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Austerity and its implications for immigrant health in France[☆]

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ABSTRACT

The ongoing economic crisis in France increasingly has affected immigrant rights, including access to health care. Consistent with a 2014 League Against Cancer survey, we identify the ways in which sickness produces a "double penalty" for immigrants with serious illness. Immigrants with chronic illnesses such as cancer, diabetes, and other debilitating conditions divert vital funds from daily needs to deal with sickness and loss of work while at the same time national austerity measures shred the state's traditional safety net of social services and support. We examine how immigrants strategize to manage financial exigencies, therapeutic itineraries and social relations in the face of these converging pressures. We base our findings on two studies related by this theme: an investigation of health inequalities in the Médoc region, in which 88 women, 44 of North African and Eastern European origin, were interviewed over a three-year period (2010–2013); and a three-year study (2014–2017) of West African immigrant women with breast cancer seeking treatment in the greater Paris region, 70 members of immigrant associations, and clinical personnel in three hospitals.

1. Introduction

In response to the global financial crisis, beginning in 2007, the European Union encouraged member states to implement austerity measures intended to restore economic stability across the region. In this article, we address the consequences of certain austerity measures for health care in France. In so doing, we do not intend to minimize variability in the severity of budget cuts across Europe, but rather to emphasize that such initiatives in France have exacerbated existing inequalities in health care access affecting the most vulnerable populations, including women of reproductive age and undocumented immigrants (Aïach, 2010; Berchet and Jusot, 2010). Our use of the term austerity follows that of Stuckler and Basu (2013:10), who state that "austerity is medicine intended to reduce symptoms of debts and deficits and to cure recessions. It cuts government spending on health care coverage, assistance to the unemployed, and housing support."

France achieved global attention in 2000 when the World Health Organization rated the French health care system first in its quality rankings (Fassin, 2004:203). High life expectancy rates and other impressive health indicators notwithstanding, the French health care system has been critiqued for significant health disparities, evident in unequal access to health care for vulnerable and marginalized populations. In stark contrast to the WHO rankings, the European Union noted the dramatic gaps in health status in France by social class, especially by occupation. As Pierre Aïach (2010, 2013) observed in his groundbreaking research on the social determinants of health in France, social inequalities are not only cumulative, but have consequences that, in synergy, are progressively amplified. Accordingly, in this article, we follow Aïach and Fassin in arguing that certain population categories, for example undocumented immigrants and seasonal workers, are subject to health risks associated with inadequate access to health services or to high quality health care (Fassin, 2004:203). But, in addition, we demonstrate, by means of case studies, the ways in which health status and access to efficient and effective health care are affected by conditions of precarity, employment, housing, revenue, immigration status, and geographic locale.

Sociologists, political scientists, economists, and humanitarian organizations use the term precarity in discussing the negative

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[☆] Ethics approval/Statement EA not required. The research conducted in the Paris region was reviewed by the Washington University in St. Louis IRB/Human Subjects Review Board, and Approved 4/8/14, no. 201403075. The research conducted in the Medoc region was approved by the Université de Bordeaux and IRESP, Convention no. 2009SS06. In each study, informants were given a verbal or written explanation of the research, depending on their level of literacy, and were requested to provide informed consent, verbal or written, as appropriate. The informed consent protocols were approved by the ethics committee or IRB of the respective institutions.

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impact of neoliberalism and globalization on diverse social groups, especially immigrants, youth, women, and others lacking stable work and job security (Holmes and Castaneda, 2016; Shaw and Byler, 2016; Standing, 2011; Kalleberg, 2009). Banki (2014) extends the notion of precarity by offering the concept "precarity of place," to suggest the challenges of physical residence for migrants, especially those who are non-citizens. Accordingly, by precarity, we refer to the economic instability and life risks experienced by certain segments of the French population, who have irregular and unpredictable employment, low income, inadequate housing, and dependency on social welfare benefits.

Those who lack steady employment and insufficient revenue to cover routine expenses are likely to experience a sense of existential precariousness as well, related to the fragility or uncertainty of social networks and support systems. Many, especially the undocumented and seasonal workers, experience "precarity of place" (Allison, 2016; Banki, 2014), as we will show in our case studies. The uncertainty of everyday life is such that any unanticipated crisis, such as serious illness, may well generate "health precarity," and a cascade of events exacerbating economic insecurity and resulting distress. For vulnerable migrants who confront barriers such as immigration status, comprehension difficulties (linked to language competence and navigating the complexities of the health care system), transportation, inadequate nutrition, and problematic housing, the national principles of equality and access to health and wellbeing remain an illusion (Kotobi et al., 2013a,b; Tapie de Celeyran et al., 2013).

We focus especially on immigrant women and itinerant women workers with chronic health problems because they exemplify the vulnerability of those lacking social legitimacy and, hence, are more likely to experience restricted access to health care as a social right. This is particularly paradoxical, as Fassin observes (2004), given that, since World War II, legal residents in France have been entitled to social security benefits, including health care. Special provisions exist to provide coverage for foreigners and others lacking legal resident status. Similarly, several papers (Bretin and Kotobi, 2016; Berchet and Jusot, 2012; Kotobi et al., 2013a,b; Kotobi and Lemonnier, 2015, 2016) point to the tension between the guarantee of health care as a universal right in France and the reduction in expenditures for health and social welfare. As we will show entitlements do not necessarily translate to understanding of existing rights or to health care access.

The French national health care system is highly centralized, with state regulation of "universal" insurance coverage and based on a foundation of both public and private institutions. Approximately 90% of urban physicians are independent, or private (professionnels libéraux). However, the status "private" may be misleading. Almost all institutions and practitioners are subject to tariffs for reimbursement set by Social Security (Sécurite sociale) at the state level, with very rare exceptions. Public hospital physicians are classified as civil servants and receive salaries from the state; the most senior among them may have the right to take private patients, but with fees set by the state social security system.

For some critics of health care financing in France, the pending issue is not an increase in privatization, with detrimental implications for marginalized populations, but rather, the question of supplemental charges for medical services which exceed the tariffs set by Social Security. These charges are in no way related to current austerity measures in the European Union or in France. Indeed, they date at least to the 1950s (Bocognano, 2009:8). A recent proposal by French presidential candidate François Fillon to partially privatize national health insurance was met with public outrage from both the left and the extreme right. Fillon subsequently denied that he had intended to privatize the system or to diminish reimbursements (Fillon, 2016:2).

Supplemental charges, known as "dépassements d'honoraires" are primarily found among specialists, such as surgeons, ophthalmologists, and anesthesiologists (Bocognano, 2009:9). Primary care physicians are prohibited from exceeding state reimbursement rates, and physicians cannot charge supplemental fees for low-income patients as identified by their health insurance status. However, in addition to full coverage for emergencies, all patients are reimbursed 100% for long-term chronic illnesses and for very costly illnesses. Clinicians must contract with Sector 1, which prohibits supplemental charges, or Sector 2, in which such charges are allowed. The affiliations and resultant fee schedules are well publicized and indicated to prospective patients (Pierre Chauvin, Haut Conseil de la Santé Publique and INSERM, National Institute of Health and Medical Research, personal communication April 4, 2017). Most low-income patients are therefore protected from supplemental charges by the caveats above, but are subject to constraints posed by a shortage of physicians and hospitals in certain geographical areas, and over-burdened gynecologists and obstetricians (Sector 1) in public hospitals and maternal and child health centers.

Since the 1990s, the French health care system has experienced organizational change stimulated by European Union economic integration policies as well as by global managerial reforms. In contrast to other countries, such as the U.K., France has selectively adopted features of new public management, or NPM, (Simonet, 2013, 2014). Although an extensive discussion of managerialism in France, or more broadly, in Europe, is beyond the scope of this article, its implications for the populations represented in our case studies merit attention. NPM is intended to improve public services delivery, more efficiently allocate resources, lower costs, and emphasize budgetary discipline (Ministère des Affaires sociales et de la Santé, 2016; Saint-Martin, 2004). A central feature of the model is activity-based payment, or Tarification à l'Activité (T2A), in which nationwide, uniform pre-determined reimbursement rates are set to reflect services delivered. Critics of T2A have observed that this model negatively affects the quality of care, putting pressure on professionals to provide more medical "acts" in less time. The tariff system does not facilitate coverage of linguistic and social costs associated with patient care, such as use of interpreters or assistance in addressing patients' legal, financial, and family crises (Kotobi et al., 2013a:75). In this regard, the NPM model and T2A work to the disadvantage of vulnerable and marginalized patients, as our cases demonstrate.

State policy and public sentiment reflect the ideological stance that health care is a human right; public hospitals are obligated to provide emergency care and to accept all patients, and national health insurance should eliminate financial barriers to medical care. This idealistic model neglects the reality that the distribution of health resources is highly skewed in favor of urban areas. Analysis of health disparities must therefore take into account geospatial disparities, in addition to other axes of inequality such as gender, ethnicity, occupation, and national origin. In this regard, we will compare health care trajectories of low-income immigrant women in Paris, focusing on the northern suburbs of Seine-Saint-Denis, with those of women in the rural Médoc region in the Southwest of the country. It is in these two regions that we conducted our respective research programs. Both studies focused on populations rendered invisible by their status as illegitimate in public health and social analyses at the state and regional levels. Most often our informants were immigrant women or women engaged in seasonal labor, living in economically and socially precarious circumstances.

Theoretically, the French system provides a safety net for low-income populations, by means of supplemental state-sponsored medical coverage such as CMUc (Couverture Maladie Universelle,