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Healthcare Renunciation: a Socio-anthropological Approach

Caroline Després^a (Irdes), Paul Dourgnon (Irdes ; Paris-Dauphine University, Leda-Legos),
Romain Fantin (Irdes), Florence Jusot (Paris-Dauphine University, Leda-Legos ; Irdes)

Although the concept of healthcare renunciation is regularly employed in health surveys and increasingly called into the French public debate, it has never been subject to methodological questioning to analyse the term's underlying significations. If health surveys frequently refer to healthcare renunciation for economic reasons, a socio-anthropological approach using in-depth interviewing permits a broader analysis of its signification for the individuals concerned and establishes the social, economic and cultural determinants involved.

This study shows that there are two main forms of healthcare renunciation: barrier-renunciation and refusal-renunciation. In the first case, individuals are confronted with an environment of constraints, more notably budgetary constraints, preventing access to the desired care. The second case is an expression of patient autonomy with regard to conventional medicine. It is characterized by the refusal of certain specific therapies or a more radical, definitive form of refusal when seeking treatment is perceived as being unnecessary. These two forms of healthcare renunciation (barrier and refusal) are often interrelated: the economic factor is rarely isolated and is frequently combined with other reasons leading individuals to forego treatment.

An econometric analysis, based on the results of a survey on healthcare renunciation for economic reasons, is being published simultaneously (Després *et al.*, 2011).

Healthcare renunciation is a concept more and more frequently called into the French public debate. The results of the Health, Health Care and Insurance survey (ESPS) are thus regularly commented and have contributed to the widespread diffusion of the term now used in a variety of social contexts be it in the political domain, health insurance regulation or

research in the social sciences. Healthcare renunciation for economic reasons is used as an indirect indicator in public policy evaluations, notably the Universal Complementary Health Insurance scheme (CMU-C)¹. However, with the exception of an economic study based on Canadian data (Allin, Grignon, Le Grand, 2010), no study has clearly defined the concept of healthcare renunciation and no metho-

dological research has been carried out to analyse the term's significance for the individuals concerned.

In the social sciences, research into healthcare renunciation echoes more

¹ The CMU-C is a free-of-charge and means-tested CHI for low-income individuals (Couverture maladie universelle complémentaire).

^a Corresponding author: despres@irdes.fr

general research on the non-take-up of social rights and public services (Hamel and Warin, 2010; Warin, 2010; Dufour, Legal, Wittwer, 2006). In the healthcare field, the non-take-up of public health services by sick individuals, even free of charge, has already been the subject of relatively dated research, notably in North America. This question thus requires re-examining in the current French context characterized by the implementation of different reforms aimed at controlling public health expenditures on the one hand, and improving access to health care services on the other.

This methodological questioning has motivated research associating two different approaches, one socio-anthropological and the other micro-economic (Després *et al.*, 2011). The aim of the socio-anthropological approach is to analyse the signification of healthcare renunciation for the different social actors involved (experts, institutional actors, researchers, population) and identify the social, economic and cultural factors determining these attitudes. The study is based on field work carried out in the Lille region (Methods insert).

It notably involved clarifying exactly what people understood by the term when questioned on healthcare renunciation in a personal context and through this, gain a better understanding of the causes behind the growing rate of healthcare renunciation according to social categories and the type of social protection from which they benefit.

The challenge consisted in evaluating the tool's ability to treat problems relating to equitable access to health care. The various ways in which healthcare renunciation is understood by different social categories was thus given particular attention.

METHOD

Semi-directive interviews

35 semi-directive interviews, lasting between one and a half and three hours, were conducted in the metropolitan region of Lille and its outlying districts (Armentières, Templeuve, and Bercey). These interviews primarily targeted individuals with precarious living conditions but the cohort was extended to other socioeconomic categories to add a comparative dimension and give greater depth to the analysis.

Interviews based on healthcare narratives

Interviews were based on healthcare narratives (Saillant, 1999), that is to say respondents' descriptions of their health and sickness histories and the way in which they had been treated at different times in their lives: serious illness or sickness episodes during the course of everyday life, actions to recover or maintain health. So as to understand the place occupied by the term 'healthcare renunciation' (or the verb to renounce) in respondents' narratives, they were invited to relate health events in their own words and ways of reasoning, the terms 'renunciation' and 'renounce' having been removed from our questions and statements.

Other than its spontaneous use during the course of the interview, the aim was to understand what 'ordinary' individuals understood by the concept of healthcare renunciation by analysing specific situations, whether perceived as renunciation or not, permitting a finer definition of the concept. To achieve this, the term was introduced by means of a question whose wording was close to that used in the ESPS survey omitting 'for financial reasons' in the first instance and introducing it in a second instance.

Finally, a third phase invited respondents to give their own definition of healthcare renunciation or renouncing a specific treatment which appeared difficult for a large number of respondents given their unease in formulating ideas in a relatively theoretical manner.

The empirical data provided by the interviews were put into perspective using academic (dictionary) definitions that helped in the construction of a common meaning, institutional interpretations and those used in the field of research on healthcare renunciation.

Understanding the causes of healthcare renunciation: an analysis of healthcare trajectories

In order to understand the origins and causes of healthcare renunciation and its different forms, we reintegrated them into a broader analysis of therapeutic trajectories (care trajectories) at different periods of individuals' lives. This broader approach permitted replacing renunciation behaviours in a diachronic perspective (in relation with past events). The complexity of each therapeutic trajectory associated with a specific health problem was restored by exploring the different health care universes experienced and by identifying the constraints weighing on these care trajectories. In the same way for the significance of the term, we studied all the associated determinants of healthcare renunciation in order to reintroduce its financial dimension within all the social logics contributing to self-reported renunciation and to permit an analysis of the different interrelationships between these dimensions. The notion of healthcare trajectory implies a series of choices within the healthcare trajectory according to the possibilities available.

These health care trajectories (preventive and curative) were analysed within a broadly defined global therapeutic space (Saillant, 1999) extended beyond the sphere of conventional medicine. It includes two additional sectors, the use of the family and domestic space and the 'alternative medicine' or 'parallel medicine' sector that we will refer to as non-conventional medicine (still referred to as, complementary and alternative medicine, in Anglo-Saxon literature) (Cohen, Rossi, 2011). This therapeutic environment provides not only care but also a social environment enabling interactions between social actors, users and institutions and those producing standards of practice.

The meaning of healthcare renunciation for the different actors concerned

Starting from the hypothesis that the different actors concerned assigned different meanings to the concept of healthcare renunciation, the analysis was approached from various angles: expert conceptions (constructed by institutional actors, public health professionals, researchers in Health Insurance field) and common conceptions (that of the population and non-experts). The different interpretations were put into perspective. The term healthcare renunciation is considered as being sufficiently explicit so as not to require a definition. Yet, this lack of definition poses a problem as several significations can come into play according to the context in which it is used.

Healthcare renunciation as conceived by the experts

The questions asked in the ESPS survey above all aim at determining whether respondents forego certain specific types of care for economic reasons and thus indirectly questions the efficiency of their health insurance coverage. In the first IRDES surveys, health care renunciation explicitly referred to insufficient health expenditure reimbursements. In the public authority reports and research publications, healthcare renunciation is primarily considered as an obstacle to accessing healthcare (access to professional health

CONTEXT

This study is part of a multidisciplinary research project financed by the DREES (Directorate of Research, Studies, Evaluation and Statistics for the Ministry of Labour, Employment and Health) Research Mission (MiRe). The project aims at studying healthcare renunciation for economic reasons in greater depth and ensures that the concept and the way it is measured is methodologically appropriate. To do this, it makes use of socio-anthropological analysis tools, econometrics and survey methodology.

care services or a specific treatment) due to financial difficulties or the unavailability of health professionals.

The etymology of the term, and dictionary definitions, refer to a voluntary act that supposes a certain degree of deliberation. Renouncement is either the abandonment of the goal pursued, rightly or wrongly considered as being inaccessible, or the result of a choice between several alternatives which leads to renouncing one option in favour of another. The institutional definitions do not take into account that a form of choice presides in these individual attitudes, even if it can involve a choice under constraint.

We thus propose a definition that allows combining all the different meanings produced: 'Healthcare renunciation applies to individuals who do not solicit healthcare services or health professionals when they have a health problem, experience a physical or psychological disorder or when they do not have access to the totality of the care prescribed.'

Healthcare renunciation is founded on the individual's subjective need

Individuals project to use healthcare services according to the way in which they identify and interpret their symptoms and social norms regarding the way to face up to them. This need is socially differentiated: it is configured by norms that vary according to social group which acts as a limit in the analysis of health care renouncement by social category.

Healthcare renunciation can occur at any moment during a healthcare trajectory

The dynamic analysis of health and treatment trajectories allowed us to identify the different forms of healthcare renunciation at different stages of a patient's care trajectory: before consulting a health professional but also once the diagnostic and therapeutic process had been engaged and in different areas within the therapeutic space (conventional but also complementary and alternative medicine). The non-observance of medical prescriptions (diagnostic or therapeutic orientations, follow-up or treatment) constitutes a form of healthcare renunciation when the patient decides not to observe or partially observe treatment recommendations.

Healthcare renunciation as understood by individual respondents

In the first part of the interviews, focusing on illness trajectory narratives (Methods insert), individuals never spontaneously used the term 'renunciation' to describe personal situations in conformity with our definition. This confirms the fact that the concept is not part of current healthcare vocabulary. These results, valid whatever the individual's social category, confirm previous research analysing illness trajectories (notably Wittwer *et al.*, 2010, in the same region of Lille).

The analysis of lay interpretations of healthcare renunciation was thus based on concrete experiences described in the illness trajectory (or health trajectory) narratives. For the researcher, it involved examining situations that qualified as healthcare renunciation and those that did not once the question had been introduced to respondents.

Asked directly, the question 'Have you at any time renounced healthcare?' is interpreted differently according to individuals' care trajectories. On hearing the question, respondents frequently interrogated the researcher before responding, revealing the term's polysemous nature rather than a lack of understanding. The term 'healthcare renunciation' is frequently subject to resistance, that is to say individuals answer the question by reformulating it, sometimes censoring the word

'renunciation' to make sure their response is correctly situated in their own personal context.

These empirical results suggest that in a questionnaire survey context where responses are prefabricated and imposed, respondents have difficulty interpreting its broader dimensions and answer in context, according to their own experiences and the way they interpret the researcher's expectations. This leads to a certain form of statistical dispersion allowing us to conclude that collected data is not homogeneous from one individual to the next. When the question specifies 'for economic reasons', responses appear relatively coherent referring back to the notion of 'barrier-renunciation' (*cf.* below) that can be juxtaposed to expert conceptions.

Barrier-renunciation: an environment of constraints that do not allow access to the desired care

Two forms of healthcare renunciation emanating from different social contexts were identified: barrier-renunciation and refusal-renunciation.

In the case of 'barrier-renunciation', the individual is confronted with an environment of constraints that do not allow access to the desired health service. This form of renunciation calls into question the efficiency of the health insurance system and the organisation of health care supply, that is to say the structural dimensions that impede access to healthcare often through budgetary constraints. In these cases, the individual makes choices between healthcare and the other dimensions of his existence.

Healthcare renunciation 'for economic reasons'

Healthcare renunciation for economic reasons includes a series of factors that are often combined: the cost of treatment, its reimbursement rate and out-of-pocket payments that vary according to health insurance and quality of coverage, income level, and available income at the time

Barrier-renunciation. The case of Loïc*

Loïc, 43 years old, born in Lille. He lives alone. He has a CAP (vocational training certificate) in accountancy and has held a variety of jobs (switchboard operator, packer) and has experienced a number of periods of unemployment. Recently employed by an association, he earns 900 Euros/month. Previously, he was entitled to the Specific Solidarity Benefit (ASS) and the CMU-C.

We will retain three different periods in his life: the one in which he benefitted from the CMU-C, the current period in which he was interviewed twice and finally, the period between the two interviews in which he experienced a health event that completely changed his view of things.

As a CMU-C beneficiary, he consults various health professionals according to his needs. He does not experience health care refusal but reluctance, notably from his general practitioner, to provide follow-up treatment. *'They make insinuations, make comments'*. He abandons consultations with this GP but finding a replacement is a problem. *'I was sceptical about consulting a GP because I had to find one that accepted treating CMU-C beneficiaries'*. During this period, however, he was able to obtain dental care and have a crown fitted.

Salaried, he tries to renew his entitlement to the CMU-C which is refused; the ACS (financial assistance to purchase complementary health insurance) is proposed. Estimating that the monthly premiums were still too expensive despite the financial assistance, he decides to go without complementary health insurance. *'One says to oneself, I'll pay for complementary health insurance and nothing will happen to me'*. During the interview, he explains that he can no longer afford health care since he lost the CMU-C benefit. *'When you look carefully, the cost of care is exorbitant. I've stopped consulting a doctor for my back problems, nothing at all. Because I know very well that backache means a visit to the doctor followed by physiotherapy sessions'*.

A few months after this first interview, he goes to the hospital emergency services suffering from a violent headache resulting in a full examination (notably an emergency MRI scan). *'When one is in great pain, it is no longer a question of having or not having money. One doesn't even think about it! I was so scared I went directly to emergency!'* He nevertheless refuses a week's hospitalization and chooses to follow the prescribed treatment at home. Since then he has decided to subscribe to a complementary health insurance.

* The respondent's name has been changed so as to respect his anonymity.

especially if the individual has to advance payment. The latter is in relationship with an individual's resources (income, savings, social benefits...) and other non-medical expenditures, notably irreducible expenses (Després *et al.*, 2011).

In the case of healthcare renunciation for economic reasons, individuals often forego a specific treatment with variable frequency depending on social situation.

Interview analyses show the existence of a social gradient in the frequency of healthcare renunciation and the type of care concerned (notably the potential gravity of healthcare renunciation). For example, individuals belonging to middle or upper socio-economic categories can forego a dental implant but still have access to an other therapeutic solution whereas economically disadvantaged individuals will forego replacing a missing tooth. The former will restrain their non-reimbursable consultations with an osteopath whereas the latter will cease consulting a gynaecologist. Among disadvantaged populations, the renunciation of healthcare represents missed opportunities in that it often concerns essential medical care: diagnoses not made or too late, chronic diseases left untreated that can lead to complications (diabetes, high blood pressure, cardiac malformation etc.). CMU-C beneficiaries are for the most part spared from this type of renunciation.

Each case of healthcare renunciation must be replaced in its particular context as an individual's attitude may change in a different context, demonstrated by the analysis of care trajectories through time. Evoking a case of

and ACS eligibility thresholds who have not subscribed to complementary health insurance (*cf.* insert opposite).

Renunciation of healthcare and social rights

If individuals are partially protected from healthcare renunciation for economic reasons by the existence of social rights, in certain cases individuals' knowledge of their rights is either insufficient or not respected by health professionals. Insufficient knowledge of one's social rights can lead to errors of judgment and lead to healthcare renunciation for financial reasons when in fact the treatment would have been reimbursed. The complexity of the French health system does not facilitate things: the co-existence of sector 1 and sector 2 professionals with non-regulated fees and complex reimbursement mechanisms shared between the National Health Insurance and complementary insurance schemes, and a plethora of schemes. The CMU-C existence is generally well known, especially among disadvantaged population categories, but the actual entitlements procured (range of healthcare services and rules to be respected by doctors) are generally unknown.

The ACS is subject to a high non-take-up rate (close to 75%) essentially due to the fact that eligible persons ignore the scheme's existence, have difficulty understanding the information received from the local insurance fund branches and are faced with a complex application procedure (Guthmuller *et al.*, 2011). Choosing a complementary health insurance policy in a competitive market environment is difficult. It demands an understanding of insurance terms, option pricing and corresponding reimbursement rates and the ability to anticipate healthcare needs.

Health professionals' non-respect of individuals' social rights is a contributing factor to healthcare renunciation among CMU-C beneficiaries in cases where reiterative care is refused or the rules are not respected: illegitimate refusal to accept direct payment by the insurers or charging excess fees. For all patients, charges exceeding the statutory fee (notably among specialists), often unannounced

prior to the consultation, contributes to creating a feeling of distrust in medicine, an overall feeling of anxiety and fear of having to advance the cost of treatment.

To the preceding problems one can add the loss of rights due to the professional and/or family instability of economically deprived persons. Protected for a time by the CMU-C, an individual can suddenly lose these rights on finding employment. This non-continuity of social rights is detrimental to long-term care projects, as is often the case for dental care. In addition, it should be noted that eligibility to the CMU-C is based on an individual's resources over the past twelve months which can be very different to an individual's present economic situation.

Healthcare renunciation due to care supply organisation and distribution

The regional healthcare supply network also has an impact on access to health care. It appears problematical in rural areas and economically deprived urban areas (Coldefy *et al.*, 2011). Healthcare supply problems (hospital restructuring, health profession demographics) combined with those previously stated render access to care even more difficult and contribute to the renunciation of healthcare.

The increased scarcity of healthcare supply has different impacts according to social category. Waiting time in the public sector can be circumvented by using the private sector where fees in excess of the statutory maximum are frequently charged by specialists, therefore limiting access to higher income groups. Individuals may also choose to travel to major cities or, in the context being examined here, cross the border to consult in Belgium. These alternatives are also costly in time, fuel or public transport tickets.

The restriction of healthcare supply is particularly constraining for CMU-C beneficiaries. Less mobile than other categories (obliged to travel to the Lille General hospital for certain specialities), and in a context where refusal of care is relatively frequent, they may experience difficulty in changing their general practitioner or finding a specialist. It may also lead

individuals unsatisfied with their doctor-patient relationship to 'give up'.

Refusal-renunciation: an act of autonomy with regard to conventional medicine

Refusal-renunciation expresses an individual's right to choose either self-medication or alternative, non-conventional forms of healthcare. Healthcare is refused within the health system context and in this respect expresses an act of patient autonomy with regard to conventional medicine (insert opposite).

This choice takes different forms: between doing something and doing nothing (*'It will take care of itself, or else I'll just get used to my body working differently, learn to live with the symptoms'*) or opting for alternatives to the treatment proposed (individuals declare foregoing care with respect to an imposed norm): *'I'm renouncing because I refuse to having to have a mammography because of my age.'*

This type of refusal, that concerns specific therapies, differs from the more radical form of healthcare renunciation: the total refusal of any form of treatment. This choice is frequently definitive suggesting that any form of care is perceived as futile and may even indicate a suicidal attitude. This is the case for individuals on an end of life pathway who take the decision to stop all forms of treatment (with or without the physician's agreement), because therapeutic resources have nothing more to offer (cancer for example) or because the cost of care (moral, emotional or in terms of qual-

ity of life) is considered too high a price to pay in relation to the estimated gain in life expectancy.

This form of refusal can indicate a form of disinterest in personal health. Some individuals admit to being negligent when speaking of themselves or others, indicating the type of relationship an individual has with the self: lack of 'self-concern', low self-esteem negating the value of one's existence. This can be encountered in its extreme forms in individuals facing extreme poverty or intense physical pain (Declerck, 2001), and its more moderate forms among economically deprived individuals interviewed within the framework of this research.

Refusal-renunciation. The case of Jean-Claude*

Jean-Claude, 61 years old, retired a year ago after a career as a social worker interrupted by several years unemployment. He is not interested in subscribing to a complementary health insurance policy as he considers the reimbursement rate insufficient.

Today, he no longer consults doctors or dentists and self-manages his health. *'It's almost by force of circumstance that I try and find alternative treatment methods: because I lost my trust in medicine because, among other things, I experienced a series of disasters...'* Current behaviour is explained by past experiences, notably regarding dental care: he consults several dentists who systematically pull out a tooth without explanation, without listening to him and without proposing a replacement. Now, when he has toothache, he takes a double dose of antibiotics until the pain disappears. Very much aware of his body, he detects and self-manages numerous minor problems through self-medication (cystitis, chronic diarrhoea) or a healthy life style and self-protective behaviour. *'I've organised my life so as to avoid stress, the majority of diseases occur through stress...I take care of my health by having a healthy diet...!'* To avoid a second heart attack, for example, he avoids physical effort directly after a meal (circumstances under which the first heart attack occurred) but has no medical supervision.

He occasionally resorts to non-conventional medicine. Following the discovery of a swollen lymph node confirmed as tuberculosis after a biopsy, triple antibiotherapy is prescribed. He decides not to take the treatment and orders a cocktail of African plants via the Internet on the advice of a naturopath who was following him at the time: *'Now that's a nice little victory! I'm telling you, me, I'm very independent! I like to pull through using a method I find correct because I don't trust drugs... [...] There's all the commercial side to it too, when you know that most drugs on the market aren't there because you need them, but because of the market...'*

* The respondent's name has been changed so as to respect his anonymity.

Autonomy and contesting medical authority

Refusal-renunciations contest the concept of biopower as defined by Foucault². It combines two forms of refusal largely dependent on socioeconomic category:

- Healthcare renunciation as an explicit refusal of conventional medicine,
- Healthcare renunciation as an expression of mistrust.

The former is more often expressed among the wealthier socioeconomic groups and the latter by more disadvantaged populations in poor living conditions.

An explicit refusal of conventional medical care

Some patients may resort to using alternative forms of care, notably non-conventional medicine. These individuals are part of a broader movement echoing contemporary social expectations and aspirations; the legitimacy of conventional medicine and the type of care it delivers is called into question and explicitly criticized (Cohen and Rossi, 2011). The spread of knowledge imported from other cultures, the emergence of spiritual or religious movements proposing techniques promoting the enhancement of physical and emotional well-being and occasionally disease and health management, increases the number of care alternatives and at the same time replies to existential questions that conventional medicine is unable to provide. It can also involve health self-management by means of a healthy diet, plants and other natural remedies including self-medication (Després, 2011).

Access to non-conventional medicines is more difficult for low income populations because in the majority of cases, it is not reimbursed by the National Health. Exceptions to this are homeopathy and acupuncture that are partially reimbursed (except for CMU-C beneficiaries). Here, refusal-renunciation is more often than not a case of falling back on the domestic sphere and getting by 'as best one can'.

Dysfunctions in the health care system can also be a motive for healthcare renunciation and the choice of complementary and alternative medicine or the total abandonment of treatment for the health problem in question. The quality of care as perceived by the user, whether in terms of technical or relational quality, also contributes to creating this type of attitude. Refusals of this kind can then be regarded as an indirect indicator of the quality of the health care system.

Mistrust of the health care system

Healthcare renunciation through mistrust expresses a form of resistance, opposed to conventional medicine leading patients to rely on the domestic sphere. The symbolic meaning attached to one's place in society contributes to creating a certain relationship with the self, others and institutions, including health care institutions.

The fear of being labelled as sick and its consequences in terms of personal identity thus plays a role in the avoidance of healthcare among the most disadvantaged populations. The stigmatising 'sickness' label is also perceived as losing control of one's fate as all decisions are in the hands of the physician and therefore contrary to the value of autonomy often underlined by these individuals.

Relations with health and social institutions (administrations, social services) are often the theatre of symbolic violence towards the poorest populations (Gaulejac (de), 2007). This can be experienced as a form of humiliation or stigmatization reinforcing individuals' low self-esteem and producing negative effects on health behaviours. In order to preserve their self-image, individuals keep their distance from the public spaces in which they risk being confronted with disqualification or relations of domination like during the general practitioner's consult. Refusing medical care to CMU-C beneficiaries, the way in which they are treated during consultations (doctor-patient relationship, information and medical treatment delivered) also contribute to excluding the poorest populations from the health care system.

In working-class environments, the relationship with medicine is thus situated more within the realms of mistrust than explicit criticism. It can in part be explained by communication difficulties between doctors and patients issued from a lower social class with a poor knowledge of the biological processes, the fact that less information is delivered to poorer patients (Fainzang, 2006). The tendency to minimise symptoms also makes it difficult for doctors to correctly assess their gravity.

Moreover, those attitudes can change according to individual and family histories. Experiencing illness, notably serious or chronic illness, thus transforms relationships with the body, the way the illness is represented and relationships with health professionals.

Barrier-renunciation and refusal-renunciation: two frequently associated forms of healthcare renunciation

If socio-economically deprived individuals more often belong in the 'barrier-renunciation category, certain individuals evoke both forms of healthcare renunciation and use the same term to describe different situations and distinct forms of explanation. A same individual can apply the two forms of healthcare renunciation at different moments in life and according to the type of treatment needed. Among the socioeconomically deprived populations, the one participates in creating the other.

An analysis of the determinants of healthcare renunciation indicates an intertwining of the different factors leading to this form of behaviour. Budgetary constraints are often related to other causes. Dissatisfaction or non-adherence to medical discourse can be additional factors that carry weight in the choices made in the face of budgetary constraint. Barrier-renunciation is thus not always the result of a 'pure' barrier. On the other hand, long-term obstacles to care will contribute to distancing the patient from medicine and creating forms of mistrust.

² M. Foucault demonstrated the political power's hold on the living, on individual bodies and the structuring and orientation of behaviours (Foucault, 1976).

A culture of healthcare renunciation among the socioeconomically disadvantaged

Finally, certain situations that fall within the domain of healthcare renunciation but are not reported as such by the individuals concerned, have also been identified. In certain environments characterized by poverty and privation, healthcare renunciation can be seen as a form of relationship with the world. The relationship with the physical body is marked by limiting one's needs and forms of self-censure: self-care methods developed to compensate for the restricted use of health care professionals. These self-care strategies based on the individual's inherent resources, privileging the domestic sphere, ignoring or getting used to certain symptoms can progressively be interiorised from one generation to another and constitute a *habitus* in the sense of the term used by Bourdieu (1980). In this case, individuals do not feel as though they are renouncing care. The culture of privation, of resistance to symptoms must be distinguished from situations in which symptoms have not been identified; in the absence of need, renunciation does not exist. Here, healthcare renunciation is part of an individual's relationship with the world; considered normal it is not completely formalized.

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The socio-anthropological approach to healthcare renunciation falls within the framework of a complex process rooted in individuals' life histories. Two forms of healthcare renunciation have been specifically examined: barrier-renunciation and refusal-renunciation. The first refers to the existence of constraints, notably financial and the second to an act of autonomy regarding conventional medicine.

Economic motives for healthcare renunciation are rarely isolated and combine with other motives making interpretations based on general factors difficult.

The study of different forms of healthcare renunciation equally requires taking the individual's environment into account, that is to say structural and individual dimensions related to life histories and experiences together with current situations; what is the health problem, what possibilities are available, what means to confront the situation. These results are coherent with the econometric study published simultaneously.

The healthcare renunciation approach, based on individual subjectivity, is particularly interesting in the study of access to health care services as it places the individual in the role of actor rather than object. This approach falls within the framework of the 2002 law that indirectly recognizes individuals as singular experts, competent to deal with their illnesses and, more globally, their personal situations. ♦

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