Questions d'économie de la Santé

n°198 - May 2014

The 2012 Health, Health Care and Insurance Survey (ESPS)

First Results

Nicolas Célant, Paul Dourgnon, Stéphanie Guillaume, Aurélie Pierre, Thierry Rochereau, Catherine Sermet (Irdes)

The Health, Health Care and Insurance Survey (ESPS) have been conducted by IRDES every two years since 1988. In 2012, over 8,000 households comprising a total of 23,000 individuals were interviewed on general health topics such as health status, access to complementary health insurance, the use of health care services or unmet care needs and more specific questionnaire modules dealing with issues such as frailty, insurance against old-age dependency, working conditions, vaccination coverage, accidents of everyday life and blood donation.

The survey's specificities, its short two-year periodicity, its longitudinal dimension and its enrichment with National Health Insurance data have contributed to creating an invaluable public policy monitoring tool as well as a research tool for the social sciences. In 2014, ESPS will be used as the basis of the European Health Interview Survey (EHIS).

The results of the 2012 survey presented in this summary are taken from the ESPS report (Célant *et al.*, 2014) which includes the totality of quantified data accessible on-line in the form of Excel tables.

Conducted by IRDES since 1988, the Health, Health Care and Insurance Survey (ESPS) explores the relationships between health status, access to healthcare services and to private and public health insurance, and respondents' socio-economic status. It is characterised by its short two-year periodicity, its longitudinal dimension (Methods insert) and its enrichment with health care consumption data provided by the National Health Insurance database. These characteristics have contributed to creating both an invaluable public health policy monitoring tool and research tool by regularly providing health data representative of the general population. In this respect, ESPS contributes to public health policy evaluation and enables the examination of issues relating to equity in the health care system.

In 2012, over 8,000 households and 23,000 individuals were interviewed regarding their health status, access to complementary health insurance, health care use or unmet

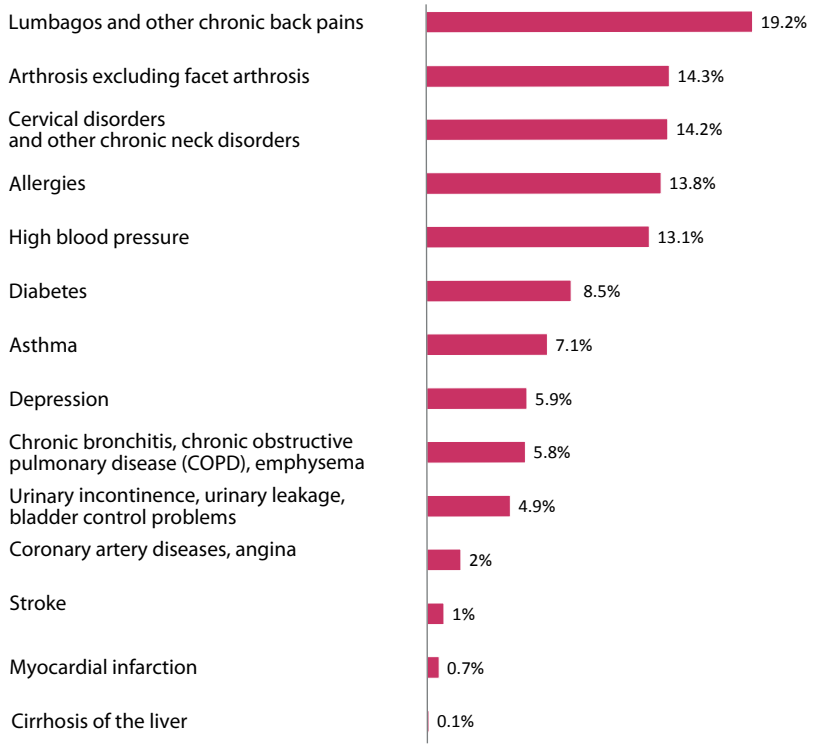
care needs and more specific modules dealing with issues such as frailty and insurance against old-age dependency, spatial practices in the access to health care services, working conditions, vaccination coverage, accidents of everyday life and blood donation. In 2014, ESPS will be used as the basis for the European health survey EHIS (European Health Interview Survey). To accommodate this, the self-administered questionnaire contents, aimed at individuals aged 15 and over, were modified in 2012 so as to durably integrate the most pertinent EHIS questions for France in ESPS (insert p.4 and Context). Following a methodological investigation, the questions on unmet care needs were also modified and specified (Després *et al.*, 2011a and b).

Health Status

Two out of three respondents self-reported good or very good health

In 2012, in metropolitan France, 65.8% of respondents aged 15 and over self-reported a "good" or "very good" health status, 26% a "fairly good" health status and 8.3% a "poor" or "very poor" health status. Of those self-reporting a "good" or "very good" health status, 68.5% were men and 63.5% women. A chronic health problem was reported by 39% of respondents aged 15 and over in 2012 (38% men and 39% women) and 27% reported limitations in activities of daily living for at least the last six months (26% men and 29% women). Although the wording for these three questions forming the European mini-module on health status was only stabilised in ESPS from 2010, they seem to indicate a slight deterioration in self-perceived health status. This result thus confirms a trend observed since 1998 using a different indicator, the self-rated health score (Sermet, 2012) used in ESPS since its origins. This deterioration should nevertheless be relativized in view of the continuous ageing of the French population.

G1 Diseases most frequently reported in 2012 by respondents aged 15 and over from a list of 14 chronic diseases proposed in ESPS



Source: ESPS 2012.
Realisation: IRDES.

Download the Excel© file on the IRDES web site

Method

ESPS, conducted every two years is representative of about 95% of persons living in ordinary householdsa (excluding persons living in institutions: retirement homes, long-stay hospital wards, sheltered housing, homeless persons, prisoners…).

Sampling and scope: The ESPS sample of National Health Insurance beneficiaries is constituted as a sub-sample of the General Sample of Beneficiaries (EGB, *Echantillon généraliste de bénéficiaires*). It is representative of beneficiaries aged 18 and over in the three main branches of the Statutory National Health Insurance which represents around 85% of National Health Insurance beneficiaries: The National Health Insurance Fund for Salaried Workers (CNAMTS, *Caisse nationale d'assurance maladie des travailleurs salariés*), the Mutual Fund for Agricultural Workers and Farmers (MSA, *Mutuelle sociale agricole*), and the National Health Insurance Fund for Self-employed workers (RSI, *Régime social des indépendants*).

By interviewing sampled beneficiaries and the members of their households, some of which belong to insurance branches that are outside the initial scope of the survey (specific funds and local mutual fund branches), ESPS is quasi representative of the whole of the general population living in an ordinary household in metropolitan France. The only persons excluded from the survey are persons living in households where all members benefit from insurance regimes absent from the initial survey scope.

Sampling from the National Health Insurance database enables every selected beneficiary and other members of their health insurance cluster (primary beneficiary and their dependents) to be associated with the year's health care consumption data from National Health Insurance reimbursement data.

Data collection method and field work. the survey is conducted in two waves, the first in the spring (from March to June) and the second in the autumn (from September to December), so as to take the seasonality of certain diseases into account. Data collection associates two survey methods, telephone interviews and one-to-one interviews based on a general questionnaire administered by the interviewer to the beneficiary sampled from the National Health Insurance database, and a self-administered questionnaire particularly for health questions concerning all the members of the household. In 2012, households in which the selected respondent was a CMU-C beneficiary, was aged 65 or over or households in which the Health Insurance cluster counted over 5 beneficiaries, were systematically solicited for a one-to-one interview

[a] An ordinary household refers to all persons sharing the same main residence.

Among the proposed list of chronic diseases, the most frequently reported are osteoarticular disorders, allergies, high blood pressure, and diabetes

Among the list of 14 chronic diseases proposed in the survey, osteoarticular disorders are the most frequently reported: 19.2% of respondents aged 15 and over reported lumbago or other chronic back pain, 14.2% cervical pain or other chronic neck disorders and 14.3% osteoarthritis in the limbs (Graph 1). Allergies, reported by 13.8% of respondents take second place, followed by high blood pressure with 13.1% and diabetes with 8.5%. Finally, 5.8% of respondents reported chronic bronchitis and 5.9% depression.

As these are self-report declarations and not measurements, it should be underlined that these figures cannot be compared with epidemiological data established by other means. As data collection methods concerning disease prevalence changed in 2012, it is no longer possible to compare this data with preceding years' data. On the other hand, the list of diseases is identical to that presented in the European Health Interview Survey (EHIS) and European comparisons will thus be possible when data from other participating countries are available.

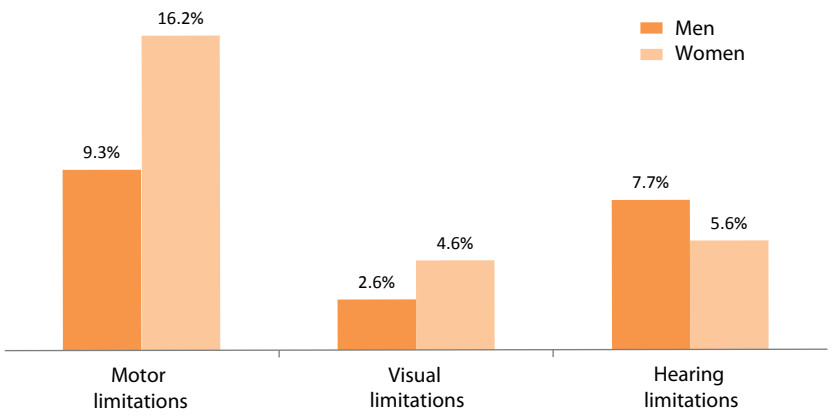
All these diseases are more frequent among women than men, and with the exception of asthma and allergies, the number of self-reported cases increases with age. Young adults are essentially affected by allergies (15.8%), lumbago or other back pain (11.4%) and asthma (7.9 %). Osteoarticular disorders increase among adults aged from 40 to 64 years old among which 21.9% self-reported suffering from dorsolumbar disorders. Cardiovascular risk factors also appear in this age group with a 12.5% prevalence rate for high blood pressure and 7.7% for diabetes. The prevalence rate for all diseases increases further in the 65 and over age group. The diseases or health problems most frequently reported in this age group are osteoarthritis in the limbs (34.7%), high blood pressure (29.9%) and lumbagos (25.3%). It should finally be noted that the prevalence rate for certain diseases doubles in the 65 and over age group: 15.9% for diabetes, 9.4% for chronic bronchitis and 5.4% for coronary diseases (excluding heart attacks).

Women are twice as many to self-report functional limitations than men…

Globally, 13% of respondents aged 15 and over self-reported a functional motor limitation, with a higher representation of women (16.2%) than men (9.2%); limitations that worsen with age to reach 34% of respondents aged 65 and over. Persistent visual impairment despite wearing glasses or contact lenses is on average reported by 3.7% of respondents aged 15 and over. It is more frequent among women (4.6%) than men (2.6%) and is increasingly reported with age: 6.8% among persons aged 65 and over. Hearing impairments affect 6.6% of respondents aged 15 and over and are more frequent among men than women (7.7% against 5.6%). The prevalence rate for hearing disorders is furthermore three times higher among the 65 and over age group (16.5%) than in the 40-64 age bracket (4.7%) [Graph 2].

G2

Percentage of respondents reporting at least one functional motor, visual or hearing limitation in 2012



Source: ESPS 2012.
Realisation: IRDES.
Download the Excel© file on the IRDES web site

… of which the most frequent are difficulties bending down or kneeling

The most frequently reported physical functional limitations are difficulties bending down or kneeling (9.1% of respondents aged 15 and over) followed by difficulties carrying heavy loads (7.6%) and remaining standing for long periods of time (7.6%).

Context

In 2012 ESPS included new questions in view of its integration in the 2014 European Health Survey (EHIS). If certain questions were already present in previous surveys, others were new such as the questions on genes, difficulties carrying out activities of daily living (ADL) and instrumental activities of daily living (IADL); questions on physical activities and the consumption of fruit and vegetables (insert). New modules were also introduced in relation to research topics developed by survey partners: a module on blood donation, questions allowing inquiry into frailty among the elderly and on sleep. Certain issues have been the subject of articles published in the ESPS report [1] (Célant *et al.*, 2014) from which this synthesis has been taken.

[1] On-line: www.irdes.fr/recherche/rapports/556-enquete-sur-la-sante-et-la-protection-sociale-2012.pdf

Complementary health insurance

89% of individuals benefit from complementary health insurance coverage (excluding CMU-C)

According to ESPS 2012, 89% of individuals in metropolitan France living in an ordinary household (outside institutions) reported benefitting from private complementary health insurance and 6% from the Universal Complementary Health

Coverage scheme (CMU-C). Thus, in 2012, 5% of the population reported not being covered by complementary health insurance despite its importance in the use of health care services (Buchmueller *et al.*, 2004; Reynaud, 2005; Albouy and Crepon, 2007, Després *et al.*, 2011, Dourgnon *et al.*, 2012).

A majority of persons covered by complementary health insurance considered themselves well reimbursed for hospital co-payments but opinions diverged on other forms of care depending on the type of insurance contract

Among the individuals covered by private complementary health insurance, 70% reported being well or very well reimbursed for hospital co-payments, 52% for glasses, 48.5% for excess specialist fees and 46.6% for dental prosthesis (Graph 3). Theses averages, however, hide considerable heterogeneity according to type of insurance contract since for glasses, for example, 69% of private sector employees benefitting from employer-provided insurance consider being well or very well reimbursed, against respectively 45% of private sector employees benefitting from individual contracts and 45% of the unemployed.

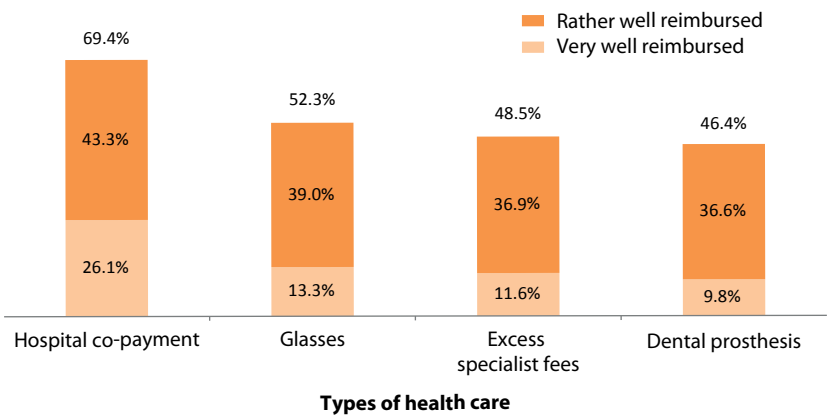
Almost two thirds of private sector employees reported already benefitting from employer-provided complementary health insurance prior to its planned generalization on January 1st 2016

The results of ESPS 2012 provide an overview of employer-provided complementary health insurance before its planned generalization to all private sector employees on January 1st 2016. It shows that in 2012, 64% of private sector employees (including those employed by individuals) reported already benefitting from employer-provided complementary health insurance (85% of executives against 50% of unskilled workers and 44% of commercial sector employees). 28% reported being covered solely by an individual insurance contract and 2.5% by the CMU-C; 3.6% reported not being covered by complementary health insurance[1], more particular-

[1] 1.4% were covered by a contract whose status was not determined.

G3

Satisfaction concerning the reimbursement of various types of care among respondents covered by complementary health insurance



Source: ESPS 2012.
Realisation: IRDES.

Download the Excel© file on the IRDES web site

I

Ad hoc questions specific to ESPS 2012

In 2012, ad hoc questions concerned research projects developed in partnership with other institutions on the one hand (see below), and on the other, themes proposed by the INVS on DTP and papillomavirus vaccination, cervical cancer screening and accidents of everyday life. Several ad hoc questions elaborated with regards to research projects gave rise to articles published in the 2012 ESPS report (Célant *et al.*, 2014) on insurance against old-age dependency (IRDES-DREES), frailty in the elderly population (IRDES-CNSA) and blood donation (IRDES-EFS). The results concerning the relationships between working conditions and health care consumption (IRDES-DARES) are evoked below (*cf.* Célant *et al.*, 2014).

The use of vaccination against DTP and HPV and cervical cancer screening increases with education level and income. According to ESPS 2012, almost 90% of persons aged 15 and over reported having received at least one vaccination renewal for diphtheria, tetanus or poliomyelitis (DTP) and that the use of DTP vaccination increases with socio-economic status. Thus, 92% of individuals belonging to the 20% wealthiest households reported having received their vaccination renewal against 82% of individuals belonging to the 20% poorest households. This difference increases further with education level: 94% of individuals with higher education levels renewed their DTP vaccination against 80% of individuals without diplomas. Women vaccinated against papillomavirus (HPV) infections appear to have the same high socio-economic profile as women who use cervical cancer screening services. Further comparisons will make it possible to target less vaccinated populations more effectively (*cf.* Célant *et al.*, 2014).

Persons in poor health more frequently report having had an accident of everyday life during the last three months. Accidents of everyday life cause over 20,000 deaths each year in France, 500,000 hospitalisations and almost 5 million visits to hospital emergency services. Inventorying these accidents is a prior necessity to improving their prevention.

In 2012, 9% of respondents reported having had at least one accident of everyday life needing care from a health professional during the past three months, with slightly more men (9.4%) than women (8.1%). Among these, the youngest and most elderly respondents were the most affected: 9.8% of the under 15s and 10.5% of the over 65s. Here again, the lower the socio-economic status the higher the probability of reporting an accident of everyday life. Furthermore, persons self-reporting poor health are more likely to have had an accident of everyday life (one out of four respondents) without the possibility of establishing a link between the two. Similarly, 17% of persons reporting severe limitations in carrying out everyday activities and 14% of persons reporting slight or moderate limitations reported having had an accident of everyday life during the last three months (*cf.* Célant *et al.*, 2014).

Working conditions: in 2012, over a third of respondents reported not feeling capable of continuing in the same job until the age of 60. The results of the 2012 ESPS indicate that 6.4% of respondents were concerned by night work. Reports of tiring or uncomfortable physical positions concerned 37% of respondents. As expected, these difficult working conditions were reported by individuals with low incomes and education levels, notably employees and unskilled workers. Finally, over 35% of respondents declared not feeling capable of working in the same conditions until the age of 60. Already included in 2010, these questions on working conditions will continue to be asked in ESPS 2014 and 2016. Information on working conditions and their development will be observed through time for the same individuals at four year intervals (between 2010 and 2014, and between 2012 and 2016) and studied for the first time in relation to their health care consumption.

ly unskilled workers (6% against 1.8% of executives) and those belonging in the first income quintile (the lowest) [8.3% *versus* 2.3% in the top income quintile].

Individuals not concerned by the generalization of employer-provided complementary health insurance (employees outside the private sector, non-salaried workers, the unemployed[2] and inactive) on average more frequently report not being covered by complementary health insurance (5,6 %) or the CMU-C (7.6%).

Foregoing health care for financial reasons

An instrument measuring access to health care since the 1990s

ESPS, in which the question on foregoing health care needs for financial reasons has been included since 1992, has contributed to transforming this question into a means of measuring the population's access to health care. This in particular was one of the factors used in the parliamentary fact-finding report on the law establishing the creation of the Universal Complementary Health Insurance Coverage CMU-C (Boulard, 1999).

The concept of foregoing health care aims to identify unmet care needs, or in other words care not received whereas the patient felt the need for it. Foregoing care for financial reasons was the subject of an in-depth methodological investigation between 2009 and 2011 associating socio-anthropological and micro-economic approaches (Després *et al.*, 2011 a and b). The study revealed a correlation between foregoing care and a lower consumption of health care, even if foregoing care does not necessarily mean not consuming any form of health care. It also shows that foregoing care has a deleterious effect on future health status. Finally, it shows that despite certain limitations regarding the questionnaire as it was formulated until 2010, unmet health care needs is a relevant instrument in the study of access to health care within the general population (Dourgnon *et al.*, 2011; Jusot *et al.*, 2009). As the question was asked in general terms until 2010 without specifying the types of care involved, it led to underestimating the level of unmet care needs within the population, in particular regarding dental and optical care which respondents may have considered as being outside the field of medical consumption.

The level of unmet care needs for financial reasons readjusted from 2012

According to ESPS 2012, 18% of National Health Insurance beneficiaries aged at least 18 in metropolitan France self-reported unmet dental care needs due to financial barriers, 10% reported unmet optical care needs, 5% medical consultations and 4% for other types of care.

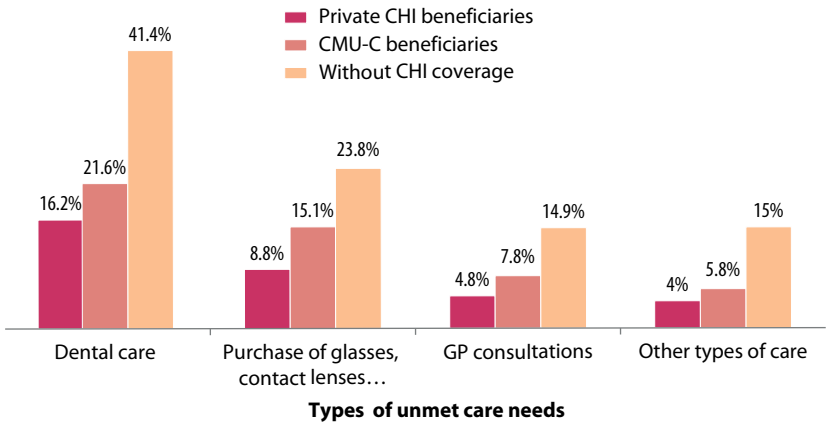
In 2012, the survey questions on foregone care for financial reasons were thus modified. The general question was replaced by successive questions regarding the types of medical consumption the most concerned by unmet care needs due to financial barriers. From the responses to these questions, a general indicator of unmet care needs can be reconstituted by summing up persons self-reporting having foregone at least one type of medical consumption highlighted in the questionnaire. Thus in 2012, according to ESPS, almost 26% of persons reported having foregone at least one type of care for financial reasons. This figure cannot be compared with figures produced by prior ESPS survey results. Of better quality, the new questionnaire by construction gives rise to a much higher rate of unmet care needs than previously. It comes from a break in series ; consequently, the monitoring of unmet care needs through time using ESPS data should be rebased from 2012.

The characteristics of respondents self-reporting unmet care needs due to financial barriers in 2012 were the same as in preceding years

If the rate of unmet care needs due to financial barriers had to be rebased in 2012, the explanatory factors remained the same whatever the type of care considered. Thus, in 2012 as in preceding ESPS, respondents most frequently reporting unmet care needs due to financial barriers were essentially those without complementary health insurance (CHI): 24% reported having foregone optical care against 15% of CMU-C beneficiaries and less than 9% for CHI beneficiaries outside CMU-C (Graph 4). Still in 2012, respondents belonging in the 20% of poorest households were 15% to have reported unmet optical care needs for financial reasons, four times higher than in the 20% of wealthiest households (3.6%). These gradients are especially pronounced for dental and optical care that is less well reimbursed by the Statutory Health Insurance scheme.

G4

Principal types of unmet care needs due to financial barriers in 2012, according to CHI coverage



Source: ESPS 2012.
Realisation: IRDES.

Download the Excel© file on the IRDES web site

[2] These rates do not take the portability of employer-provided CHI into account that remains active during the first year of unemployment.

In 2012, new questions on unmet care needs related to difficulties in accessing health care

In 2012, in metropolitan France, 17% of National Health Insurance beneficiaries aged 18 and over reported having foregone at least one type of care over the last twelve months because the waiting time for an appointment was too long, and 3% because the surgery was too far away or because of transport difficulties. Contrary to foregoing care for financial reasons, these unmet needs due to difficulties in accessing health care services are not related to the absence of CHI coverage or economic factors.

* * *

Rich in data on health status, the use of health care services and CHI coverage within the metropolitan population, ESPS contributes in fuelling the knowledge base and reflections on public health policy. It also offers a unique tool made available to research teams in health economics and, more broadly, the social sciences and epidemiology even if this is not its primary objective.

In addition to its permanent modules, and in collaboration with the Ministry of Health Directorate for Research, Studies, Assessment and Statistics (DREES, *Direction de la recherche, des études, de l'évaluation et des statistiques*) and the National Solidarity Fund for Autonomy (CNSA, *Caisse nationale de solidarité pour l'autonomie*), ESPS 2012 focused on questions related to major societal issues such as insurance against old-age dependency and frailty in the elderly population (*cf.* Fontaine *et al.*, 2014; Sirven, 2014). In partnership with the Directorate for Research, Studies and Statistics (DARES, *Direction de l'animation de la recherche, des études et des statistiques*), it continues to collect longitudinal data on working conditions that will allow ground-breaking research on the relationships between working conditions and health care consumption in the future (Célant *et al.*, 2014). ESPS has also enabled the French Blood Service (EFS, *Etablissement français du sang*) to gain better knowledge on blood donors and thereby enhance reflection on how to conduct its blood donation campaigns to incite new donors (*cf.* Errera *et al.*, 2014). It also continues to contribute to the French Institute for Public Health Surveillance (INVS, *Institut de veille sanitaire*) missions on vaccination (DTP and HPV), cervical cancer screening and accidents of everyday life (*cf.* Célant *et al.*, 2014).

A reference tool in the domains of healthcare, access to health care and health insurance, ESPS has been chosen by the DREES as the basis of the European health survey (EHIS) in 2014. ♦

For further information

- Albouy V., Crepon B. (2007). « Aléa moral en santé : une évaluation dans le cadre du modèle causal de Rubin ». Insee, Document de travail, décembre.
- Buchmueller T. C., Couffinhal A., Grignon M., Perronnin M. (2004). "Access to Physician Services: Does Supplemental Insurance Matter? Evidence from France". *Health Economics,* 13 (7), pp. 669-687.
- Célant N., Guillaume S., Rochereau T. (2014). « Enquête sur la santé et la protection sociale 2012 ». Rapport de l'Irdes n° 556, juin. En ligne : www.irdes.fr/recherche/rapports/556-enquete-sur-la-sante-et-la-protection-sociale-2012.pdf
- Després C., Dourgnon P., Fantin R., Jusot F. (2011a). « Le renoncement aux soins : une approche socio-anthropologique ». Irdes , *Questions d'économie de la santé*, n° 169, octobre.
- Després C., Dourgnon P., Fantin R., Jusot F. (2011b). « Le renoncement aux soins pour raisons financières : une approche économétrique ». Irdes , *Questions d'économie de la santé*, n° 170, novembre.
- Dourgnon P., Després C., Jusot F., Fantin R. (2011). « Dépense de santé et accès financier aux services de santé : une étude du renoncement aux soins », *in* : « Les comptes de la santé 2010 ». Série Statistiques – Document de travail de la Drees n° 161, septembre, p. 85-96.
- Dourgnon P., Jusot F., Fantin R. (2012). « Payer nuit gravement à la santé : une étude de l'impact du renoncement financier aux soins sur l'état de santé », *Economie Publique*, n° 28-29, p. 123-147.
- Errera M., Sirven N., Rochereau T. (2014). « Les déterminants du don du sang en France. Une analyse sur données de l'enquête ESPS 2012 », *in* Célant N., Guillaume S. et Rochereau T. « Enquête sur la santé et la protection sociale 2012 », Les rapports de l'Irdes, n° 556, juin.
- Fontaine R., Perronnin M., Sirven N., Zerrar N. (2014). « Comment la perception du risque de dépendance influence-t-elle la demande de couverture ? », *in* Célant N., Guillaume S. et Rochereau T. « Enquête sur la santé et la protection sociale 2012 », Les rapports de l'Irdes, n° 556, juin.
- Jusot F., Silva J., Dourgnon P., Sermet C. (2009). « Inégalités de santé liées à l'immigration en France. Effet des conditions de vie ou sélection à la migration ? », *Revue Economique*, n° 2, vol 60, 2009/03, 385-411.
- Raynaud D. (2005). « Les déterminants individuels des dépenses de santé : l'influence de la catégorie sociale et de l'assurance maladie complémentaire ». Drees, *Etudes et Résultats* n° 378, février.
- Sermet C. (2012). « Santé perçue et morbidité déclarée : état des lieux et évolution ». in Basset B., Demeulemeester R., Jougla E. (*coord.*) « Vingt ans de santé publique », *ADSP (Actualité et dossier en santé publique)*, n° 80, septembre.
- Sirven N. (2014). « Mesurer la fragilité des personnes âgées en population générale : une comparaison entre ESPS et SHARE », in Célant N., Guillaume S. et Rochereau T. « Enquête sur la santé et la protection sociale 2012 », Les rapports de l'Irdes, n° 556, juin.

IRDES Institut de recherche et documentation en économie de la santé •
10, rue Vauvenargues 75018 Paris • Tel. : 01 53 93 43 02 • Fax : 01 53 93 43 07 •
www.irdes.fr • Email : publications@irdes.fr •

Director of the publication: Yann Bourgueil • **Technical senior editor:** Anne Evans • **Associate editor**: Anna Marek • **Reviewers**: Catherine Sermet, Clément Nestrigue • **Translator**: Véronique Dandeker • **Copy Editing**: Anna Marek • **Layout compositor**: Damien Le Torrec • **ISSN** : 1283-4769.