Questions d'économie de la Santé

n°280 - July-August 2023

Access to Healthcare Services and Usual Source of Care of Undocumented Immigrants when Covered by State Medical Aid

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State Medical Aid (*Aide Médicale de l'État*, AME) is a public health insurance that entitles undocumented immigrants access to medical care, including access to GP and specialist services, free of premium and out-of-pocket payments.

Does State Medical Aid actually improve access to and use of healthcare services of undocumented immigrants? In this Issues in Health Economics, we analysed whether undocumented immigrants covered by State Medical Aid use healthcare services in a different way to those who are eligible but who are not covered, both in terms of access to healthcare services and usual source of care.

Based on data from the 2019 "Premiers Pas" survey, which was conducted in Paris and the Bordeaux agglomeration, the results show that State Medical Aid coverage is linked with a greater use of healthcare services. The longer the length of the State Medical Aid coverage, the greater the likelihood of consulting a doctor in a medical practice, while the probability of using the emergency services or those provided by a NGO decreases. Furthermore, when insured, immigrants are more likely to choose a medical practice as their usual source of care. Hence, State Medical Aid appears to improve integration into the healthcare system, as the scheme's beneficiaries use mainstream medical practices instead of facilities dedicated to vulnerable populations. These forms of healthcare use are likely to improve the treatment of patients whose chronic disease needs to be regularly monitored.

In France, the access to social benefits is traditionally based on the constitutional principle of equality between foreign residents and French citizens. Until 1993, the regularity of a person's residence in France was not used as a condition to benefit from social protection. In 1993, by introducing the regularity of a person's residency as a condition for benefitting from healthcare insurance, the law relating to immigration control and the entry, reception, and regularity of residency conditions of foreign persons living in France – the so-called "Loi Pasqua" – removed the right to healthcare provision for undocumented immigrants over a certain period. This led – at a time when the universal health insurance (*Couverture Maladie Universelle*, CMU) and free comple-

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mentary health insurance (*Couverture Maladie Universelle Complémentaire*, CMU-C) schemes were introduced in 2000 – to the creation of a specific insurance scheme for undocumented immigrants. Funded by the French state, State Medical Aid is a healthcare scheme exclusively aimed at undocumented immigrants. The State Medical Aid enables the latter to have free access to healthcare services, based on their resources (André and Azzedine, 2016; Wittwer et al., 2019). To be eligible, a person must prove that he/she has been living in France on a continuous basis for at least three months and has insufficient financial resources – that is less than 798 euros per month for a single person, since July 2022. Refugees and asylum seekers are not eligible for State Medical Aid, but they are entitled to public health insurance (see Inset 1). Only 51% of the eligible persons were effectively covered. Furthermore, the access to this coverage does not seem to be correlated to healthcare needs. Hence, many persons who suffer from health problems and require regular treatment and monitoring remain without coverage (Dourgnon et al., 2022).

What are the healthcare needs of undocumented immigrants? Even if it remains incomplete, information about the state of health of undocumented immigrants have highlighted specific and often major health problems. Hence, individuals who come from North Africa or sub-Saharan Africa are more likely to suffer from infectious diseases (i.e. AIDS, tuberculosis, or hepatitis B) and mental health problems (Marsaudon et al., 2020; Vignier et al., 2022). Furthermore, accessing healthcare services is often problematic for undocumented immigrants (Winters et al., 2018).

Faced with a health problem, an undocumented immigrant can access medical care in two ways. Without State Medical Aid coverage, the person can consult a healthcare professional in a specific care facility for vulnerable people, such as a NGO (for example, a healthcare facility run by the NGO *Médecins du Monde*), an emergency hospital service, or Hospital Medical Social Services (*Permanences d'Access aux Soins de Santé*, PASS). Covered by State Medical Aid scheme, the person can have access to the above-mentioned care facilities if he or she wishes, but also, and above all, to care facilities accessible to persons covered by public healthcare insurance (a medical practice, a health facility, etc.), which would otherwise be very expensive (Sargent, 2017). The treatment programmes of undocumented immigrants with identical healthcare needs covered by State Medical Aid should therefore converge with or, at the very least, be similar to those of the rest of the resident population. Furthermore, treatment provided in a medical practice may make it easier to monitor patients, which may be of benefit to the patients, as well as making treatment less expensive.

The aim of this study is to analyse whether the persons covered by State Medical Aid use healthcare differently to persons who have no coverage, both in terms of access, the type of healthcare professional, and the point of entry selected in the healthcare system. Did the covered persons with equivalent healthcare needs use healthcare services more often? Did they use usual source of care, such as medical practices, instead of care facilities provided specifically for vulnerable populations?

A subsample from the 2019 "Premiers Pas" survey

The "Premiers Pas" survey questioned a sample of 1,223 undocumented immigrants in 2019 (Dourgnon et al., 2019) [see Context and Inset 2]. The 754 persons interviewed and resident for more than a year in France were selected for this study. On the one hand, because they were all eligible for State Medical Aid; and, on the other, because as the healthcare consumption was recorded over the previous twelve months it was only possible to compare persons living in France for more than one year. If the individuals living in France for less than a year had been retained, it would have introduced a bias because they would not have had the same period of time to consult a healthcare professional as persons who had been resident in France for a longer time.

Healthcare use was examined via questions on use per type of health service, and then via questions about the usual source of care. Healthcare use was assessed on the basis of the following question: "Over the last twelve months, have you consulted a doctor in the following places?" In response to which several non-exclusive options could be selected: in a medical practice, in the emergency services, in Hospital Medical Social Services (PASS), in a hospital, or in a NGO.

I1

The State Medical Aid

The State Medical Aid (*Aide Médicale de l'État*, AME) is a health insurance aimed at undocumented immigrants who have been living in France for a continuous period of more than three months. It is provided according to income conditions similar to those of the Public Health Insurance (*Complémentaire Santé Solidaire*, CSS) scheme. The application to be covered by State Medical Aid is managed by the Public Health Insurance local branches (*Caisses Primaires d'Assurance Maladie*, CPAM). The State Medical Aid scheme entitles to a basket of care for one year, which is slightly less comprehensive than the Public Health Insurance basket. Over a one-year period, the beneficiary of State Medical Aid is able to benefit from certain medical services for free: sickness and maternity care are covered 100% as are hospital stays. However, this scheme does not cover the cost of thermal treatments, medically assisted procreation (*Aide Médicale à la Procréation*), medications providing insufficient therapeutic value (reimbursed at 15% for the other insured persons), and originator medicines, if a generic version exists. Lastly, optical and dental care are covered on the basis of the standard rate. State Medical Aid is funded from the State budget and not that of the Public Health Insurance. In 2022, around 415,000 persons were covered by State Medical Aid, at a cost of around 968 million euros. An additional sum of around 86 million euros was spent on urgent and vital medical care for undocumented immigrant patients, who were not eligible for statutory State Medical Aid, because they had lived in France for less than three months. Lastly, 0.5 million euros was spent on hospital care for French or foreign patients who do not usually live in France, attributed on the decision of the Ministry of Health (Wittwer et al., 2019). In 2022, the cost of State Medical Aid represented 0.5% of the public health expenditure.

I2

The "Premiers Pas" survey

The "Premiers Pas" survey set out to gain a better understanding of undocumented immigrants eligible for State Medical Aid, in particular their access to State Medical Aid and healthcare services. It collected information about migrations history, the individuals' state of health, access to insurance, and healthcare use in a sample of undocumented immigrants, that is to say without a residents' permit and not involved in an application for asylum. The survey was conducted in the Bordeaux agglomeration and Paris between February and April 2019, and involved 1,223 persons, in 63 places and organisations that provide assistance to persons in precarious situations. The surveys were drafted in 14 languages (Dourgnon et al., 2019).

This study took into account the 754 persons interviewed who had been living for more than twelve months on French territory, hence eligible to State Medical Aid, and for whom information about healthcare use was available.

The usual source of care was identified through the following question: "In France, when you have a health problem, where do you generally go to consult a doctor?" The same question was used to identify the usual source of care in the country of origin. Having a usual source of care improves the quality of the healthcare, reduces healthcare costs, and improves access to preventive care (Vargas Bustamante et al., 2012).

The length of coverage – that is to say the time that had elapsed since the first time the person was covered by State Medical Aid scheme – was calculated to assess whether joining the State Medical Aid scheme resulted in greater healthcare consumption (for example, the person was directed towards State Medical Aid following a visit to the emergency services where a chronic health problem was diagnosed), and to observe if the patient was more likely to use conventional entry points to the healthcare system as he or she became more familiar with the healthcare system, access to which was made possible by State Medical Aid.

Two thirds of the sample used for the analysis consisted of men (67.7%) and young persons (55.3% under the age of 40), most of whom originated from sub-Saharan Africa (50%) and North Africa (29%). 25% of them came to France less than two years beforehand, 36% between two and five years, and 39% had been living in France for more than five years. 26% of them lived on the street; 67.8% declared that they suffered from at least one disease, and 16.3% had at least one functional limitation.

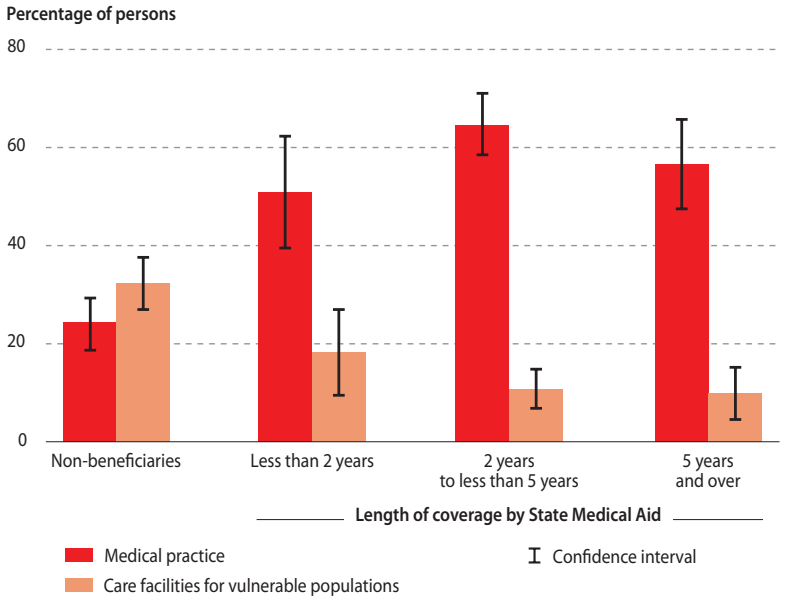
Less non-use and more visits to a medical practice among persons covered by State Medical Aid

79.5% of undocumented immigrants living in France for more than a year had used healthcare services in France at least once over the previous twelve months. This proportion reached 89% amongst persons covered by State Medical Aid, compared with 67% amongst persons with no coverage. Likewise, 71% of the covered persons had visited visited a medical practice at least once, compared with 34% of persons with no coverage. 58% of the persons with coverage chose a medical practice as their usual source of care, while this was stated by only 25% of the persons who had no coverage.

Coverage as well as length of coverage influenced access to healthcare and usual source of care. The individuals not covered by State Medical Aid were more likely to visit the care facilities used by vulnerable populations, that is to say the emergency services, Hospital Medical Social Services (PASS), and NGOs, and were less likely to visit the GP's practice, whether a private practice, group practice, or a medical facility. The persons covered by State Medical Aid were more likely to opt for the GP's practice. Furthermore, as the length of time of the coverage increased, the medical practice was also selected more frequently, while Hospital Medical Social Services (PASS), emergency services, and non-governmental organisations were increasingly less considered as entry points to the healthcare system (see Graph). Hence, while one out of five persons covered for less than two

G

Access to healthcare services and length of coverage by State Medical Aid



Note: Care facilities for vulnerable populations include NGOs, Hospital Medical Social Services (PASS), and the emergency services.

Reading: More than half of the persons covered by State Medical Aid for more than two years consulted a doctor in a medical practice.

Source: 2019 "Premiers Pas" survey.

Download the data

years used care facilities designed specifically for vulnerable populations, only one out of ten persons covered for more than five years used such facilities.

The length of coverage influenced the care facility used

A number of models were estimated to assess the correlation between State Medical Aid coverage and healthcare use. The explained variable of the models used was healthcare use, measured successively by the use of healthcare services over the previous twelve months (a variable that indicates use versus non-use), healthcare use by care facility (a variable that indicates use versus non-use per care facility), and the usual source of care (indicator variable per usual source of care versus another source of care or the absence of a usual source of care).

The estimations were adjusted for the effects of age, gender, state of health, and variables that characterise migration (the country of origin, the reason for the migration, the means of entry into France, the duration of the stay on French territory, and the level of their mastery of the French language). Lastly, the modelling of the usual source of care in France was adjusted for the usual source of care in the country of origin. These estimations were made in distinct probit models (see Methodology Inset).

In an initial series of models, we studied the use of healthcare services. We analysed the correlation between State Medical Aid coverage and the use of the healthcare, then whether the length of the State Medical Aid coverage had – all things being equal – an influence on the healthcare facilities frequented. The results of this analysis, represented by percentage points (pp), are presented in Table 1.

State Medical Aid coverage was associated with more frequent healthcare use during the previous twelve months (+ 8.9 pp consulted at least once) and a number of consultations that was also greater than persons not covered by State Medical Aid.

The length of coverage is correlated with the use of healthcare services. Amongst the persons covered, the probability of having consulted a doctor was 17.3 pp higher when the coverage had lasted for under two years; then this gap shifted to 8.5 pp when the coverage lasted between two and five years. Beyond this period the gap was insignificant.

The persons covered were more likely to consult a GP in a medical practice. This difference decreased slightly with the length of coverage, shifting from 29.7 pp amongst the persons covered for less than two years to 22.1 pp from five years onwards.

Context

The "Premiers Pas" survey is part of a multidisciplinary project. The "Premiers Pas" project, comprising rights access, healthcare trajectories, and the use of State Medical Aid (AME) in France', set out to study the means of access to rights and healthcare use by foreign persons who are illegally present on French territory.
This project included a qualitative section, a survey aimed at undocumented immigrants — the "Premiers Pas" survey — and a panel of administrative data provided by State Medical Aid. "Premiers Pas" was conducted by a research consortium that brought together researchers in anthropology, sociology, and economics, as well as a GP. The participating teams also came from Bordeaux University (UMR 5319 Passages-CNRS and U1219 Bordeaux Population Health, EMOS-INSERM), the Paris-Dauphine University (EA 4404 LEDA-LEGOS), and the Institute for Research and Information in Health Economics (IRDES). This research was supported by the Nouvelle Aquitaine Regional Health Agency (*Agence Régionale de Sante*, ARS), the *Fondation des Amis de Médecins du Monde* (2016–2019), and the French National Research Agency (*Agence Nationale de la Recherche*, ANR), following calls for proposals for generic projects in 2015.

Methodology

The multivariate models used in this study set out to assess the correlation between State Medical Aid coverage and the access to healthcare services. This was measured via three groups of dichotomous variables: the fact of having used the services over the previous twelve months; use per type of healthcare service (practice, hospital, emergency services, Hospital Medical Social Services (PASS), or a non-governmental organisation); and the care facility usually used by the person in the event of a health problem (practice, hospital, emergency services, a non-governmental organisation, PASS, no usual source of care).

The correlation between the State Medical Aid coverage and the access to healthcare services was assessed using simple probit models, that is a model for each indicator variable above. Alternative modelling, in particular non-ordered polytomous models, were tested. The findings presented here are robust to the choice of model.

We measured the correlation between the State Medical Aid (AME) scheme and use, then we modulated the effect of AME by introducing the duration of the AME, that is to say the length of time that the person had been insured, in such a way as to distinguish the initial effects (catch-up effect, the effect of an initial health problem, and hence the effect of healthcare use after being referred to State Medical Aid (AME), via Hospital Medical Social Services (PASS), for example).

The small size of the working sample meant limiting the range of control variables. Age, gender, monthly income brackets, and the fact of being homeless provided information about the individuals' social situation. The state of health was taken into account according to whether a person suffered from at least one disease diagnosed in France or in the country of origin (these two pieces of information were drawn from a list of health problems recorded in the surveys), functional limitations, or mental health problems (suffering from a severe depression). The region of the country of origin, the reason for the migration, the means of entry in France, the length of the stay on French territory, and the level of their mastery of the French language enabled the characteristics specific to migration to be analysed.

The length of stay in France was also introduced as a control variable. Hence, the effect of the length of coverage on healthcare use was dissociable from that of the length of the stay in France. Indeed, we compared the persons who had different periods of State Medical Aid coverage, but who had lived in France for the same length of time.

Lastly, the models of the usual source of care in France took into account the usual source of care in the country of origin. The correlation between State Medical Aid and the usual source of care may in fact reflect the access to the healthcare services in the country of origin, which is itself potentially correlated with the coverage requirements.

T1

Access to healthcare and length of coverage by State Medical Aid: probit model

	Medical consultation in any healthcare facility		Healthcare facility				
			Medical practice	Hospital Medical Social Services (PASS)	Hospital	Emergency services	NGO
Eligible but not covered by State Medical Aid (AME)	*Ref.*	*Ref.*	*Ref.*	*Ref.*	*Ref.*	*Ref.*	*Ref.*
Covered for less than two years		0.173*** (0.037) 0.000	0.297*** (0.061) 0.000	-0.009 (0.055) 0.871	0.157*** (0.061) 0.010	0.162*** (0.063) 0.010	-0.032 (0.040) 0.431
Covered for between two and five years		0.085** (0.036) 0.019	0.276*** (0.045) 0.000	-0.097*** (0.036) 0.006	0.027 (0.039) 0.483	0.061 (0.043) 0.161	-0.065** (0.030) 0.028
Covered for more than five years		0.039 (0.053) 0.460	0.221*** (0.062) 0.000	-0.132*** (0.041) 0.001	0.064 (0.051) 0.211	-0.052 (0.048) 0.282	-0.069** (0.035) 0.050
State Medical Aid	0.089*** (0.031) 0.004						
Observations	**752**	**754**	**754**	**747**	**752**	**754**	**747**

Note: The coefficients are marginal effects (that can be interpreted as percentage points) using a probit model, and the standard deviations are in brackets. *** p<0.01, ** p<0.05, * p<0.1.

Reading: Undocumented immigrants who have been covered by State Medical Aid for five years or more are 22.1 percentage points (pp) more likely to consult a GP working in a medical practice compared with those who have had no coverage.

Source: 2019 "Premiers Pas" survey.

Download the data

Persons covered for less than two years were more likely than the persons with no coverage to use emergency services (+16.2 pp) or consult a hospital doctor (+15.7 pp). Beyond two years of coverage, no significant difference was observed.

After two years of coverage, healthcare use decreased in the NGOs and the Hospital Medical Social Services (PASS).

… as well as the usual source of care

A second series of models related to the usual source of care. While 45% of the respondents stated that a medical practice was their usual source of care, only 24% of persons without coverage stated this, compared with 58% of the persons covered by State Medical Aid. While the choice of medical practice as the usual source of care seemed to be relatively unaffected by the length of coverage, the likelihood of declaring a NGO, the emergency services, or Hospital Medical Social Services (PASS) decreased with the length of coverage (see Table 2). After two years of coverage, the persons covered by State Medical Aid used these services much less frequently.

T2

Usual source of care and length of coverage by State Medical Aid: probit model

	Medical practice	Emergency services	Hospital Medical Social Services (PASS)	Hospital	Non-governmental Organisation	No usual source of care
Eligible but not covered by State Medical Aid	*Ref.*	*Ref.*	*Ref.*	*Ref.*	*Ref.*	*Ref.*
Covered for less than two years	0.246*** (0.062) 0.000	-0.014 (0.043) 0.749	-0.015 (0.042) 0.718	0.033 (0.054) 0.535	-0.029 (0.032) 0.360	
Covered for between two and five years	0.288*** (0.045) 0.000	-0.012 (0.032) 0.692	-0.062** (0.028) 0.027	-0.004 (0.037) 0.918	-0.070*** (0.020) 0.000	-0.087*** (0.017) 0.000
Covered for more than five years	0.251*** (0.060) 0.000	-0.070** (0.029) 0.017	-0.086*** (0.030) 0.004	0.135** (0.058) 0.020		-0.072*** (0.025) 0.004
Observations	**745**	**715**	**726**	**742**	**557**	**652**

Note: The coefficients are marginal effects (that can be interpreted as percentage points) using a probit model, and the standard deviations are in brackets. *** p<0.01, ** p<0.05, * p<0.1.

Reading: Persons covered by State Medical Aid for five years or more have an increased probability of 25.1 percentage points (pp) of declaring a medical practice as their usual place of care.

Source: 2019 "Premiers Pas" survey.

Download the data

An improvement in access to healthcare and a modification of the usual source of care

The State Medical Aid scheme drastically reduces the financial cost of healthcare use. Hence, there is an expected correlation between coverage and healthcare access. Nevertheless, it did not enable us to identify with certainty the mechanism(s) involved. Access to coverage may occur following an urgent need for treatment and an initial use of a healthcare service such as an emergency service, followed by a referral to a Primary Health Insurance Fund (CPAM) or Hospital Medical Social Services (PASS), or access to information about State Medical Aid. Conversely, a person already covered may use a treatment because it has been made accessible. The persons covered by State Medical Aid are probably better informed about the available healthcare services.

Time plays a significant role in the access to coverage and healthcare. While State Medical Aid coverage is correlated with the length of stay in France (Dourgnon et al., 2022), the use of healthcare services depends on the length of time the person has been covered by State Medical Aid (AME). During the first year in which the person is covered, the use of healthcare services is greater. This initial effect of coverage on healthcare use also concerns consultations in a medical practice or a hospital rather than emergency services. After five years of coverage, the individuals concerned generally opted to use a medical practice rather than Hospital Medical Social Services (PASS).

Lastly, the pattern of use of healthcare services also changed over time. In particular, the Hospital Medical Social Services (PASS) and the emergency services became entry points that were increasingly less used by insured persons as entry points to the healthcare system. These results show that healthcare use is not solely linked to an initial healthcare need or use, and that the insurance changes healthcare use in the longer term. State Medical Aid is therefore likely to improve the treatment of persons whose state of health requires regular follow-up care.

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Our results are in line with previous studies on the effects of insurance on access to healthcare among deprived populations. Hence, in the United States, the persons covered by Medicaid for a chronic disease, such as diabetes or mental health problems, are greater users of healthcare services. The persons covered reduce their risk of being exposed to catastrophic out-of-pocket healthcare costs or of using another person's prescription to receive a treatment (Baicker et al., 2017). In France, the healthcare access assistance programmes for vulnerable persons who are legally resident, such as the Complementary Health Solidarity (*Complémentaire Santé Solidaire*, CSS) scheme, have proved effective in improving the access to a GP (Grignon et al., 2008), in particular amongst young adults (Guthmuller and Wittwer, 2017).

The results of the multivariate models show that undocumented immigrants, when they are covered by State Medical Aid, generally consult a doctor in a medical practice for a new health problem. Medical practices, as opposed to emergency services, NGO and the like, facilitate better follow-up care, in particular for chronic diseases. State Medical Aid therefore seems to allow for better integration into the healthcare system, as the scheme's beneficiaries use medical practices and healthcare facilities instead of care facilities provided specifically for vulnerable populations. Nevertheless, although State Medical Aid was introduced more than twenty years ago, the non take-up of this scheme is still high, including amongst persons who have been living in France for many years. 49% of eligible persons are not covered, and this rate is still 35% amongst persons who have been living in France for five years and more. Lastly, persons who require regular care, such as persons suffering from chronic diseases, frequently remain uncovered. ♦

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Director of the publication: Denis Raynaud • **Technical senior editor:** Anne Evans • **Associate editor**: Anna Marek • **Translators**: David and Jonathan Michaelson (JD-Trad) • **Layout compositor**: Damien Le Torrec • **Reviewers**: Guillaume Chevillard and Renaud Legal • **ISSN:** 2498-0803.