasons and user contributions under the applicable rules. Autonomous communities organise delivery within the common framework and may provide complementary arrangements.

Italy. Non-emergency transport is highly territorial. The Ministry of Health describes 116117 as an access point for non-urgent care and local health services, with implementation and associated services varying by region. Scheduled transport, transfers and emergency services must not be conflated; organisation and funding depend on regional arrangements and the medical indication.

Country profiles: Norway, Finland, Sweden

Norway. Pasientreiser generally reimburses travel to publicly funded treatment at a standard per-kilometre rate, regardless of transport mode, subject to distance and zone conditions. Where public transport is unsuitable for health or transport reasons, adapted transport may be arranged. Taxis are generally requisitioned by the healthcare provider or local patient-travel office when medically necessary.

Finland. Kela reimburses certain medical journeys when a taxi is needed for health reasons or because public transport is unavailable. Patients must book through a regional dispatch centre linked to Kela; taxis booked outside that route are generally not reimbursed. A per-journey copayment and annual out-of-pocket ceiling apply.

Sweden. Sjukresor are administered regionally. Patients may apply for reimbursement for journeys related to illness or childbirth, but a patient contribution is generally payable. Eligible modes, amounts and conditions vary between regions. Private car, bus and train journeys may be reimbursed under local rules.

EU law: platform work

Directive (EU) 2024/2831 of 23 October 2024 aims to improve working conditions in platform work. Member States must transpose it by 2 December 2026. It addresses, among other matters, correct employment-status determination and algorithmic management.

The directive does not itself create a European entitlement to medical transport, set medical eligibility criteria or replace national reimbursement rules. Its relevance lies in platform business models that organise or control drivers’ work, particularly where a platform determines prices, access to jobs, ratings or sanctions.

Data protection, patient safety, public procurement, competition law and professional regulation also remain relevant. A booking application is not automatically a regulated medical transport operator.

Digital platforms and the risk of platformisation

Platforms can reduce coordination costs through centralised requests, availability visibility, journey tracking, communication with healthcare facilities, delay management and document transmission. They can also improve traceability and service quality when integrated with operators' and payers' systems.

The risk of platformisation arises when a platform moves beyond coordination and exercises economic or operational control over professionals without clearly assuming the corresponding responsibilities. Warning signs include unilateral price setting, intermediary dependency, opaque ratings, automated penalties, discriminatory access to jobs and shifting cancellation risk to drivers.

Uber Health publicly describes a ride-coordination service for healthcare organisations and lists availability in several countries, including Germany, the UK and the Netherlands, while its French page states that the service is not yet available in France. Commercial availability does not mean the service provides regulated medical transport in every market: ordinary rides, accessible transport and medically governed transport must be distinguished.

In France, an independent platform should be designed as a coordination tool that respects operators' legal status, rather than as a substitute for authorisations, agreements, prescriptions or billing obligations.

Method note: figures and eligibility criteria reflect the cited sources; they are not universal tariffs or an automatic individual entitlement.

Lessons for an independent platform

An independent booking platform can create value if it follows five principles. First, it must correctly qualify the need: seated travel, VSL, ambulance, wheelchair access, escort or other constraints. Second, allocation must be limited to operators authorised for the requested service. Third, prescription and billing data must be separated from commercial data and protected.

Fourth, the platform should maintain an audit trail: timestamps, acceptance, cancellation, reason, allocation, pick-up, completion and journey closure. Fifth, its relationship with operators must be transparent: commissions, priority rules, payment terms, responsibilities, complaints handling and ownership of the customer relationship.

The most resilient model is not necessarily the one that controls supply most tightly. It may be a neutral infrastructure that improves matching, data quality, availability visibility and coordination while leaving operational and regulatory responsibility with the professionals.

2025–2027 roadmap and recommendations

2025: new national contractual framework for taxis and an expenditure-control agreement with medical transport operators; progressive implementation of shared transport, certification and traceability requirements.

2026: stronger social and tax fraud controls; preparation for transposition of the EU Platform Work Directive, due by 2 December 2026.

2027: French contractual deadline for wider SEFi use and certified geolocation for contracted taxis; increased focus on billing reliability and oversight.

For public authorities: publish harmonised indicators, distinguish journey expenditure from total expenditure, document patient contributions, measure delays and cancellations, and assess shared transport by its impact on patients as well as savings.

For healthcare providers: improve prescription quality, anticipate discharges, share only necessary information and include mobility constraints in care pathways.

For operators: prepare for digital deadlines, document journeys, secure data and participate in coordination schemes without surrendering professional autonomy.

For platforms: make compliance a core product function, not a check added after launch.

Conclusion

Patient transport is an essential service at the intersection of healthcare, mobility and social protection. France is entering a more digital and demanding regulatory phase, while European countries illustrate very different institutional choices: eligibility-based funding, regional organisation, fixed-rate reimbursement or local commissioning.

The challenge is not simply to move more people at lower cost. It is to preserve continuity of care, make expenditure auditable, protect patients and maintain sustainable working conditions for professionals. Technology can help when it strengthens transparency and coordination without blurring accountability.

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