Questions d'économie de la Santé

n°259 - June 2021

Expectable Effects on Poverty Reduction of the Health System Reforms Introduced in the National Strategy for the Prevention and Reduction of Poverty

Conceptual Framework and Literature Review

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What are the consequences of health policies on the economic and social situation of individuals? Based on a literature review on French and foreign programmes and policies, we set forth a conceptual framework for the analysis of the effects on poverty of several health policies embedded in the National Strategy for the Prevention and Reduction of Poverty (*Stratégie Nationale de Prévention et de Lutte Contre la Pauvreté*) and the healthcare stakeholders' national consultation (*Ségur de la Santé*). Within this framework, healthcare influences poverty via two causality channels. On the one hand, the improvement of the financial accessibility of healthcare reduces healthcare costs that are likely to lead to individuals fall into or remaining in poverty. On the other hand, the improvement in access to healthcare, and thus individuals' health status, has an impact on individual's educational level, access to employment, and income, over the life cycle.

Literature providing an insight into the impact of the complementary health insurance reforms on the poor in France is mostly American and French. In France, the generalisation of complementary health insurance has become a public policy issue in the absence of a mechanism for capping out of pocket expenses. In the United States, the absence of universal health coverage led to the development of programmes to facilitate access to healthcare cover for the poorest people. Despite the Affordable Care Act (Obamacare), which was introduced in 2010, 28% of adults were still uninsured in 2016 (Collins, 2017). In France, studies have focused on the impact of Complementary Health Insurance plan for the poor (*Couverture Maladie Universelle Complémentaire*, CMU-C) the Health Insurance Voucher Plan (*Aide au paiement d'une Complémentaire Santé*, ACS), either looking at non-take up and impact on the use of healthcare services. In the United States, studies have assessed the effects of the extensions of Medicaid on healthcare costs, the use of healthcare, the health status, and employment. The programmes addressing local healthcare provision and the adaptation of health services to deprived population groups or ethnic minorities can be illustrated by Community Health Centers programmes in the United States and Canada. Lastly, the Housing First and Medical Respite programmes make it possible to study the likely effects of medico-social programmes aiming at tackling extreme poverty.

The National Strategy for the Prevention and Reduction of Poverty (*Stratégie Nationale de Prévention et de Lutte contre la Pauvreté*), introduced in 2018, is a package of measures aimed at reducing poverty and social and economic inequalities. The measures studied concern three main aspects: access to complementary health insurance and the quality of the coverage, the strengthening of local healthcare provision in disadvantaged areas, and the strengthening of medico-social provision for very poor people (see Inset, p. 2, and Figure 1, p. 3). These measures have in common the themes of the non-take up of health insurance, the inclusiveness of healthcare provision, and the social medical case management of patients. The extension, since 2000, of health insurance to the poor, either the public insurance (*Couverture Maladie Universelle*, CMU), the Complementary Health Insurance (Complementary insurance for the poor "*Couverture Maladie Universelle Complémentaire*, CMU-C" and the Complementary Health Insurance Voucher Plan, "*Aide au Paiement d'une Complémentaire Santé*, ACS"), and the health insurance program for undocumented immigrants (*Aide Médicale de l'État*, AME) were all hampered by large scale non-take up.

The organisation of health services to achieve greater inclusiveness aims to adapt healthcare provision to segments of the population that it is supposed to benefit –disadvantaged people– by reducing the physical distances, and the financial and cultural barriers to care. In the measures studied, the inclusiveness is based on interpretation services, mobile healthcare units (and more generally initiatives that are often referred to as "proactive"), the adaptation of consultation times, patients' participation in the management of institutions, and the training of healthcare professionals.

The positive outcomes of social medical case management have been confirmed by studies and experiments conducted abroad as well as in the French context. There is currently a form of consensus about the fact that health inequalities largely develop outside the healthcare system, hence the need to involve the other social protection actors. Social protection can simultaneously improve individuals' health and their social and economic situation. However, the French context is characterised by the large number of organisations and schemes in the social protection field. This accumulation of protection bodies is a source of inefficiency for the actors in the social protection field and a source of complexity for the populations concerned.

Context

This article is based on a review of literature conducted with the financial support of France Stratégie as part of an assessment of the 2018 National Strategy for the Prevention and Reduction of Poverty (*Stratégie Nationale de Prévention et de Lutte contre la Pauvreté*). The strategy aims to reduce poverty and economic and social inequalities. It has been implemented in five areas: health; early childhood and education; support, training and employment; housing; and social rights. Furthermore, the health stakeholders' national consultation (*Ségur de la Santé*, July 2020) focuses on healthcare provision, with funding measures, and healthcare management measures, and also an objective of combatting the social inequalities in health.
This study aims to gain a better understanding of the potential effect on poverty and on persons suffering from poverty of the five health policies proposed in the National Strategy for the Prevention and Reduction of Poverty and three policies included in the health system stakeholders' national consultation (see Inset, p. 2).
The project has been published as a report on the website of France Stratégie[1] as well as a working paper by the Institute for Research and Information in Health Economics (IRDES) [Bricard et al., to be published].

[1] https://www.strategie.gouv.fr/publications/evaluation-de-strategie-nationale-de-prevention-de-lutte-contre-pauvrete-rapport-2021

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The measures studied

The National Strategy for the Prevention and Reduction of Poverty

- P1 : "Ensuring that everyone has access to complementary health insurance";
- P2 : "Automatic renewal of the complementary health cover (CMU-C) for the beneficiaries of the Active Solidarity Income (RSA)";
- P3 : "Creating 100 community health centres in the high-priority city neighbourhoods (QPV)";
- P4 : "Supporting the '100% Santé' health insurance measure with regard to optical care, hearing aids, and dental care";
- P5 : "Radically increasing intensive social support services: 1,450 additional places by 2022 for the medical centres for homeless people (LAM) and the overnight short-term nursing homes (LHSS); and 1,200 additional places for the temporary accommodation and medical centres (ACT), which represents an increase of 25% of the specific national healthcare expenditure objective (ONDAM)".

The Stakeholder Consultation

- S1 : "Strengthening the medical and paramedical services in the 400 Healthcare Access Offices (PASS) that ensure medical and social care for uninsured patients in hospitals";
- S2 : "Creating 60 'participative' health centres with health provision that is adapted to people living in disadvantaged areas";
- S3 : "Creating 500 new overnight short-term nursing homes (LHSS) to attain 2,600 places between now and 2022, providing health and social support for homeless persons".

Although disparities in health status are partly attributable to the social field, health is a determinant of individual trajectories, such as professional careers. Although the primary aims of these measures focused on access to healthcare, the effectiveness of healthcare, and the health of the poor, they were introduced as part of a wider plan to reduce poverty. This study adopts a regulatory perspective, by providing an explanatory framework of the potential effects of the various health policies on poverty. It is not a critical assessment of public policy choices, that is to say a comparison with alternative policies, but rather an initial step towards a future assessment. The explanatory framework of the effects of the measures in the National Strategy for the Prevention and Reduction of Poverty (*Stratégie Nationale de Prévention et de Lutte contre la Pauvreté*) and the stakeholders' national consultation (*Ségur de la Santé*) on poverty is at the crossroads of two reciprocal causalities, one of which points to health as a determinant of individuals' social and economic situation, and the other points to health as the product of social determinants.

How can health policies affect poverty?

The declared objectives of the health measures in the National Strategy for the Prevention and Reduction of Poverty (*Stratégie Nationale de Prévention et de Lutte contre la Pauvreté*) and the stakeholders' national consultation (*Ségur de la Santé*) are reducing financial insecurity resulting from healthcare expenses, reducing barriers to accessing healthcare, and improving the health of the poor. Although poverty is not explicitly mentioned, the measures studied target types of poverty and hence distinct segments of the population. The health insurance measures are part of a drive to universalise complementary health insurance and mainly target vulnerable persons, who have different types of fragility (professional, financial, etc.) in terms of health coverage, and who are at risk of falling into long-term poverty. The investment in local healthcare centres is aimed at the poorer areas where there is a lack of public services and healthcare provision. The residential nursing care measures are aimed at very poor people, whose basic needs are not being met (housing, food, etc.), who are socially excluded, and who often have no access to social protection (see Inset above and Figure 1, p. 3).

Health status as a determinant of income and social status

The measures studied have three principal aims: increasing and improving the use of healthcare services by poor segments of the population, improving their health, and reducing poverty (final objectives in Figure 1).

There are reciprocal causal relationships between individuals' health and socioeconomic status, which are self-perpetuating throughout their lives. An individual's state of health during his/her childhood has a long-term effect on his/her social situation in adulthood. Likewise, certain social inequalities in health are passed down from generation to generation. In the shorter term, good health increases the likelihood of being employed, whereas poor health increases the risk of being unemployed or inactive. Employability can also be negatively affected by health problems such as obesity and poor oral health. However, in light of the range of measures assessed, merely studying the effect of measures –whose principal aim is to improve access to healthcare– on the social situation of individuals is of little relevance. It was important to focus initially on the aims designed to improve access to health coverage, the use

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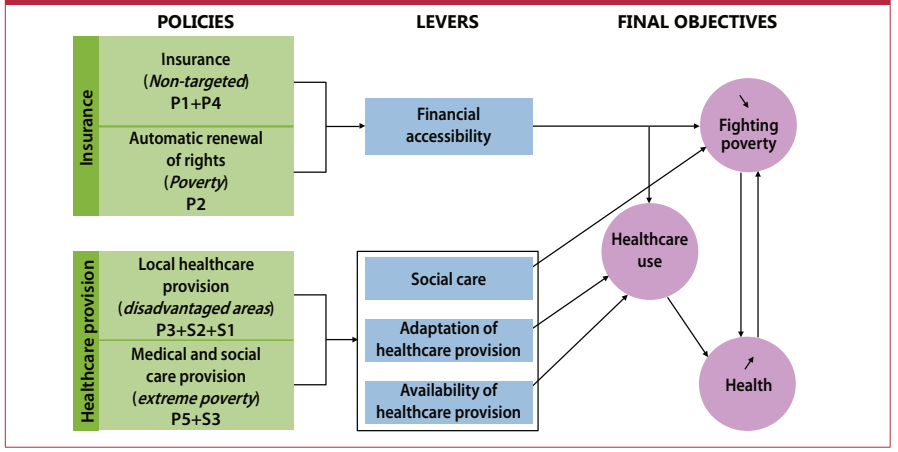
Conceptual framework



of healthcare services, and health. Indeed, an improvement in access to healthcare leads to an improvement in health, especially for disadvantaged people, who are heavily affected by the problem of unmet healthcare needs.

Policies aiming at improving access to healthcare influence out-of-pocket expenses and health status

The main aim of the health insurance measures is to improve financial accessibility to healthcare provision by lowering insurance premiums and reducing non-reimbursed healthcare costs, by offering better levels of coverage (better healthcare coverage and extending the "basket of care"). Lowering premiums and reducing out-of-pocket expenses may have a direct effect on the financial insecurity of disadvantaged households, resulting from significant expenses and which may be unforeseen in terms of insurance and healthcare. Improving the "basket of care" may make it possible to reduce the rejection of medical treatment for financial reasons, which is the leading cause of the rejection of medical treatment in France.

The establishment of health centres in disadvantaged areas may make it possible to remove several barriers to healthcare, especially the geographical remoteness of healthcare provision (which is also a major source of the rejection of medical treatment), and improve the interaction between patients and medical staff. Schemes aimed at very poor people may also put these levers into action.

Three levers to improve access to healthcare

The policies studied in this study use three types of healthcare access lever identified in the literature (Penchansky & Thomas, 1981):

- Financial accessibility involves both the cost of insurance premiums and the amount of out-of-pocket expenses after coverage by compulsory health insurance and complementary health insurance;
- Accessibility and the availability of care involves the geographical proximity of care facilities and the matching of resources in terms of medical and medico-social staff to the needs of the target population;
- Medical interaction and interaction with the healthcare system involves adapting healthcare and social services to the target population, in particular reducing the cultural distance between doctor and patient (participation of users, "proactive" initiatives, interpretation services, the training of healthcare professionals, the social medical case management of patients, etc.).

Insurance, out-of-pocket, and poverty

The expansion of Complementary Health Insurance (CMU-C) to populations who were previously eligible for the Health Insurance Voucher Plan (ACS) enables them to benefit from complementary health cover (*Complémentaire Santé Solidaire*, C2S) in exchange for a financial contribution, depending on their age. The new coverage may be less expensive and of better quality than complementary health insurance available on the market. The C2S system also enables beneficiaries to reduce the cost of healthcare compared with a traditional health insurance plan, because it waives medical deductibles, non-refundable deductibles, and additional fees in coordinated treatment plans. Lastly, it enables patients to avoid having to make prepayments (i.e., before being reimbursed by public and complementary insurances) thanks to the "*tiers payant*"system of direct payment by insurers for medical treatment, which has been shown to have an effect on social inequalities in healthcare utilisation. On the whole, the reduction in the number of cases in which people lose their rights, at least for beneficiaries of the Active Solidarity Income (*Revenu de Solidarité Active*, or RSA), whose rights are automatically renewed, and the improvement in cover reduce the risk of the rejection of medical treatment and the need to pay catastrophically high healthcare costs, which could result in people descending into or staying in poverty (Figure 2).

Inclusiveness and social medical case management in Community Health Centres

Inclusiveness policies aim to improve the interaction between health and social professionals and users. In particular, the community health centres and participatory health facilities, and the medico-social support schemes for very poor people aim to reduce the distance, particularly the cultural dis-

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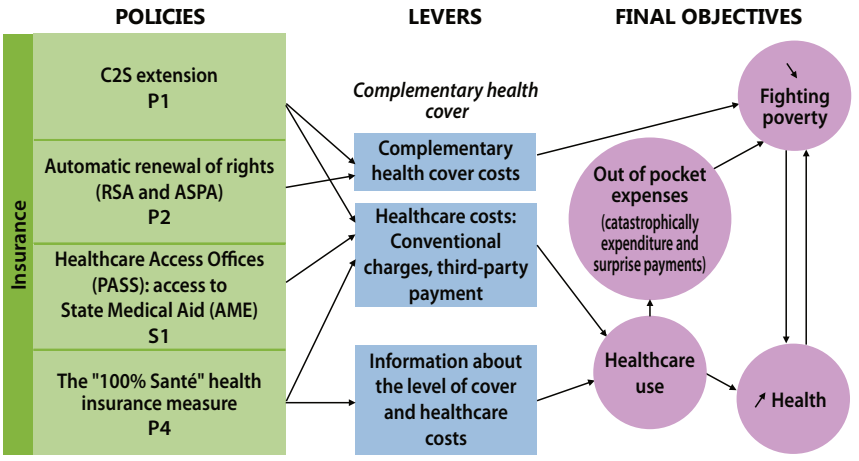
Insurance policies: obstacles and levers



tance, between users and health professionals, through interpretation services and the training of professionals. These programmes adopt a proactive approach of "reach out to patients", with a view to improving the effectiveness of the interaction with the medical and social services, in terms of quality of care, user satisfaction, and, in fine, reducing social health inequalities. They also aim to facilitate the take up of health coverages and programmes through better access to information (Figure 3).

A review of comparable policies

Method and resources used

The review's main field of study was economics, in particular an assessment of public policies, which was associated with approaches to sociology, public health, and social epidemiology. The sources used were: (1) the document database of the Institute for Research and Information in Health Economics (*Institut de recherche et documentation en économie de la santé*, IRDES); (2) "snowball" research based on relevant reference material before and after the study; (3) documentary research using key words in a bibliographical database (Medline) for certain specific topics (community health centres, Healthcare Access Offices (*Permanences d'Accès aux Soins de Santé*, PASS), etc.); and (4) grey literature comprising the administrative documents relating to the National Strategy for the Prevention and Reduction of Poverty (*Stratégie Nationale de Prévention et de Lutte contre la Pauvreté*) and the stakeholders' national consultation (*Ségur de la Santé)*, as well as the assessment reports and activity records of certain schemes.

Tackling health insurance non-take up and expanding insurance to the poor

Literature clarifying complementary health insurance reforms is usually American and French. Indeed, the American health insurance system falls short of being universal and has been the subject of reforms and initiatives on a federal level –if Trump's term of office is excluded– and on state and community levels, aimed in particular at improving access to care and coverage for the most disadvantaged people (Medicaid). In France, many studies have focused on the non-take up of the Health Insurance Voucher Plan (ACS), Complementary Health Insurance (CMU-C), and the extension of complementary health insurance.

The French situation with regard to Complementary Health Insurance (CMU-C) and the Health Insurance Voucher Plan (ACS): France is the OECD country in which the proportion of out-of-pocket expenses borne by the users, in the total healthcare expenditure, is on average the lowest. However, the rates of rejection of medical treatment for financial reasons in France are amongst the highest and there are significant social inequalities in the use of healthcare services (Chaupain-Guillot & Guillot, 2015; Devaux, 2015). This finding may reflect financial barriers to healthcare that are greater for lower income individuals, which are linked both to greater healthcare needs and their lower complementary health insurance coverage rate. The creation of Complementary Health Insurance (CMU-C) and the Health Insurance Voucher Plan (ACS) aimed to reduce difficulties in accessing complementary health insurance. But the rates of non-take up of the two schemes are high (between 34 and 45% for complementary health insurance, and between 41 and 59% for the Health Insurance Voucher Plan) [Fonds CMU, 2018], in a context in which they are run by a combination of public and private operators. The creation of the C2S complementary health cover in November 2019 aimed to improve access to complementary health insurance for lower income individuals, particularly for households that had previously been eligible for the Health Insurance Voucher Plan (ACS). The expected effects of the measure can be extrapolated initially from studies that were conducted after the establishment of Complementary Health Insurance (CMU-C) in France.

With regard to the financial accessibility to healthcare, it has been shown that Complementary Health Insurance (CMU-C) made it possible –by removing the premium for complementary health insurance– not only to directly affect the household budgets of beneficiaries with significant redistributive effects, but also to eliminate out-of-pocket expenses for most of the beneficiaries (Ricci & Gilles, 2010; Sireyjol, 2016). Several studies have also shown that Complementary Health Insurance (CMU-C) has an impact on the likelihood of consuming outpatient care (dental treatment, GPs, specialists, pharmacy) and on the volume of healthcare expenditure (Carré et al., 2021; Grignon et al., 2008). Hence, complementary Health Insurance (CMU-C) enables its beneficiaries to have healthcare consumption that is similar to the rest of the population (Guthmuller & Wittwer, 2017). However, the households whose income is just above the CMU-C threshold continue to face great difficulty in paying for complementary health insurance, despite the existence of the Health Insurance Voucher Plan (ACS) [Jusot et al., 2011].

The situation in the United States with regard to Medicaid and Obamacare: in the United States, public health insurance for low-income households, Medicaid, has existed since 1965 and has been extended on numerous occasions over the last few decades, including the Affordable Care Act (ACA) and Obamacare in 2010. Many studies have analysed the effects of these insurance coverage extensions on several aspects of poverty, and could provide insight into the expected effects of the implementation of the C2S complementary health cover in France.

The Medicaid extensions have led to a significant improvement in the use of healthcare for poor households that initially had no coverage, notably with improvements in the

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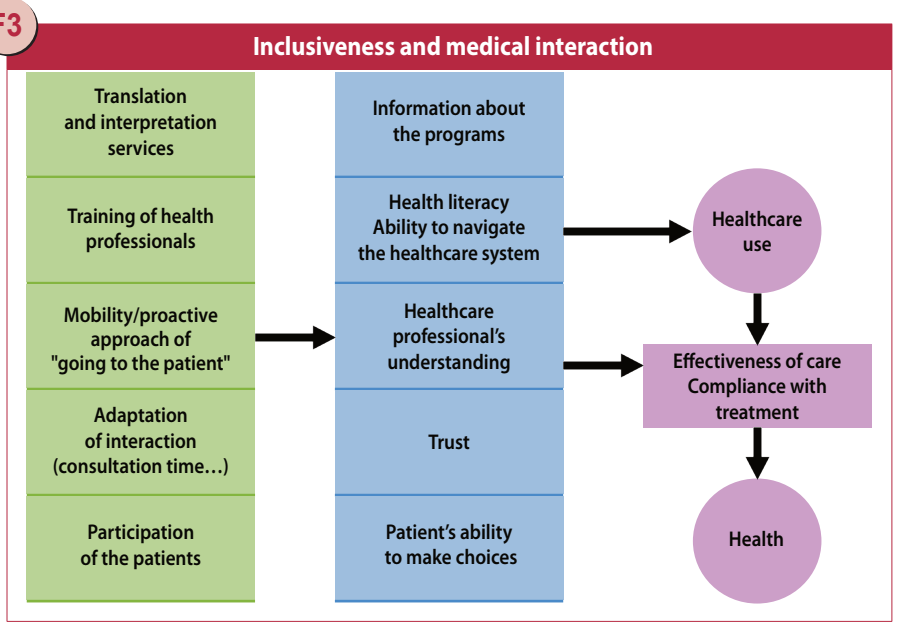

use of primary and preventive care and hospitalisations (Finkelstein et al., 2012; McKenna et al., 2018). Consequently, there has been an overall decrease in the use of the emergency services (Sommers et al., 2016; Wherry et al., 2015). In terms of people's health, positive effects have also been observed, both in the short term (improvements in perceived health and mental health) and the long term (reduced rates of mortality, impairment, and certain chronic diseases and obesity) (Baicker et al., 2013; Goodman-Bacon, 2016; and Miller & Wherry, 2019). Access to Medicaid has enabled many low-income households to reduce their healthcare expenditure for medical services, insurance premiums, and prescriptions for drugs, thereby relieving the financial pressure that is sometimes difficult to cope with (Glied et al., 2017). Long-term effects have also been observed with regard to secondary school graduation rates and a reduction in exits from the labour market, as well as an improvement in access to employment.

The situation in Taiwan: universal health insurance has been implemented on a wide scale. In 1995, a universal health insurance system was introduced in Taiwan (a national health insurance (NHI) scheme), jointly funded by social security contributions, State subsidies, and individual insurance premiums. The proportion of the population benefitting from healthcare coverage thus rose from 57% to 98%, and the beneficiaries have almost free access to healthcare with low patient contributions in most of the hospitals and clinics. The implementation of the NHI has led to a substantial increase in the use of hospital and outpatient healthcare, particularly for the elderly (Chen et al., 2007), while reducing non-reimbursed healthcare costs, particularly healthcare and pharmaceutical costs, with a greater impact for socially disadvantaged people (Ku et al., 2019). There has been a significant increase in the life expectancy of the poor segments of the population, with a consequent reduction in health disparities in the population (Wen et al., 2008). On the economic front, the introduction of the NHI has had a negative impact on household savings, which is explained by less uncertainty with regard to possible future medical costs (Chou et al, 2003).

The situations in the United States and Taiwan do not make it possible to anticipate the full effects of the French measures, because there are major differences between the health insurance systems ("first-dollar" coverage in the United States and Taiwan, for people who initially had no coverage; complementary health insurance in France, which concerns a smaller number of people). They do however demonstrate that it is relevant to question the effects on poverty of the health insurance policies implemented in France.

The extension of dental and optical cover: certain studies have also examined the effects of an extension of the dental and optical cover in the Medicaid reforms. These assessments could help predict the possible effects of the "100% Santé" health insurance measure. The coverage of optical expenses has been associated with an increased likelihood of consulting an ophthalmologist and a lower rate of healthcare renunciation for financial reasons, as well as a reduction in impaired vision and functional limitations associated with vision disabilities (Lipton & Decker, 2015). Dental care coverage has had similar effects, with an increase in dental visits and a lower likelihood of having untreated tooth decay (Decker & Lipton, 2015). In South Korea, an extension of dental care cover for people aged 65 or over has also made it possible to improve the use of dental services, and to reduce the social disparities in the use of dental services (Choi & Jung, 2020).

Combatting the non-take up of health insurance: the reasons for the non-take up of free or subsidised health insurance programmes, such as Complementary Health Insurance (CMU-C) and the Health Insurance Voucher Plan (ACS) in France, have been studied extensively in the literature. The main reasons put forward are a lack of information, the complexity of the procedures, the benefits, which are considered insufficient, social stigma, doctors' refusal to treat people with Complementary Health Insurance (CMU-C), and an absence of healthcare requirements (Dufour-Kippelen et al., 2006; Guthmuller et al., 2014a). A certain number of trials have been conducted to improve the rates of use, particularly the use of the Health Insurance Voucher Plan (ACS) in France (Guthmuller et al., 2014b). The literature highlights the fact that automatic enrolment with a right of cancellation would be the most effective way of achieving this objective (Remler & Glied, 2003). In the United States, several examples confirm this idea, such as the Medicare Part B programme, whose enrolment is automatic (but the beneficiaries have the right to cancel the plan), and whose rate of use is three times higher than that of the Medicare Saving Program, whose enrolment is subject to eligibility (96% versus 33%) [Dorn & Kenney, 2006]. The measure relating to the renewal of Complementary Health Insurance (CMU-C) for beneficiaries of the Active Solidarity Income (*Revenu de Solidarité Active*, or RSA) could prove beneficial in this regard, at least for this segment of the population, which is only a minority of eligible people. It is also important to note that this measure solely concerns renewal and not enrolment.

Improving local healthcare provision: the community and participatory healthcare facilities

The local healthcare provision policies primarily aim to create or invest in community and participatory healthcare facilities in high-priority urban areas. The expected effect of this measure is an improvement in healthcare provision in France and a facilitation of access to healthcare for disadvantaged people. Better accessibility and availability of care, and a strengthening of medical interaction and interaction with the healthcare system could contribute to improving accessibility to healthcare for a segment of the population that is geographically distant, financially underprivileged, and culturally distant. In fact, the literature on the social medical case management provided in the facilities indicates that they could improve access to minimum social benefits and employment integration schemes, thereby contributing to a reduction in poverty.

The French health system is increasingly lagging behind the Anglo-Saxon and northern European countries with regard to community-based care and the inclusiveness of healthcare provision. Indeed, the development of such facilities is recent in France, and, to our knowledge, no assessment of the impact of participatory healthcare facilities on the use of healthcare and poverty has been published to date. The measures can, however, be underpinned by the examples of the Community Health Centers (CHCs) in the United States and Canada which, under a generic term, encompass various schemes.

Many studies, most of which were conducted in the United States, have highlighted the impact of the CHCs on various aspects of healthcare use, whether this consists of regular consultations with a GP or the use of preventive healthcare, and also more generally on the improvement in patient experience (Shi & Stevens, 2007). It has also been shown that the use of CHCs has made it possible to increase healthcare quality for patients suffering from chronic diseases that is equivalent to that provided in other types of healthcare facilities, with nevertheless less effective monitoring for uninsured patients compared with patients who have Medicaid (Hicks et al., 2006). A greater density of CHCs in an area

is also associated with less use of hospital services as compared with areas with less healthcare facilities, particularly with regard to the emergency services and avoidable hospitalisations (Evans et al., 2015; Rothkopf et al., 2011). A study of the long-term consequences of the differential establishment of CHCs in the United States during the period 1965–1974 also highlighted a decrease in mortality for Americans aged over fifty (Bailey & Goodman-Bacon, 2015).

The CHCs also provide other services. These include health education, transport, or help to obtain food, housing, or social services. The provision of these services has been linked to more frequent use of healthcare services (such as vaccinations and preventive treatments), as well as a more systematic use of these healthcare establishments as a regular source of healthcare rather than as emergency services (Nguyen et al., 2020; Yue et al., 2019).

With regard to the Canadian situation, a qualitative study demonstrated the important role played by community initiatives in the fight against social isolation and poverty in Ontario, by improving social relations and providing opportunities and partnerships in order to direct individuals towards training and employment (Collins et al., 2014).

Hence, the examples of community health centres in the United States and Canada are encouraging on various levels. However, like the health insurance measures, the structural differences between the healthcare systems compel us to tone down the expected effects of the creation of community health centres in France, which should also be observed to a lesser extent.

The Hospital Healthcare Access Services (PASS): a unique but little studied initiative

The Hospital Healthcare Access Services (PASS) were created in 1998 by the Social Exclusion Act. These initiatives, which have no equivalent outside France, provide medical and social services, and enable hospitals —which can reduce their bad debts via these initiatives— to redirect uninsured patients towards the French public health insurance system *(Assurance Maladie)* or State Medical Assistance (*Aide médicale de l'État*, AME) for undocumented immigrants. The State Medical Assistance, like other health insurance schemes aimed at poor individuals, faces high rate of non-take up (49%) (Jusot et al., 2019). A study conducted in 2003 showed that it was possible to set up an information system, at least on an ad hoc basis, which made it possible to identify the people who used the Hospital Healthcare Access Services (PASS) [Trinh-Duc et al., 2005]. This study also highlighted the importance of interpretation services, as a third of the users did not speak French. The impact of Hospital Healthcare Access Services (PASS) on the use of emergency departments as well as on the treatment programme of their users, has not to our knowledge been studied quantitatively.

Medical-social housing for persons in severe poverty

The last group of measures relates to the strengthening of the overnight short-term nursing homes (*Lits Halte Soins Santé*, LHSS), medical centres for homeless people (*Lits d'Accueil Médicalisés*, LAM), and temporary accommodation and medical centres (*Appartements de Coordination Thérapeutique*, ACT). Over the last decades, there has been a huge increase in the number of homeless people in developed countries (Fazel et al., 2014), particularly in France, where the figures increased by fifty percent between 2001 and 2012 (Yaouancq et al., 2013), and then doubled between 2012 and 2020, reaching almost 300,000 persons at the end of 2020 (Fondation Abbé Pierre, 2020). Homeless persons have a state of health that is significantly poorer than that of the rest of the population and often suffer from somatic or mental illnesses, and psychoactive substances addiction (Feantsa & Fondation Abbé Pierre, 2018). The overnight short-term nursing homes (LHSS), medical centres for homeless people (LAM), and temporary accommodation and medical centres (ACT) provide accommodation and health and social services for homeless adults, whose state of health does not require hospital treatment, but which is incompatible with living outdoors.

Assessment reports and activity records of these initiatives highlight the contributions made by and benefits for the target populations (the Directorate General of Social Cohesion – the French Ministry of Health and Solidarity (DGCS – *Ministère des Solidarités et de la Santé*), 2018; the *Fédération Santé & Habitat*, a federation of associations that manage temporary accommodation and medical centres (ACT), 2020; Picon et al., 2013). The relatively long period of accommodation –ranging from two months for the overnight short-term nursing homes (LHSS) to one or several years for the temporary accommodation and medical centres (ACT)– makes it possible to provide social medical case management for the patients, with comprehensive medical monitoring, social care, and the development of a medium-term discharge plan. In this respect, the temporary accommodation and medical centres (ACT) have demonstrated that they can improve the socio-economic situation of their users, as they are four times more likely to be employed (4% to 16%), and three times less likely to be without financial resources (36% to 12%) or without complementary health cover (28% to 10%) when they have left the centres compared to when they entered them. The support provided by these schemes has also enabled 62% of the users to have access to permanent housing, and while more than 9 out of 10 of the entrants were homeless or in precarious housing, this situation only concerned 14% of the patients who left the centres in 2019. However, the situation regarding the overnight short-term nursing homes (LHSS) is more contrasted; 47% of the patients left to live on the street or in emergency overnight shelters in 2011. However, the situation has since improved, with 16 to 32% of patients ending up in vulnerable situations after discharge in 2018, depending on the départements studied.

Assessments of these schemes have, however, highlighted certain limits, such as the significant lack of places and the absence of regulation of the available places, complex admission procedures that could put people off the idea of joining the schemes, the inadequate accommodation for women, underage individuals, and specific populations with particular needs (foreign persons in precarious situations, and persons with complex medical situations), and the lack of suitable discharge plans. These limits concern the overnight short-term nursing homes (LHSS) more than the other two schemes.

Abroad, the "Housing First" model, strengthened to combat extreme poverty, is similar to the French medical and social care schemes, and the extensive literature on the subject provides a good basis for studying its potential effects. It is a scheme that provides services for homeless persons suffering from severe mental disorders or addictions, developed in the United States in the 1980s and 1990s, which focuses on unconditional access to secure housing as the starting point of the recovery process, and which places user's freedom of choice at the heart of the programme (Tsemberis, 1999, 2011). It reflects a paradigm shift in the provision of support for these vulnerable populations, and contrasts with the traditional model based on treatment (Treatment First) in developed countries, which is a step-by-step process: appli-

cants must first take a certain number of steps before being offered housing, and in particular have to start a treatment programme or stop the consumption of psychoactive substances.

The model has been implemented in fifteen countries in North America and Europe (including France), and has been the subject of many assessments. In Canada, a large-scale experiment conducted between 2009 and 2013 showed positive results in relation to housing sustainability, the quality of life, and the satisfaction of the patients, and less use of emergency services (Goering et al., 2014). In Lisbon, a qualitative study with an ecological approach showed a significant improvement in social and economic integration, as well as the physical and mental wellbeing of the patients (Ornelas et al., 2014). Other studies have also highlighted conclusive and globally homogenous results, with a reduction in homelessness, and an improvement in health and wellbeing, as well as help with the social reinsertion of the patients (Bretherton & Pleace, 2015; Busch-Geertsema, 2016; Padgett et al., 2011; and Tinland et al., 2020). However, no direct effect was observed on poverty or employability.

More short-term care schemes also exist in the United States, with the Medical Respite Programs (40 days on average). The latter have shown positive effects in terms of healthcare access and health, and in certain cases an improvement in the housing situation of the persons who have received care (Zerger, 2006).

This information from the literature made it possible to provide insight into the expected effects of the measures aimed at strengthening the ACT, LAM, and LHSS schemes in France. These medical and social housing projects seem to be effective in helping persons suffering from significant material poverty and poor sanitary conditions to escape the "poverty trap". However, the apparent effectiveness of the temporary accommodation and medical centres (ACT) and the "Housing First" model, on the one hand, and the much more contrasted situation with regard to the overnight short-term nursing homes (LHSS), on the other hand, suggest that the provision of social medical case management over a relatively long period is required to enable these people with multiple needs to get their lives back on track in a more sustainable way.

* * *

Our conceptual framework, based on our review of the literature, postulated that health is a determinant as much as a consequence of an individual's social and economic status. There exists a reciprocal causal relationship between health and economic and social status. This dual relationship engenders a self-sustaining and cumulative mechanism over a life cycle and over generations, which contributes to the creation of social inequalities and social health inequalities.

How can the evidence be transferred to public policies? At the beginning of the 2000s, many countries implemented policies that explicitly targeted healthcare inequalities (Dourgnon et al., 2001; Couffinhal et al., 2002). They were based on the increasingly damning observation of the existence of extensive social inequalities in health, which were often on the rise, in countries that had socialised healthcare systems (see the report by Black and Marmot). More recently, health impact assessment tools have been developed to assess the consequences on health of policies that fall outside the realm of health. On the other hand, cross-sectoral approaches, known as Health in all Policies (HiAP), aim to integrate health-related issues into the development of all public policies. This kind of approach was encouraged by the World Health Organisation (WHO, 2014). South Australia and Finland were the pioneers of this approach (Delany et al., 2016; Puska & Stahl, 2010), and the initiative was subsequently implemented in fifteen states and countries around the world. The first evaluations carried out in South Australia showed that the HiAP has strengthened cross-sectoral collaboration and has led to better understanding amongst the various actors, and also underlined the fact that greater efforts will be required to be able to significantly reduce health inequalities (Lin & Kickbusch, 2017; Van Eyk et al., 2017).

Aside from providing insight into the measures in the National Strategy for the Prevention and Reduction of Poverty and the Health stakeholders' National consultation the research compiled in this study underlines the importance of taking into account the dual causality that links health with economic and social status in the development and assessment of public policies. This means studying the effect on health of policies that fall outside the realm of health, and the effect of health policies on the social situation of the people concerned.♦

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Director of the publication: Denis Raynaud • **Technical senior editor:** Anne Evans • **Associate editor**: Anna Marek • **Translators**: David and Jonathan Michaelson (JD-Trad) • **Layout compositor**: Damien Le Torrec • **Reviewers**: Guillaume Chevillard, Michel Grignon • **ISSN:** 2498-0803.