International Journal of Drug Policy 49 (2017) 1–7

Contents lists available at ScienceDirect

International Journal of Drug Policy

journal homepage: www.elsevier.com/locate/drugpo

Research paper

Addictive behaviors and healthcare renunciation for economic reasons in a French population-based sample

Stéphanie Baggio[a,f,*], Marc Dupuis[b], Jean-Baptiste Richard[c], François Beck[d,e]

[a] Life Course and Social Inequality Research Centre, University of Lausanne, Switzerland
[b] Institute of Psychology, University of Lausanne, Switzerland
[c] Santé publique France, The French National Public Health Agency, France
[d] Observatoire Français des Drogues et des Toxicomanies (OFDT), The French Monitoring Center for Drugs and Drug Addiction, France
[e] ERES, Sorbonne Universités, UPMC Univ Paris 06, INSERM, Institut Pierre Louis d'Epidémiologie et de Santé Publique, UMRS, 1136 Paris, France
[f] Division of Correctional Medicine, Geneva University Hospitals and University of Geneva, Geneva, Switzerland

ARTICLE INFO

Article history:
Received 7 February 2017
Received in revised form 22 April 2017
Accepted 10 July 2017
Available online xxx

Keywords:
Forgone care
Gambling
Population-based survey
Substance use
Health social inequalities

ABSTRACT

Background: Healthcare renunciation for economic reasons is a major health concern, but it has been scarcely investigated among drug users, even if drug users constitute a vulnerable population in need of medical care. This study investigated associations of healthcare renunciation for economic reasons and addictive behaviors (alcohol, tobacco, cannabis, illicit drug use, and gambling) in a population-based sample of adults living in France, a country with universal health coverage.
Methods: Data were collected using the 2014 Health Barometer, a French cross-sectional survey conducted among a random representative sample of the general population aged 18–64 (n = 12,852). Measures included healthcare renunciation, substance use (alcohol, tobacco, cannabis, and other illicit drugs) and gambling. Experimental/recreational and heavy/chronic use were assessed. Logistic regressions were used to test the relationship between healthcare renunciation and addictive behaviors, controlling for relevant covariates.
Results: A total of 25% of the participants had renounced care at least once in the previous twelve months. Most variables of drug use were significantly associated with increased healthcare renunciation. This was the case for heavy/hazardous use and experimental/recreational use. Regular gambling was not associated with healthcare renunciation, but disordered gambling was.
Conclusion: This study showed that addictive behaviors, including substance use and gambling, were part of the burden of vulnerability of people who forgo care. Therefore, drug use and gambling patterns should be a focus in the development of policies to reduce health inequalities, not only for heavy and chronic drug users.

Introduction

Healthcare renunciation for economic reasons, i.e., forgoing care due to financial reasons although clearly perceiving the need for it, is a major health concern in health inequality research. Vulnerable people are especially a focus because people in situations of deprivation and high-risk populations (e.g., those with chronic illnesses) are more likely to forgo care for economic reasons worldwide (Bodenmann et al., 2014; Guessous, Gaspoz, Theler, & Wolff, 2012; Pampel, Krueger, & Denney, 2010; Röttger, Blümel, Köppen, & Busse, 2016; Wolff, Gaspoz, & Guessous, 2011). Previous studies have mainly focused on the relationships of forgone care with socioeconomic status, demographics, and perceived health status. Studies found consistent associations of healthcare renunciation for economic reasons of having low income or job position, being older, being female, having dependent children, being divorced or single, and having bad health outcomes in different countries (Bodenmann et al., 2014; Guessous et al., 2012; Pampel et al., 2010; Röttger et al., 2016; Wolff et al., 2011).

Another part of the literature on the utilization of health care services highlighted that drug users constitute a vulnerable population in need of medical care. In several countries, drug users have been described as having an important lack of access to primary care (Myers, 2012) and are considered medically underserved (Metsch et al., 2002), although addiction is associated

* Corresponding author at: Institute for Social Sciences, University of Lausanne, Geopolis Building, CH-1015 Lausanne, Switzerland.
E-mail addresses: stephanie.baggio@unil.ch (S. Baggio), marc.dupuis@unil.ch (M. Dupuis), jean-baptiste.richard@inpes-sante.fr (J.-B. Richard), frbec@ofdt.fr (F. Beck).

http://dx.doi.org/10.1016/j.drugpo.2017.07.004
0955-3959/

with adverse medical consequences. Studies have mostly focused on high-risk drug users' unmet healthcare needs, such as injecting drug users (Al-Tayyib, Thiede, Burt, & Koester, 2015; Chitwood, McBride, French, & Comerford, 1999; Metsch et al., 2002; Robbins, Wenger, Lorvick, Shiboski, & Kral, 2010) and methamphetamine users (Powelson et al., 2014). This population has a large burden of unmet health needs and is more likely to visit hospital emergency departments (Vu et al., 2015). However, information on associations of occasional or recreational drug use and other addictive behaviors such as gambling with unmet health care in the general population is lacking. Some studies reported that, in the general population, unhealthy substance use was a risk factor for not receiving preventive healthcare, such as breast-cancer screening, flu vaccination, and control visits to general practitioners (Chitwood, Sanchez, Comerford, & McCoy, 2001; Lasser et al., 2011), but investigations on the relationship between forgone care and experimental or recreational drug use are needed.

Overall, if healthcare renunciation is a topic of growing interest, to our knowledge, no study has focused specifically on the association between addictive behaviors and healthcare renunciation in the general population. Because drug users are likely to have unmet healthcare needs, they are susceptible to be a high-risk population for healthcare renunciation. For example, Guessous et al. (2012) reported that current smokers were more likely to renounce care than non-smokers, and Guessous et al. (2014) reported that current smokers were more likely to renounce dental care than nonsmokers. However, these studies did not report other substance use, and no information on the addictive level of tobacco use was available.

This study aimed to fill this gap and investigated associations of healthcare renunciation for economic reasons and addictive behaviors (alcohol, tobacco, cannabis, other illicit drug use, and gambling) in a population-based sample of French adults. France has a universal health system, with a national public health insurance based on income. It includes significant cost sharing (approximately 30% of health care costs). Cost sharing is eliminated for individuals with several specified chronic conditions and low-income individuals (in 2017, the upper limit for cost sharing elimination is 727€ [$778] for one person, 1090€ [$1167] for two persons). It is also lowered or eliminated for highly effective prescription drugs (Schoen et al., 2010). However, out-of-pocket expenditures may affect even low-income individuals (e.g., one single person having more than 727€ per month). Most French citizens buy private complementary insurance that covers cost sharing (Pierre & Jusot, 2017). Data on healthcare renunciation are scarce in France.

Methods

Participants and procedure

Data were collected using the 2014 Health Barometer, a French cross-sectional survey conducted among a random representative sample of the French population aged 15–75 years between December 2013 and May 2014. It is conducted using computer-assisted telephone interviews. Telephone numbers of households (landlines and cell phones) were randomly generated, and individuals in households were randomly selected among eligible household members: having a member between 15 and 75 years old, speaking French, and living within the household during the survey. When the selected individual was unavailable, an appointment was made. Households or individuals were considered unreachable after 40 telephone calls. The response rate was 61% for landlines and 52% for cell phones. The sample included 15,635 participants, with n = 7577 for landlines and n = 8058 for cell phones. This study focused on an adult population that was 18–64 years old (n = 13,039). We excluded participants older than 64 (65–75 years old) because they did not complete the questions related to illicit drug use. Missing values on the variables included in the study were listwise deleted (187 participants had missing values), leaving a final sample of n = 12,852. Weights were constructed in two steps: the design weight computation (which reflects the differential probabilities of selection, depending on several factors, including probability of selection of the telephone number, number of eligible individuals living in the households, number of landline and cellular telephones owned by the respondent), followed by an overall post-stratification to correct under-coverage. The questionnaire included questions on demographics, health behaviors, health status, and social determinants. The questionnaire, method, and evaluation of the method are available elsewhere (Richard et al., 2016).

Measures

Healthcare renunciation

Participants answered whether they had renounced care for financial reasons using the following dimensions for the previous 12 months: (1) dental care, (2) eye care, (3) medical appointment, and (4) other health care. Healthcare renunciation was coded 1 if participants renounced at least to one situation in which healthcare was needed and 0 otherwise.

We assessed lifetime and 12-month prevalence of substance use and gambling patterns. A 12-month period has been recommended to assess substance use behavior and problems (Dawson, 2003).

Alcohol use

Alcohol use was assessed using three variables: (1) alcohol use with three categories: *no lifetime use, lifetime use but not in the previous twelve months, and previous twelve-months use*; (2) binge drinking, defined as having drunk at least six drinks in a single session in the previous month (*yes*/*no*) (Herring, Berridge, & Thom, 2008), and (3) hazardous drinking (*at risk*/*not at risk*), defined usually as drinking more than 21 drinks a week for a man and 14 for a woman or drinking six drinks or more on a single occasion weekly (Mouquet & Villet, 2002).

Tobacco use

Tobacco use was assessed using a variable related to smoking status with five categories: *no lifetime tobacco use*, *lifetime smoker but currently non-smoker*, *occasional smoker* (smoking but not daily), *daily smoker* (with less than ten cigarettes per day), and *heavy smoker* (daily smoker with ten cigarettes or more per day). We classified participants who had smoked only once or twice in their lives as non-smokers.

Cannabis use

Cannabis use was assessed with two variables: (1) cannabis use with three categories: *no lifetime use*, *lifetime use but not in the previous twelve months*, and *previous twelve-months use* and (2) score on the cannabis abuse screening test (CAST, Legleye et al., 2015), ranging from 0 to 24, with a larger score indicating cannabis-use disorder. Previous studies reported good psychometric properties of the CAST (Legleye et al., 2013; Legleye, Piontek, Kraus, Morand, & Falissard, 2013).

Other illicit drug use

Participants indicated whether they used any illicit drug use other than cannabis (one question for each of the following illicit drugs: magic mushrooms, poppers, other inhalants, ecstasy,