# Evolution of inequalities in health care use in France

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# Context

- Access to health care constitutes a basic right according to the Charter of Fundamental Rights of the European Union
- France, as all European countries, is concerned with ensuring their populations have equitable access to high quality health services
- The principle of horizontal equity requires that people in equal need of care are treated equally irrespective of their income or their social position
- However numerous studies have shown the existence of differences in health care utilisation among socioeconomic groups for a same level of needs

*Couffinhal et al, 2004; van Doorslaer and Koolman, 2004; van Doorslaer et al. 2006; Huber, 2008 ; Or et al., 2009 ; Or et al., 2009 ; Bago d'Uva and Jones, 2009 ; Jusot et al., 2012 ; Devaux and de Looper, 2012*

# Objectives

During the last decades, several policy programs have been implemented in France in order to protect vulnerable populations by ensuring health services are delivered according to need and not ability to pay

Therefore :

- Is the principle of horizontal equity in access to medical care respected in France today ?
- What are the potential causes of inequalities in health care utilisation ?
- What has been the evolution of inequalities in health care utilisation in France since 1998 ?

# Measuring inequities in health care use

Three common approaches to measuring social inequalities in health care utilisation :

1. Odds ratios for measuring the association between socioeconomic status and the probability of health care use, after adjustment for needs of care (age, sex, health status)

   Horizontal equity in health care use is achieved when the odds ratios associated to all socioeconomic categories are equal to 1

2. Horizontal inequity index which indicates the intensity of the concentration of health care use among the rich (index > 0) or the poor (index < 0), after adjustment for needs of care

   Horizontal equity in health care use is achieved when the index is equal to 0

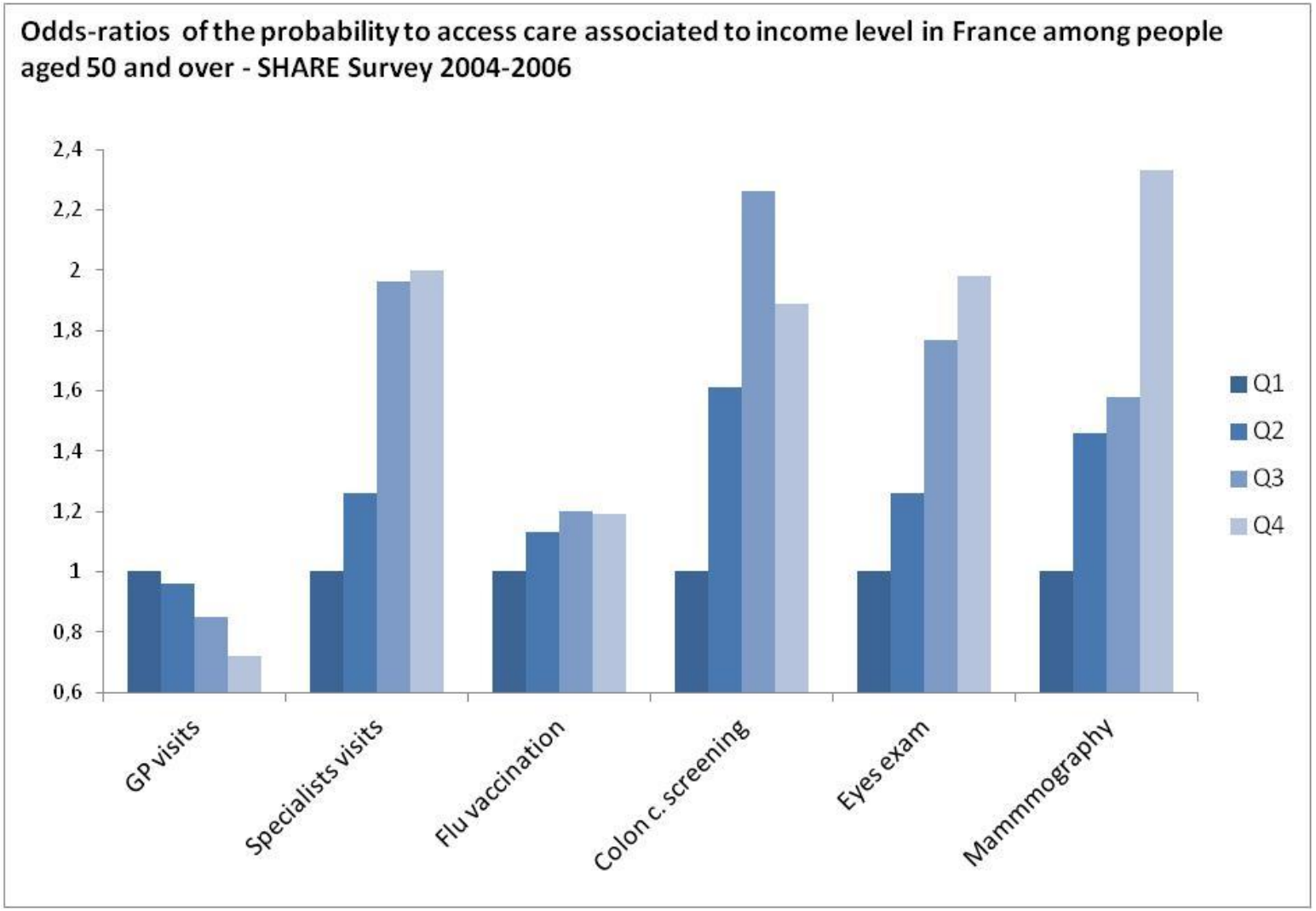
3. The report of forgone of care for financial reasons during the last 12 months allows assessing directly difficulties to access care related to socioeconomic status

# Inequalities in health care use in France in 2004

- Little evidence of inequitable distribution of GP services

- But strong evidence of pro-rich inequity in access to:
  - Specialist services
  - Preventive services, in particular for preventive services provided by specialists

# Income related inequalities in health care use in France in 2004 – Share data




Source : Or, Jusot, Marcoux, Yilmaz (2010)

# Causes of social differences in health care use: differences in health care demand

Factors influencing health care demand:

- Cultural and informational barriers (lack of knowledge of care pathways)

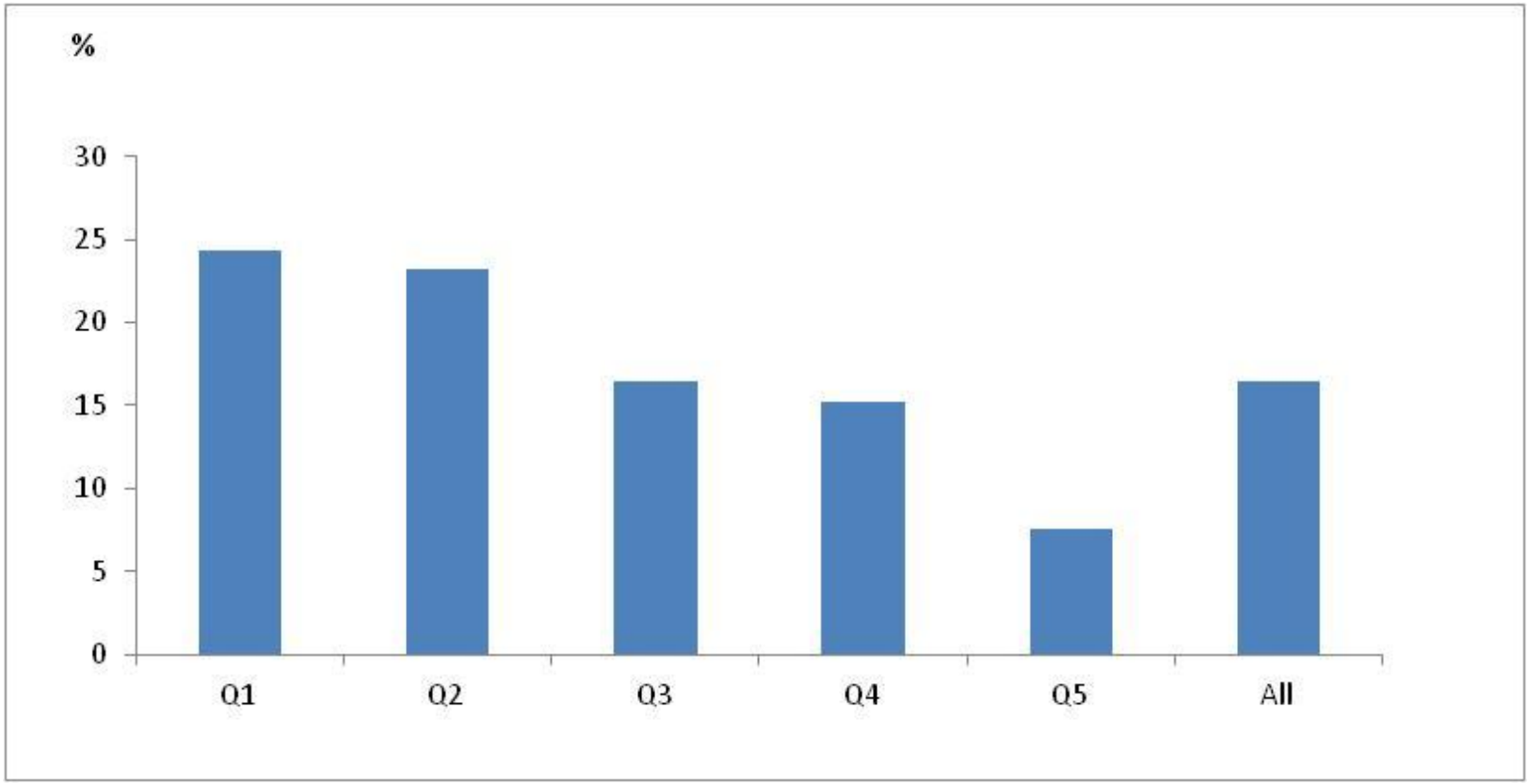
*Alberts et al., 1997, 1998 ; Couffinhal and al, 2005*

- Budget constraint :
  - income level
  - direct cost of care and in particular, possession (or not) of complementary health insurance

*Bongers et al., 1997 ; van Doorsler et al., 2000*

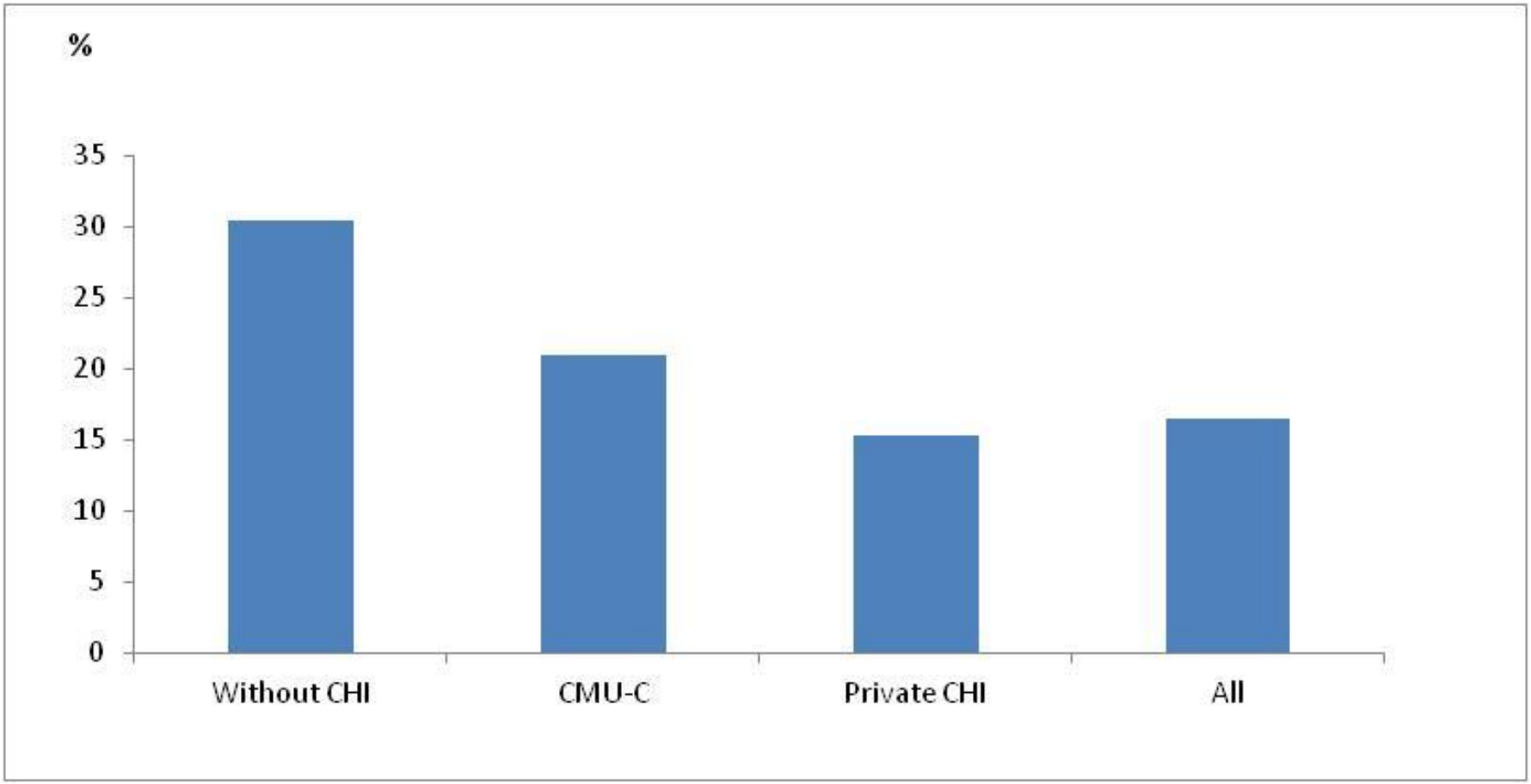
*van Doorslaer & Masseria, 2004 ; Dourgnon et al., 2012*

# Forgone care and income
# 2008 ESPS Survey




Source: Boisguérin, Després, Dourgnon, Fantin, Legal (2010), Etudier l'accès aux soins des assurés CMU-C, une approche par le renoncement aux soins, In Santé, soins et protection sociale en 2008. Paris : IRDES, 2010/06, 31-40.

# Forgone care and complementary health insurance 2008 ESPS survey




Source: Boisguérin, Després, Dourgnon, Fantin, Legal (2010), Etudier l'accès aux soins des assurés CMU-C, une approche par le renoncement aux soins, In Santé, soins et protection sociale en 2008. Paris : IRDES, 2010/06, 31-40.

# Health insurance in France

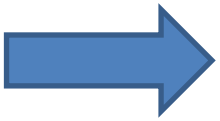
- 75,5% of overall health expenditures are covered by French public health insurance and 90% of in-patient care
- People suffering from chronic diseases benefit from a full coverage of treatments related to their disease (Affections de longue durée)

- The out-of-pocket can be covered by a complementary health insurance, which can be provided by employers (40%) or can be voluntary purchased by patients (60%)

# Evolution of health insurance in France

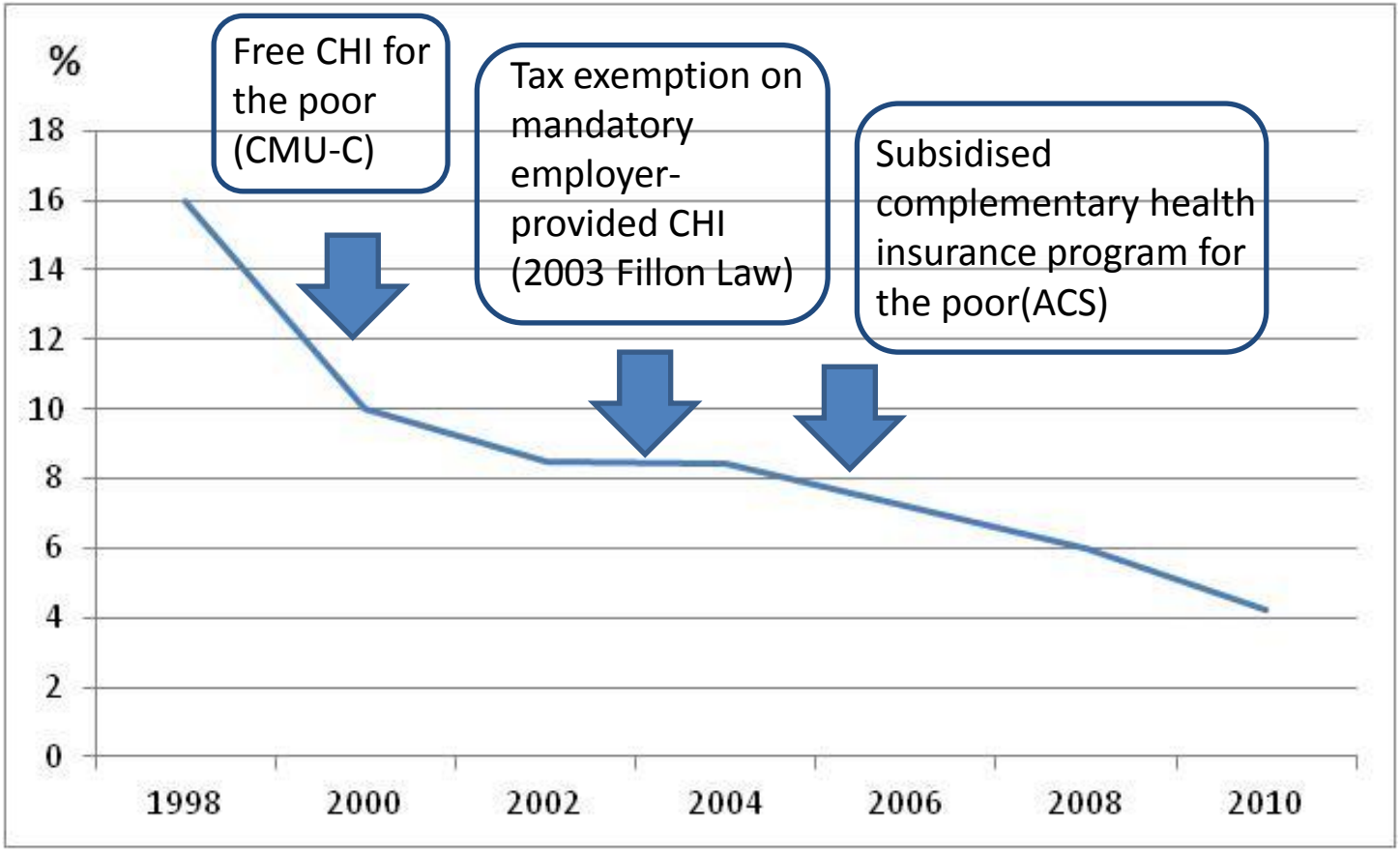
In order to promote complementary health insurance and to reduce financial barriers to access to complementary health insurance among the poorest :

- A free complementary health insurance has been implemented in 2000 (the Couverture Maladie Universelle complémentaire – so called CMUC), which concerns 7% of the poorest French population
- A Tax exemption on mandatory employer-provided CHI has been introduced in 2003 ( Fillon Law)
- A subsidised complementary health insurance program has been has been implemented in 2005 (the Aide complémentaire santé)



The proportion of individuals without complementary health insurance has strongly decreased

# Proportion of the population without complementary health insurance (CHI)




Source: ESPS surveys

# Causes of social differences in health care use: Health system organisation

Several studies have shown that:

- Social inequalities in health care use are higher in countries where out-of-pocket payments are higher or the level of public health resources are small
- Social inequalities in specialist use are less important in countries where there is a referral system for specialist use (Gatekeeping)
- Social inequalities in specialist use are lower in countries with National Health Systems financed by general taxation than in countries with social insurance based systems

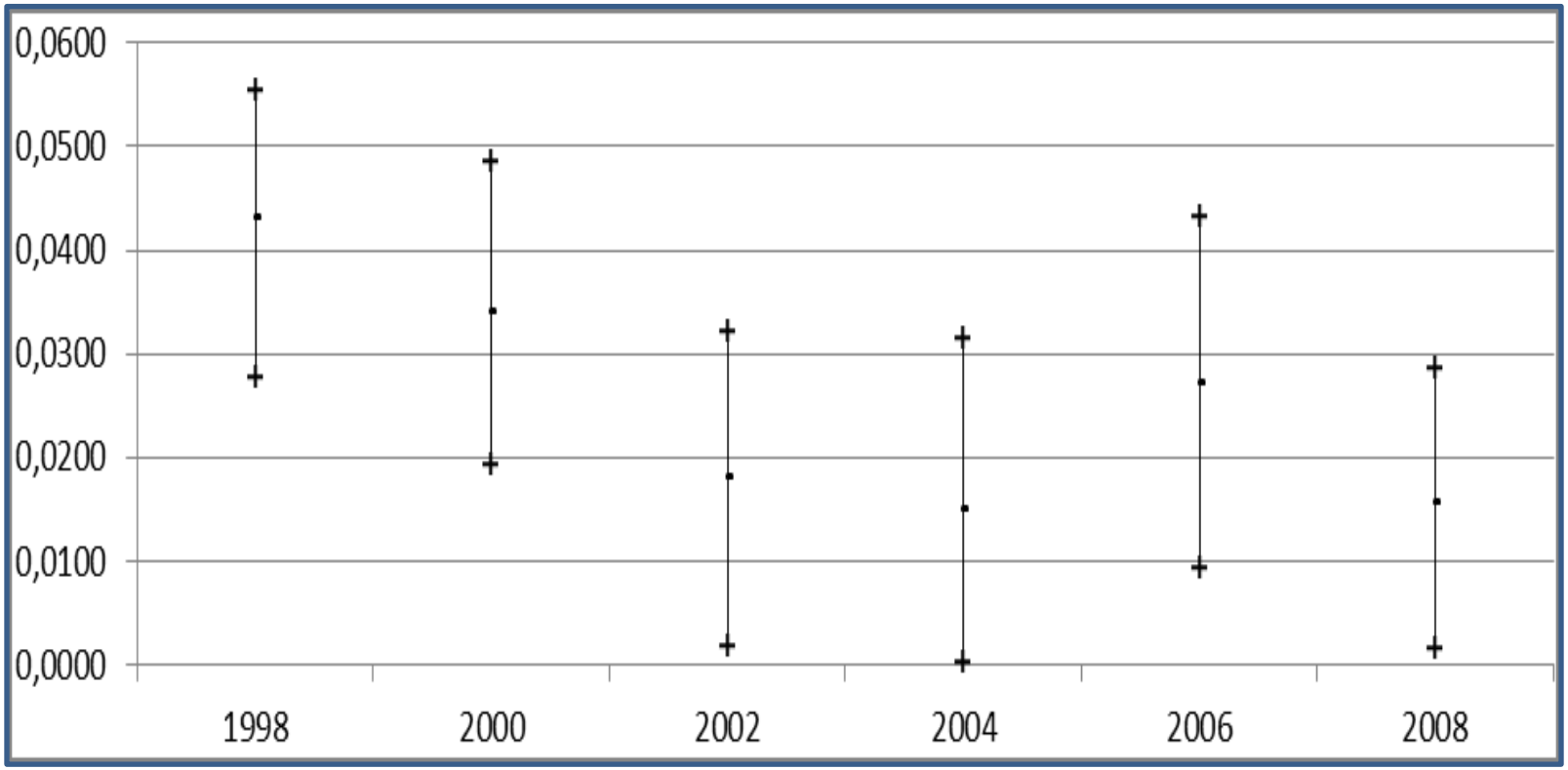
*Or, Jusot, Yilmaz, 2008 ; Bago d'Uva and Jones, 2009 ; Jusot et al., 2012*

# Inequalities in health care utilisation during the last decade

- Given the diffusion of complementary insurance, in particular among the poorest with the CMU-C implementation
- Given the introduction of light gatekeeping in 2005 (preferred doctor scheme)

- We could expect a reduction of inequalities in health care use during the last decade

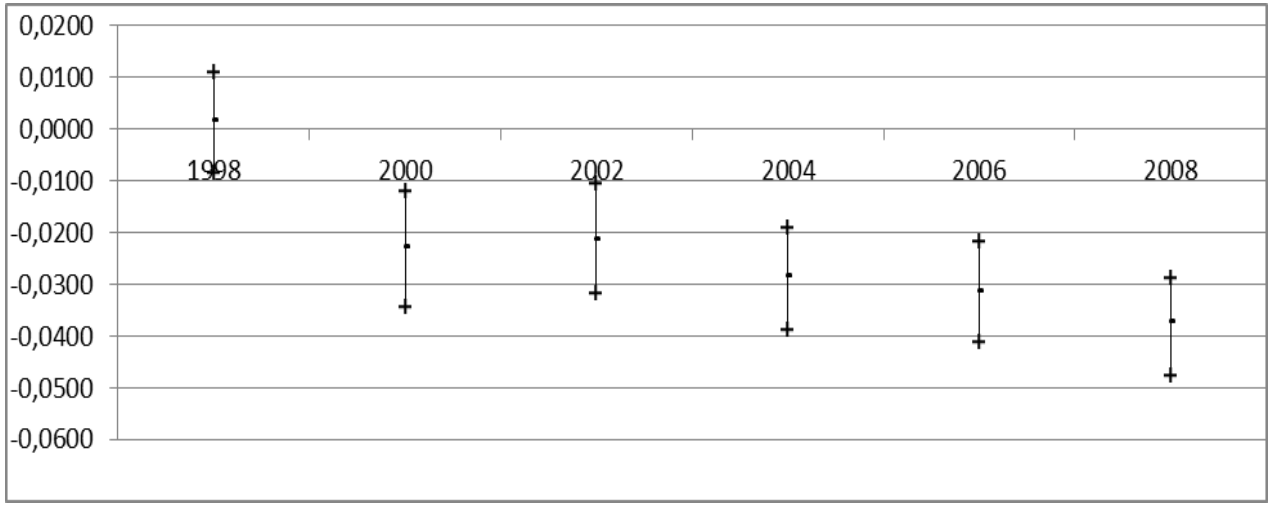
# Evolution of inequalities in ambulatory health care expenditure – ESPS survey and National Health Fund data



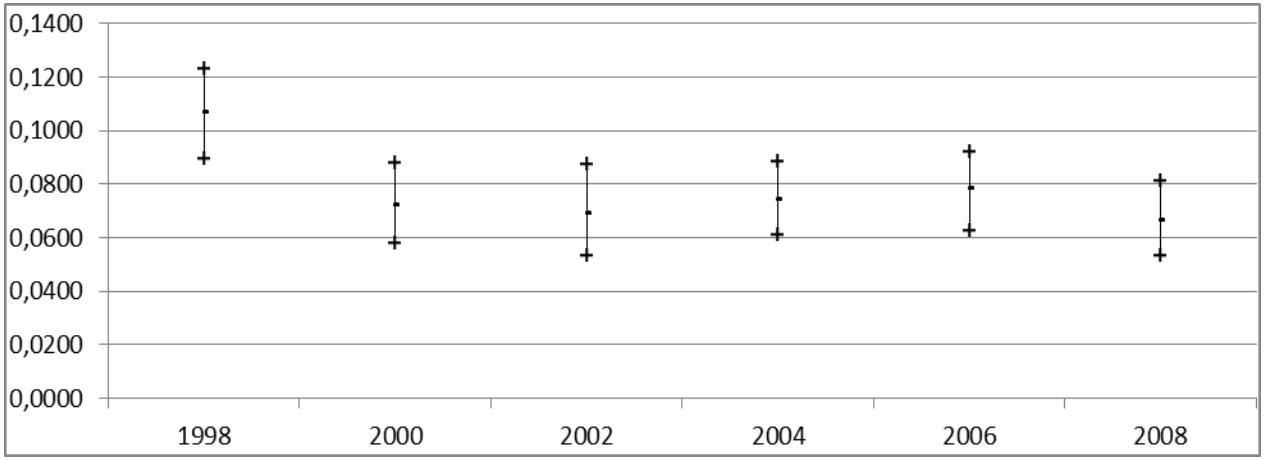

Source: Dourgnon, Or, Sorasith (2012), les inégalités de recours aux soins en France, retour sur une décennie de réforme , Actualités et Dossier en Santé Publique, à paraître.

# Evolution of inequalities in GP and specialist health care use

Inequalities in the annual probability to visit a GP




Inequalities in the annual probabiity to visit a specialist

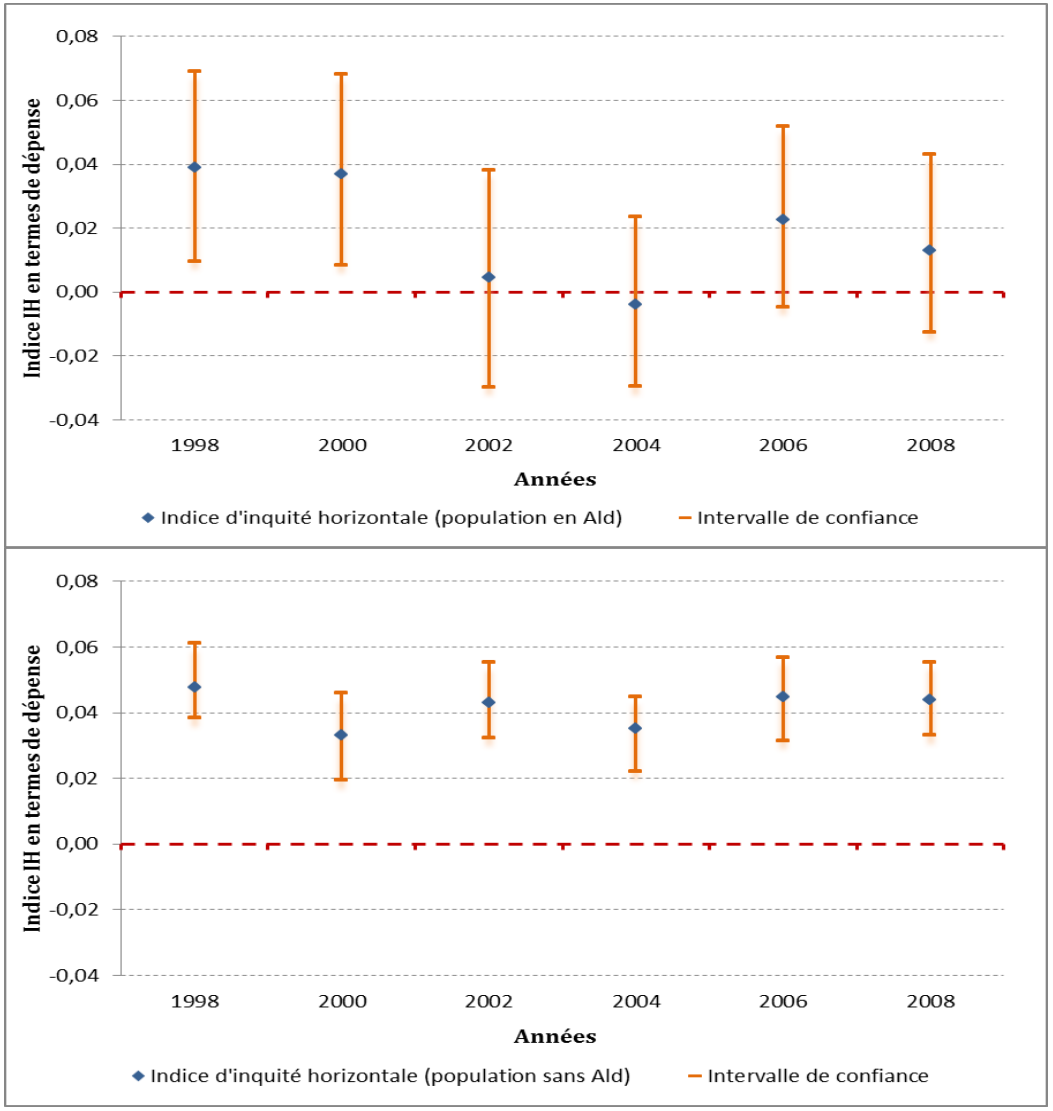



Source: Dourgnon, Or, Sorasith (2012)

# Evolution of inequalities in ambulatory health care expenditure according to ALD status

Population benefitting from a full coverage for their chronic disease treatment (ALD)

Rest of the population




Source: Dourgnon, Or, Sorasith (2012)

# Conclusion

- During the last decade, inequalities in health care expenditure have decreased but they are still significant
- This reduction of inequalities is particularly important:
  - for GP use: inequalities in GP use are now pro-poor inequalities
  - for individuals suffering from chronic disease (ALD patients)
- However there are persistent inequalities in access to specialist care, as well as in dental and optical care, as suggested by forgone care
- This evolution suggests:
  - a positive impact of the diffusion of complementary insurance with the CMU-C implementation on inequalities in health care use, and in particular on GP use
  - no impact of the introduction of gatekeeping in 2005 on inequalities in specialist care use

**References:**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