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Healthcare renunciation among young adults in French higher education: A population-based study

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ABSTRACT

Healthcare renunciation has been a recent focus of the public health debate, but large-scale investigations of healthcare renunciation are scarce. The goal of this study was to examine healthcare renunciation among young adults at French universities. It investigated prevalence of and reasons for healthcare renunciation and identified subgroups of vulnerable youths. Data were collected in the 2013 triennial study conducted by the French National Observatory of Student Life. That study had a sample of 35,810 18- to 25-year-old participants. Measures included healthcare renunciation, reasons for healthcare renunciation, demographics, cultural and socioeconomic background, health and social outcomes, healthcare system-related variables, and markers of adulthood. The results showed that the prevalence of healthcare renunciation was 27.2%. The most common reasons for healthcare renunciation were refusal renunciation (self-care, 12.7%; wait for improvement, 15.5%) and barrier renunciation (financial reasons, 12.1%; lack of time, 10.2%). Therefore, healthcare renunciation is linked not only to financial constraints but also to individuals' subjective needs and ways of facing illness. Overall, disadvantaged youths and youths transitioning to adulthood were likelier to renounce care, especially for financial reasons. To conclude, there are social inequalities in the use of healthcare by emerging adults in higher education in France. Emerging adulthood appears to be a risky period in which people are likely to renounce healthcare for multiple reasons. Support should be provided for vulnerable youths to prevent them from becoming increasingly vulnerable.

1. Introduction

Healthcare renunciation—that is, foregoing or delaying healthcare—has been a recent focus of public health debate (Després et al., 2011a). Disadvantaged populations, such as low-income groups, are more prone to foregoing care (Chaupain-Guillot et al., 2014; Guessous et al., 2012; Mielck et al., 2009; Wolff et al., 2011), and healthcare renunciation is associated with worse health outcomes (Guessous et al., 2012). Broadly speaking, vulnerable people are likelier to renounce care due to both socioeconomic and social conditions (Bazin et al., 2006; Després et al., 2011b). Thus, at-risk individuals may become increasingly vulnerable (Wolff et al., 2011).

Despite these important issues, recent large-scale investigations of healthcare renunciation are scarce, especially in countries outside of the United States. The few recent studies of European populations found a worrisome level of healthcare renunciation among adult populations, particularly for financial reasons: for example, 13–14% in Switzerland (Guessous et al., 2012) and 15.4% in France (Després et al., 2011b). However, to our knowledge, no studies have focused on people transitioning into adulthood. Young adults are starting to take on the responsibilities of adulthood (Arnett et al., 2014), including taking care of their own health, and may thus be an at-risk population.

Moreover, most studies have focused on financially motivated healthcare renunciation; other reasons for foregoing healthcare have received less attention (Chaupain-Guillot et al., 2014; Chaupain-Guillot and Guillot, 2015). Previous research has distinguished between barrier renunciation (i.e., due to economic and environmental constraints) and refusal renunciation (i.e., choosing self-medication or unconventional healthcare instead of conventional medicine, for example because of mistrust). The use of healthcare services depends not only on financial constraints but also on individuals' subjective needs (Després et al., 2011b), and thus other reasons for healthcare renunciation should be investigated.

Healthcare renunciation also depends on the organization of national healthcare systems. This study was conducted in France, which has a universal healthcare system. The national public health insurance,

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which is based on income and deducted from employees' pay, includes significant cost sharing (around 30% of healthcare costs). Until the age of 20, young people can be insured with their parents. By age 20, students have to be insured by the national student health insurance (e.g., €215 a year for a first-year student in 2015–2016 and free for low-income students). Young people who work at least 60 h per month rely on the general national health insurance. Cost sharing is eliminated for people with several specified chronic conditions and for low-income people (through a subsystem called "Universal Health Insurance Coverage," e.g., max €721/month for one person and €1082/month for two people). Additionally, cost sharing is lowered or eliminated for highly effective prescription drugs (Schoen et al., 2010). Otherwise, most French citizens voluntarily buy a private complementary insurance that covers cost sharing. Young people who depend on their parents' national health insurance can have parental complementary private insurance, and there is also a complementary private insurance available specifically for students.

This study investigated healthcare renunciation in a population-based survey of French university students. It aimed to examine healthcare renunciation among French youths transitioning into adulthood in higher education, including recent prevalence of and reasons for healthcare renunciation as well as associated vulnerabilities.

2. Methods

2.1. Participants

Data were collected during the 2013 triennial study conducted by the French National Observatory of Student Life. The questionnaire included different areas of students' living conditions: sociodemographic variables, current studies, previous studies, organization and timetable for studies, projects and future studies/job, study environment (housing, transport, dining, and university services), study conditions (financial questions and paid work), well-being and health, and familial variables (family composition and socioeconomic conditions of the family). From a random sample of 200,000 students, 40,911 students completed the questionnaire online between March and June 2013. We focused on participants between 18 and 25 years old ($n = 36.984$), which correspond to the age range of emerging adulthood. Participants with at least one missing value on the variables included in the study were listwise deleted, and the final sample of this study included 35,756 participants (96.7% of the sample of 18- to 25-year-old participants, mean age $= 21.6 \pm 1.9$). A total of 116 participants (0.3%) had missing values for the questions about healthcare renunciation, 322 for adulthood markers (0.9%), 582 for socioeconomic background (1.6%), 128 for healthcare system (0.4%), 95 for health (0.3%), and 235 for social variables (0.6%). The results were almost the same when including and excluding the missing values.

2.2. Measures

2.2.1. Healthcare renunciation

Participants were asked whether they had already foregone care (translation from French: "Have you foregone seeing a doctor?"). Answers were collected dichotomously ("yes" or "no"). If participants answered "yes," they explained why they forewent care by answering a multipart question (i.e., answers were not mutually exclusive) with yes/no answers: because of financial reasons, lack of time, fear (of seeing a doctor, of being treated, of undergoing medical examinations), preference for self-care and self-medication, desire to wait until health improved, lack of a good doctor, and other reasons. No time period was provided for this question.

We also investigated several factors to identify groups that were at risk for healthcare renunciation.

2.2.2. Demographics

Age, gender, and current study level ("bachelor," "master's," "PhD") were recorded.

2.2.3. Transition to adulthood

Transition to adulthood was measured using markers of adulthood. Markers of adulthood are indicators of achieved adulthood that are measured using social roles. Adulthood has long been measured using the "big five" social roles: educational attainment, employment, residential independence, stable partnership, and parenthood (Settersten, 2007). We assessed whether the participants were parents ("yes"/"no"), whether they were working ("yes"/"no"), living on their own (independent home versus parental home or collective residence), and living with a partner ("yes"/"no").

2.2.4. Socioeconomic background

We assessed the occupational level of the students' parents ("lower," "intermediate," "higher," "retired", "jobless," or "unknown"). We also assessed whether the students had enough money to cover their needs on a five-point scale ranging from "not enough money to cover monthly expenses" to "enough money to cover monthly expenses." This variable was recoded into three categories (1–2: financial problems, 3: average, 4–5: no financial problems).

2.2.5. Cultural background

The parents' level of education ("primary," "secondary" [i.e., high school diploma and vocational training], and "tertiary") was used as a proxy for the participants' cultural background.

2.2.6. Healthcare system

Participants indicated which kind of public health insurance they had: "national student health insurance," "general health insurance" (for those who worked at least 60 h per month or were younger than 20), or "do not know." They also indicated whether they had one of the following types of private complementary insurances: "student private insurance," "parents' private insurance," "Universal Health Insurance Coverage," "another private insurance," "no private insurance," or "do not know."

2.2.7. Health and social variables

Health was assessed using a question about perceived health satisfaction on a five-point scale ranging from 1, "very bad," to 5, "very good." This variable was recoded into three categories (1–2: low, 3: average, 4–5: high). Chronic illness, mental health-related problem (being depressed), and social isolation were assessed dichotomously ("yes"/"no").

2.3. Statistical analyses

First, we computed descriptive statistics for all variables. Next, we performed multivariate analyses in order to identify the main predictors of healthcare renunciation. We computed a logistic regression predicting healthcare renunciation with all variables. Then, we focused on participants who renounced care ($n = 9713$), and we performed six separate logistic regressions for the reasons for healthcare renunciation: 1) financial reasons, 2) lack of time, 3) fear, 4) preference for self-care and self-medication, 5) desire to wait until health improved, and 6) lack of a good doctor. We reported odds ratios (OR) and confidence intervals for each predictor. Analyses were performed using SPSS 24.

3. Results

Descriptive statistics are reported in Table 1. Participants were mostly women (62.9%), <21.5 years old (68.6%), and studying at the bachelor level (71.1%). Half of them had paid work (55.8%) and were residentially independent (51.3%). A minority lived with a partner (11.0%) and were