Using demographic indicators for Reducing Regional Health Inequalities in France

Martine M Bellanger, Alain Jourdain

Ecole nationale de la santé publique

Laboratoire d'analyse des politiques sociales et sanitaires.

INTRODUCTION :

Two policies were developed since 1995, but are called into question today. An evaluation is therefore worthwhile almost 10 years later.

The first one a centralised management of regional hospital budgets. One of the objective was to improve the limits between public health policies, health priorities and resource allocation. The disparity gap expressed in terms of the difference between the mean of the extremes of the regional hospital budgets weighted by mortality rates had an intensity of 20%

A convergence method was introduced to fill the gap, that means an optimal amount is calculated and compared to the current budget observed in each region. The aim is to narrow, if not to close this budgetary disparity, within the relatively short time.

The second policy has consisted in setting regional health priorities. This second initiative is related to health inequalities policy and was a result of the 1994 High Committee in Public Health report.

Which recommended the adoption of priorities in fields such as suicide, alcohol related disease prevention, cancer and cardiovascular disease.

The health minister requested each region to set and to implement its own health priorities within the framework of regional health programme (PRS).

The fact that the programme was supported to tackle the most important causes of mortality within a region must in principle enable more rapid catching up process and thus to a reduction of inequality between regions

HYPOTHESIS

If the regional allocation of hospital budgets is efficient, a more marked reduction of mortality should be found in 'poor regions' which have benefited from the equalisation of the budget allocation : the substantial hypothesis.

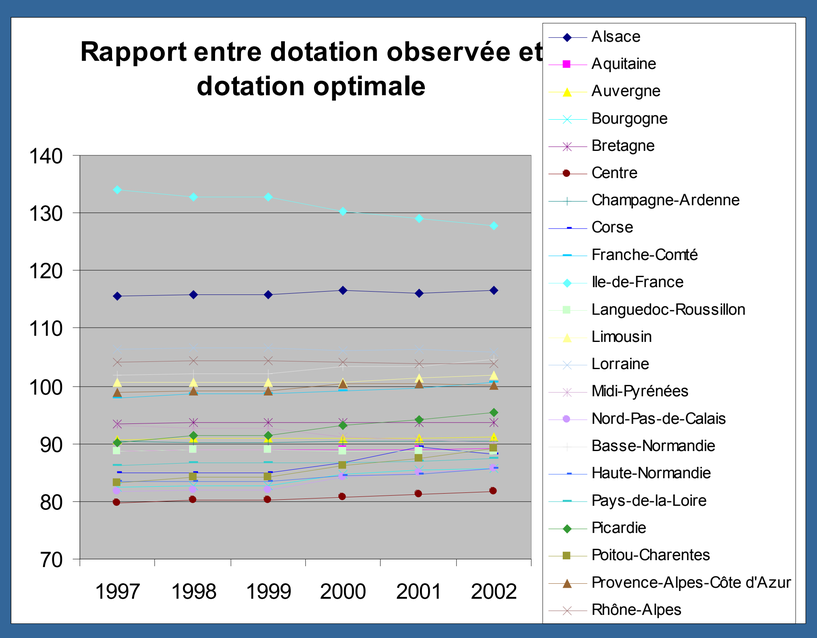
If the PRS are efficient, a more marked decrease in mortality should be found in those regions with PRS than in the others : the procedural hypothesis.

DATA

Preliminary and descriptive analysis :

Standardised mortality ratios in the most over- or under-funded regions

Standardised mortality rates by causes

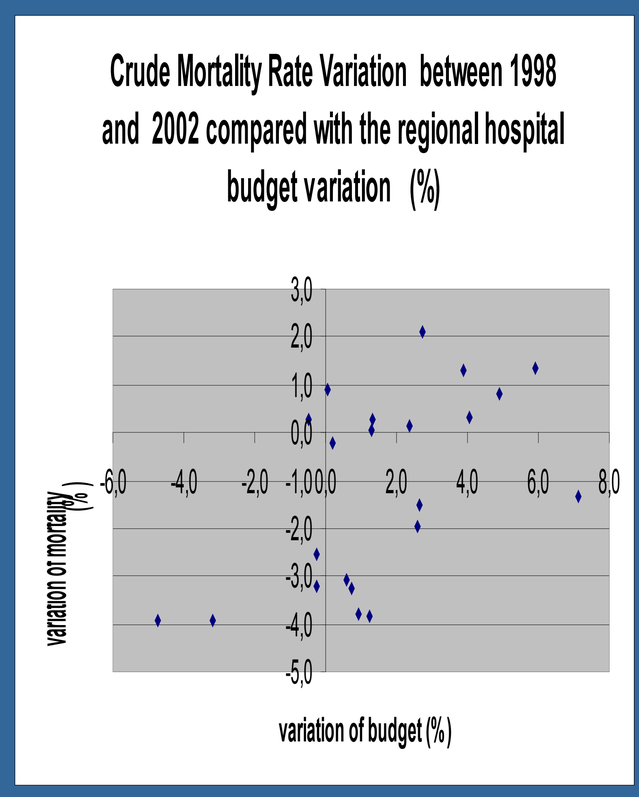


RESULTS : SUBSTANTIAL APPROACH

It seems, through the figure in the left side, that a slight convergence between the resource allocations between regions happens, due to the mechanism of adjustment;

BUT

No impact or no link with mortality, inversely the correlation is positive (R2 =0,31) the regions with the highest rate of decreasing mortality are close with the highest budget cuts! (right side)



Suicide	1989 -92	1992 -95	1995- 98
Regions without PRS	2.0	-2.0	-6.7
Regions with PRS	0.3	-1.8	-11.7

Alcohol\ year n	1989	1992	1995	1998
SMR per 100,000 Regions with PRS	42.0	35.7	34.3	32.7
Regions without PRS	36.7	31.4	29.1	28.5
Trends between n and n+3 Regions with PRS	-15.1	-3.8	-4.8	
Regions without PRS	-14.4	-7.2	-2.3	

Cancers\ year n	1989	1992	1995	1998
SMR per 100,000 Regions with PRS	190.1	190.0	178.9	169.4
Regions without PRS	164.7	165.1	158.8	151.7
Trends between between et n+3 Regions with PRS	0.0	-5.9	-5.3	
Regions without PRS	0.2	-3.8	-4.5	

RESULTS : PROCEDURAL APPROACH

The question is : do health priority programs lead to interregional health inequality reduction? We go through the analysis of mortality by suicide, alcohol-related diseases, and cancer. The decrease of standardised mortality rates is higher in the regions with regional health programs than in the others, while the decrease of the SMR were the same before the introduction of the PRS. We get the same outcomes for alcohol related diseases. Conversely we do not get explicit outcomes for SMR by cancers.

CONCLUSION

Only a significant decrease was observed in the regions with programs dealing with high mortality for the causes more sensitive, in a short term, to a collective approach

DISCUSSION

1 - Limits of the two approaches based more or less on health system, and only on hospitals in the case of the instrumental approach

2- Limited scope of results, which was only to be expected, bearing in mind the effect of other factors which determine health inequalities

3- Process-based approach : only outcomes have been evaluated, the process has not yet been assessed.