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Immigrants' Access to Ambulatory Care in France

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Immigrants have a lower rate of access to office-based medical practices (whether general practitioners or specialists) than the rest of the French population. This can be explained more by immigrants' disadvantaged social conditions than differences in age, gender and health status between the two populations.

This analysis remains valid whatever the region of origin with the exception of North Africa whose immigrant population has a higher GP consultation rate.

This study also reports a more contrasted situation with regard to preventive care; immigrants are more numerous in declaring themselves vaccinated than the French but fewer to use screening tests.

According to the Charter of Fundamental Rights of the European Union, access to health care constitutes a fundamental right. Social inequalities in health care use persist in France as they do in most European countries [Wagstaff and van Doorslaer, 2000]. Numerous countries recognise the vulnerability of foreign immigrants and consider their access to healthcare as a major public health issue [Couffinhal et al., 2005; van Doorslaer, Masseria and Koolman, 2006], whereas in France understanding of the issue remains limited.

In 1999, the immigrant population represented 7.3% of the French population and foreign immigrants 5.6%. In collecting precise data concerning both nationality and country of origin as well as health status and healthcare use, the 2002-2003 National Health Survey car-ried out by Insee in France, provides an opportunity to study correlations between nationality, immigration, health status and healthcare use (*Cf.* Sources insert).

A first study [Dourgnon *et al.*, 2008] revealed the existence of health inequalities among individuals of foreign origin; partially explained by immigrants' disadvantaged socio-economic situation in France and the level of economic development in the country of origin. Whether it concerns general practitioners (GP) or specialists, foreign immigrants' consult less than French-born citizens. In the same way as health status, these disparities are essentially related to the foreign population's social condition in France. Naturalised immigrants are less affected by difficulties in accessing healthcare.

Explaining differences in healthcare use according to country of origin

Several hypotheses can explain the differences in immigrants' use of healthcare. They concern healthcare needs, consumption behaviour, health system responses and immigrants' socio-economic conditions.

Do foreign and naturalized immigrants have different health status and healthcare needs? International literature shows differences in the health status of foreign and immigrant populations. The migration selection effect, according to which recent immigrants frequently havea better health status, is eventually counter-

balanced by adverse effects on health occasioned by the loss of social networks and disadvan-taged socio-professional situations in the host country. Furthermore, observed differences in health status according to country of origin are partly due to living conditions in the country of origin [Dourgnon *et al.*, 2008].

Are use rates different for equivalent healthcare needs? Some authors suggest that cultural and informational barriers explain a belated and more curatively oriented use of healthcare among the poorest and less educated populations [Alberts *et al.*, 1998]. Hospital and Health Centre services are equally more frequently used by these patients. For immigrants, difficulties in access to care can be reinforced through isolation and the loss of their social networks in France, in turn associated with difficulties in orientating themselves within the health system [Cambois, 2004; Shaw, Dorling and Smith, 1999]. Finally, discriminatory attitudes and practices from the health service due to a patient's origins cannot to be excluded [Balsa and McGuire, 2003; Sundquist, 1993]. Three forms of discrimination have been identified. The first concerns pure prejudice, where the doctor applies the principle of 'national or racial preference' to the efforts devoted to pa-tients. Secondly, patients can be treated according to stereotypes related to origins or social class (relationship with the body, level of comprehension, following medical instructions). Finally, the doctor's diagnostic and therapeutic strategy can be oriented on the basis of statistics on the prevalence of diseases by country of origin. This can lead to differences in treatment and result in positive or negative effects on health inequalities between social groups.

Immigrants' disadvantaged social conditions in the host country and a more difficult access to rights, notably social protection, have both an impact on disparities in healthcare services utilization [Mizrahi and Mizrahi, 2008]. The immigrant population, more likely to be affected by unemployment and to receive lower wages, is also less frequently covered by a complementary health insurance.

On the basis of the hypotheses and results proposed by the literature, our analysis consists in measuring the direct influence of migration and nationality on the use of office-based medical services and their indirect influence with regard to socio-economic conditions and health status (*Cf.* Methods insert).

T1 Health status and access rates to GP and/or specialist over the last twelve months

	Rates of access to...		Perceived health status			Numbers
	GP	Specialist	Poor health	Chronic illness	Limited activity	
Region of birth	%	%	%	%	%	
Northern Europe	83.5	55.8	18.5	43.7	10.2	206
Central Europe	82.8	61.2	41.5	50.8	25.4	134
Southern Europe	84.8	63.4	43.5	51.0	16.4	670
Turkey	77.7	47.9	28.4	29.8	8.5	94
North Africa	83.3	54.2	38.5	36.6	13.6	683
Middle East	69.0	62.1	21.1	39.7	10.3	58
Africa (excluding North Africa)	76.2	50.3	23.0	27.2	7.3	151
Indian sub-continent and islands	73.8	36.0	25.9	31.2	3.3	61
Asia	74.4	48.8	28.3	36.3	6.3	160
America, Australia, New-Zeland	81.0	59.5	15.2	44.3	6.3	79
Migration profile						
Foreign immigrants	80.6	52.2	31.2	38.2	11.4	1,399
Naturalised immigrants	83.5	63.0	36.0	46.7	15.6	897
France and Overseas territories	84.7	62.6	25.0	42.1	13.9	22,891
Sample size	-	-	-	-	-	25,187

Data: 2002-2003 National Health Survey (Insee). **Exploitation:** Irdes.

Download detailed table: http://www.irdes.fr/EspaceRecherche/Qes/Qes146.htm

Background

This study on immigrants' consumption of medical care in France completes previous research on immigrant populations' health status [Dourgnon P. *et al.*, 2008] and forms part of the ongoing research on health inequalities and their determinants conducted by the Irdes. The project is financed within the framework of the Directorate for Research, Analysis, Evaluation and Statistics Research Mission (Drees MiRe) call for research projects 'Secondary Analyses of the Insee National Health and Medical Care Survey 2002-2003'. The exploitation of this survey enables to study the links between the use of health services, health status, socio-economic status and migratory profile by distinguishing the French by birth, foreign immigrants and naturalised immigrants

GP consultation rates are lower among foreign immigrants…

85% of individuals born in France and 84% of naturalised immigrants declare having consulted a GP at least once during the last twelve months preceding the survey (*Cf.* table 1), while only 81% of foreign immigrants did so. Among the individuals who consulted a GP, the number of consultations is on average 4.8 for the French borns and 4.7 for foreign immigrants against 5.3 for naturalised immigrants. According to region of birth (*Cf.* Sources insert p. 4), the proportion of individuals having consulted a GP varies from 69% to 85%. With the exception of individuals originating from Southern Europe, that are as numerous as the French born population to have consulted, immigrants have a lower rate of access to a GP whatever the country of origin.

… and as well as specialist consultation rates

The gap is even greater for specialist consultations: 63% of French born citizens and naturalised immigrants consulted a specialist over the last twelve months against 52% of foreigners. Individuals of foreign origin have a lower access rate whatever the region of birth, once again with the exception of immigrants from Southern Europe (63%). Among those having consulted, the average number of

consultations is lower among foreigners (2.9 consultations on average against 3.3 for the French and naturalised immigrants).

Immigrants' disadvantaged social and economic conditions explain the lower GP consultation rates…

These first comparisons do not take into account the differences in health status, healthcare needs or individuals' socio-economic situation. Further analysis differentiates the effects directly related to migration from those related to health status and to socio-economic status.

Age and health status have an influence on the probability of consulting. Individuals self-reporting poor health are more likely than those self-reporting good health to have consulted a GP over the last twelve months (odds ratio (OR) = 2, *Cf.* Definitions insert below). The 30-70 age range has a lower consultation rate than the 18-29 age range, and individuals aged 70 and have a higher consultation rate. Finally, the probability of women consulting a GP is considerably higher than for men (OR=1.52).

For equivalent healthcare needs (approximated by age, gender and health status), immigrants (both foreign and naturalised) have a lower probability of having consulted a GP than individuals born in France (OR=0.78 and 0.83) [*Cf.* table 2, section use of a GP, model 1].

Socio-professional category, education level, occupation, income level, household structure and complementary health insurance coverage all have a significant influence on the probability of consulting a GP (*Cf.* table 2, use of a GP, model 2). Most of the socio-professional categories have a higher probability of consulting a GP than managers (OR significantly higher than 1). Globally, a lower level of education is equally associated with a higher probability of consulting a GP. Finally the absence of complementary health insurance reduces the probability of consulting a GP. Yet, 35% of foreign immigrants and 20% of naturalised immigrants do not have a complementary health insurance against 7% of French-born citizens.

T2 — Modelling of the probability of using office-based care over the last twelve months and the migration profile effect

	Probability of consulting a… GP		specialist	
	Model 1	Model 2	Model 1	Model 2
	Odds ratios		*Odds ratios*	
Migration profile				
French born in France	*Ref.*	*Ref.*	*Ref.*	*Ref.*
Foreign immigrant	0.78***	1.12	0.66***	0.93
Naturalised immigrant	0.83*	1	0.96	1.1
Perceived health indicator				
Poor self-reported health	2***	2.07***	1.28***	1.58***
Chronic illness	2.63***	2.6***	1.6***	1.59***
Activity limitations	1.83***	1.85***	1.86***	1.98***
SOCIO-ECONOMIC CHARACTERISTICS				
Age				
18-29 years old	*Ref.*	*Ref.*	*Ref.*	*Ref.*
30-49 years old	0.89**	0.87**	1.08*	1
50-69 years old	0.93	0.8***	1.07	0.98
70 and over	1.87***	1.46***	0.78***	0.81***
Gender				
Male	*Ref.*	*Ref.*	*Ref.*	*Ref.*
Female	1.52***	1.57***	2.3***	2.43***
Profession socio-professional category				
Farmer		1.1		0.57***
Craftsperson, shopkeeper		0.89		0.78***
White-collar worker		1.23***		0.87**
Manual worker		1.15**		0.68***
Intermediate profession		1.21***		0.9**
Manager		*Ref.*		*Ref.*
Does not appy		1.72***		0.84
Level of education				
No qualifications		0.98		0.54***
Technical certificate, age of 15/16 (BEP-CAP)		1.2***		0.64***
School leaving certificate, age 17/18 (Bac)		1.17***		0.85***
Two or more years of higher education		*Ref.*		*Ref.*
Situation regarding employment				
Working		*Ref.*		*Ref.*
Unemployed		0.9		0.91
Student		1.1		0.83**
Houseperson		0.83**		0.9*
Retired		1.29***		1.06
Other inactive		1.05		0.91
Monthly income by consumption unit (divided into quartiles)				
First quartile		0.91		0.7***
Second quartile		1.17***		0.82***
Third quartile		1.24***		0.92**
Fourth quartile		*Ref.*		*Ref.*
Household structure				
Single person		0.91		0.81***
Couple without children		1.18***		1.04
Couple with children		*Ref.*		*Ref.*
Single parent family		0.93		0.85**
Other cases		0.77***		0.81***
Type of complementary health coverage				
Means-tested complementary health cover		1.05		0.87
Private complementary health insurance		*Ref.*		*Ref.*
No coverage		0.48***		0.61***
Adjustment statistics				
Constant	1.050	0.82***	-0.240	0.5***
Sample size	24,599	24,599	24,599	24,599

Significance: * 10%, ** 5%, *** <1%.
Data: 2002-2003 National Health Survey (Insee). **Exploitation:** Irdes.

DEFINITION

An odds ratio expresses the effect of a variable (for example the fact of being a foreign immigrant) on the probability of using office-based care in relation to a reference situation (in this case being French by birth). The correlation is measured by comparing the odds ratio value to 1. If the value is superior to 1, being a foreign immigrant increases the possibility of consulting a GP.

Sources

The National Health Survey (EDS) of 2002-2003. This survey is carried out every ten years by the Insee among a representative sample of ordinary households residing in mainland France. The last survey was conducted between October 2002 and September 2003. In total, 40,796 individuals belonging to 16,800 households were interrogated. Households were interviewed over an eight week period comprising three visits by an interviewer at one month intervals. The survey permitted data collection on individuals' socio-economic characteristics (living conditions, professional situation and social protection) together with data on nationality, country of birth, health status and healthcare consumption. It should however be pointed out that this survey by definition excludes populations living in collective households or in highly precarious situations, categories in which foreign populations are over-represented.

The survey field is restricted to individuals aged 18 and over having participated in the three visits and belonging to one of the three following categories: French by birth, foreigners born in another country (foreign immigrants) and persons born in another country that have acquired French citizenship (naturalised immigrants). French citizens born in a foreign country (n=921) were excluded from the survey because of the high proportion of individuals born in Algeria before 1962, and for whom it is difficult to define the contextual elements of the country of origin. Immigrants' countries of origin were grouped together by geographic zone. In total, the final sample is constituted of 25,187 individuals, of which 2,296 immigrants.

After controlling for the effects of socio-economic characteristics, the probability of consulting a GP is not significantly different for for-eign and naturalised immigrants than for the French born in France. The lower access rate among foreigners is thus above all due to differences in social condition, and differences in the use of healthcare between French-born and immigrant populations reflect social inequalities that exist within the population as a whole.

… and specialist consultation rates

There is no significant difference in naturalised immigrants' and French-born citizens' probability of having consulted a specialist at least once over the last twelve months. The result remains the same after controlling for the effects of socio-economic characteristics. As is the case for GPs, the probability of consulting a specialist is largely determined by health status, age and gender. Socio-economic characteristics have a significant impact on access to specialist care and reveal a social gradient already largely documented whether in terms of socio-professional category, education level, income level or complementary health insurance coverage.

Inversely, for matching health status, age and gender, the probability of having consulted a specialist is lower for foreign immigrants than for the French born in France. This probability gap disappears after controlling for the effects of socio-economic characteristics. In depth analyses[1] reveal that complementary health insurance has a determining impact on access to specialist care.

Disparities according to region of birth…

Models 3 and 4 (*Cf.* table 3) reveal the effects of geographical region of birth on the probability of consulting a GP (*Cf.* Sources insert). For matching age, gender and health status, originating from the Middle East (OR=0.44), Asia (OR=0.52) and the Indian sub-continent (OR=0.59) significantly reduces the probability of consulting a GP compared with French-born citizens. Immigrants from central (OR=0.66) and southern Europe (OR=0.82) are equally less likely to consult a GP but the gap is slighter.

For the majority of regions of birth, immigrants' probability of having consulted a specialist is significantly lower. Immigrants from Northern Europe, Turkey, North Africa, Africa excluding North Africa, Asia and the Indian sub-continent are less likely to have consulted a specialist over the last twelve months and this at a comparable age, gender and health status.

… primarily due to different social and economic conditions to that of the French

After having taken socio-economic characteristics and complementary health insurance into account, the majority of observed differences in GP access rates disappear. Reduced access to a GP is thus largely explained by the immigrant populations' lower socio-economic status. The only exception concerns North African immigrants: whereas age and health status-

1 Results not presented here.

T3 Modelling of the probability of using office-based care in the last twelve months, and the region of birth effect

	Probability of consulting a…			
	GP		specialist	
	Model 3	Model 4	Model 3	Model 4
	Odds ratios		Odds ratios	
Region of birth				
France and Overseas Territories	*Ref.*	*Ref.*	*Ref.*	*Ref.*
Northern Europe	0.92	1.16	0.77*	0.64***
Central Europe	0.66*	0.91	0.8	0.97
Southern Europe	0.82*	0.9	0.92	1.18*
Turkey	0.67	1.07	0.55**	0.93
North Africa	0.98	1.46***	0.73***	1.14
Middle East	0.44***	0.62	1.13	1.11
Africa (excluding N.Africa)	0.73	1.18	0.67**	0.99
Indian sub-continent + islands	0.59*	0.91	0.34***	0.51**
Asia	0.52***	0.73	0.58***	0.72*
América, Australia, New-Zealand	0.84	1.24	0.86	0.78
Control for the effect of…				
Age, gender and health status[a]	X	X	X	X
Socio-economic characteristics and type of complementary health insurance cover[a]		X		X
Sample size	24,599	24,599	24,599	24,599

[a] Odds ratio values for the control variables (age, gender, health status and socio-demographic) are similar to those of the regression in table 1. The reader can thus refer to that table for these results.

Significance: * 10%, ** 5% *** <1%

Data: 2002-2003 National Health Survey (Insee). Exploitation: Irdes.

adjusted data reveal their healthcare use as being identical to that of French-born citizens, adjustment by health and socio-economic variables reveal a higher probability that they had consulted a GP over the last twelve months. If the limiting effect induced by social conditions on access to care is observed for this population, it nevertheless appears that their GP consultation rate remains superior to that of the French by birth.

Concerning access to specialists, numerous differences equally disappear when socio-economic characteristics are taken into account. Reduced access to specialist care is again due to immigrant populations' lower socio-economic status compared to that of French-born citizens. Only immigrants from Northern Europe, Asia and the Indian sub-continent have a lower probability of consulting a specialist after taking social status into account. Cultural differences and the natural adoption of a Gatekeeping principle, traditional in Nordic countries, can explain lower rates of access for Northern Europeans who first consult a GP who then refers them to a specialist if neces-sary. Immigrants from this region would automatically reproduce this care pathway and are naturally inclined to consult a GP before eventually consulting a specialist.

More vaccines, less screening tests for individuals of foreign origin

After the analysis of access to ambulatory care, the following phase consisted in assessing access to different acts of preventive care. The same statistical methodology was used to assess the impact of socio-economic factors on disparities between immigrants and the French.

Naturalised immigrants are 27% to declare having been vaccinated over the last twelve months against 23% of French-born citizens and 20% of foreign immigrants. Vaccination rates for hepatitis B among immigrants, in particular foreign immigrants are lower (23%) than those for individuals born in France (34%) (*Cf.* Graph 1).

Screening tests are equally less frequent among both foreign and naturalised immigrants. 14% of the French by birth and only 11,5% of foreign and naturalised immigrants benefitted from a screening test against hepatitis C. 37% of the French against only about 30% of immigrants were screened for HIV-AIDS.

After controlling for the effects of age, gender and socio-economic characteristics, foreign and naturalised immigrants have a higher prob-ability of having been vaccinated over the last twelve months than persons born in France (OR of 1.18 and 1.21) [*Cf.* table 4]. This higher probability does not concern the hepatitis B vaccine for which foreign immigrants were fewer to have been vaccinated (OR=0.7). Finally, foreign and naturalised immigrants are less likely to have been screened for HIV-AIDS during their lifetime.

* * *

METHODS

Indicators of access to healthcare. The information used to measure the use of healthcare is divided into two categories. On the one hand we have the individual declaration of having consulted a GP (or specialist respectively) at least once over the last twelve months. The observed GP sessions consisted of consultations and home visits. The terms session or consultation are however used indifferently in this article. On the other hand, we have at our disposal individual declaration indicators concerning acts of prevention: having been vaccinated over the last twelve months (whatever the vaccine); having been vaccinated against hepatitis B during ones lifetime; having been screened for hepatitis C and/or Aids during ones lifetime.

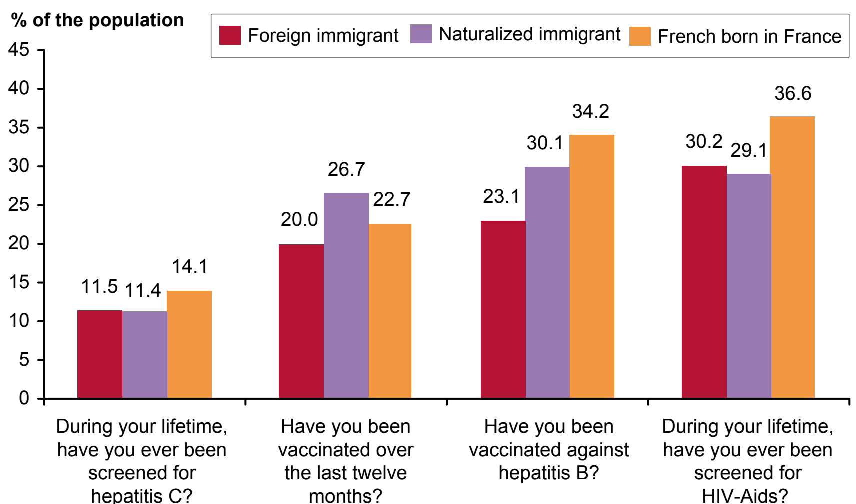
Indicators of health status. So as to determine healthcare needs, three questions from the Eurostat's Minimum European Health Module* were used to define three dichotomic indicators in the usual manner: 'Self-reporting an average, poor or very poor general health status versus a good or very good general health status'; 'Self-reporting one or several chronic illnesses'; 'Declaring being limited in ones activities for at least six months due to a health problem'. This approach to healthcare needs by means of health status is widely used in available literature [Wagstaff and van Doorslaer, 2000].

Other indicators. To determine social and economic status, several indicators were retained; level of education, occupation, profession and social category, the household's available income and household structure.

Statistical methods. The factors associated with the probability of having consumed healthcare are analysed over the last twelve months. This modelling allows to take into account patients' refusal of health care (difficulty of access, foregoing healthcare services…) but does not deal with the level of consumption.

The probability of having consulted is modelled using logistic regression methods. By modelling the fact of having consulted a GP at least once during the last twelve months, and by first controlling for the effects of health status, age and gender (models 1 and 3), and then adding social and economic characteristics and complementary health insurance coverage (models 2 and 4), we break down the origin of these inequalities in healthcare use and distinguish the direct effects of migration and nationality from the indirect effects whilst including the impact of social and economic situation.

G1 Proportion of individuals having had screening tests for hepatitis C, Aids and vaccinations



Data: 2002-2003 National Health Survey (Insee). **Exploitation:** Irdes.

T4 **Modelling of the probability of using office-based care in the last twelve months, migration profile and health status effect**

	Probability of having been vaccinated		had a screening test...	
	Over the last 12 months	against hepatitis B	hepatitis C	Aids
	Odds ratios		Odds ratios	
Migration profile				
French born in France	*Ref.*	*Ref.*	*Ref..*	*Ref.*
Naturalised immigrant	1.18**	0.7***	0.9	0.79***
Foreign immigrant	1.21**	1.16*	0.87	0.82**
Perceived health indicator				
Poor self-reported health	1.08*	0.91**	1.2***	1.03
Chronic illness	1.29***	1.07**	1.29***	1.15***
Activity limitations	1.19***	1.02	1.23***	1.2***
Controlling for the effect of...				
Age, gender and health status, socio-economic characteristics, type of complementary health coverage	X	X	X	X
Sample size	24,930	24,930	24,930	24,930

Data: 2002-2003 National Health Survey (Insee). **Exploitation:** Irdes.

The differences observed for immigrants originating from certain regions open up interesting research perspectives. International litera-ture seems to point to similarities between immigrants of the same origins residing in different host countries. Several studies (Sander, 2008; Reijneveld, 1998) thus demons-trate a higher use of general practi-tioners among Turkish populations in Germany and the Netherlands, and the Moroccan population in the Netherlands. Complementary analyses on the number of visits to a GP, not presented here, confirm these results for Turkish immigrants in France. The integration of new variables that are not available in our data, and in particular the time spent in the host country, would provide a deeper insight of the determinants at work in these specific modes of access to medical care among immigrant populations. ♦

GLOSSARY

- **Minimum European Health Module (MEHM):** Mini module européen
- **National Health Survey:** Enquête décennale santé

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- **French by birth :** Français de naissance
- **Foreign immigrant :** immigrant étranger
- **Naturalized immigrant:** immigrant naturalisé

French studies on immigrants' access to health care

Little research has broached the question of immigrants' access to healthcare in France. A comparison of the results obtained in the *Enquête Passage à la retraite des immigrés (Immigrants' Pathways to Retirement survey)* carried out among a sample of immigrants aged between 45 to 70 years old, with those of the *Enquête Emploi du temps* (Time Use survey) conducted among the population as a whole, revealed a lower consumption of specialist care but little difference in immigrants' consumption of general office-based care [Athias-Donfut and Tessier, 2005]. Foreigners' low consumption of care is furthermore confirmed in France by the results of the ESPS 2000-2002 surveys and INSEE's national health surveys from 1970 to 2003 [Mizrahi and Mizrahi, 2008]. These results are, however, difficult to interpret in terms of iniquity since they do not take differences in care needs into account.

More recently, the survey conducted in the first quarter of 2007 in the Ile-de-France region among benefi-ciaries of State medical assistance in contact with the health system, underlined that the immigrant popula-tion frequently forewent care for financial reasons and testified to obstacles in access to care, notably health professionals' refusal to deliver care [Boisguérin and Haury, 2008].

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