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Background

From September 1999 to May 2000 a survey known as Précalog, of patients attending 80 free health centres in France, was carried out. This survey looked at their health status and their approach to seeking health care. It was implemented within the framework of INSERM's "Social exclusion and health" Invitation to Tender, and carried out before the introduction of Universal Health Insurance (CMU). In particular it uses the questions of INPES' "Health Barometer 2000" in order to compare our sample's experience of illness with that of the adult population living in France. In addition, by collecting 24 qualitative accounts of their life situation from patients attending the centres it has been possible to carry out a sociological analysis of their health and use of the health system.

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Why patients attending free health centres seek care

Precalog Survey 1999-2000

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Marc Collet and Hervé Picard worked at IRDES at the time of the survey

One in two persons living in social exclusion reports having suffered pain which is difficult to endure during the year preceding the survey. Yet more than half refuse or delay seeking treatment. It appears that some of them are reluctant to seek medical care: they put off seeking a consultation or attend haphasardly, while others do not adhere to the prescribed treatment or even refuse to treat their health problems. Why is there this resistance or denial? While it does not completely answer this question, our survey shows the importance of people's relationship with the health system and the important influence of the particularly difficult lives which people living in social exclusion have endured (serious family problems during their youth, prolonged unemployment etc.).

This new exploration of the survey of persons consulting free health centres, carried out in 1999/2000, enables us to analyse the variety of motives for seeking care of the socially excluded population. It completes the recent study of Médecins du monde by looking again at a bigger sample.

Reasons for seeking care among persons consulting free health centres

	Reason for seeking medical care		Reason for non-compliance with the course of treatment		Reason for refusing care
	Demand for care without substantial financial difficulty (34%)	Some refusal of care because of financial constraints (13%)	Difficulty starting an episode of care (24%)	Difficulty complying with a medical prescription (8%)	FStrong refusal to start or follow medical treatment (21 %)
Medical care for pain or recent symptoms	Care sought immediately		Request for care delayed	immediate or delayed request for care	No request
Compliance with the latest prescriptions (drugs, related examinations)	Total compliance		Total compliance	Partial compliance	Non-compliance or very partial compliance
Refusal of care declared for financial reasons	No financial difficulty	Refusal of care reported particularly oral-dental care	Financial difficulty reported	No financial difficulty reported	Substantial financial difficulty reported

Source : IRDES, Précalog Survey 1999-2000
Note for the reader: The distribution of different reasons for seeking care relates to the sub-sample we were able to observe. Hence it is not representative of the complete range of **behaviour of the socially excluded population.**

The last report of Médecins du monde (2006) highlights the obstacles to access to care and specific aspects of the problems of destitute patients cared for in these centres in France. Notably it shows that these patients do not present a particular group of illnesses but that their problems are aggravated by their living conditions or delays in seeking treatment. The Précalog survey[1], carried out in 1999/2000 by IRDES[2], relates to a population more representative of the range of situations which constitute social exclusion than that of Médecins du monde: in addition to foreigners recently arrived in France, it includes SDF, single mothers, long-term unemployed, students, etc. (see Box, p. 3). Because it was carried out more than 5 years ago, before the implementation of CMU, it shows similar problems of health and interaction with the health system and throws further light on how people living in social exclusion obtain health care (Collet *et al.*, 2006a). We will briefly describe their health behaviour and attitudes to health care in order to understand their response to symptoms of illness, and will then show how they deal with health problems and attempt to understand why.

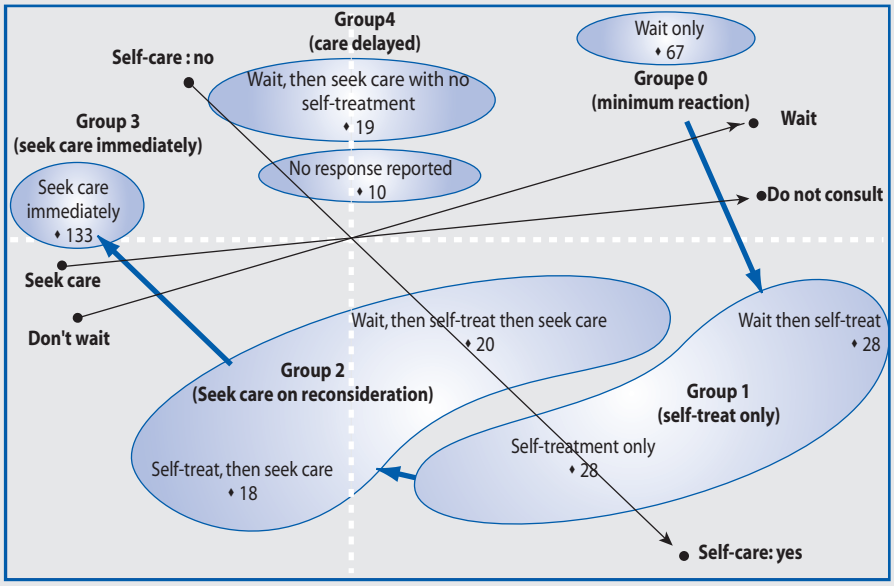
The approach to health and health care of patients attending free health centres

Among those individuals who have consulted a free health centre, 55%[3] report having "suffered pain which is difficult to endure during the previous twelve months" while this was the case for only one in three persons in a sample of the general reference population (Health Barometer 2000). An analysis of these former episodes of pain, carried out using multivariate analysis (see Figure below), shows that 60% of these result in medical consultations and 40% do not. More precisely, 41% of individuals report seeking care immediately, 6% seek care after a waiting period and 12% seek care having first tried to treat themselves before realising this was insufficient and consulting a doctor. In contrast, 17% preferred to treat their own problems whereas 24% simply preferred to wait.

Impared mobility is more likely than the intensity or duration of pain to result in consultation

The Précalog survey shows that some reasons for seeking care are much more important than others among patients of free health centres; psychological complaints, drug addiction, problems with mobility or motor function (Collet *et al.*, 2006a and 2006b). Interest in different organs or parts of the body varies between cultures and societies (Adam *et al.*, 1994). Hence it is interesting to observe how patients' reactions vary with the location of pain (see the figure below). For throat and stomach pain (generally considered to be worrying) or for dental or ear, nose and throat problems, they usually do very little. On the other hand pain in the upper or lower limbs concerns patients more, to the extent that they seem to seek treatment immedia-

Responses of patients at free health centres to an episode of pain



Source: IRDES, Précalog survey 1999-2000

Note for the reader: This multiple correspondence analysis (MCA) relates to those variables describing individuals' reactions to an episode of pain (wait or no wait, self-treat or not, consult a doctor or not).

The factoral plan (vertical and horizontal axes) summarises 84% of individual information on the range of responses to the last reported episode of pain. The horizontal axis compares individuals according to whether or not they consulted a doctor. The vertical axis contrasts individuals who self-treated with those who were content to wait until the pain passed. The number of patients in each group is given after the group labels.

1 The Précalog survey was carried out in 80 free health centres, with 590 patients responding to the questionnaire (see Box, p. 5)

2 At the time of the survey IRDES was called CREDES

3 That is 323 of the 590 individuals surveyed (see Box p. 5)

tely. Similarly, patients with dorsal or lumbar pain are more likely to consult a doctor, these two phenomena supporting the hypothesis that loss of independence of movement is more likely to provoke a response to their problem than the intensity or duration of pain. Other areas of pain result in more subtle or varied reactions. Sadness and anxiety (low morale) are often not dealt with or result in one-off medication, suggesting that a more comprehensive or profound solution is being rejected to a certain extent.

Big differences of approach to managing illness

If the greater exposure of the body to certain problems is a priori due to the often poor living conditions of persons living in social exclusion, it is equally a function of their relationship with health and the health system. The 24 in-depth interviews confirm that they have a different approach to managing illness, and throw further light on this. More than one individual in two pays some attention to his health problems and has a "utilitarian" view of his body. These people manage their problems pragmatically, albeit with variable success given the precariousness of their resources. In contrast the other interviewees seem to be largely governed by their illness and by the anxiety it causes. This impotence together with a certain passivity, and, very often, ignorance of and distance from the health system, often goes hand in hand with an inability to get on top of chronic psychosomatic problems (asthma, spasmophilia, psoriasis). These are often associated with feelings of guilt, lack of self-esteem and depression (Laplantine, 1986), all of which make medical help seem pointless.

Characteristics of free health centres and of the surveyed patients

80 free health centres agreed to take part in the survey.

The Précalog survey was carried out from 1999 to 2000 in 80 centres for free health care, distributed across the country. The characteristics of the centres which agreed to participate in the survey are quite varied, in particular:

- Most of them are small: 49% have fewer than three doctors practising regularly, 27% have between 3 and 9 doctors, and 24% have 10 or more;
- Most of them are organised as associations (45%), or report to humanitarian organsations (24%), or to communal organisations, or Centres for Lodging and Social Reinsertion (CHRS), (20%) or hospitals (11%);
- free health centres are usually located in big cities: 66% are in urban centres of more than 80,000 inhabitants;
- they are more often located in northern France: 44% are north of the Paris region compared to 39% to the south.

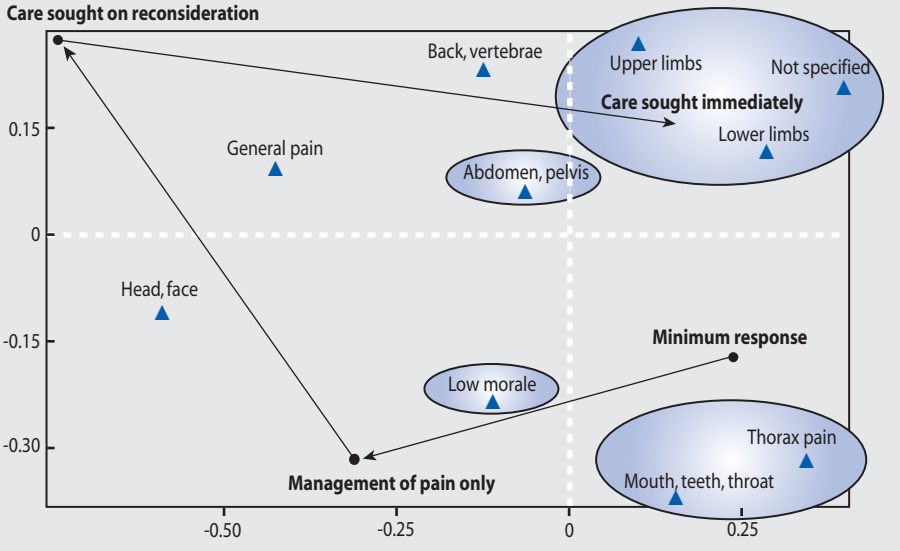
Almost 600 patients were surveyed.

In total 590 patients agreed to participate in the survey. This population is predominantly male (70%) and young (more than half are younger than 35). They are mostly of French origin (52%), while 18% come from the Maghreb, 16% from the regions of Africa and 7% from European countries.

The following variables relate to material aspects of social exclusion or isolation (Collet, 2001):

- fewer than 18% are in stable or temporary employment;
- only 13% have access to a pension or a declared salary, 36% live on unemployment benefits, on income support (RMI), or on other benefits;
- only 26% live in their own accommodation, 28% live in instituions32% live with friends or family and 14% have no fixed abode;
- 42% of foreigners do not have a residence permit;
- 45% of respondents are covered by Social Security and 9% by medical assistance. 40% report no social protection and 6% do not know what their administrative situation is;
- finally, 52% live completely alone (more than three quarters being men) and 9.5% live alone with their children (68% are women).

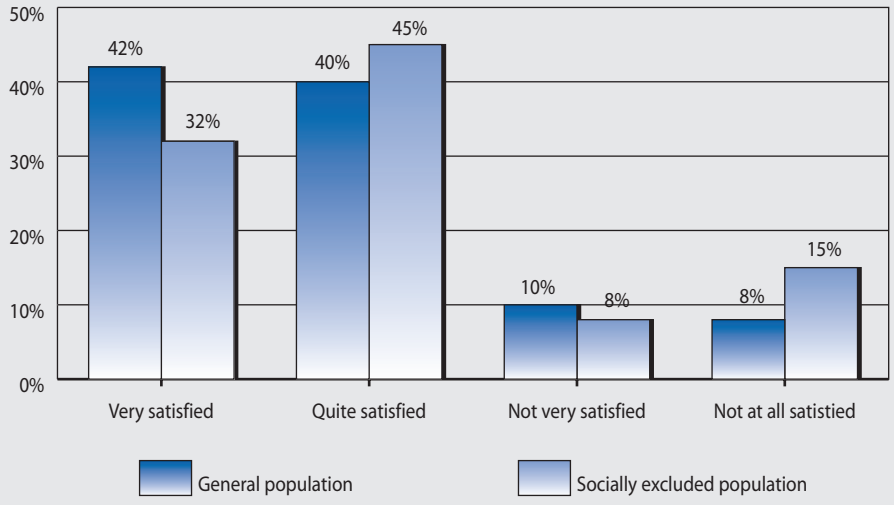
Approach to dealing with pain by location of pain



Source: IRDES, Précalog survey 1999-2000

Note for the reader: This correspondence factor analysis (AFC) enables us to show graphically the intersection between the four principle means of responding to an episode of pain according to its physical location.

Standardised comparison of degrees of satisfaction of socially excluded patients and the general population following medical treatment of an episode of pain



Source : IRDES, Précalog survey 1999-2000 & INPES Health Barometer 2000

Note for the reader: Differences are significant at p = 0,05

Varied compliance with prescriptions and a strong tendency to self-prescribe

According to the questionnaire survey, more than 80% of persons with treatment prescribed at their last consultation report adhering to it closely. However the semi-structured interviews show that specific aspects of people's living conditions, their previous experience, or their views of themselves and of medical care can affect their attitudes to medication. Hence lack of housing security – much more than lack of social protection or financial resources – may prevent proper dosage compliance, particularly over long periods. Being more concerned with the immediate future may also mean that people do not comply properly with prescriptions: more attention is paid to pain relief than to the cause of pain, stopping the course early at the slightest sign of improvement of health status, etc. Finally, the importance of self-medication should be noted, given that 30% of patients reporting an episode of pain have practised this.

Apprehension and defiance of doctors

The interviews carried out show that relationships with health personnel can sometimes be problematic, quite apart from the reluctance of some health staff to see socially excluded patients. Considerable apprehension of the idea of consulting the "white coats" or feelings of defiance towards health staff may result in considerable delays in or refusal to seek medical treatment. In the Précalog sample, one individual in eight reports being afraid of going to see the doctor. The more problems reported by an individual before the age of 18, the greater this fear of doctors.

Initially it would appear that socially excluded persons' general level of satisfaction with treatment of an episode of pain is similar to that of the general population (77% of the 590 patients of free health centres are very or quite satisfied, compared to 82% of the Health Barometer sample). However more detailed analysis of the responses (see the figure below) shows that individuals from the socially excluded population are more likely to be resistant to medical care. Compared to the general population, for a similar distribution of age and sex, they are less likely to be completely satisfied (32% compared to 42% of the general population) and are more likely to be extremely dissatisfied (15% compared to 8%). The interviews suggest however that this defiance, which is often due to their personal circumstances, is reserved for particular health professionals (general practitioners and psychiatrists in particular).

Three main approaches to seeking care

Thanks to a wide range of questions, the Précalog survey provides an overall view of individuals' health behaviour: reported refusal of care, compliance with prescriptions, responses to an episode of pain, etc. However it is difficult to pinpoint and understand the approach taken to medical care when faced with health problems given the numerous, interrelated and overlapping factors affecting this population's use of the health system: attitudes to the body and to health risks, perceptions of illness and of the health system, and people's perceptions of themselves. Thus we have tried to differentiate and describe as well as possible the common features of the different approaches to care taken by people living in social exclusion, consider their specific aspects, and then look for their economic, social and psychological determinants.

Methodological limitations in constructing a typology of approaches to seeking care

One key difficulty in constructing our typology of approaches to care relates to the great variety of individual information; both in terms of quantity and type of information. It was therefore necessary to select individuals for whom we have enough homogeneous and comparable information to provide an overall view of their approach to seeking care (see the box on p. 6); that is 261 of the 590 (44%) patients providing information on those dimensions considered to be fundamental. This restriction induces selection bias: those individuals with fewer health problems (currently or in the recent past) are less likely to provide information on their approach to seeking care.

Another limitation is that patients at free health centres are not completely representative of the so-called "socially-excluded" population; in particular those people who see no point in caring for oneself or refuse to consult any health professionals, do not seek care from these organisations.

Hence, the multidimensional analysis of the results presented below does enable the identification and differentiation of three approaches to seeking care but does not purport to be either representative or exhaustive of their actual distribution in the population consulting free health centres (still less of the socially excluded population). Below we present these three approaches: that of using medical care, that of non-compliance with the treatment process, and that of refusing or giving up care (see the summary table on p 1).

Using medical care

124 individuals (47% of the sub-sample) display behaviour which we label "using medical care". As soon as they have pain or discern a medical problem they consult a doctor as quickly as possible. When they are issued with a prescription, they state that they follow it scrupulously. They pay attention to bodily stimuli, have a strong tendency to medicalise their possible heath problems, and consider medical advice and diagnoses to be relevant. In fact it is possible to identify two subgroups: those who do not report any financial difficulties in taking care of their health (75% of them); and those who consider that their lack of financial resources has hindered their health care (several cases of giving up care were reported, particular for mouth and dental problems).

Non-compliance with the treatment process

82 individuals (32% of the sub-sample studied) are ambivalent about consulting a doctor and following a course of treatment. While medical consultations and complying with prescriptions for a health problem are not rejected as a matter of principle, such behaviour is not automatic. This "non-compliance with the treatment process" takes two forms:

- 62 patients (76% of them) seem to find it difficult to make contact with the medical system when they have physical or psychological problems; either they delay this, or their response depends on the intensity or location of the pain. They are very likely to cover up a problem, or diminish its significance, or to put off consulting until the "pain becomes too severe". These attitudes correspond to the approach of delaying care: medical treatment is only considered when the problem gets worse.

- The 20 other patients (24%) have difficulty complying with a medical prescription. When they go the doctor it is normally for a diagnosis or to seek reassurance. In this situation, they are likely to decide for themselves whether a particu-

Data sources: Precalog Survey

The IRDES survey « Approaches to seeking care among persons living in social exclusion », so-called "Précalog", was carried out in 80 free health centres across France. In these centres, each participating doctor included the first three patients seen on a given day. The social section of the questionnaire was completed by reception staff, and the medical section by the doctor. In total 590 adult patients responded to the different sections of the questionnaire.

An initial series of questions enabled evaluation of the level and types of social exclusion among the patients based on their financial resources and social situation. The questionnaire then moved on to review various points relating to problems during childhood, any serious accidents suffered and to care-seeking behaviour (delays in seeking care, response to an episode of pain, compliance with medical prescriptions etc.). Finally, the doctor collected information on the reasons for seeking care (specific diagnoses relevant to the purpose of the consultation) and finally on any dental problems of the patients.

At the same time, qualitative interviews were carried out with 24 persons attending the free health centres. Their purpose was to gather accounts of the patients' lives in order to relate life events to perceived health and approaches to seeking care, in order to understand more clearly how this came about and to capture additional detail.

Method for developing a typology of approaches to seeking care

Care-seeking behaviour can be described using 4 key dimensions:

- refusal of care for financial reasons;
- response to an episode of pain or illness detected by the individual;
- compliance (with drug prescriptions, diagnostic tests);
- response to a dental problem (replacement of missing teeth, tendency to go to the dentist to treat caries or obtain dental prostheses).

Because not every individual provided information on each of these dimensions, we selected a sub-population for whom we have a level of information consistent enough to enable analysis of approaches to seeking care, i.e. 261 patients of the 590 survey participants. The criterion for inclusion of patients in this survey (information available for each of the dimensions, with the possible exception of response to a dental problem) was made intentionally strict in order to obtain understandable and reliable groups for modelling using regression methods. For this population, and for each of the dimensions, individual behaviour is characterised quite simply in terms of its distance from "an ideal behavioural norm" – propensity to reject or delay care. Then, using an ascending hierarchical classification preceded my multiple correspondence analysis, we obtain homogeneous and coherent groups in terms of their approach to care.

lar treatment is necessary or useful. Hence their approach is to seek care quickly, with the consultation viewed as a source of information and advice rather than a serious engagement with a course of medical treatment.

Refusing medical care

55 subjects (21% of the sub-sample) take a minimalist approach to the health care system. They are not very likely to seek medical consultations or comply with any prescriptions. More than one in two persons decide not to consult a doctor even for an episode of severe pain, and if they do prescriptions are only partly complied with. Most of them report having refused necessary care for financial reasons at least once during the year. The behaviour of this group corresponds to "an approach of refusing or giving up care". The remarks made in these interviews suggest that this approach is often related to feelings of worthlessness and stigmatisation concerning their lifestyle, as well as a refusal to let others intrude in their suffering (connected with mistrust and suspicion of the medical and social care system).

The determinants of approaches to care-seeking

Using regression models we can begin to assess, "all else being equal", those factors which prevent or encourage the three main approaches to care-seeking studied here (probability of adopting one approach rather than the other two). This consists principally of identifying the relative weight of, apart from the classical socio-demographic variables (age, sex, nationality), objective living conditions (social protection, economic constraints, housing insecurity, etc.[4]) or more subjective variables which show particular aspects of fragility in difficult situations (feelings of isolation, difficulties in childhood, risk behaviour, fear of doctors, etc.). The table on p. 7) summarises the weights of the different significant variables.

This approach fits into social policy research on what restricts use of the medical system: is this due principally to material constraints facing individuals which objectively cause inequality of access to care? Is it due to the resources which individuals do or do not have because of earlier successes or failures or events during childhood (Fidion, 2006; Menahem *et al.*, 1994)? Or do these individuals refuse care because of their personality which is also related to their social exclusion?

The young are more likely to refuse care

If, "all other things being equal", neither sex nor nationality have any influence on the likelihood of adopting one approach over another, this is not the case for age. Individuals over 30 are much more likely to seek a medical solution to their problems than others (with a 1.8 times greater probability of belonging to this group). On the other hand, the probability of belonging to the group which refuses care is three times greater among patients under 30.

The care-seeking approach is usually asociated with better living conditions...

If living conditions deteriorate, there is less room for manoeuvre when a health problem arises. Given material hardship, certain problems (often considered minor or transitory) are not given top priority which may mean a delay in seeking care. The weight of the variables of unemployment or occupational insecurity considerably reduces the likeli-

4 The health status of patients was not determined medically in this survey, hence this a priori important variable was not included in the models.

hood of belonging to the "care-seeking" group (the odds ratio of 0,43 is highly significant) and makes it more likely to use the medical system less or look for alternatives. Financial constraints affect decisions to begin an episode of care: limited resources mean that people will seek to reduce the financial burden of their health problems, either by refusing care or treatment on an ad hoc basis, or by delaying consultations as long as possible. Finally we note that while the lack of social protection might make an individual highly likely to refuse care, this does not appear to explain approaches to seeking care in this study. However, it should be noted that given the methodology of this survey we have only interviewed those individuals who know that they can obtain free health care without having to demonstrate their entitlement. This would tend to minimise the effect of the lack of social protection or financial resources....

Significant variables* for the probability of adopting different approaches to care-seeking (odds ratios)**

Significant variables	Using care approach	Non-compliance with care approach	Refusing care approach
31 years and more *versus* less than 30 years	1.81	n.s.	0.38
No social protection *versus* social protection	n.s.	n.s.	*1.65*
Illegal immigrant *versus* regularised administrative situation	n.s.	n.s.	0.61
Unemployed or black market *versus* stable employment	0.43	n.s.	*2.63*
Very precarious economic situation *versus* regular income	n.s.	*1.75*	n.s.
Childhood problems reported *versus* no problems	n.s.	n.s.	2.9
No apprehension of doctors *versus* apprehension	n.s.	*2,97*	0.35
	1,28	n.s.	n.s.
Fumeur *versus* non fumeur	*0,8*	1,59	*0,78*
R2	**0,13**	**0,15**	**0,26**

Source : IRDES, Enquête Précalog 1999-2000

* Seules les variables ayant une influence significative sont mentionnées dans ce tableau. Pour autant, d'autres variables ont été intégrées aux modèles de régression sans que leur impact s'avère significatif : le sexe, la nationalité, le type et la taille du centre de soins, la situation à l'égard du logement, la situation familiale, le niveau de scolarisation, le sentiment d'isolement, les comportements face à l'alcool et les accidents graves connus au cours de l'existence.

** Chaque odds-ratio représente le risque relatif associé à une variable de relever d'un type de logique par rapport à la situation de référence, « toutes choses égales par ailleurs » quant aux autres variables du modèle. Un odds-ratio supérieur (respectivement inférieur) à 1 pour une variable est interprété comme un facteur d'accroissement (respectivement de réduction) de la propension à adopter la logique de soins étudiée.

La mention « n.s. » signifie que la variable n'est pas significative avec un risque d'erreur de moins de 10%; un odds-ratio en caractère italique indique une significativité comprise entre 90 et 95% et en caractère normal un risque d'erreur inférieur à 5%.

... but it is the comined effect of external and internal aspects of social exclusion which results in the approach of refusing care »

How can we explain the fact that some people decide to seek care when the pain becomes intolerable and the problems persist, despite their lack of resources (non-compliance with care approach); while others still refuse to seek treatment (refusing care approach)? Very often it is this combination of external and internal aspects of social exclusion which we find in many individuals who are very likely to refuse care altogether, while individuals who are less traumatised psychologically end up seeking care. Hence, we are three times more likely to observe "wait and see" behaviour among individuals who report at least two problems during their youth. Adopting an approach of refusing care is also associated with a strong tendency to feel threatened or anxious in their dealings with doctors. Taken together these factors show that difficulties in mobilising resources to care for oneself and a state of distress, isolation and lack of affection are highly likely to go hand in hand.

Finally, we note that individuals who actively engage in care are less likely to engage in harmful behaviour (less likely to smoke heavily). On the other hand those who are more inclined to adopt a wait and see attitude in dealing with their problems pay less attention to their health, and are more likely to display addictive behaviour (heavy smokers).

* * *

The difficult lives of patients who use free health centres result in more frequent reporting of health problems compared to the general population. More fundamentally, they result in approaches to seeking care which differ according to people's personal situation, lack of employment and experience of serious problems during childhood, these being the variables most likely to

Extracts of interview responses illustrating the three approaches to care

The responses presented here, collected during interviews, show that the three approaches to care defined in this study remain very theoretical. If we examine each case, we see that people's experiences vary widely.

The approach of using care: the example of Kadisha

Kadisha is a 25 year old Moroccan illegal immigrant. She is unemployed and lives with friends. Being two months pregnant, she seeks a consultation at a Médecins du monde centre. Kadisha says that she pays great attention to her health: *"Health, it's totally important in your life.. It's the most important thing. Life isn't a game, above all your health."* In fact she thinks that you should consult a doctor for any kind of health problem: *"Because apart from the simple illnesses, there are much more serious problems. For example sore throats can cause serious heart problems."*But her approach is based on a notion of blame. She thinks she has done something wrong if she is ill and does not go to see a doctor. As a child, and still today, she thinks it is her fault if she is ill: *"I always say: it's, it's my fault; why did I do that? Why did I do that?"*

The approach of non-compliance with care: the example of Morice

Morice is a 48 year old Breton. He has been unemployed since 1998 and works on the black market. His income is poor and he lives in a communal social action centre following treatment for alcoholism. During the interview he expresses a profound mistrust of medical treatment and a preference for alternative medicine (herbal treatments, bonesetters etc.). He says that he seeks treatment for serious problems. *"Sore throats I treat myself with lemon juice, with honey. No! I don't like that. Medicines are useless for that. But if I see that the lemon isn't working I'm not going to wait several days before consulting a doctor. I'll wait 2 or 3 days. But if I see that it's not going away then there's maybe something else, like a cold, say. Because they don't heat the house very much, stupid things like that. I prefer to know....."*

The approach of refusing care: the example of René

René is a 45-year old Frenchman who has a disability pension (Cotorep). He has not come for a consultation, but to get a food package (which he is given). His approach is one of refusing care, but in this case as well for specific reasons: *"(...) I've escaped death a few times, I've slashed my wrists, I've hanged myself, I've swallowed sleeping pills, when I've had crises I've hanged myself for my ex-wife, I've done crazy things for my children when they've taken them away"*He has a very ambivalent attitude to the health system. He is very suspicious: *"Doctors, some are good, some are stupid. For me, they're not all the same. But there are some who are bastards as well, who put me in a mental hospital when I didn't deserve it. Them, they're bastards. And there are those who got me out, they're good, they understood that I'm not mad."*

But this lack of trust is not the only reason he refuses to be treated. He has a religious side which means that he should put up with pain: *"When I cut my leg, I didn't go to the doctor. I don't want to see the doctor, I want my wife to look after me, that's all. My wife and me that's all. They saidif it got worse I would get gangrene. But as long as it doesn't get worse I don't want anything. Jesus, he didn't cry, and I do what he did, I do. Me, I'm just like Jesus, he served the world, I serve the world, if I can help. If I can love, I love. If I don't love, well...that's all!"*

result in delaying or refusing care. Our results do not show whether one variable is more important than the others. But they do show that measures designed to assist this population will have to take into account a diverse range of situations.

Thus, the CMU, which was implemented just after this survey, does not appear to have addressed everything. On one hand, it would appear that a significant proportion of doctors refuse to treat patients covered by the CMU or by the AME, a situation recently highlighted by the CMU Fund and confirmed by Médecins du monde. On the other, some socially excluded patients delay seeking care and even refuse it, often at particularly difficult periods in their lives. This shows that there is still much to be done to improve the way in which we care for this population, if we want to reduce the impact of their health problems.

Further information

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