

The 2006 Health, Health Care and Insurance Survey, a panel for health policies analysis, public health and health economics research

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Since 1988, the Health, Health Care and Insurance Survey (Enquête Santé Protection Sociale, ESPS) provide information on French population's health status, utilization of healthcare services and health insurance. Thanks to its frequency, scope and longitudinal dimension, the survey participates in evaluating health policies, monitoring of public health problems in general population and research in the field of health economics.

In 2006, the Health, Health Care and Insurance Survey interviewed 8,100 households and 22,000 individuals. A oversample of households covered by public means tested complementary insurance was added, in order to better describe the health status access to health care of this population.

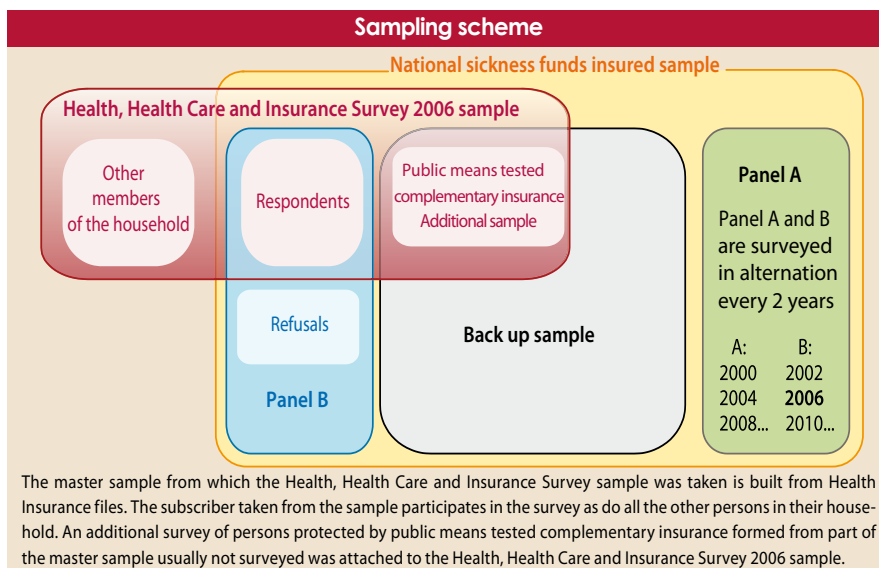
The 2006 survey incorporates new questions. In particular it is intended to participate in the evaluation of the "preferred doctor" reform and the coordinated treatment pathway scheme. Besides, questions on respiratory health and asthma will permit monitoring the evolution of the disease, studying its social and environmental determinants, and evaluating the adequacy of the treatments effectively dispensed as referred to medical guidelines. A module on living conditions during childhood and parent's health status will permit deepening studies on the intergenerational mechanisms at play in the construction of unequal health status, especially the transmission of risk behaviours.

The Health, Health Care and Insurance Survey (ESPS) is a general population survey carried out by IRDES since 1988 that collects information on individuals' health status, access to health care services, health insurance and economic and social status. ESPS is a panel survey and their health care consumption is recorded from Public Health Insurance files. In this document we set out the survey's aims then describe the protocol, participation and questionnaires, with an emphasis on the question modules recently introduced.

The survey's objectives

The Health, Health Care and Insurance Survey permits studying the links existing at individual level between health status, access to healthcare services, access to public and private health insurance and economic and social status. The causality of some of these links can be assessed by monitoring individuals through time. Besides, association of survey data with public health insurance files makes it possible to calculate volume and expense of healthcare consumption with very good accuracy.

The multidimensional, individual and panelised nature of the data makes it possible to use the survey for several study objectives. First of all, equity analyses in the health system (studies of social inequality in health and access to health care). Secondly evaluation of public policies,



BACKGROUND...

The Health, Health Care and Insurance Survey (ESPS) has been carried out by IRDES since 1988. Initially annual, then biannual from 1998, the 2006 survey questioned about 8 100 households, *i.e.* 22,000 people. The sample is composed of insured to the main social security funds (CNAMTS, MSA, RSI).

It is self-financed (IRDES is financed by CNAMTS, RSI, MSA, FNMF, CNRS and by contracts), with participation from DREES and INVS. The survey's orientations and protocol are defined by a scientific committee which, besides the representatives of the financing bodies, involves Eurostat, CNRS, INED, INSEE, INSERM, INPES and AFFSA.

In 2006, DREES also financed an additional sample of about 400 households eligible for public means tested complementary insurance.

whether directly or indirectly linked with health. For instance the impact of complementary public means tested complementary insurance was studied using ESPS data (Le Fur and Perronnin, 2002). The preferred doctor scheme and coordinated treatment procedure came into force in 2006 and has been studied in an initial study (Dourgnon *et al.*, 2007) that focused on compliance with the scheme and patients opinions.

ESPS survey is also intended to be a reactive tool for social science researchers that allows them to test new research hypotheses on French data. The 2006 survey includes an original module on the intergenerational transmission of health status as a function of social status, which will permit deepening analysis of the causes of social inequality in health.

ESPS is also used for public health studies. It permits exploratory approach of pathologies prevalence in the absence of specific instruments and exhaustive sources, by making use of detailed self assessed questionnaire on morbidity. It also allows, via specific questions, a more detailed approach to certain diseases and health problems, such as asthma in 2006.

Lastly, ESPS Survey remains a unique source of data on complementary health

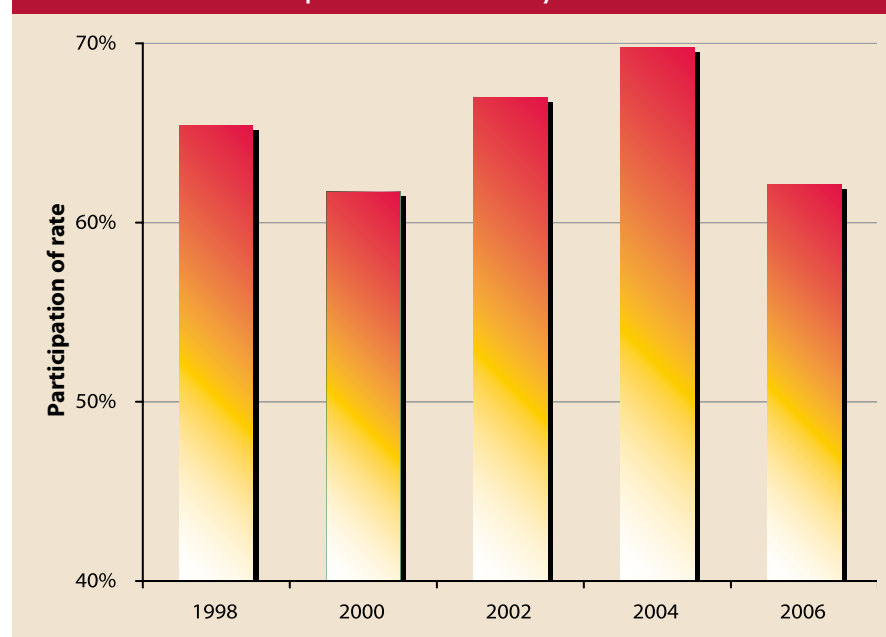
insurance in France. The specific questions asked about contracts provide a representative picture of the contracts effectively held and thus of the distribution of levels of coverage and their evolution in French population. In combination with IRDES survey on company complementary insurance (PSCE, 2003) and DREES survey on complementary insurance organisations and contracts, it forms a relatively complete triptych on complementary insurance in France.

Analysis of healthcare services utilization

The collection of data on healthcare consumption plays a central role in the Survey. Health care consumption data is collected in two ways, through reported and administrative data. The latter come from the insured's reimbursement file from the Public Health Insurance. Self reported data are also collected in the survey. The administrative source is reliable and exhaustive and was enriched in 2006 for two reasons. The common classification of medical procedures (CCAM), which entered into force in 2006, permits more precise identification of the technical procedures performed during treatments. Furthermore, administrative information relating to the preferred doctor and coordinated treatment pathway, designed

to regulate recourse to specialist care, should permit better identification of the pathways followed to obtain healthcare by these patients, something that was previously impossible. However, this information is only available for half the sample and above all does not describe how consultations proceed or the patient's opinions. Healthcare information is therefore also collected in the survey, by two questionnaires focussing on respondent's last consultation with a general practitioner and a specialist. This low intensive questioning permits collecting certain items of healthcare history (addressing, visit contains, prescribed treatments, waiting time, etc.) and also patient's opinions (understanding of medical communication, satisfaction with medical treatment, etc.). Collection of health care on a prospective one month record basis was abandoned in 2004. This methodological choice aims at lightening the respondent's burden (the rate of completion and return of self-administered questionnaires increased considerably afterwards), and was decided also because reporting bias in reporting medical consultations where assessed (Dourgnon, Renaud, 2005). Questioning on the respondent's last consultation has also been used in many other surveys in France and abroad.

Participation rate in the survey 1998-2006



A Panel sample observed for almost twenty years

ESPS Survey is drawn from a sample composed of Health Insurance subscribers (*Cf.* figure p. 1). This procedure makes it possible to:

- localise and follow up the selected insured through time, as they are questioned every four years;
- append data from the public health insurance files to individual data collected during the survey.

The sampling method guarantees constant representativeness of the sample through time. The sample remains representative of the population in metropolitan France. Consequently, it permits display a regular picture of health, healthcare consumption and complementary health insurance as well as monitoring individual life itineraries through time.

The master sample from which the ESPS Survey sample is taken is built using three files of insured from the main Public health Insurance funds: CNAMTS (salaried workers), MSA (farmers) and RSI (self employed). It is an extraction of approximately 1/600th of the insured of each of the funds. The sampling selection is based on a key that combines the subscribers' national identification numbers, which has good representativeness properties and permits observation of the sample through time. In particular the sample does not deform or age. In particular, deceased persons are statistically "replaced" by new arrivals whose national identity number corresponds to the survey key.

The insured selected in the sample is not surveyed alone as all the persons in his household participate in the survey. In all, ESPS Survey sample includes, when they respond, the insured selected in the sample and the other members of the household.

The survey was realized annually from 1988 to 1997, and became biannual in 1998. The sampling protocol permits re-questioning the same individuals in time, *i.e.* the insured present in the survey base and those members of the household

still present after four years interval. The 2006 survey therefore marked the end of the fifth cycle of the ESPS Survey panel, which has existed since 1988.

The survey is carried out in two waves, in spring and in autumn, to take into account the seasonality of certain pathologies. Data collection include telephonic survey, face-to-face surveys, especially for elderly households and public means tested complementary insurance beneficiaries, and self-administered questionnaires.

Following a regular progression from 2000 to 2004, participation decreased slightly in 2006, to reach 63% (*Cf.* figure). The rate of return of self-administered questionnaires remains very high, at 78%. Difficulties of contact stem in particular from households without fixed telephone lines, while the propensity to respond in large cities (Paris, Lyon, and Marseille) is traditionally lower. Reasons for refusal related to the repeated nature of the survey remains limited (7% of refusals), demonstrating low attrition through time.

An oversample of public means tested complementary insurance (CMUC) beneficiaries in 2006

The "Universal complementary health insurance" (Couverture maladie universelle complémentaire: CMUC), in force since 2000, is public complementary insurance complementary granted as a function of resources. CMUC's objective is to improve access to healthcare, covering a large part of dental and optical care, and part of pharmaceutical and hospital expenses which are usually covered by private complementary health insurance, whether for profit or non profit organizations. About 85% of the population is covered by complementary insurance, of which two fifths are paid by employers. Those not covered are most often the poorest. Persons benefiting from public means tested complementary insurance represent 7% of the French population. In order to control the system's monitor its health and real access to healthcare, this population have to be followed up regularly. Specific surveys of CMUC insured do not make it possible to check whether

their health status or access to healthcare converges with that of the rest of the population. Making such comparisons requires the collection of information on the entire population. The frequency of ESPS Survey makes it a reference source when examining these issues. However, persons benefiting from CMUC are relatively rare –less than one in ten– and their rate of participation is lower than the average. Indeed, households with insecure social situations generally participate less in surveys. What is more, the percentage of these beneficiaries in the surveys performed in 2000, 2002 and 2004 was nearly half that of the actual number, at about 4%. To offset this under representation, an additional sample of persons covered CMUC was added to the 2006 survey. This over sample consisted of persons identified as being CMUC covered in the part of the master sample not surveyed. Consequently, nearly 400 additional households were surveyed, permitting the inclusion of 1,700 beneficiaries of public means tested complementary insurance in the total sample in 2006. It should be noted that the survey procedures used for ordinary households do not permit observing individuals whose social situations are particularly bad. These include the homeless, persons living in hostels or squats, etc. These highly specific populations require equally specific observation tools.

New questions in the 2006 Survey

Besides using the standard socio-demographic questionnaire (age, sex, house-hold composition, socio-professional category, income, occupation, education), the ESPS Survey gathers very detailed information on health status, the patient's experience in the healthcare system, complementary insurance and other dimensions of socio-demographic status. The aim is to display a regular picture of changes in the health system on the basis of stabilised questionnaires but also to answer specific research questions on the basis of equally specific questionnaires.

Health status data is collected via a self-administered questionnaire. It includes data on pathology (coded by the WHO 10th revision of the International Classification),

disability, subjective assessments of health, risk behaviours.

Access to healthcare and patient experience are collected via a module on self assessed unmet needs for financial reasons and a new module of questions relating to the last consultation with a general practitioner and a specialist. This permits building a sample of consultations, on which information is available on the position of the consultation in the treatment pathway, waiting time, the emergency status, the contents of the consultation, doctor-patient relationships, etc.

The complementary health insurance contracts held by the household are assessed in a specific questionnaire. The sample of contracts built in this way comprises in particular information on the characteristics of the cover proposed. A module of questions is also proposed for public means tested complementary insurance.

The preferred doctor and the coordinated treatment pathway scheme, in force since 2006, are the subjects of a specific module. The participants are questioned on the reasons of their choice of a preferred doctor or not, on their recourse to specialist treatment and on the quality of the treatment received. The objective was to answer the following questions: how was the reform understood and accepted by the insured? What does the preferred doctor provide in comparison to the informal family doctor? On the basis of the users' experience, what is the impact on access to a specialist and on healthcare quality?¹

A module on respiratory health was also included, in line with the public health asthma plan of 2002-2005. The questionnaire aims to identify asthma sufferers and clinical severity of the asthma. The aim is to evaluate the evolution of the disease and of its stages of severity since 1998 when the last study was realized, to study its social and environmental determinants and, lastly, evaluate whether the effective treatments match medical guidelines.

The questions of the 2006 Health, Health Care and Insurance Survey

Main questionnaire

Respondent:

one per household, most usually the main subscriber (90% of cases) or another adult;

Content:

- composition of the household
- household income, professional status and educational attainments
- self assessed unmet needs for financial reasons
- social capital
- reform of preferred doctor
- living conditions in childhood

Health questionnaire

Respondent:

each member of the household

Content:

- health status
- tobacco, alcohol consumption
- respiratory problems (asthma)
- last consultation with a general practitioner
- last consultation with a specialist

Complementary health insurance questionnaire

Respondent:

One questionnaire per contract

Content:

- coverage origin (individual or company contract)
- premium
- guarantees

A module on childhood living conditions and parents' health status was also included in order to backup research works carried out on the intergenerational mechanisms in play in creating unequal health status when adult (Devaux *et al.*, 2007). Data will permit analysing the long term influence of the social status of parents and their longevity on their children health status, as well as the transmission of health behaviours.



FURTHER INFORMATION

- Survey website : <http://www.irdes.fr/EspaceRecherche/Enquetes/ESPS/EnqueteESPS.html>
- Data information and availability: esps@irdes.fr
- Health, Health Care and Insurance Survey 2006: report <http://www.irdes.fr/Publications/Rapports2008/rap1701.pdf>
- Dourgnon P., Guillaume S., Naiditch M., Ordonneau C. (2007), Les assurés et le médecin traitant : premier bilan après la réforme, *Questions d'économie de la santé* (124).
- Devaux M., Jusot F., Trannoy A., Tubeuf S. (2007), Inégalités des chances en santé : influence de la profession et de l'état de santé des parents, *Questions d'économie de la santé* (118).
- Dourgnon P., Renaud T. (2006), La qualité du recueil par carnet de soins : une analyse des différences entre recueil prospectif des consommations de soins et sources administratives. In « Méthodes d'enquêtes et sondages : Pratiques européenne et nord-américaine ».
- Le Fur P., Perronin M. (2003), L'état de santé des bénéficiaires de la couverture maladie universelle complémentaire en 2002, *Questions d'économie de la santé IRDES* (76).

Glossary

Cnamts: Caisse nationale d'Assurance Maladie des Travailleurs Salariés : Public health insurance fund for salaried workers.

CNRS: Centre National de la Recherche scientifique : National Center for Scientific Research, main government funded research organization.

DREES: Direction de la recherche, des études, de l'évaluation et des statistiques : Ministry of Health's Directory of Research, Study, Evaluation and Statistics.

FNMF: Fédération Nationale de la Mutualité Française : Complementary Health Insurance mutual funds main federation.

InVS: Institut de Veille Sanitaire : French Institute for Public Health Surveillance.

MSA: Mutuelle Sociale Agricole : Public health insurance fund for farmers.

RSI: Régime Social des Indépendants : Public health insurance and retirement fund for the self employed.

¹ The first results were presented in mid-2007 (Dourgnon *et al.*, 2007).