



Disparities in access to health care in three French regions



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ABSTRACT

Objectives: This paper compares access to primary and specialty care in three metropolitan regions of France: Ile de France (IDF), Nord-Pas-de-Calais (NPC) and Provence-Alpes-Côte d'Azur (PACA); and identifies the factors that contribute to disparities in access to care within and among these regions.

Methods: To assess access to primary care, we compare variation among residence-based, age-adjusted hospital discharge rates for ambulatory care sensitive conditions (ASC). To assess access on one dimension of specialty care, we compare residence-based, age-adjusted hospital discharge rates for revascularization – bypass surgery and angioplasty – among patients diagnosed with ischemic heart disease (IHD). In addition, for each region we rely on a multilevel generalized linear mixed effect model to identify a range of individual and area-level factors that affect the discharge rates for ASC and revascularization.

Results: In comparison with other large metropolitan regions, in France, access to primary care is greater in Paris and its surrounding region (IDF) than in NPC but worse than in PACA. With regard to revascularization, after controlling for the burden of IHD, use of services is highest in PACA followed by IDF and NPC. In all three regions, disparities in access are much greater for revascularization than for ASC. Residents of low-income areas and those who are treated in public hospitals have poorer access to primary care and revascularizations. In addition, the odds of hospitalization for ASC and revascularization are higher for men. Finally, people who are treated in public hospitals, have poorer access to primary care and revascularization services than those who are admitted for ASC and revascularization services in private hospitals.

Conclusions: Within each region, we find significant income disparities among geographic areas in access to primary care as well as revascularization. Even within a national health insurance system that minimizes the financial barriers to health care and has one of the highest rates of spending on health care in Europe, the challenge of minimizing these disparities remains.

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1. Introduction

Comparisons of access to health care in Paris and other world cities suggest that Paris enjoys better access to health

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services and experiences less variation in access to care across geographic areas [1]. It is valuable to compare Paris with other world cities such as New York, London or Hong Kong because a comparison of cities with similar population size, per capita income and health care resources, among nations with radically different health care systems, allows one to explore the influence of national policy on access to health care services at the local level. In contrast, it can be revealing to complement this approach with a comparison of regions of different sizes, local economies and delivery system characteristics within the same country. How does Paris, and its surrounding metropolitan region, Ile de France (IDF), compare to other French regions and what is the extent of disparities within these regions?

We address this question by comparing access to health care in IDF with two other French regions: Nord-Pas-de-Calais (NPC) around Lille and Provence-Alpes-Côte d'Azur (PACA) around Marseille. IDF is the most heavily populated and wealthiest region in France [2]. NPC, located in the north of France, on the Belgian border, is the fourth largest metropolitan region in France and one of the poorest due to its high unemployment rate, its de-industrialized economy, low density of physicians and hospital beds and lowest levels of population health [3]. Provence-Alpes-Côte-d'Azur (PACA) is a culturally and economically diverse region located in the south of France along the Mediterranean Sea. It includes the wealthy cities of Aix-en-Provence, and Nice as well as Marseille, the second largest city in France, which is characterized by striking socioeconomic disparities [4]. In addition, it is characterized by a high density of physicians and hospital beds and high levels of population health.

We find that access to primary care is best in PACA followed by IDF and NPC, but after controlling for the burden of IHD, we find that use of revascularization – our example of specialty care – is greater in PACA than in IDF and NPC. More importantly, within each region, we find significant income disparities among geographic areas in access to primary care as well as revascularization. In all three regions, access to health care appears to be significantly worse among residents of lower-income areas and patients treated in public hospitals. Even within a system that minimizes the financial barriers to health care and has one of the highest rates of spending on health care in Europe, there are significant disparities in access to care among residents of these regions.

2. Measuring access to health care

One conventional approach for measuring health care access is to compare densities of health care professionals. Although it is possible to compare health system “inputs,” a purely supply-side approach fails to account for differences in health care needs and other outcomes we may value [5]. A more recent French approach to measuring spatial access attempts to refine this measure of supply by accounting for a population's use of full-time equivalent health care professionals, not only within a given distance of their residence, but also in neighboring localities. Moreover, this method introduces a demand side dimension by adjusting the measure to the age distribution of the population

[6]. But even if this approach were to result in proposed standards about appropriate relationships between health care resources and population health needs, we still have insufficient information and agreement about criteria for assessing needs [7].

Population health surveys can be used to provide helpful information about access to and the use of health care services. In the U.S., the Behavioral Risk Factor Surveillance System (BRFSS) is a telephone health survey that tracks health conditions, risk behaviors and access to care (<http://www.cdc.gov/brfss/>). Many of the questions from this survey have been adapted by local authorities, including Los Angeles and New York City, to provide information at the city level [8,9]. These efforts are rare, however, and there are no local or national surveys that allow us to compare morbidity and access to primary and specialty health care services across or within metropolitan areas in most countries, including France. The French National Health Survey (Enquete décennale santé, EDS) provides information about the use of health services at the national level, but it is carried out once every 10 years and although in specific cases it oversamples selected regions, it does not have sufficient power to disaggregate the results to local levels. Another more in-depth French survey (Enquete santé et protection sociale) combines telephone and face-to-face interviews, but it is carried out on a biennial basis and is also limited to national estimates.

In addition to measures of health care resources and population health surveys, health services and policy researchers often rely on hospital administrative data as indirect measures of access to primary care and as direct measures of residence-based hospital utilization for specific procedures. Our analysis of access to specialty care based on use of revascularizations (angioplasties and coronary artery bypass surgery) grows out of an extensive literature on variations in medical practice [10–12] and invasive treatment of heart disease [13,14]. Our analysis of access to primary care is based on the concept of hospital discharges for so-called “ambulatory-care sensitive conditions” (ASC), which has been less frequently used in France than in the U.S., Australia and the rest of Europe.

The rationale for studying ASC (Table 1) is that if patients have access to timely and effective primary care, it should be possible to avoid most hospitalizations for these conditions by preventing the occurrence of the disease (e.g. bacterial pneumonia) or managing the chronic condition in an outpatient setting (e.g. asthma, arterial hypertension, diabetes, congestive heart failure). High rates of ASC, therefore, are believed to reflect poor access to primary care [15,16].

Weissman et al. [17] reviewed the literature on ASC and selected 12 hospital discharge diagnoses, using a panel of internists, for which variations in hospitalization rates can be attributed to poor access to ambulatory care. Billings et al. [18] and Billings and Weinick [19] identified a more extensive group of principal discharge diagnoses, which they defined as “avoidable,” if patients had received timely and effective primary care. One could infer from these studies that disadvantaged populations, or those with poorer coverage, are at greater risk of being hospitalized for ASC because of their higher rates of morbidity. Along with

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