

# questions

## d'économie de la santé

Issues in health economics

results

### Background

The information presented in this document comes from the 2004 Health, Health Care and Insurance Survey (ESPS). This survey has been carried out by IRDES since 1998. Initially annual, then biannual from 1998, in 2004 it surveyed approximately 8 000 households including 22 000 people. The ESPS survey is representative of ordinary households (not living in institutions) with at least one member covered by one of the three main social security funds (CNAMTS, MSA, RSI). Hence it is representative of more than 96% of the population living in metropolitan France.

Statistics on health status, health insurance cover and health service use by social characteristics are among those available from the survey.

### Health, Health Care and Insurance Survey 2004: First results

Caroline Allonier, Stéphanie Guillaume, Thierry Rochereau

The Health, Health Care and Insurance survey (ESPS) depicts how health care and health insurance cover are distributed among the French population.

The 2004 survey provides new results on health status. Women are less likely than men to report good health (29.6% compared to 22.5%). They also declare more illnesses (3.9 compared to 2.7 for men), but these are less severe. Men, whose life expectancy is lower, declare more serious illnesses.

Access to supplementary health insurance on health care appear to be an issue for a non negligible part of the French population.

Nearly one in ten persons report neither CMU supplementary health insurance. 13% report almost one not sought care for financial reasons during the previous twelve months. Almost half of not sought care concern dental care, 18% medical optics, and 9% specialist care.

The survey confirms the strong social gradient in health insurance and health care status: blue collar households and those of employees report poor health status most frequently, are least likely to have supplementary health insurance cover and are most likely to forego care.

INSTITUTE FOR RESEARCH AND INFORMATION  
IN HEALTH ECONOMICS

Address:

10, rue Vauvenargues 75018 Paris - France

Téléphone : 33 (0)1 53 93 43 02/17

Télécopie : 33 (0)1 53 93 43 50

E-mail : [document@irdes.fr](mailto:document@irdes.fr)

Web : [www.irdes.fr](http://www.irdes.fr)

Director of the publication:  
Chantal Cases

Writer as a head:  
Nathalie Meunier

Dummy maker:  
Khadija Ben Larbi

Translator:  
Marian Craig

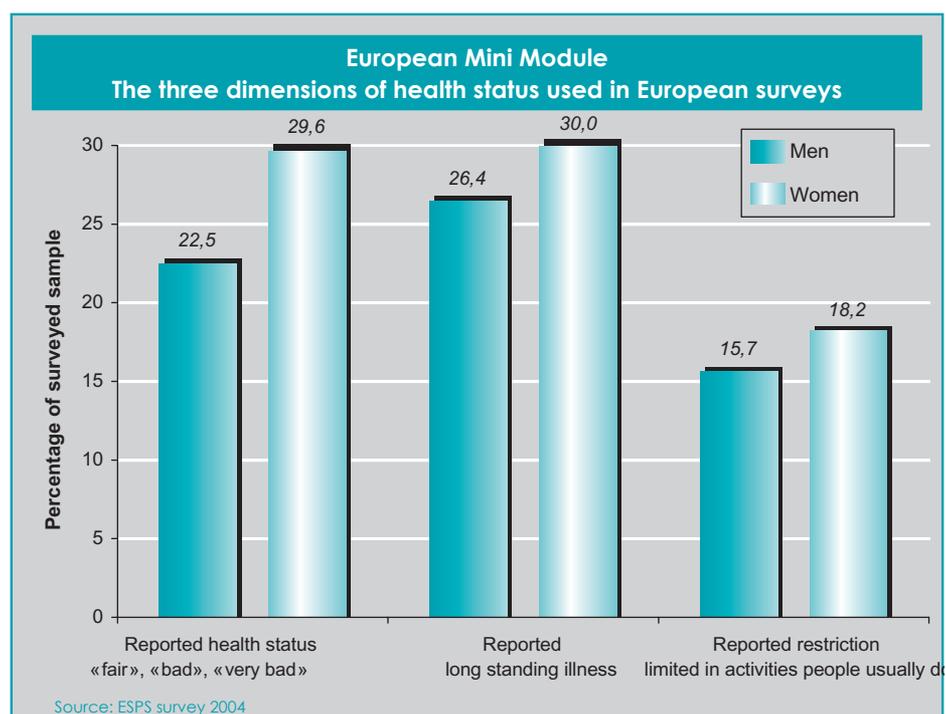
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## Health status: how do the French feel?

In 2004, the three synthetic health status questions recommended in European health surveys or the “European health status module” were included in the ESPS survey questionnaires. These questions relate to self perceived health status, experience of long standing illness and longterm activite limitation (or “functional health”) (see Box below).

In this paper we present results from this module for persons aged over 16, amplifying them with indicators of morbidity specific to the ESPS survey: number of diseases reported and their level of severity.

### Men declare a more healthy subjective health status than women

One in four (26.3%) persons do not perceive their health to be good: 22.3% report “fair” health status, 3.5%, “bad” and 0.5%, “very bad”. Translator’s note: In the original there are 4 percentage values and only 3 labels.

This proportion increases greatly with age and after 65, one person in two considers their health to be “fair”, “bad” or “very bad”. At all ages women report poorer health status than men. Across the whole age range, 29.6% of women compared to 22.5% of men report “fair”, “bad” or “very bad” health status.

Furthermore, more than one third of the inhabitants of metropolitan France report limitation in normal activities, and one person in two reports having long standing illness. These percentages increase substantially with age, but in contrast to what we see for perceived health status, they are not lower for elderly men<sup>1</sup>. From age 65, they declare

long standing illness more frequently. This is no doubt related to the nature of the indicators. Among the three indicators, that of perceived health encapsulates more dimensions of health, in contrast to the other two which measure more precise and specific elements: the existence of an illness or limitation in activities. The latter leave less room for the subjective dimensions of health.

<sup>1</sup>These results are consistent with those of the INSEE 2002-2003 health survey (Lanoë and Makdessi-Raynaud, 2005) except for level of declared long standing illness (different methodology for data collection)..

Responses to the European Minimodule by age							
Age groups:	Men (6 687)			Women(7 084)			Total
	[16-39]	[40-64]	[65[	[16-39]	[40-64]	[65[	
Number:	2 799	2 820	1 068	2 814	3 001	1 269	
<b>Percentage of persons declaring...</b>							
«fair», « bad », or « very bad » health	7,6	24,9	52,1	10,9	31,2	59,7	26,3
Suffering from a long standing illness or health problem	11,7	28,9	58,2	14,3	32	55,4	28,3
A limitation in activities	5,3	16,3	39,8	6,6	18,4	39,5	17,0

Source: ESPS survey 2004

### Measuring health status in the ESPS survey

Health status in the ESPS survey is measured using a self-administered questionnaire distributed to each member of the household. In 2004, 77% of persons surveyed completed the questionnaire. Those surveyed are invited to complete the questionnaire themselves unless they are under 16. However 30% of over 16 year olds are assisted by another member of the household, usually the mother.

The results relate to the population of individuals over 16 years of age who complete a questionnaire, i.e. 13 771 individuals.

In 2004, the three synthetic health status questions which make up the European Minimodule have been integrated in this self-administered questionnaire. They assess perceived health status, experience of long standing illness, limitation in ac-

tivities people usually do (or “functional health”). These questions have been validated at the European level and are used in numerous surveys of the general population.

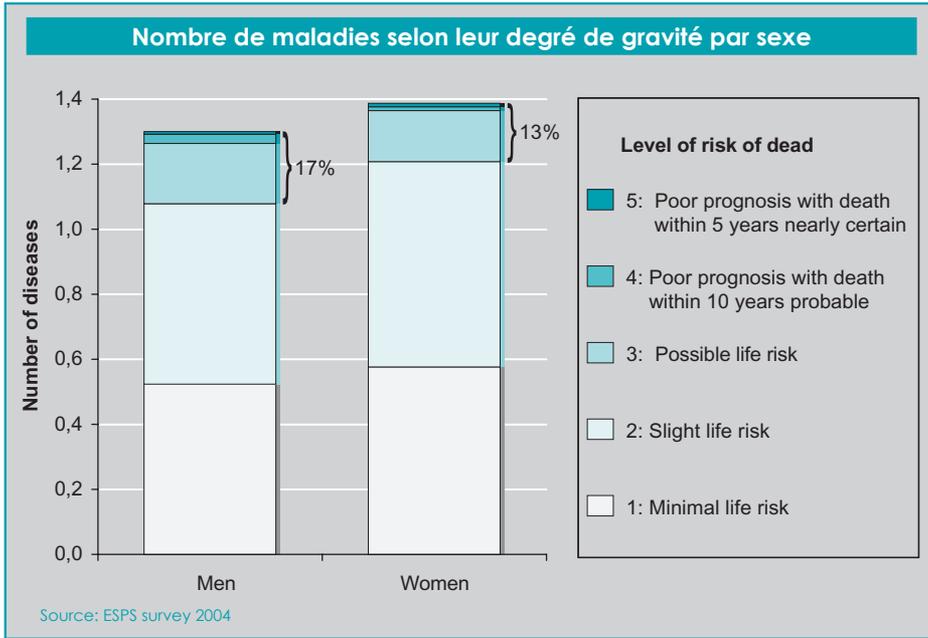
The three questions which make up the European Minimodule are:

- “How is your health in general?” (Very good/good/fair/ bad/very bad) ·
- “Do you suffer from a long standing illness or health problem?” (yes/no/ don’t know) ·
- “Have you been limited for at least 6 months in the activities people usually do?”(yes, very limited/yes, limited/ no).

Together with the european health status module, health status in the ESPS is evaluated by collecting data on diseases

(declared by each respondent on the basis of a group of questions on current diseases, previous surgery, reasons for drug consumption etc.). All declared diseases are coded using the International Classification of Diseases (ICD 10th Revision). For each disease, a group of expert praticien have attributed a level of severity based on expert opinion on the probability of death in the short or medium term. This six level index is called the minimum risk of life

0. No indication of risk
1. Minimal life risk
2. Slight life risk
3. Possible life risk
4. Poor prognosis with (death within 10 years probable
5. Poor prognosis with death within 5 years nearly certain.



### Measuring social groups in the ESPS survey

We define social group as the socio-professional category of the household reference person (according to the INSEE definition).

This is most often the male of the couple, or the parent of a single parent family, or the oldest male. If there are several possible reference persons, the employed person takes priority, and after that the eldest.

If the reference person has retired, his final occupation is used (or the final occupation of the partner of widows or widowers who have never worked).

### Men have more serious diseases

Persons resident in metropolitan France declare 3.3 diseases on average<sup>2</sup>, women on average declaring one more than men (3,9 compared to 2,7). Only 16.6% of women do not report a disease compared to 23.2% of men. However, although women declare more diseases, these are on average less severe (see Box above). If non-life threatening diseases are excluded<sup>3</sup>, the difference between men and women reduces substantially (1,30 diseases for men and 1,38 for women). In fact men report more serious diseases than women: hence among those diseases with some risk of life, 17% entail a possible risk of life (risk of life < 2) among men, compared to 13% for women (see Figure below).

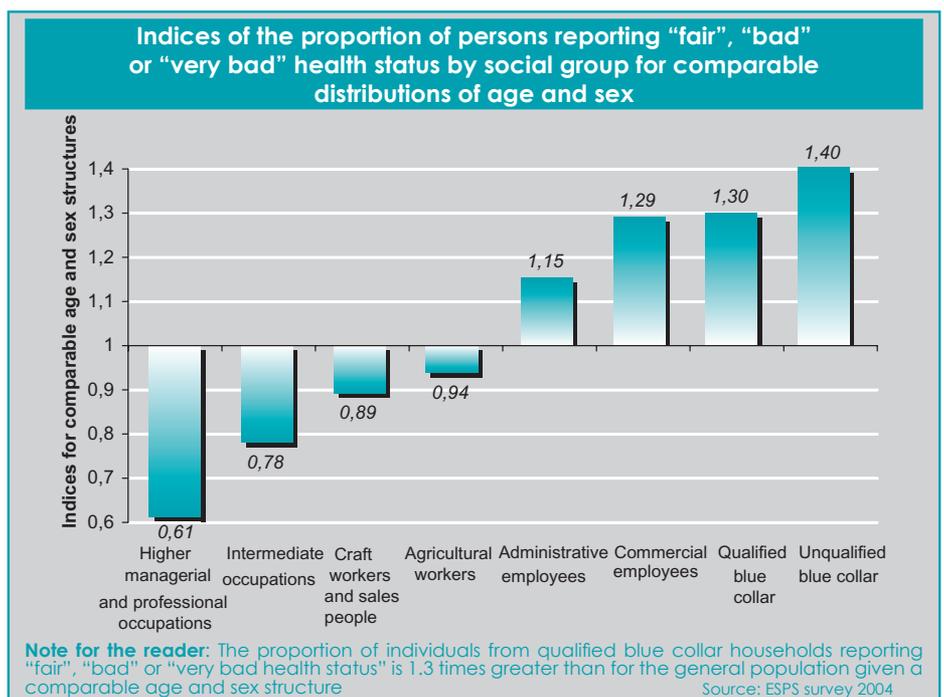
This reflects worse health status in men, who also have lower life expectancy. Among women, several hypotheses may explain poorer perceived health: a greater tendency to report illness, a greater incidence of less severe health problems, or a better unders-

tanding of their health status. This latter hypothesis is in line with that of the 2003 INSEE health survey (Lanoë and Makdessi-Raynaud, 2005) which suggests that women are definitely better informed about their illnesses, given their more frequent use of health services and preventive care.

### Reported health status varies by social group

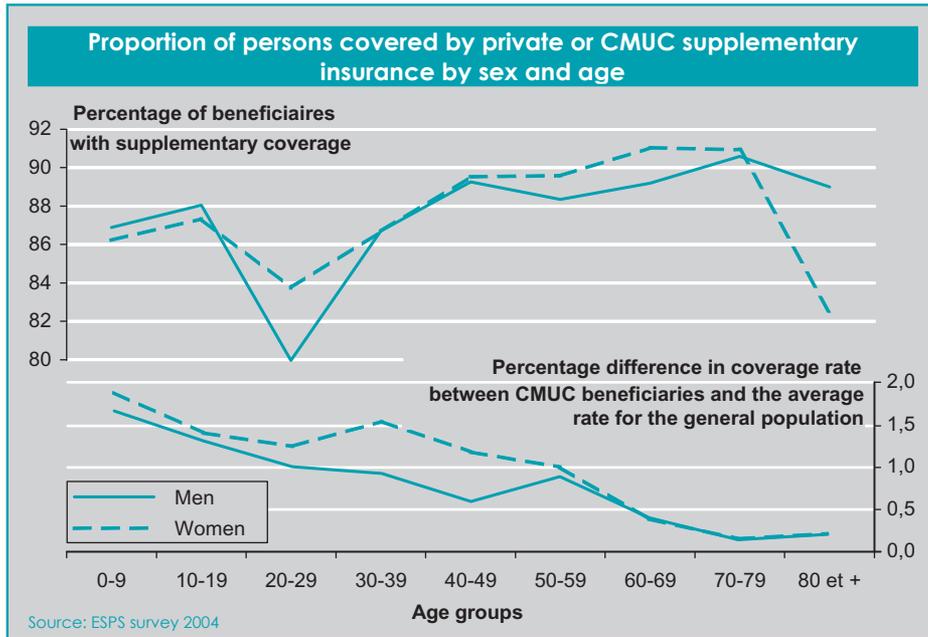
The percentage of persons reporting “fair”, “bad” or “very bad” health

status varies by social group, from 17% among households of managers to 32% among households of commercial employees. This social gradient remains after controlling for age and sex in the categories of the social group classification system. Thus the households of non-qualified blue-collar workers most often declare poor health status (1.4 more than the population average), and those of managers least often (1.6 times less than the average).



<sup>2</sup> If dental problems and vision problems are not taken into account.

<sup>3</sup> Here severity is assessed in terms of risk of life, not of risk of invalidity.



### Private and CMUC supplementary insurance: who is covered and who is not?

#### Young adults and the very elderly are least likely to use supplementary health insurance

Almost 92% of the general population state that they have supplementary insurance, 4% of whom have Universal Supplementary Health Care Coverage (CMUC). The ESPS survey underestimates the proportion of persons reporting CMUC cover because the population coverage rate is estimated to be 7% for 2004 in metropolitan France (Boisguérin, 2005). This underestimation is due to the under representation of the most marginal population groups in general population surveys.

If the proportion of beneficiaries is high during the early years (88% for 10-18 year olds), it declines steeply for 20-29 year olds, in particular for young men. Until the age of 20, most young men are covered by virtue of their parents' cover. After this, some of them do not take out supplementary cover, particularly given that health problems are rare at this age. Between 30 and 79 the proportion of beneficiaries increases with age, as the standard of living in-

creases and health problems emerge. Finally above the age of eighty, the proportion covered declines steeply again. Several factors could explain this, all of which would require further study:

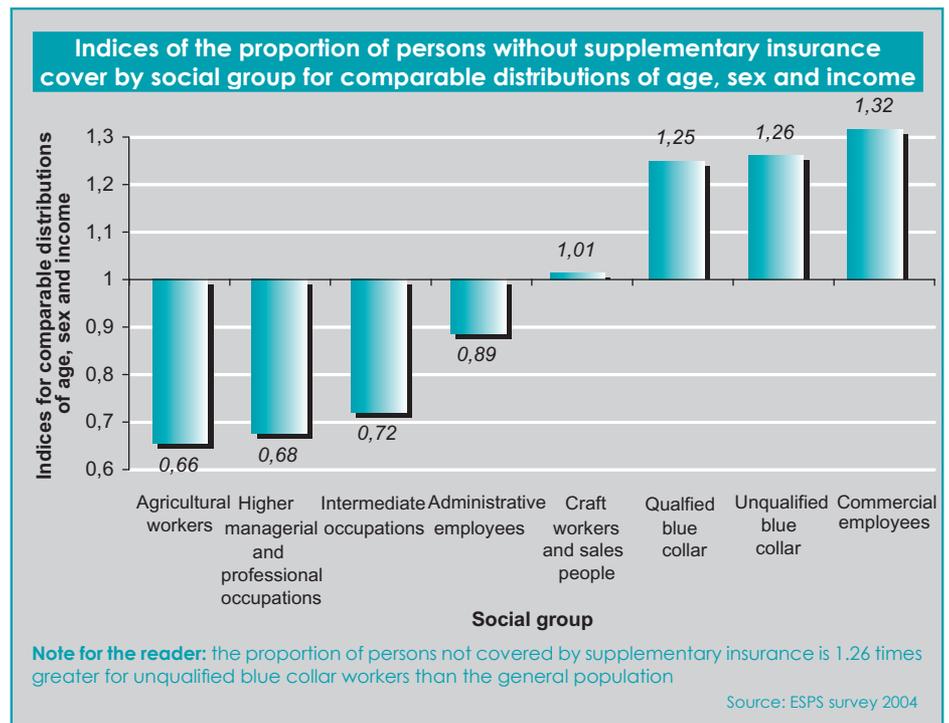
- an income-price effect: supplementary insurance is too expensive for this age group;
- a generational effect: during their lives older people have not been

accustomed to pay to cover their health risks;

- a "widow" effect: widows previously covered by their husbands' supplementary insurance lose this benefit following their partner's death and do not then take out their own insurance – this would explain the marked decline among women;
- an exemption from public co-payment (*ticket modérateur*) effect: one in two over 80 years old are exempted from co-payments. The fact that this cost is met may in some cases justify the absence of supplementary insurance.

#### Exemption from public co-payment

100% cover for care by the health insurance scheme for medical reasons (long standing illness, work accident or professional illness, maternity etc.) or social reasons (Universal supplementary Health Care Coverage (CMUC), State Medical Aid (AME).



**Women and children are more often covered by the CMUC than adult males**

The percentage of persons covered by the CMUC declines with age. It is 1.9 times higher than average for under 10 years old girls (1.7 times for boys) and five times less than average for over 70 years old. We note that the minimum retirement pension exceeds the income threshold determining eligibility for CMUC. The proportion of CMUC beneficiaries is 25% higher for women, specifically between 30 and 50 years old. This illustrates the poverty of some large and single parent families who are overrepresented among CMUC beneficiaries (Boisguérin *et al.*, 2001).

**Lack of supplementary cover is essentially related to income levels**

The absence of supplementary cover is closely related to level of household income. Hence, despite the existence of the CMUC, 18% of persons living in households earning less than 400 Euros per unit of consumption<sup>4</sup> state that they do not have supplementary insurance. This proportion reduces steadily with increasing income. It is only 4.5% among the most affluent households (more than 1 300 Euros per consumption unit).

The proportion of persons without supplementary health insurance varies by social group (see Box) even after

<sup>4</sup>To compare the standard of living of households of different size and composition, a measure of income corrected for consumption units (CU) is used, based on an equivalence scale:  
 - 1 CU for the first adult in the household;  
 - 0,5 CU for other members aged 14 or more;  
 - 0,3 CU for children younger than 14.  
 Hence a household made up of a father, mother, a child of 16 and another aged 12 has  $(1+0.5+0.5+0.3) = 2.3$  . CU. The household income per CU is equal to total household income divided by 2.3.

controlling for age, sex and income level. Members of households of commercial employees, and qualified and unqualified blue collar workers are least likely to be covered (1.3 times less than the average). Apart from differences between social groups in preferences or behaviour related to health risks, this result may also be explained by the fact that one in two persons are covered by a employer's group insurance contract and that the probability of being employed by a business which has such a contract is 80% for managers, 70% for blue collar workers and 64% for employees (Couffinhall *et al.*, 20045). Furthermore, unqualified blue collar workers and employees are the socioprofessional groups most likely to be affected by unemployment or to lack job security (CDD, temporary working) thereby risking the loss of private supplementary insurance cover.

<sup>5</sup> Following a modification in the weighting of surveyed establishments for extrapolation to the population of salaried workers, the data presented here have been corrected, and therefore differ slightly from those presented in QES 83.

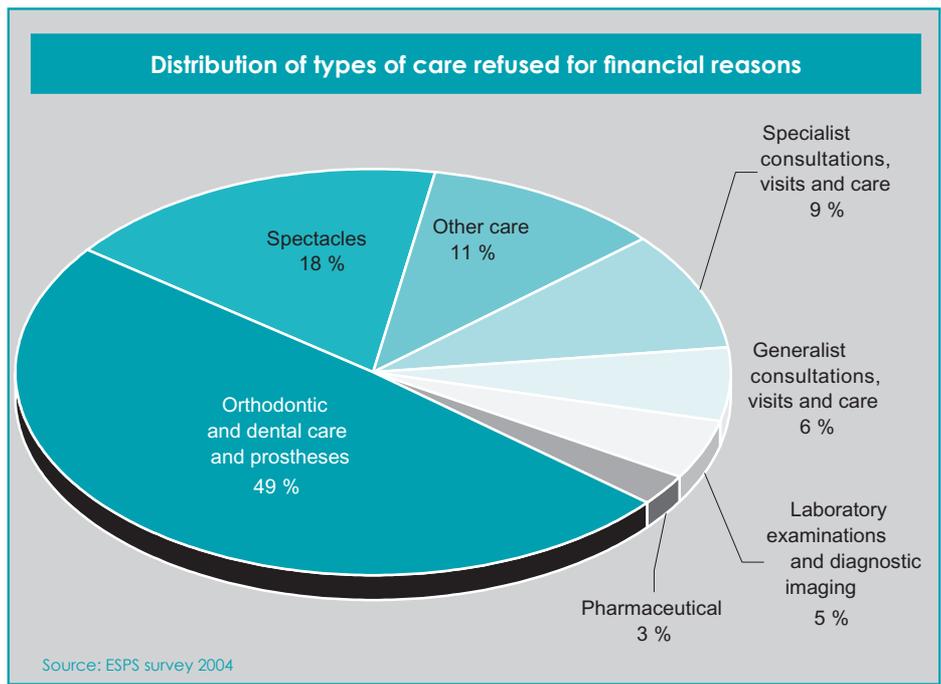
**Not sought care behaviour: who refuses what care?**

**Almost half of not sought care concern oral and dental health**

Overall in 2004, 13% of the population of metropolitan France report having not sought health care for financial reasons during the previous 12 months, 20% of these refusals being definitive, and the rest postponed. The not sought care or postponements concern a limited range of services, those for which the excess payable by the insured is greatest: 49% relate to oral and dental health, 18% to medical optics and 9% specialist care.

**Households of employees and blue collar workers refuse care most often**

The rate of not sought care varies by age, sex and supplementary health insurance cover. 16% of women report not sought care compared to 11% for men. A greater demand for health on the part of women may explain this difference (Azogui-Levy and Rochereau, 2005). Not sought care also differ by age group: it is highest between 18



### Collecting data on refusal of care in the ESPS survey

Information on refusal of health care is collected using the following questions in the ESPS survey:

1. During the last 12 months, have you refused health care for yourself for financial reasons? (yes/no)
2. What kind of health care have you refused? (3 possible responses)
3. Have you definitively refused care or just postponed it?

Hence it consists of subjective information, the analysis of which has shown for dental care that it depends on individuals' perception and representation of their health status (Azogui-Levy and Rochereau, 2005).

### Methodology

The Health and Social Protection Survey currently represents 96% of households resident in metropolitan France. It questions households with at least one member insured by the General Social Security Scheme (Cnamts), the Independent Professionals' Scheme (RSI) or the Agricultural Scheme (MSA).

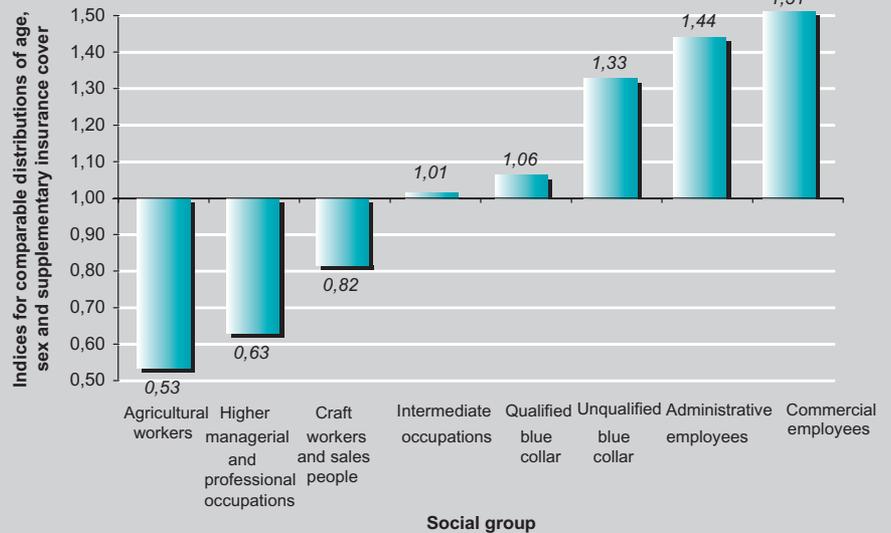
The survey is carried out for a sample of the population socially insured by Cnamts, the RSI or the MSA for consumption of medical care and medical goods. Every two years, half of the sample is approached.

The sampling frame enables the same individuals to be requestioned, i.e. insured persons present in the baseline survey and members of the household still cohabiting after four years. Secondly, the data collected by the ESPS survey is matched, for half the individuals, with data on reimbursed benefits held in the EPAS.

The survey takes place in two waves, one in Spring, from April to June, and one in Autumn, from October to December.

Telephone and face to face interviews are used as well as self-administered questionnaires. 70% of households contacted in 2004 agreed to participate in the survey, namely 8 000 households with 22 000 persons.

### Indices of refusal rates by social group for comparable structures of age, sex and supplementary insurance cover



**Note for the reader:** The proportion of persons refusing care for financial reasons is 1.5 times greater among commercial employees than for the general population for comparable distributions of age, sex and supplementary insurance cover.

Source: ESPS survey 2004

and 40 years of age (15%) and lowest among those older than 65 (7%).

Lack of supplementary health insurance cover is the main reason for not sought care: 28% of persons without cover report almost one not sought care, compared to 18% of those with universal supplementary insurance cover and 12% of those with private supplementary insurance.

After controlling for the effects of sex, age and supplementary health insurance, the rate of not sought care differs by social group. Households of employees and blue collar workers, both being groups with low incomes, refuse care most often (1.5 times the average for commercial employees). Households of managers refuse care infrequently and the households of agricultural workers even less (almost two times less often than the average).

These results hold for all types of care, whether it be dental, optical or specialist care. It is always women, persons without supplementary insurance, and households of employees and blue collar workers who are most likely to report not sought care.

### Further information

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